

**State of New Hampshire
Doorway Program
Performance Audit Report
June 2026**



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To the Fiscal Committee of the General Court:

The purpose of this audit was to determine if the Department of Health and Human Services effectively monitored the services provided by the Doorway Program. The audit was to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Office of Legislative Budget Assistant
Office of Legislative Budget Assistant

June 2026

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**State Of New Hampshire
Doorway Program**

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ABBREVIATIONS

BDAS	Bureau of Drug and Alcohol Services
DBH	Division of Behavioral Health
DHHS	New Hampshire Department of Health and Human Services
EBP	Evidence-Based Practice
FFY	Federal Fiscal Year
GAO	United States Government Accountability Office
GCATP	Governor’s Commission on Addiction, Treatment, and Prevention
GPRA	Government Performance and Results Act
IHPP	Institute for Health Policy and Practice
LBA	Office of Legislative Budget Assistant
MAT	Medication-Assisted Treatment
OSFV	Other State Opioid Response Funded Vendor
ODU	Opioid Use Disorder
Program	Doorway Program
QoL	Quality of Life
RPHN	Regional Public Health Network
SAMHSA	Substance Abuse and Mental Health Services Administration
SFY	State Fiscal Year
SOR	State Opioid Response
SPARS	SAMHSA Performance Accountability and Reporting System
StimUD	Stimulant Use Disorder
SUD	Substance Use Disorder
SUPRT	SAMHSA Unified Performance Reporting Tool
UNH	University of New Hampshire
WITS	Web Information Technology System

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**State Of New Hampshire
Doorway Program**

Executive Summary

We found the Doorway Program (Program) needs to implement a number of changes to improve its program monitoring and better measure its effectiveness in assisting people with obtaining treatment for their substance use disorders (SUD). Using primarily federal grant funds, the New Hampshire Department of Health and Human Services (DHHS) contracted with nine hospitals to provide screening, evaluation, referrals, and coordination of care for clients. These nine regional locations established single points of entry (i.e., doorways) for client support and services. However, DHHS staffing levels and employee turnover in the Program hampered DHHS' ability to adequately manage the Program and effectively oversee doorway contractors. Administratively, the Program suffered from insufficient management controls, unleveraged client data, and a protracted reimbursement process. The Program spent more than \$27 million during State fiscal years (SFY) 2022 through 2024 and, on average, served 1,805 clients each year. This report outlines opportunities for Program management to examine its current practices and make significant improvements in its system of internal control.

Measuring Effectiveness Was Challenging

Substance use addiction was a chronic, relapsing, health condition – a lifelong medical disease to be treated rather than cured. We were unable to find an expected success rate for addiction recovery programs, so we could not compare the results of the Program to any recognized standards or benchmarks. Recovery from SUD could be measured in several ways, including subjective measurements like quality of life (QoL). One measure reported to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) reflected self-reported changes in a client's QoL over time. Using New Hampshire's Government Performance and Results Act (GPRA) data for SFYs 2022 through 2024, we found that QoL improved in 45.5 percent of clients after six months in the Program. We further found the successful completion rate of clients in the Program was 16.5 percent. These results were based on a non-random subpopulation that had data available to analyze and should not be projected to the entire population.

Program Management Should Be Improved

The Program needs to strengthen internal controls to help accomplish its goals. It lacked comprehensive policies and procedures for monitoring the Program, and it had not established a model of care framework as recommended in a prior external program evaluation report. We also found that most recommendations made in two 2023 external program evaluation reports were not fully resolved and were still in various stages of remediation as of November 2025. Additionally, the Program published monthly output reports that were incomplete and contained inaccuracies. The Governor's Commission on Addiction, Treatment, and Prevention (GCATP), which financially supported some Program services not covered by federal funding,

similarly did not develop GCATP-specific policies and procedures for its operations related to the Program. Additionally, we found the GCATP did not comply with certain reporting requirements and hosted information on two separate website domains, potentially causing confusion.

We found that the invoice process did not have effective controls in place to ensure it received complete, accurate, and timely requests for reimbursement from doorway locations resulting in delays of payments to doorway locations.

Available Client Data Should Be Fully Leveraged

Program management had access to broad, client-level data, but chose instead to rely on an optional client satisfaction survey for tracking client experiences at the doorways. Specifically, the QoL variable tracked by the GPRA interview could have been used to measure client outcomes over time. The client satisfaction survey had a low response rate, making it a less reliable source of information than the broad-based client-level data from the GPRA interview for management to rely on in measuring the effectiveness of the Program. Although the GPRA interview provided significantly more data than the client satisfaction survey, interview rates for the GPRA were significantly lower than the federally-required rate. In October 2025, the federal government replaced the GPRA interview with a new tool designed to reduce the burden on respondents, improve data consistency, and streamline data collection.

