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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH

105 PLEASANT STREET, CONCORD, NH 03301
603-271-5000 1-800-852-3345 Ext. 5000
Fax: 603-271-5058 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Lori A. Shibinette
Commissioner

Katja S. Fox
Director

August 26, 2021

The Honorable Ken Weyler, Chairman
Fiscal Committee of the General Court and

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Pursuant to the provisions of RSA 14:30-a, authorize the Department of Health and Human Services, Division for Behavioral Health to accept and expend funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), entitled Substance Abuse Prevention & Treatment Block Grant, in the amount of $5,640,385.00 effective upon Fiscal Committee and Governor and Executive Council approvals through June 30, 2023. Funding source: 100% Federal Funds.

05-92-92-920510-19810000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF DRUG & ALCOHOL SERVICES, SABG ADDITIONAL

Class	Description	SFY22 Current Adjusted Authorized	Requested Action	Revised SFY22 Adjusted Authorized
000 - 404600	Federal Funds	$0.00	$5,640,385.00	$5,640,385.00
041 - 500801	Audit Fund Set Aside	$0.00	$5,641.00	$5,641.00
074 - 500585	Grants for Public Assistance and Rel	$0.00	$4,984,744.00	$4,984,744.00
102 - 500731	Contracts for Program Services	$0.00	$650,000.00	$650,000.00
501 - 500425	Payments to Clients	$0.00	$0.00	$0.00
	Total	$0.00	$5,640,385.00	$5,640,385.00

EXPLANATION

The US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded American Rescue Plan Act (ARPA) of 2021 funding to assist states in responding to the COVID-19 pandemic through the Substance Abuse Prevention and Treatment Block Grant (SABG) program. States are expected to use this supplemental COVID-19 Relief funding to promote effective planning, monitoring, and oversight of efforts to deliver SUD prevention, intervention, treatment, and recovery services; promote support for providers; maximize efficiency by leveraging the current infrastructure and capacity; and address local SUD related needs resulting from the COVID pandemic. The New Hampshire (NH) funding plan will address gaps across the alcohol and other drug continuum of care, many of which have been exacerbated by the pandemic. The American Rescue Plan Act funds will be utilized to work in coordination with the Bureau of Mental Health

Services ARPA funding to address the needs of residents experiencing mental health and co-occurring substance use disorders.

The funds are to be budgeted as follows:

Funds in class 041, Audit Fund Set Aside, for financial and compliance audits.

Funds in class 074, Grants for Public Assistance, are to work with providers to address gaps across the alcohol and other drug continuum of care, many of which have been exacerbated by the pandemic.

Funds in class 102, Contracts for Program Services, are to contract for a robust messaging campaign and training for providers.

Area served: Statewide.

Source of Funds: 100% Federal Funds.

In the event that Federal Funds become no longer available, general funds will not be requested to support the program expenditures.

Respectfully submitted,

Lori A. Shibinette
Commissioner

Recipient Information

1. Recipient Name
HEALTH AND HUMAN SERVICES,NEW HAMPSHIRE,DEPT OF
129 PLEASANT ST
CONCORD, NH 03301

2. Congressional District of Recipient
02

3. Payment System Identifier (ID)
1026000618B3

4. Employer Identification Number (EIN)
026000618

5. Data Universal Numbering System (DUNS)
011040545

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator
Katja Fox
katja.fox@dhhs.nh.gov

8. Authorized Official
katja.fox@dhhs.nh.gov

Federal Agency Information

9. Awarding Agency Contact Information
Wendy Pang
Grants Management Specialist
Center for Substance Abuse Treatment
wendy.pang@samhsa.hhs.gov
(240) 276-1419

10. Program Official Contact Information
Spencer Clark
Center for Substance Abuse Treatment
Spencer.Clark@samhsa.hhs.gov
240-276-1027

Federal Award Information

11. Award Number
1B08TI083955-01

12. Unique Federal Award Identification Number (FAIN)
B08TI083955

13. Statutory Authority
Subparts II&III,B,Title XIX,PHS Act/45 CFR Part96

14. Federal Award Project Title
Substance Abuse Prevention & Treatment Block Grant

15. Assistance Listing Number
93.959

16. Assistance Listing Program Title
Block Grants for Prevention and Treatment of Substance Abuse

17. Award Action Type
New Competing

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 09/01/2021 - End Date 09/30/2025	
20. Total Amount of Federal Funds Obligated by this Action	$5,640,385
20 a. Direct Cost Amount	$5,640,385
20 b. Indirect Cost Amount	$0
21. Authorized Carryover	
22. Offset	
23. Total Amount of Federal Funds Obligated this budget period	$5,640,385
24. Total Approved Cost Sharing or Matching, where applicable	$0
25. Total Federal and Non-Federal Approved this Budget Period	$5,640,385
26. Project Period Start Date 09/01/2021 - End Date 09/30/2025	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$5,640,385

28. Authorized Treatment of Program Income
Additional Costs

29. Grants Management Officer - Signature
Odessa Crocker

30. Remarks
Acceptance of this award, including the "Terms and Conditions," is acknowledged by the recipient when funds are drawn down or otherwise requested from the grant payment system.

SABG **Issue Date:** 05/17/2021
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Award Number: 1B08TI083955-01
FAIN: B08TI083955-01
Contact Person: Katja Fox

Program: Substance Abuse Prevention & Treatment Block Grant

HEALTH AND HUMAN SERVICES, NEW HAMPSHIRE DEPT OF
129 PLEASANT ST

CONCORD, NH 03301

Award Period: 09/01/2021 – 09/30/2025

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $5,640,385 (see "Award Calculation" in Section I) to HEALTH AND HUMAN SERVICES, NEW HAMPSHIRE DEPT OF in support of the above referenced project. This award is pursuant to the authority of Subparts II&III,B,Title XIX,PHS Act/45 CFR Part96 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,
Odessa Crocker
Grants Management Officer
Division of Grants Management

See additional information below

SECTION I – AWARD DATA – 1B08TI083955-01

FEDERAL FUNDS APPROVED:	$5,640,385
AMOUNT OF THIS ACTION (FEDERAL SHARE):	$5,640,385
CUMULATIVE AWARDS TO DATE:	$5,640,385
UNAWARDED BALANCE OF CURRENT YEAR'S FUNDS:	$0

Fiscal Information:

CFDA Number:	93.959
EIN:	1026000618B3
Document Number:	21B1NHSAPTC6
Fiscal Year:	2021

IC	CAN	2021
TI	C96D570	$5,640,385

PCC: SAPT / **OC:** 4115

SECTION II – PAYMENT/HOTLINE INFORMATION – 1B08TI083955-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1B08TI083955-01

STANDARD TERMS AND CONDITIONS

SABG FY2021 ARPA funding

Remarks:

This Notice of Award (NoA) provides American Rescue Plan Act (ARPA) Supplemental Funding for the Substance Abuse Prevention and Treatment (SABG) Block Grant Program, in accordance with H.R. 1319 - American Rescue Plan Act of 2021. Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the SABG as deemed necessary to facilitate a grantee's response to coronavirus.

A proposal of the state's spending plan must be submitted by July 2, 2021 via the Web Block Grant Application System (WebBGAS). Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, grantees are required to upload the Plan document (Microsoft Word or pdf), using the associated tab in the State Information Section, Chief Executive Officer's Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [SA]. Please title this document "ARPA Funding Plan 2021-SA" (States must upload separate proposals based on MHBG and SABG guidance into the WebBGAS system.

Further information on this is included in the letter from Acting Assistant Secretary for Mental Health and Substance Use, Tom Coderre.

Standard Terms of Award:

1) Acceptance of the Terms of an Award

By drawing or otherwise obtaining funds from the HHS Payment Management System, the recipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. Except for any waiver granted explicitly elsewhere in this section, this award does not constitute approval for waiver of any Federal statutory/regulatory requirements for a SABG. Once a recipient accepts an award, the contents of the Notice of Award (NoA) are binding on the recipient unless and until modified by a revised NoA signed by the GMO.

Certification Statement:

By drawing down funds, The recipient agrees to abide by the statutory requirements of all sections of the Substance Abuse Prevention and Treatment Block Grant (SABG) (Public Health Service Act, Sections 1921-1935 and sections 1941-1957) (42 U.S.C. 300x-21-300x-35 and 300x-51-300x-67, as amended), and other administrative and legal requirements as applicable for the duration of the award.

2) Availability of Funds

Funds provided under this grant must be obligated and expended by September 30, 2025.

3) Fiscal and administrative requirements

This NoA issued is subject to the administrative requirements for HHS block grants under 45 CFR Part 96, as applicable, and 45 CFR Part 75, as specified. Except for section 75.202 of Subpart C, and sections 75.351 through 75.353 of Subpart D, the requirements in Subpart C, Subpart D, and Subpart E do not apply to this program (reference 45 CFR Part 75 Subpart B, 75.101(d)).

Fiscal control and accounting procedures - Fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.

ARPA funding is being issued under a separate grant award number and has a unique subaccount in the Payment Management System. Accordingly, ARPA funds must be tracked and reported separately from other FY 2021 awarded funds, including COVID-19 Supplemental funding and the Annual Block Grant Allotment.

Audits - Grantees and subgrantees are responsible for obtaining audits in accordance with the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507) and revised OMB Circular A-133, "Audits of State, Local Governments, and Non-Profit Organizations." The audits shall be made by an independent auditor in accordance with generally accepted Government auditing standards covering financial audits.

Except for any waiver granted explicitly elsewhere in this section, this award does not constitute approval for waiver of any Federal statutory/regulatory requirements for a SABG.

4) Flow-down of requirements to sub-recipients

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 45 CFR 75.351-75.353, Sub-recipient monitoring and management.

5) Executive Pay

The Consolidated Appropriations Act, 2021 (Public Law 116-260), signed into law on December 27, 2020 restricts the amount of direct salary to Executive Level II of the Federal Executive Pay scale. Effective January 3, 2021, the salary limitation for Executive Level II is $199,300.

For awards issued prior to this change, if adequate funds are available in active awards, and if the salary cap increase is consistent with the institutional base salary, recipients may re-budget to accommodate the current Executive Level II salary level. However, no additional funds will be provided to these grant awards.

6) Marijuana Restriction:

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

7) SAM and DUNS Requirements

THIS AWARD IS SUBJECT TO REQUIREMENTS AS SET FORTH IN 2 CFR 25.110 CENTRAL CONTRACTOR REGISTRATION CCR) (NOW SAM) AND DATA UNIVERSAL NUMBER SYSTEM (DUNS) NUMBERS. 2 CFR Part 25 - Appendix A4

System of Award Management (SAM) and Universal Identifier Requirements

A. Requirement for System of Award Management:

Unless you are exempted from this requirement under 2 CFR 25.110, you, as the recipient, must maintain the currency of your information in the SAM, until you submit the final financial report required under this award or receive the final payment, whichever is later. This requires that you review and update the information at least annually after the initial registration, and more frequently if required by changes in your information or another award term.

B. Requirement for unique entity identifier If you are authorized (reference project description) to make subawards under this award, you:

1. Must notify potential subrecipients that no entity (see definition in paragraph C of this award term) may receive a subaward from you, unless the entity has provided its unique entity identifier to you.

2. May not make a subaward to an entity, unless the entity has provided its unique entity identifier to you.

C. Definitions. For purposes of this award term:

1. System of Award Management (SAM) means the federal repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the SAM Internet site (currently at: http://www.sam.gov).

2. Unique entity identifier means the identifier required for SAM registration to uniquely identify business entities.

3. Entity, as it is used in this award term, means all of the following, as defined at 2 CFR Part 25, Subpart C:

a. A governmental organization, which is a state, local government, or Indian Tribe; b. A foreign public entity; c. A domestic or foreign nonprofit organization; d. A domestic or foreign for-profit organization; and e. A Federal agency, but only as a sub-recipient under an award or sub-award to a nonfederal entity.

4. Sub-award:

a. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible sub-recipient. b. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see 2 CFR 200.330). c. A sub-award may be provided through any legal agreement, including an agreement that you consider a contract.

5. Sub-recipient means an entity that: a. Receives a sub-award from you under this award; and b. Is accountable to you for the use of the federal funds provided by the sub-award.

8) Federal Financial Accountability and Transparency Act (FFATA)

Reporting Subawards and Executive Compensation, 2 CFR, Appendix A to Part 170

a. Reporting of first tier subawards.

1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a subaward to an entity (see definitions in paragraph e. of this award term).

2. Where and when to report.

i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

b. Reporting Total Compensation of Recipient Executives.

1. Applicability and what to report. You must report total compensation for each of your five most highly compensated executives for the preceding completed fiscal year, if

i. the total Federal funding authorized to date under this award is $25,000 or more;

ii. in the preceding fiscal year, you received (A) 80 percent or more of your annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170. 320 (and subawards); and (B) $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.)