**State Of New Hampshire
Doorway Program**

Recommendation Summary

Observation Number	Page	Legislative Action May Be Required	Recommendations	Agency Response
1	17	No	Establish and implement comprehensive policies and procedures supporting significant processes.	Concur
2	19	No	Implement the recommendation from the 2023 external program evaluation and establish a formal, written model of care framework to be followed by all the doorway locations statewide.	Concur
3	20	No	Establish formal policies and procedures for monitoring the performance of the doorway locations. Increase the frequency of performing regularly scheduled formal on-site contract compliance reviews. Consider reclassifying the State Opioid Response Field Auditor position to a Program Specialist position that requires clinical experience.	Concur
4	23	No	Prioritize the timely implementation of all feasible recommendations in external program evaluation reports and develop and implement corrective action plans.	Concur In Part
5	27	No	Use federally-required interview data to more effectively measure client outcomes.	Concur In Part

Recommendation Summary

Observation Number	Page	Legislative Action May Be Required	Recommendations	Agency Response
6	31	No	Utilize data-driven outcomes, such as the quality of life outcome, to assess whether the Doorway Program is achieving its programmatic goals, collect and track data needed to assess all goals identified in the State budget, and include identified outcome measures in all contracts with the doorways.	Concur
7	33	No	Comply with Substance Abuse and Mental Health Services Administration requirements for collecting and reporting data.	Concur
8	34	No	Improve the accuracy and completeness of monthly statistical reporting and consider automating the process.	Concur
9	36	No	Evaluate the process for reviewing reimbursement requests submitted by the doorways to determine the root cause of payment delays and ensure compliance with the 30-day payment term. Examine vendor training and compliance requirements.	Concur
10	39	No	Governor's Commission on Addiction, Treatment, and Prevention (GCATP) management should establish comprehensive policies and procedures to support significant processes.	Concur
11	40	No	The GCATP should comply with all reporting requirements in its governing statute, RSA 12-J, and develop written policies and procedures to ensure compliance with the reporting requirements.	Concur

Observation Number	Page	Legislative Action May Be Required	Recommendations	Agency Response
12	43	No	The GCATP should consolidate all website content onto a single domain.	Concur

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State Of New Hampshire Doorway Program

Background

The Doorway Program (Program) was established in January 2019 and was responsible for providing Substance Use Disorder (SUD) screening, evaluation, referrals, and care coordination for its clients. The Program was authorized to develop, implement, and operationalize a statewide network of regional hubs for Opioid Use Disorder (OUD) treatment and recovery support services using federal grant funds. The concept of the Program was to create a single point of entry (i.e., a doorway) into a system of support and services located around the State. Each doorway was regionally located so that no client had to travel more than 60 minutes to begin the process towards recovery. The New Hampshire Department of Health and Human Services (DHHS) administered the Program and contracted with hospitals around the State to provide these services.

The Program used federal funding to expand access to medication-assisted treatment (MAT), peer recovery support services, recovery housing, training and education, evidence-based prevention programs, and workforce opportunities. MAT used federally approved medications, such as methadone, buprenorphine, and naltrexone, along with counseling and behavioral therapies to treat OUD. These medications reduced cravings and feelings of pleasure experienced with opioids.

The Program's scope expanded in 2020 to assist those with a Stimulant Use Disorder (StimUD). State Opioid Response (SOR) grant funds could be used to assist individuals with an OUD or StimUD, as well as those at risk of such disorders.

Although the Program was not specifically established in statute, RSA 172:2-a authorized DHHS to "establish, maintain, implement, and coordinate a system of substance use disorder treatment services..." in 1969. In 1995, RSA 126-A authorized DHHS "to provide an integrated, administrative structure for the design and delivery of a comprehensive and coordinated system of health and human services which is family-centered and community-based for the citizens of New Hampshire." However, legislation effective June 28, 2025 amended RSA 126-A to authorize the DHHS to "establish and administer statewide access points for delivery of substance use services and supports," such as referrals for screening and evaluation, treatment, prevention, and other support services.

Addiction Is Treated, Not Cured

According to the Partnership to End Addiction, addiction may be defined as a chronic disease characterized by "the continued use of one or more substances even though there may be serious health and social consequences" of such substance use. The American Society of Addiction Medicine defined addiction as:

a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful

consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Addiction was a lifelong health condition – a medical disease to be treated rather than “cured.” According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) *National Survey on Drug Use and Health*, in New Hampshire, the prevalence of SUD was estimated at 18.9 percent of the adult (age 18+) population in 2023/2024 compared to the national average of 17.8 percent.

The *American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders* defined:

- SUD as, “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems;”
- OUD as, “a problematic pattern of opioid use leading to clinically significant impairment or distress...;” and
- StimUD as, “a pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress...”

Because SUD was treated rather than cured, the definition of treatment efficacy was elusive. We determined, based on data collected by DHHS, the best indicator of program success for Program clients was the individual’s self-assessment of their overall quality of life (QoL) over time. Based on DHHS data, for State fiscal years (SFY) 2022 through 2024, 45.5 percent of Program clients reported an improvement in their QoL (see Figure 4). We were able to calculate a successful completion rate of 16.5 percent using existing data which was limited to a small number of cases.

Core And Support Program Services

Program services could be categorized as either core services or support services. Core services focused on:

- screening;
- prevention;
- evaluation;
- treatment, including MAT;
- recovery from SUD, specifically OUD and StimUD, including long-term recovery support services; and
- peer recovery support services.

Support services were intended to remove barriers to Program participation and included:

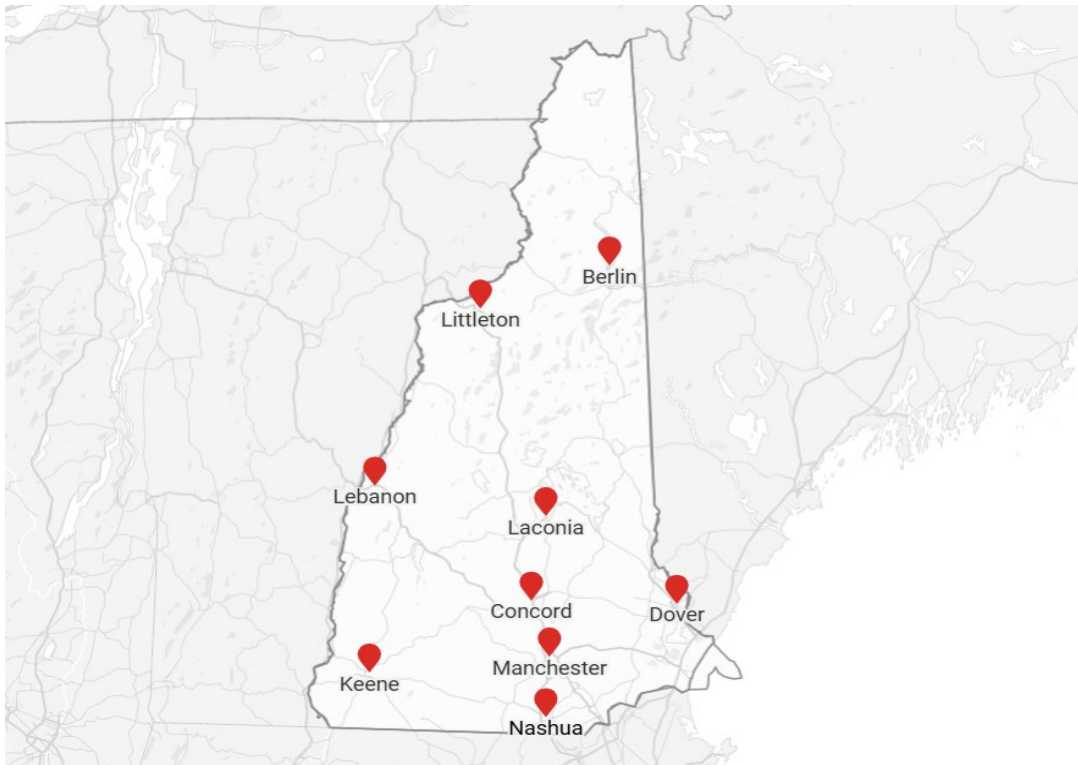
- transportation;
- childcare;
- housing costs, including respite and recovery housing;
- clothing and toiletries;

- gift cards and gas cards;
- out-of-pocket expenses; and
- other pre-approved uses.

Structure And Locations

As shown in Figure 1, there were nine doorways located throughout the State in: Berlin, Concord, Dover, Keene, Laconia, Lebanon, Littleton, Manchester, and Nashua. Program services were decentralized using access points for the delivery of SUD treatment around the State. Each doorway was affiliated with a regional hospital. The Program generally operated in-person during weekdays from 8:00 a.m. to 5:00 p.m., with support available 24 hours a day, seven days a week by dialing 2-1-1. In addition, the Lebanon doorway offered after-hours services in person on nights, weekends, and on holidays through September 29, 2025. On September 30, 2025, a new contractor took over the responsibility of providing after-hours services for all doorway locations.