2. Where and when to report. You must report executive total compensation described in paragraph b. 1. of this award term:

i. As part of your registration profile at https://www.sam.gov.

ii. By the end of the month following the month in which this award is made, and annually thereafter.

c. Reporting of Total Compensation of Subrecipient Executives.

1. Applicability and what to report. Unless you are exempt as provided in paragraph d. of this award term, for each first tier subrecipient under this award, you shall report the names and total compensation of each of the subrecipient's five most highly

compensated executives for the subrecipient's preceding completed fiscal year, if

i. in the subrecipient's preceding fiscal year, the subrecipient received (A) 80 percent or more of its annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and (B) $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and

ii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.)

2. Where and when to report. You must report subrecipient executive total compensation described in paragraph c. 1. of this award term:

i. To the recipient.

ii. By the end of the month following the month during which you make the subaward. For example, if a subaward is obligated on any date during the month of October of a given year (i.e., between October 1 and 31), you must report any required compensation information of the subrecipient by November 30 of that year.

d. Exemptions If, in the previous tax year, you had gross income, from all sources, under $300,000, you are exempt from the requirements to report:

i. Subawards, and

ii. The total compensation of the five most highly compensated executives of any subrecipient.

e. Definitions. For purposes of this award term:

1. Entity means all of the following, as defined in 2 CFR part 25:

i. A Governmental organization, which is a State, local government, or Indian tribe;

ii. A foreign public entity;

iii. A domestic or foreign nonprofit organization;

iv. A domestic or foreign for-profit organization;

v. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.

2. Executive means officers, managing partners, or any other employees in management positions.

3. Subaward:

i. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.

ii. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see Sec. __. 210 of the attachment to OMB Circular A-133, Audits of States, Local Governments, and Nonprofit Organizations).

iii. A subaward may be provided through any legal agreement, including an agreement that you or a subrecipient considers a contract.

4. Subrecipient means an entity that: i. Receives a subaward from you (the recipient) under this award; and ii. Is accountable to you for the use of the Federal funds provided by the subaward.

5. Total compensation means the cash and noncash dollar value earned by the executive during the recipient's or subrecipient's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):

i. Salary and bonus.

ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.

iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives and are available generally to all salaried employees.

iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

v. Above-market earnings on deferred compensation which is not tax-qualified. vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000. [75 FR 55669, Sept. 14, 2010, as amended at 79 FR 75879, Dec. 19, 2014]

9) Mandatory Disclosures

Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the HHS Office of Inspector General (OIG), all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Subrecipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following addresses:

U.S. Department of Health and Human Services Office of Inspector General

ATTN: Mandatory Grant Disclosures, Intake Coordinator 330 Independence Avenue,

SW, Cohen Building Room5527 Washington, DC 20201

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or email:

MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 remedies for noncompliance, including suspension or debarment (see 2 CFR parts 180 & 376 and 31 U.S.C. 3321).

10) The Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(G)), as amended, and 2 C.F.R. PART 175

The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees: a) Engage in severe forms of trafficking in persons during the period of time that the award is in effect; b) Procure a commercial sex act during the period of time that the award is in effect; or, c) Use forced labor in the performance of the award or subawards under the award. The text of the full award term is available at 2 C.F.R. 175.15(b). See http://www.gpo.gov/fdsys/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-sec175-15.pdf.

11) Drug-Free Workplace Requirements

The Drug-Free Workplace Act of 1988 (41 U.S.C. 701 et seq.) requires that all organizations receiving grants from any Federal agency agree to maintain a drug-free workplace. When the AR signed the application, the AR agreed that the recipient will provide a drug-free workplace and will comply with the requirement to notify SAMHSA if an employee is convicted of violating a criminal drug statute. Failure to comply with these requirements may be cause for debarment. Government-wide requirements for Drug-Free Workplace for Financial Assistance are found in 2 CFR part 182; HHS implementing regulations are set forth in 2 CFR part 382.400. All recipients of SAMHSA grant funds must comply with the requirements in Subpart B (or Subpart C if the recipient is an individual) of Part 382.

12) Lobbying

No funds provided under the attached Notice of Award (NoA) may be used by you or any sub-recipient under the grant to support lobbying activities to influence proposed or pending federal or state legislation or appropriations. The prohibition relates to the use of federal grant funds and is not intended to affect your right or that of any other organization, to petition Congress or any other level of government, through the use of other nonfederal resources. Reference 45 CFR Part 93.

13) Accessibility Provisions

Grant recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person s race, color, national origin, disability, age, and in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency. The HHS Office for Civil Rights also provides guidance on complying with civil rights laws enforced by HHS. Please see

http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html. Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html. Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under Federal civil rights laws at https://www.hhs.gov/civil-rights/index.html or call 1-800-368-1019 or TDD 1-800-537-7697. Also note that it is an HHS Departmental goal to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. For further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6.

14) Audits

Non-Federal recipients that expend $750,000 or more in federal awards during the recipient's fiscal year must obtain an audit conducted for that year in accordance with the provisions of 45 CFR 96.31.
Recipients are responsible for submitting their Single Audit Reports and the Data Collections Forms (SF-FAC) electronically to the to the Federal Audit Clearinghouse Visit disclaimer page (FAC) within the earlier of 30 days after receipt or nine months after the FY s end of the audit period. The FAC operates on behalf of the OMB.

For specific questions and information concerning the submission process: Visit the Federal Audit Clearinghouse at https://harvester.census.gov/facweb or Call FAC at the toll-free number: (800) 253-0696

Reporting Requirements:

Federal Financial Report (FFR)

The recipient is required to submit a Federal Financial Report (FFR) 90 days after the close of the performance period (project period). The SF-425 shall report total funds obligated and total funds expended by the grantee.

Effective January 1, 2021, award recipients are required to submit the SF-425 Federal Financial Report (FFR) via the Payment Management System (PMS). If the individual responsible for FFR submission does not already have an account with PMS, please contact PMS to obtain access.

Recipients must liquidate all obligations incurred under an award not later than ninety (90) days after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, *Federal Financial Report* (FFR). After ninety (90) days, letter of credit accounts are locked. SAMHSA does not approve extensions to the ninety (90) day post-award reconciliation/liquidation period. Therefore, recipients are expected to complete all work and reporting within the approved project period and the aforementioned 90-day post-award reconciliation/liquidation period. Recipients (late) withdrawal requests occurring after the aforementioned periods are denied. In rare instances, SAMHSA

may approve an extension to submit a FINAL SF-425 FFR report, but this is *not* an extension of the 90-day post award reconciliation/liquidation period, but rather only an extension to submit the Final SF-425 report (FFR).