**Figure 1 – Doorway Locations,
March 2026**

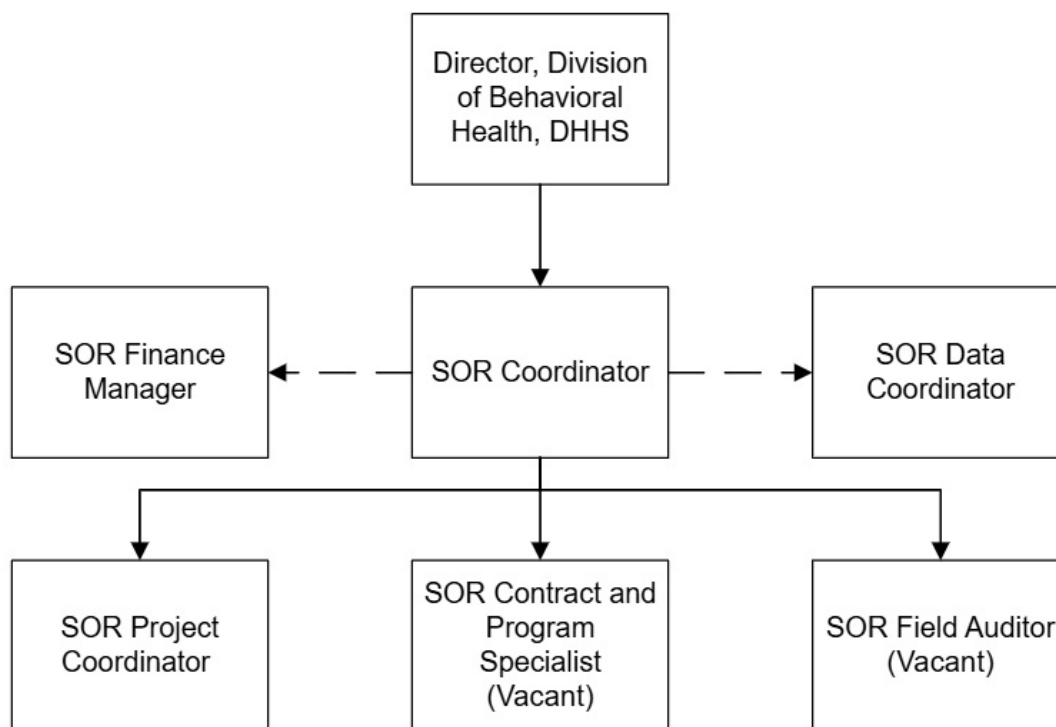


Source: LBA analysis of the Program locations. Map created with Datawrapper.

Staffing

As of March 2026, Program staff consisted of six temporary full-time equivalent, authorized positions as shown in Figure 2. For most of our audit period, the SOR Field Auditor and SOR Project Coordinator positions were vacant. All staff who performed work for the Program during the audit period also performed duties to support other SOR programs.

**Figure 2 – Program Organizational Chart,
March 2026**



Source: LBA analysis of Program staffing documents.

The Governor’s Commission On Addiction, Treatment, And Prevention (GCATP)

The GCATP was established in 2000 and amended in 2025 to:

serve in an advisory capacity to the [G]overnor and the [G]eneral [C]ourt regarding the importance of prevention as well as the delivery of effective and coordinated alcohol and other drug misuse programs of prevention, problem gambling prevention, treatment using a public informed approach to address addiction, and recovery services throughout the [S]tate.

The statute outlined requirements for membership, terms, organization, duties, meetings, and report filings. The chairperson was charged with creating – at a minimum – five task forces: prevention, treatment, recovery, program monitoring and evaluation, and the GCATP’s budget. Each task force was assigned to develop a mission statement including goals and objectives, report to the GCATP regularly, and identify areas for improvement.

In accordance with RSA 12-J:3, the statutory duties of the GCATP were as follows:

1. “Develop and revise, as necessary, a statewide plan for the effective prevention of alcohol and other drug misuse and problem gambling, particularly among youth, and a comprehensive system of treatment including reduction of societal and individual harm and recovery services for individuals and families affected by alcohol and other drug misuse and problem gambling.”
2. “Advise the [G]overnor and [G]eneral [C]ourt on and promote the development of effective community-based alcohol and other drug misuse and problem gambling prevention strategies.”
3. “Advise the [G]overnor and [G]eneral [C]ourt on and promote the development of treatment... [and] recovery services to meet the needs of citizens in recovery from alcohol and other drug misuse and problem gambling.”
4. “Identify unmet needs and the resources required to reduce the incidence of alcohol and drug misuse and problem gambling in New Hampshire and to make recommendations to the [G]overnor and [G]eneral [C]ourt regarding legislation and funding to address such needs.”
5. “Authorize the disbursement of moneys from the addiction, treatment, and prevention fund....”
6. “Make presentations at least once each legislative session...” to the [Legislature].
7. “Develop a handout which shall describe the risks of opioid use and how to mitigate them....”

Program Funding

The Program was primarily funded by a federal block grant called the Opioid State Targeted Response grant, also known as the SOR grant, from the SAMHSA. RSA 126-A:106 also permitted DHHS to, “accept funds from any source, including [S]tate appropriations, federal funds, and private gifts, grants, or donations to operate and sustain the access points.”