Annual Report

Reporting on the ARPA funding is required. States must prepare and submit their respective reports utilizing WebBGAS. Failure to comply with these requirements may cause the initiation of enforcement actions that can culminate in discontinuation of SABG grants.

Your assigned SABG Program Official will provide further guidance and additional submission information.

In accordance with the regulatory requirements provided at 45 CFR 75.113 and Appendix XII to 45 CFR Part 75, recipients that have currently active Federal grants, cooperative agreements, and procurement contracts with cumulative total value greater than $10,000,000 must report and maintain information in the System for Award Management (SAM) about civil, criminal, and administrative proceedings in connection with the award or performance of a Federal award that reached final disposition within the most recent five-year period. The recipient must also make semiannual disclosures regarding such proceedings. Proceedings information will be made publicly available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)). Full reporting requirements and procedures are found in Appendix XII to 45 CFR Part 75.

Staff Contacts:

Spencer Clark, Program Official
Phone: 240-276-1027 **Email:** Spencer.Clark@samhsa.hhs.gov

Wendy Pang, Grants Specialist
Phone: (240) 276-1419 **Email:** wendy.pang@samhsa.hhs.gov **Fax:** (240) 276-1430

SAMHSA
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

May 18, 2021

Dear Single State Authority Director and State Mental Health Commissioner:

Public Law 117-2, the American Rescue Plan Act of 2021 (ARPA), signed by President Biden on March 11, 2021, directed the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide additional funds to support states through Block Grants to address the effects of the COVID -19 pandemic for Americans with mental illness and substance use disorders. The COVID-19 pandemic has exposed and exacerbated severe and pervasive health and social inequities in America, including the critical importance of supporting people with mental illness and substance use disorders. As the pandemic swept through the states, societal stress and distress over this newly emerging disaster created the need for nimble and evolving policy and planning in addressing mental and substance use disorder services. SAMHSA, through this guidance, is asking states to improve and enhance the mental health and substance use service array that serves the community.

ARPA allocated $1.5 billion each for Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block (SABG) grants to the states. States have until September 30, 2025, to expend these funds. Federal block grant monies are provided to support state priorities and SAMHSA asks that states consider the following in developing an ARPA Funding Plan.

A. MHBG Guidance

States must spend the MHBG funds based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart I: Block Grants for Community Mental Health Services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). () Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the MHBG, as deemed necessary to facilitate a grantee's response to coronavirus.

The MHBG allocation requires states to set aside ten percent (10%) of their total allocation for first-episode psychosis or early SMI programs.

SAMHSA encourages states to consider a focus on support of a behavioral health crisis continuum. An effective statewide crisis system affords equal access to crisis supports that meet needs anytime, anyplace, and for anyone. This includes those living in remote areas and underserved communities as well as youth, older adults, persons of diverse backgrounds, and other marginalized populations; the crisis service continuum will need to be able to equally and adeptly serve everyone. SAMHSA recommends states consider use of the ARPA MHBG funds to develop, enhance, or improve the following:

- Develop partnerships with the emerging Suicide Lifeline (9-8-8) systems, Law Enforcement, EMS, health care providers, housing authorities, Housing and Urban Development (HUD) Continuum of Care, hospital systems, peer-based recovery organizations, and substance use specific treatment providers, all of whom have a critical role in the crisis continuum.
- Utilize five percent of funds for crisis services, as described in the FY 2021 appropriations language.
- A comprehensive 24/7 crisis continuum for children including screening and assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination.
- Provide increased outpatient access, including same-day or next-day appointments, for those in crisis.
- Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and frontier areas; use of GPS, to expedite response times, and to remotely meet with the individual in crisis.
- The adoption and use of health information technology, such as electronic health records, to improve access to and coordination of behavioral health services and care delivery.
- Consider digital platforms, such as Network of Care, which facilitate access to behavioral health services for persons with SMI-SED.
- Advance telehealth opportunities to expand crisis services for hard to reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States cannot use the funds to purchase any items for consumers/clients.
- Implement an electronic bed registry that coordinates with existing HHS provider directory efforts and treatment locator system that will help people access information on crisis bed facilities, including their locations, available services, and contact information.
- Support for crisis and school-based services that promote access to care for children with SED.
- Develop medication-assisted treatment (MAT) protocols to assist children and adults who are in crisis, which may leverage telehealth when possible.
- Expand Assisted Outpatient Treatment (AOT) services.
- Develop outpatient intensive Crisis Stabilization Teams to avert and address crisis.
- Technical Assistance for the development of enhanced treatment and recovery support services including planning for Certified Community Behavioral Health Clinics (CCBHC).

SAMHSA requests that the following information is included when submitting the proposals:

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

2. Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.
3. Describe your state's spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.
4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the Guidebook on crisis services.
5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.
6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.
7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.
8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the, the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.

Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer's Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [MH]. Please title this document "ARPA Funding Plan 2021 (MH)."

B. SABG Guidance

States are required to plan for, expend, and report on the FY 21 SABG ARPA Supplemental Funding based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart II: Block Grants for Prevention and Treatment of Substance Abuse, and 45 CFR, Part 96, Subpart L.

Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the SABG as deemed necessary to facilitate a grantee's response to coronavirus.

Accordingly, all regular provisions of the statute and regulations pertaining to the SABG are fully applicable to the planning and expenditure of the SABG ARPA Supplemental Funding.

This includes, but is not limited to, the definitions, assurances, requirements, and restrictions of the SABG standard funding.

The SABG allocation requires states to expend not less than twenty percent (20%) of their total allocation for substance use disorder (SUD) primary prevention services for individuals who do not require treatment for substance abuse, in accordance with 42 USC 300x-22 and 45 CFR 96.124 and 96.125. The SABG allocation also requires "designated states" to expend five percent (5%) of their total allocation for EIS/HIV Services, in accordance with 42 USC 300x-24(b) and 45 CFR 96.128.

The SUD prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; persons experiencing homelessness; persons involved in the justice system; persons involved in the child welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQ individuals; rural populations; and other underserved groups.