Funding for Program clients was also provided by the GCATP. The GCATP was primarily responsible for managing the Alcohol Abuse Prevention and Treatment Fund,

which, during the audit period, was funded by five percent of the State's gross profit from liquor sales pursuant to RSA 176:16, III.¹

Flexible And Unmet Needs Funds

There were two funding sources available for eligible client support services. Flexible needs funds were provided by the SOR grant. Unmet needs funds were provided through the GCATP, formerly known as the Governor's Commission on Alcohol and Other Drugs, which funded services for non-SOR-eligible clients, such as those with an alcohol use disorder. Both funding sources were used as a payor of last resort for support services. Both flexible and unmet needs funds could be used to facilitate the same recovery-related medical appointments, treatment programming, or other supports as approved by Program staff.

Non-payroll Program Expenditures

Table 1 depicts non-payroll Program expenditures for SFYs 2022 through 2025. The majority of Program expenditures were funded with federal funds (97.8 percent), and the GCATP funded the remaining 2.2 percent over the four years. Management was unable to provide us with Program-specific payroll expenditure data for staff who administered the Program.

Table 1 – Non-payroll Program Expenditures By Funding Source, SFYs 2022–2025

Expenditures	2022	2023	2024	2025	Total
Federal Funds	\$ 8,213,432	\$ 9,319,731	\$ 9,702,516	\$ 9,810,083	\$ 37,045,762
GCATP Funds	148,549	-	366,429	324,434	839,412
Total Expenditures	\$ 8,361,981	\$ 9,319,731	\$ 10,068,945	\$ 10,134,517	\$ 37,885,174

Source: LBA analysis of Program expenditures.

Role Of The SAMHSA

The intent of SAMHSA's SOR grant was to address increased opioid misuse, OUD, and opioid-related overdoses. Eligibility for the grant was limited to single state agencies and territories. The SAMHSA required recipients of the grant to implement effective prevention, harm reduction, and recovery support services. The SOR grant targeted OUD, StimUD, and other drugs. Alcohol was not targeted by the SOR grant.

¹ Chapter 141:296, Laws of 2025 provided that, if the Legislature made an appropriation to the GCATP upon enactment of the State's operating budget, the Department of Administrative Services shall not transfer the five percent deposit from liquor sales into the Alcohol Abuse Prevention and Treatment Fund. The Legislature made an appropriation to the GCATP for SFYs 2026 and 2027.

Data Collection And Reporting Requirements

Under the SOR grant, recipients were required by the Government Performance and Results (GPRA) Modernization Act of 2010 to collect data and provide reports to the federal government. To comply with GPRA, the Program collected data on clients and services provided at three distinct checkpoints: intake, six months post intake, and discharge. The Program was expected to conduct intake interviews with all clients and achieve a six-month follow-up rate of 80 percent. Doorway locations used the SAMHSA Center for Substance Abuse Treatment's data collection tool known as "the GPRA interview" to gather information about clients seeking services. The tool collected client:

- demographic information such as education, employment status, and income;
- substance use and medications;
- mental and physical health;
- family, housing, and living conditions;
- status within the criminal justice system; and
- feelings on social connectedness.

GPRA data was transmitted to the SAMHSA and used to report to the United States Congress on program effectiveness.

The GPRA interview changed several times during the audit period, and consistent data for all but one variable was impossible to measure throughout the four-year audit period. However, one outcome measure captured consistently throughout the audit period was "LifeQuality," a client's rating of their QoL at different checkpoints during their affiliation with the Program. It was this that variable we used to determine whether the program was effective.

To record GPRA data, treatment providers entered the GPRA interview responses into the State's Web Information Technology System (WITS), an electronic medical record application used by the DHHS, Bureau of Drug and Alcohol Services and treatment providers to log treatment information, including GPRA data, for clients. The Program only interacted with this system to upload GPRA information nightly into the SAMHSA Performance Accountability and Reporting System.

The SAMHSA's SOR grant Notice of Funding Opportunity for federal fiscal year 2024 placed additional reporting requirements on state recipients. SOR grant recipients were required to submit progress reports at six and 12 months, in addition to a final report at the end of the project period.