SAMHSA recommends states develop, enhance or improve the following through the SABG ARPA funds:

- Develop and expand the use of FDA-approved medications and digital therapeutics as a part of addiction treatment that can provide interactive, evidence-based behavioral therapies for the treatment of opioid use disorders, alcohol use disorders, and tobacco use disorders, along with the implementation of other evidence-based treatments and practices.
- Provide increased access, including same-day or next-day appointments, and low barrier approaches, for those in need of SUD treatment services.
- Direct critical resources in expanding broad-based state and local community strategies and approaches in addressing the drug overdose epidemic, involving SUD prevention, intervention, treatment, and recovery support services.
- Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and frontier areas, and use of GPS to expedite response times and to remotely meet with the individual in need of services.
- The adoption and use of health information technology to improve access to and coordination of SUD prevention, intervention, treatment, and recovery support services and care delivery, consistent with the provisions of HIPAA and 42 CFR, Part 2.
- Advance telehealth opportunities to expand services for hard-to-reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States may not use the funds to purchase any items for consumers/clients.

- Enhance the primary prevention infrastructure within your state and communities using the Strategic Prevention Framework planning model and implementing evidence-based practices, the six CSAP prevention strategies with an emphasis on environmental approaches.
- Consider incorporating strategies around adverse childhood experiences to improve substance misuse outcomes among all populations, but especially young adults 18-25 and those over 26 years of age; preventing and reducing marijuana use by youth below the state's legal age of use; and mitigating the impact of increased alcohol access by youth as identified during the COVID-19 pandemic. It is important to identify and address disparities and describe how you are incorporating equitable approaches.
- Support expansion of peer-based recovery support services (e.g. recovery community organizations, recovery community centers, recovery high schools, collegiate recovery programs, recovery residences, alternative peer group programs) to ensure a recovery orientation which expands support networks and recovery services. These programs are helping people sustain their recovery, engaging families and significant others, bridging the gap between treatment and long-term recovery, and supporting people reentering the community from incarceration.

SAMHSA requests that the following information is included when submitting the proposals:

1. Identify the needs and gaps of your state's SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.
2. Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.
3. Describe your state's progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.
4. Describe your state's progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.
5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.
6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address heath disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.
7. Describe the state's efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.
9. Describe your state plans for enhancing your state's prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)
    a. The impact of increased access to marijuana and the state's strategies to prevent misuse by the underage population.
    b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse.
    c. How the state is using equitable strategies to reduce disparities in the state's prevention planning and approaches. Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer's Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [SA]. Please title this document "ARPA Funding Plan 2021 (SA)."
10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.

States must upload separate proposals based on MHBG and SABG guidance into the WebBGAS system. Upon submission, SAMHSA will review the proposal to ensure it is complete and responsive. Proposals must be submitted to WebBGAS by Friday, July 2, 2021,11:59 EST.

SAMHSA is ready and willing to assist you in addressing the needs of individuals with mental illness and substance use disorders. Please feel free to contact your SAMHSA state project officers and grants management specialists with any questions that you may have.

Sincerely,

Tom Coderre
Acting Assistant Secretary for
Mental Health and Substance Use

1. **Identify the needs and gaps of your state's SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.**

Although NH has continued to invest in a robust continuum of care resulting in steadily improving outcomes, including reduction in overdose fatalities, regional differences still exist in service capacity and resources to address the epidemic. NH has an additional need to invest in prevention, intervention, treatment and recovery services in resource limited areas and to expand outreach efforts to increase awareness of NH's crisis response system. Housing continues to be a critical gap, with the majority of NH's SUD access point system, the Doorways, participants reporting unstable housing or homelessness. Addressing substance misuse other than opioids has also been an ongoing challenge for existing substance use contracts funded under the State Opioid Response grant, with data showing that nearly 1/3 of clients coming to a Doorway for assistance have a problem with a substance other than opioids. The opioid epidemic continues to be one of the worst public health crises in NH's history and this is layered on top of a long history of very high rates of alcohol and binge drinking in the state. In 2018, NH was ranked as having the sixth highest overdose rate in the country at 35.8 per 100,000 population. The striking escalation of opioid and substance misuse is overwhelming community and state systems of care, from emergency departments and law enforcement to child protection and treatment services. In 2019, NH had 415 drug overdose deaths, 1,966 emergency naloxone administrations and 5,562 emergency department opioid related visits. Though opioids have been the main cause of the rapid rise in overdose fatalities in NH, in more recent years, drug deaths involving methamphetamines have increased dramatically. Between 2012 and 2015, NH saw less than 6 deaths per year involving methamphetamines, by 2019 that number was more than eight times higher at 50 fatalities. The total number of deaths involving cocaine has seen a similar rise, increasing from 20 fatalities in 2012 to 74 in 2019. The majority of stimulant deaths also involve opioids, further substantiating the complexity of poly-substance use in the state. In addition to the high rates of opioid use among the adult population, NH consistently ranks among the top in the nation for young adult binge drinking. Regular (past month) illicit drug use rates are significantly higher in NH than the nation (11.5 US, 15.5 NH) and in the18-25 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). As striking as these data are, the scope of the crisis has wide ranging impacts on NH's children and families, public resources (law enforcement, judicial, corrections), public and private healthcare costs, and economic productivity.

The Governor's Commission on Alcohol and Other Drugs Action Plan 2019-2022 and the NH State Opioid Response Plan have remained guiding documents for the work of BDAS and have identified areas where the continuum of care is falling short of meeting the needs of NH's residents. The Bureau of Mental Health Services utilizing the 10-year Mental Health Plan as the guiding document for their work.

Both the Bureau of Mental Health Services and The Bureau of Drug and Alcohol Services (BDAS) recognize that many of New Hampshire's residents experience mental illness with co-occurring substance use. To address this reality, both Bureaus have historically worked in tandem to develop systems and services that meet the needs of all such residents experiencing mental health and co-occurring substance use disorders. Consequently, the Bureaus are committed to continuing to work together to develop systems and services that best serve New Hampshire's citizens and address the needs and gaps previously identified.

In coordination with the Bureau of Mental Health Services, BDAS recognizes the need to develop a rural crisis response model for deployment and stabilization. BDAS along with BMHS seeks to develop a crisis

response model that is accessible to those in more rural and demographically secluded areas on New Hampshire.

As New Hampshire has put systems in place to develop services that meet the needs of its residents, we recognize that there has not been consistent marketing or advertising of such programs to aid residents in locating and accessing the services that they need. With the promising growth of the service array, a messaging campaign has yet to be designed that will serve to alert and inform the public as to what services are available, and how to access them on a consistent basis across mental health and substance use services. To this point, the two crisis response systems have remained largely operating in siloes and marketed to the community as separate.

As part of the effort to best support individuals in crisis the state recognizes that training law enforcement, first responders, service providers, and the peers and family members of those experiencing mental illness or substance use disorder is an imperative need. In tandem with educating the public on what services are available and how to access them, New Hampshire recognizes that it is working with a substance use workforce that is experiencing shortages nationally which can impact how quickly residents can access those services.