Program Metrics

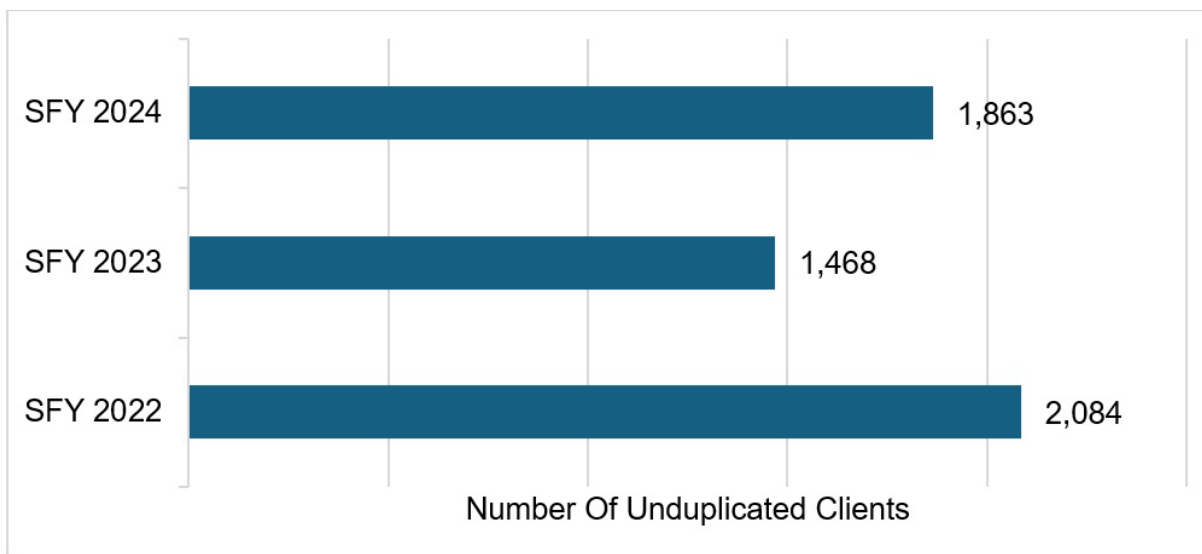
We analyzed both GPRA data and output data produced by the Program.

GPRA Data Analysis

When tracking Program metrics, the Program included friends and family members that contacted the Program seeking information on how to help a loved one in the total

number of clients served by the Program. Since only clients with SUD were eligible for Program services, the graphical illustrations in Figure 3 and Figure 4 include only clients that were eligible for services, and not their friends and family members. According to GPRA data, an average of 1,805 unduplicated clients were served each year during SFYs 2022 through 2024,. Figure 3 shows the number of unduplicated clients interviewed by the doorway locations each year during SFYs 2022 through 2024.

Figure 3 – Number Of Clients Served, SFYs 2022–2024



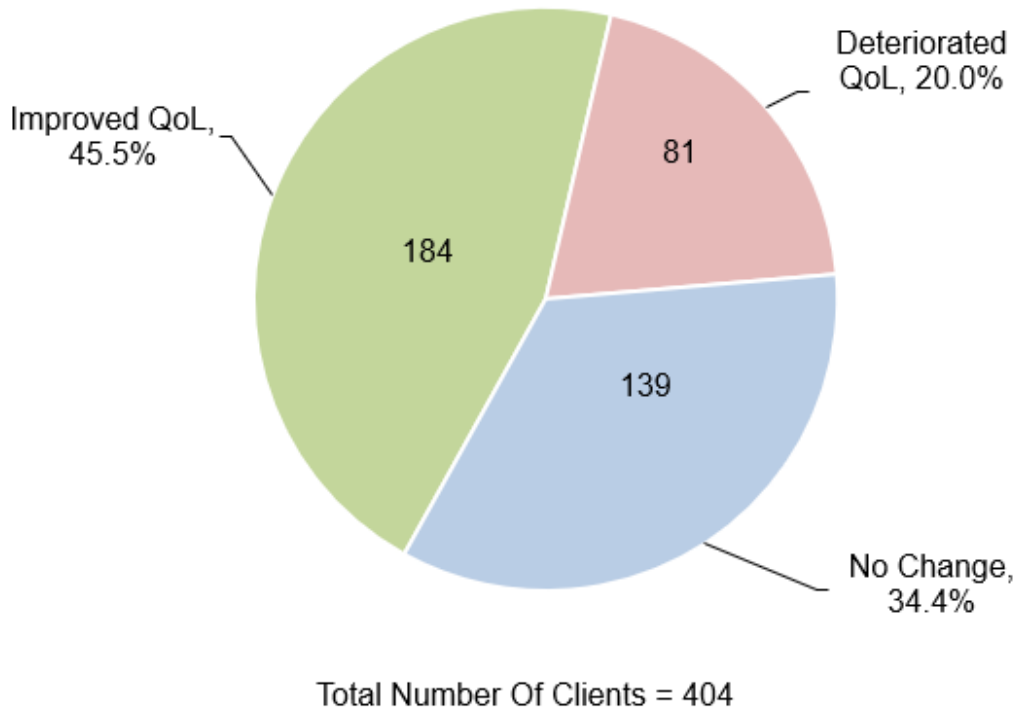
Note: Clients were unduplicated for each year, but duplicates may exist year over year.

Source: LBA analysis of unaudited GPRA data.

Figure 4 shows the number of clients who reported changes to their QoL. In the GPRA interview, clients were asked to rate their response to the following question at intake and at six-month intervals: “How would you rate your quality of life over the past 30 days?” The client could select one of the following choices: “Very poor,” “Poor,” “Neither poor nor good,” “Good,” “Very good,” or they could refuse to answer the question.

We examined pairs of intake and corresponding six-month follow-up interview responses to the QoL question. When we identified missing data between one or more interviews or when the client did not answer the question, we could not measure the QoL and discarded that pair of records from our analysis. We also discarded pairs when the six-month follow-up was conducted less than 150 days or more than 240 days after the intake interview date. After adjusting the initial dataset for instances where there was insufficient data to analyze, the QoL data for clients was reported as shown in Figure 4.

Figure 4 – Clients Reporting Changes In Their QoL, SFYs 2022–2024



Notes: Excludes “missing” and “refused” responses.

Totals may not add to 100 percent due to rounding.

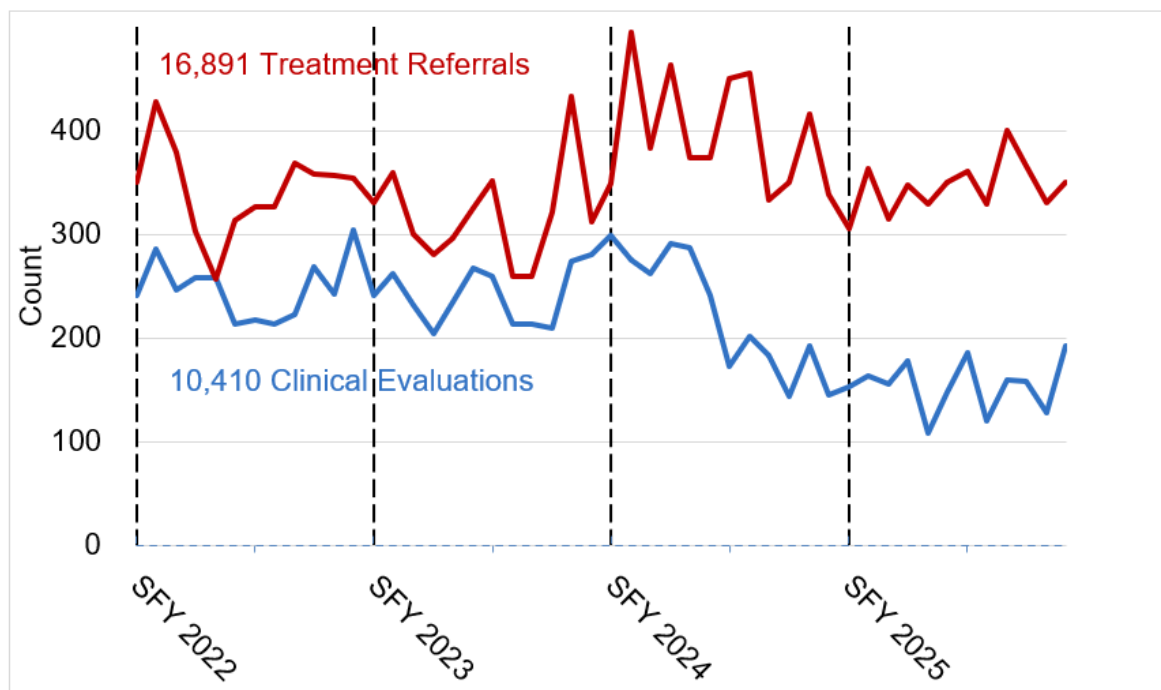
Because of the non-random nature of cases with data that could be analyzed compared to the entire population of clients receiving services, the results cannot be generalized to the entire population of clients receiving services.

Source: LBA analysis of unaudited GPRA data.

Monthly Data Reports

Monthly reports published by Program staff indicated a total of more than 10,000 clinical evaluations and more than 16,000 treatment referrals were provided to clients during the audit period. Figure 5 shows the monthly number of clinical evaluations and treatment referrals provided to clients for each SFY.

Figure 5 – Monthly Clinical Evaluations And Treatment Referrals, SFYs 2022–2025



Source: LBA analysis of unaudited Program data reports.

Programs Providing Similar Services

We identified two other State programs that provide similar services to the Doorway Program.

Certified Community Behavioral Health Clinics

Certified Community Behavioral Health Clinics provided similar services to that of the Program, including peer support, screening, case management, crisis services, and SUD care. The clinics launched on January 1, 2025 and were funded by a SAMHSA planning grant. Unlike the Program, which focused on MAT, the clinics focused on mental health care in addition to SUD.

Regional Public Health Networks

The Regional Public Health Networks (RPHN) were a partnership between the New Hampshire DHHS' Bureau of Drug and Alcohol Services and the Division of Public Health Services to align multiple public health services throughout the State. The RPHNs engaged in public health emergency preparedness planning and acted in an advisory role to public health partners in their respective regions. The RPHNs did not provide direct treatment services for SUD, but both the Program and the RPHNs were involved in SUD prevention.

Management Controls

Management was responsible for designing comprehensive internal controls, also known as management controls, such as the policies and procedures used to efficiently and effectively achieve its goals. The U.S. Government Accountability Office's (GAO) *Standards for Internal Control in the Federal Government* defined internal control as "a process effected by an entity's oversight body, management, and other personnel, designed to provide reasonable assurance that the objectives of an entity will be achieved." Internal controls were comprised of "the plans, methods, policies, procedures, and other mechanisms used to fulfill the mission, strategic plan, goals, and objectives of the entity."