2. **Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.**

The chart below shows the proposed projects and justification for New Hampshire. Items marked with an asterisk (*) are shared initiatives with the Bureau of Mental Health Services and equal amounts will be provided by that agency utilizing American Rescue Plan Act funding, pending approval by SAMHSA of both proposals.

Project Name & Justification	Estimated Project Cost
*9-8-8 crisis response infrastructure** As New Hampshire continues to work toward centralization of access to services, including crisis services, an expansion of the crisis continuum, including Mobile Crisis Response Teams (MCRT), and a renewed focus on suicide prevention. Expansion initiatives are underway to develop a centralized crisis operations center, statewide mobile crisis response system, and a State suicide prevention coordinator, these crisis services are inclusive of substance use disorder crises. The current mental health crisis delivery system is comprised of one national suicide prevention lifeline and ten regionally based community mental health centers (CMHCs) that each provide services in their designated community mental health region, each with unique crisis phone number(s). Additionally, NH operates the Doorway system that includes 9 regional access points for substance use disorder with messaging to call 211 to reach a Doorway. These mental health and substance use crisis systems have a siloed approach today and place additional strain on workforce capacity challenges in the state as well as on connectively for those with co-occurring disorders. In sum, there are more than 20 crisis phone numbers statewide, which makes accessing crisis services for individuals and families extremely confusing. This identifies the need for a central call center that can be accessed anywhere in the state for those in a crisis and that central location can provide warm handoffs to and deployment of regionally based mobile teams. Additionally, there	$1,250,000

exists a need to assess and develop a crisis model to meet New Hampshire's unique geographical needs. Mobile Crisis Response Team (MCRT) services and apartments are only located in the three, more urban regions of Nashua, Manchester and Concord. However, New Hampshire is undergoing a system re-design to expand MCRTs and crisis stabilization services into all regions of the state. These efforts align with goals of the Plan and national roll-out of 9-8-8 and are inclusive of mental health and substance use crises. With a vast and highly rural Northern region of the State, services can be a challenging to access due to geographical distance to service agencies and reduced or slower access to technology. A response model would look to break down those barriers, allowing residents in all regions immediate and appropriate supports during crisis, in addition to establishing a chat and text function. While other New Hampshire Departments work on building infrastructure to develop more widespread access to technology in the Northern region of the state, the Bureaus of Mental Health and Drug and Alcohol Services expect to see widespread utilization of the chat and text functions. An assessment will need to be completed to determine the unique needs of the isolated Northern region of the state, and the development of Mobile Crisis Response Team (MCRT) delivery options in rural New Hampshire communities that include response to substance use crises. Funding will be used to work with a subject matter expert on this assessment and develop technical assistance to those in need of these supports. Additionally, NH is planning to explore producing a model for a centrally located behavioral health crisis treatment center that provides an intersection between criminal justice entities and MH/BH entities. Funds will be used to work with a subject matter expert to develop and implement this model.	
Public outreach and education procurement to create materials for three projects. (9-8-8, suicide prevention, access to care)* Through public, first responders, and natural support system education and training, we can expect to see that those in crisis or who are experiencing mental illness receive support and services that are best suited to their individual needs, and connecting them to service agencies that can support them in the most informed way possible. It also expands the natural supports systems knowledge throughout the state allowing for more educated responses to mental illness and substance use needs and knowledge of supports available for those close to them and in their communities. A more robust messaging campaign also needs to be developed and implemented to ensure the public awareness of the 9-8-8 implementation is broadly heard and utilized throughout the state.	$150,000
Workforce Development* Peers are essential to our system of care but New Hampshire does not have a robust peer workforce infrastructure or enough trained peers to meet the staffing demands. NH's goals are to integrate peers and natural supports throughout the continuum of care by expanding the availability of peers in practice settings through training and education. Both the Bureau of Mental Health Services (BMHS) and The Bureau of Drug and Alcohol Services (BDAS) recognize that many of New Hampshire's residents experience mental illness with co-occurring substance use. To address this reality, both Bureaus have historically worked in tandem to develop systems and services that meet the needs of all such residents experiencing co-occurring mental health and substance use disorders. Gaps continue to exist in large part due to workforce shortages and consequently strategies to cross-train the mental health and substance	$200,000

use workforce is needed. The Bureaus are committed to continuing this integrated work to develop systems and services that best serve the behavioral health needs of New Hampshire's citizens.	
Co-Occurring Disorder Infrastructure Development* As New Hampshire assesses and redesigns our behavioral health system of care, it is clear that additional training is required for mental health professionals in the area of substance misuse and for substance misuse professionals in the area of mental health. This funding would support a full time trainer to address these needs across the behavioral health continuum of care. Approximately half of people with SMI/SPMI develop a co-occurring substance use disorder during their lifetime. Alcohol is the most common substance followed by cannabis, opioids and then stimulants. This rate is three times higher than general population rates of substance use disorder. People with co-occurring SMI/SPMI and substance use disorders have higher rates of treatment non-adherence, experience a worse course of illness, utilize emergency rooms and hospitals at higher rates, and experience premature mortality. Conversely, about a third people with substance use disorders have higher rates of co-occurring mental illnesses during their lifetime; among people in treatment settings, two-thirds have co-occurring mental illnesses with a substance use disorder. Mood disorders, post-traumatic stress disorder and anxiety disorders are common. People with these co-occurring disorders also experience worse outcomes. Due to the high rates of co-occurring disorders among people receiving treatment in New Hampshire, clinicians need the knowledge and skills to help service recipients manage both illnesses – the substance use disorder and the mental illness - in order to achieve recovery and return to community functioning. Our service providers have requested training and technical assistance in this area to help their existing employees gain the necessary knowledge and skills for evidence-based co-occurring disorders treatment.	$250,000
Suicide Prevention Having a substance use disorder is a known risk factor for suicide (Risk and Protective Factors (cdc.gov)). Even when not in a life threatening crisis, it is very common for individuals with a substance use disorder to also have a co-occurring mental health disorder and addressing the co-occurring disorder (COD) during treatment for a substance use disorder can improve outcomes for clients (Substance Use Disorder Treatment for People With Co-Occurring Disorders TIP 42 (samhsa.gov)). As a step towards more comprehensive treatment of COD and support for individuals in recovery experiencing COD, this funding will be used to provide Mental Health First Aid and/or Zero Suicide trainings to all contracted SUD treatment providers as well as recovery community organizations under the umbrella of the Department's contracted facilitating organization. Trainings may also be made available to other treatment and recovery providers outside of those contracted with the department upon review of the implementation design.	$150,000
Crisis Respite Centers*	$175,000

New Hampshire is in the midst of a system transformation for behavioral health which includes implementing a statewide mobile crisis response model, which will work in tandem with our existing infrastructure, such as the Doorways (https://www.thedoorway.nh.gov/), which provide 24/7 support to individuals seeking treatment for a substance use disorder, and our community mental health centers. An identified gap in this system is the lack of places for individuals to go who are in crisis but do not require an inpatient intervention. Several states, including Arizona, have stood up effective, non-residential respite center models that not only provide safety and stabilization for individuals in an acute behavioral health crisis, but also divert individuals from emergency departments, jails, and other institutional settings, which is healthier for the individuals and reduces unnecessary burden on the institutions. New Hampshire will use this funding to research the systems developed in other states and identify a solution for implementation in New Hampshire. Once identified, this funding will also be used to stand up one to two pilot programs in identified high need areas of the state.	
Crisis Respite and Withdrawal Management Services In addition to the need for non-residential crisis respite services, New Hampshire's network of Doorways have also identified the need for non-clinical, safe housing for individuals who are waiting to access either residential treatment services or safe housing. Currently, three such programs are funded through State Opioid Response funds; however, it appears that a need still remains especially as it relates to individuals who use substances other than opioids or stimulants, such as alcohol. These funds would be utilized to stand up respite housing in areas of the state that are currently underserved in this area. A third area of need is for Medically Monitored Residential Withdrawal Management (ASAM Level 3.7-WM). These critical services are virtually nonexistent within New Hampshire with long waiting lists at the facilities where they are provided. A key component of this service development would be that the providers must be able to bill Medicaid and private insurance for services beyond the initial startup period for on-going service sustainability beyond the grant period.	$1,015,000
Brain Injury and Substance Misuse A significant body of research supports the link between brain injury and substance use disorder. This funding will be utilized to support expanded awareness of and response to brain injuries related to substance use disorders in partnership with the Brain Injury Associate of NH (BIANH). Activities may include, but are not limited to: • Speakers Bureau: The Brain Injury Association of NH (BIANH) has developed several presentations on the topic of SUD and Brain Injury and have identified several subject matter experts on the topic that can be used to raise awareness at targeted conferences and professional association meetings. • Website: Develop a "one stop shop" section of the BIANH website that would be devoted to the topic of SUD and Brain Injury. It would be set up to offer information tailored to each of the target audiences, and allow the ability for content to be shared with partner organizations. In order to keep the information in front of those most likely to benefit from it, contractors would develop informational blogs that would contain key words to elevate Search Engine Optimization (SEO) and that content can be repurposed for newsletters, direct email etc.	$200,000

• Materials: Currently, BIANH has a 2-sided rack card that has been used by several organizations and public health networks to get the word out about the connection between SUD and brain injury. With funding, BIANH could print a larger quantity of cards and distribute them via partners and make them available in strategic locations. In addition, BIANH could develop a companion piece that contains more information for families and caregivers. • Evaluation of Campaign Materials and Key Messages: Using qualitative and quantitative research methods, the SUD/BI and Mental Health task force would work with organizations like the NH Providers Association to evaluate the effectiveness of current campaign materials, including the website, for the purpose of making improvements and measuring knowledge and behavior changes based on training sessions, website use and comprehension of key messages in written materials. • Statewide Research: While the NH Dept. of Health and Human Services has statistics on the increase and decrease of opioid-related deaths in NH, they do not currently have any statistics on the number of brain injuries sustained as a result of opioid overdose. It would be prudent to get baseline research from hospitals, providers and other resources to identify the numbers before a public information campaign and pilot program with NH emergency programs and then repeat the research annually to track progress. • Working with Foundation for a Healthy Community On An Emergency Dept. Pilot Program to Improve Skills On Evaluating Brain Injury Related to SUD.	
Development and Coordination of Prevention Services New Hampshire's prevention efforts are largely driven by the state's Regional Public Health Networks (RPHNs, New Hampshire Regional Public Health Networks (nhphn.org)) and Community Coalitions. These groups are already providing a good network of support and there is more work to be done in this space. This funding will be utilized to apply the Strategic Prevention Framework at both the state and local levels (work that has already begun) to support and expand existing initiatives, such as Student Assistance Programming and the I Care NH Initiative (I Care Mental Health & Wellness Initiative | NH Department of Health and Human Services) as well as to develop new initiatives, including the rollout of 988. The goal of this work is to help regions and communities identify the evidenced based and/or promising practices that will be the most effective in their localities and assist them in standing up those programs as well as to better coordinate the efforts of these groups in providing population, targeted, and direct prevention services across New Hampshire.	$2,250,000
Total	**$5,640,000**

3. **Describe your state's progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.**

New Hampshire is one of the few states in the country that did not experience a rise in overdose deaths in 2020, while the decline was minimal (413 deaths in 2020 vs. 415 in 2019) it does indicate that we are on a good road in New Hampshire. When comparing year to date deaths for 2020 vs. 2021, we are still on a downward trend with some cases pending results from the Office of the Medical Examiner (dmi-april-

2021.pdf (nh.gov)). We believe that this is largely due to an aggressive naloxone distribution strategy through our network of Doorways, Regional Public Health Networks, and Recovery Community Organizations among other avenues. In addition, our prevention, treatment and recovery provider networks showed admirable flexibility in pivoting to telehealth and other remote services in the face of COVID-19, ensuring that as many individuals as possible remained (or became) engaged with critical substance misuse services.

As discussed previously, New Hampshire is in the midst of a crisis system redesign as well as developing more aggressive marketing around our substance misuse access points, the Doorways. In addition, we are working with the Doorways on an individual basis to help them to improve their processes to insure that individuals are engaged in treatment services in as timely and seamless a manner as possible. We have already seen success with this programming and believe that it will only continue to improve treatment access.

Improved engagement and retention in treatment and recovery services are being pursues in three major ways. First, we are transitioning our state and block grant funded treatment services from a fee for service model to a cost reimbursement model and believe that this will offer providers the ability to be more flexible in meeting the needs of clients, thereby increasing engagement in retention. Second, through supplemental block grant funding, we will be increasing the utilization of technology platforms that have shown promise in engaging and retaining clients in both treatment and recovery services. Finally, we are working with the Bureau of Program Quality within the Department of Health and Human Services on a vibrant quality monitoring and improvement effort, again with the end goal of engaging and retaining clients in treatment services. We also expect that the crisis, respite, and withdrawal management services described above will further our progress in this area.

4. **Describe your state's progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.**

New Hampshire's efforts to expand the use of medication assisted treatment (MAT) have been varied and vigorous over the past several years. This effort began with the publication and dissemination of a formal guidance document for MAT providers (matguidancedoc.pdf (nh.gov)) in 2016, which was updated in 2018. This document formed the basis for a series of provider trainings and ECHO model collaborations (What is the ECHO Model? - ECHO (uthscsa.edu)) over the ensuing years to improve providers' comfort and competency with MAT. In addition, both the state and many of our partners sponsored trainings for prescribers to become DATA waivered. We have also entered into a number of contracts to expand MAT in the following areas:

- Practices serving pregnant and parenting women;
- Hospital associated physician practices;
- Hospital Emergency Departments; and
- Hospital systems as a whole.

Finally, many of our Doorways (which are all associated with hospitals) recognized an on-going need as we were working to develop a strong network of prescribers and launched MAT initiatives internally to serve their clients.

5. **Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.**

The New Hampshire Governor's Commission on Alcohol and Other Drugs (Governors Commission on Alcohol and Drug Abuse | Bureau of Alcohol and Drug Services | NH Department of Health and Human Services) is comprised of Commissioners from a wide range of state agencies as well as members of the public representing various sectors on the continuum of care, including healthcare, prevention, treatment, intervention, and recovery (gc-members-list.pdf (nh.gov)). In addition to the Commission itself, there are a number of taskforces, which are tasked with making both funding and policy recommendations to the Commission. While these recommendations occur on an ad-hoc basis, the taskforces are also very actively involved in a strategic planning process, which occurs every three years. This strategic plan forms the backbone of the Commission's work during the plan period. The development of the plan is based on subject matter expertise and data driven decision making by the taskforces as well as consultation with those with lived experience with substance misuse (FINAL-Gov-Comm-1_16_19rev.pdf (netdna-ssl.com)). Statutorily, the Director of the Bureau of Drug and Alcohol Services serves as the Executive Director of the Commission and the Bureau is charged with carrying out the recommendations of the Commission as defined in the strategic plan.

In addition to the broader strategic planning work described above, the Bureau regularly works with other departments and agencies, including but not limited to the Bureaus of Mental Health Services and Children's Behavioral Health. Some of the partnering projects in this plan include:

- Collaboration with the Bureaus of Mental Health and Children's Behavioral Health, Community Mental Health Centers, substance misuse treatment and recovery providers, and other community level stakeholders in the
    - Development of a 9-8-8 based crisis response infrastructure; and
    - Development of a workforce, including peers, that is able to respond effectively to both substance misuse and mental health.
- Consultation with other states in developing crisis respite services.
- Partnering with both the Brain Injury Association of New Hampshire and the Department's Bureau of Developmental Services to address the co-occurrence of brain injury and substance misuse.
- Working with the state's Regional Public Health Networks, the Department of Education and other stakeholders in the development and coordination of prevention services.

6. **Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address heath disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.**

By expanding the crisis continuum of care, NH is providing assistance to the most vulnerable populations as they attempt to avoid hospital stays, incarceration or transition from community-based care to residential services. Additionally by lowering the Emergency Department utilization among individuals with co-occurring disorders and immediately connecting them with community based providers NH will address the ongoing high rates of MH and SUD concerns in NH. Studies show that the use of Peer Recovery Specialists and Certified Recovery Support Workers are very effective for this group and increase engagement and access to services in times of need. By further educating the peer workforce throughout our state and integrating them further into all care settings, there is a higher likelihood that individuals will reach out to and engage in established services.

By recognizing the need to establish a more interlocking system of care to address more comprehensively the current challenges experienced by patients, families and providers resulting from fragmented care

through multiple mental health and SUD service agencies, NH hopes to reduce the high rates of MH and SUD.

As a result of school and college closures due to the Covid-19 pandemic, many youth and young adults spent extensive periods of time at home and socially isolated. Consequently, New Hampshire is experiencing an increased demand for children's behavioral health services.

The Office of Health Equity (OHE) assures equitable access to effective, quality DHHS programs and services across all populations, with specialized focus on racial, ethnic, language, gender and sexual minorities, and individuals with disabilities. OHE provides coaching and TA to BDAS as well as external organizations to improve systems and practices for organizations to be able to serve all people with high quality care and services. These include effective strategies for communication access, cultural competence, data collection to identify disparities, community engagement, CLAS Standards implementation, gender identity 101, immigrant/refugee integration, and more. BDAS often partners with OHE on data collection standards, training of providers, and technical assistance needed to ensure programs and services are meeting the needs of all populations in our state. OHE has worked with NH's 9-8-8 planning coalition to provide an equity foundation across the work of all subcommittees and prioritized a resident centric approach to building a system that is community driven and community informed and inclusive of voice of underserved and unserved populations including those with lived experience, people who use drugs, immigrant and refugee communities, deaf and hard of hearing residents, and voices of youth being prioritized in the planning.

7. **Describe the state's efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.**

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. Utilizing the previously released supplemental block grant funding, DHHS will engage with our state Medicaid program as well as programs in other states to further these efforts towards sustainability. Workforce proves to be an additional challenge for our RCOs and, as described above, ARPA funding will be utilized to develop the peer workforce for both substance misuse and co-occurring mental health disorders.

8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.

See outline of activities in response to question 2.

9. Describe your state plans for enhancing your state's prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside) a. The impact of increased access to marijuana and the state's strategies to prevent misuse by the underage population.
b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse.
c. How the state is using equitable strategies to reduce disparities in the state's prevention planning and approaches.

NH is currently working on a strategic planning process for prevention to understand root cause and best practice response. The existing infrastructure for prevention in the state can be strengthened and built upon. Additionally, there is potential in NH for expansion of the services offered today in the prevention scope. NH is focused on upstream primary prevention addressing shared risk and protective factors across mental health and substance use prevention inclusive of suicidality. These prevention programs include but are not limited to healthcare systems, law enforcement, school based services and support for community coalitions to implement best practice programming across the state. While pockets of excellence in prevention exist in NH, like in many areas of the country, a need for comprehensive prevention blanketing the state is evident in all of the needs and gaps assessments. The long term vision for prevention is for every resident to receive upstream prevention information, education and resources long before a moment of crisis or a need for an intervention.

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

These funds will not be utilized for health IT infrastructure or advancement projects.

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