Internal controls were a system of integrated actions and practices implemented to mitigate risks. Internal controls included written policies and procedures, reviews and approvals, reconciliations, segregation of duties, and other actions and practices.

We found that Doorway Program (Program) management did not develop policies and procedures for its significant operations. The Program's model of care framework was not developed and established as a policy directive.

Observation No. 1

Comprehensive Policies And Procedures Should Be Established

Management did not establish comprehensive policies and procedures for Program operations. Program management reported it had one policy for the Program during the audit period, the *State Opioid Response Flexible and Unmet Needs Fund Policy*. This policy established guidelines under which flexible and unmet needs funds could be utilized to eliminate financial barriers in access to care, but no other policies were in place to provide structure, establish expectations, guide decision-making, or otherwise administer the Program.

A procedure manual for the Bureau of Drug and Alcohol Services (BDAS) State Opioid Response (SOR), which we received after the audit period in July 2025, included policies for invoice processing and other matters affecting the SOR grant, but the manual was not specific to Program operations.

The Program lacked written policies and procedures, such as those relating to:

- data collection, management, and publication;
- standard operating procedures or "working instructions" for each Program position; and
- contract management specific to the Program.

A similar issue was noted in both 2023 external program evaluation reports. One evaluation, which was conducted by Pacific Health Policy Group, found policies varied across doorway locations and recommended enhancing policies applicable to the

doorways, such as developing uniform statewide model of care standards including communication and collaboration across doorway locations, respite, and treatment providers, and aligning oversight, funding, and initiatives across all New Hampshire Department of Health and Human Services (DHHS) behavioral health programs. The University of New Hampshire (UNH) Institute for Health Policy and Practice program evaluation report recommended the Program develop Government Performance and Results Act (GPRA)-related communication and action policies and procedures, the key components of which would include performance goals, performance reviews, performance improvement plans, data collection, and continuous improvement.

According to the GAO's *Standards for Internal Control in the Federal Government*, management was responsible for designing control activities through the establishment of policies and procedures. Policies and procedures mitigated risks to achieving the entity's objectives. Also, as part of the federal grant award requirements, the State had to establish and maintain internal controls that provided reasonable assurance it was managing the federal award in compliance with federal laws, regulations, and the terms and conditions of the award.

Program staff were unable to explain why there were no policies and procedures for the State operation of the Program and reported that policies were created and owned by the nine doorway locations themselves. Without formal policies and procedures, inconsistent practices could develop and institutional knowledge could be lost due to staff turnover. The absence of comprehensive policies and procedures could have also led to inefficiency, ineffectiveness, and increased the risk of errors or fraud occurring without timely detection and correction by management.

Recommendations:

We recommend management establish and implement comprehensive policies and procedures to support significant processes associated with operating the Program. Management should ensure all policy and procedure recommendations from the 2023 external program evaluation reports are addressed when drafting new policies and procedures for the Program.

Auditee Response:

We concur. Corrective Action Planned: While many processes have been developed and consistently instituted, these have not been formalized into written policies and procedures. Therefore, management will develop, approve, implement, and continuously monitor policies and procedures governing all major program operations. This process will include a structured review of all recommendations from the 2023 external program evaluations, ensuring each recommendation is evaluated and integrated into the new policies and procedures as appropriate. We anticipate creating policies and procedures related to:

- *Data collection, analysis and reporting;*
- *Contract development;*
- *Contract monitoring, including on-site contract compliance reviews;*
- *SOR grant operations, roles, and responsibilities;*

- *DHHS-determined Opioid Use Disorder model of care framework; and*
- *Governor’s Commission on Addiction, Treatment, And Prevention administrative support.*

We will substantially complete the policies and related procedures by June 30, 2028.

Observation No. 2

Model Of Care Framework Should Be Established In Policy

The Program did not establish a formal, written statewide model of care framework as recommended by the 2023 external program evaluation conducted by Pacific Health Policy Group. Management reported the Program’s model of care was to provide as much care as possible as fast as possible but also described the model as “more of a vibe.”

According to a research paper in the *International Nursing Review*, a model of care can generally be defined as:

the overarching theoretical and conceptual framework that influences all aspects of healthcare delivery.... [It is] a structure for both the delivery and evaluation of care..., and defined standards and principles of care.... [A model of care], at its most basic level, describes the way in which care is delivered within a specific context.²

According to this paper, defined models of care were “required to ensure approaches to care result[ed] in the best outcomes...” for clients and staff.

Program management did not indicate why they had not developed a formal model of care for the Program. Without a uniform model of care framework, there was an increased risk the Program provided inconsistent services at its nine doorway locations across the State and client outcomes may have suffered.

Recommendation:

We recommend management implement the recommendation from the 2023 external program evaluation conducted by Pacific Health Policy Group and establish a formal, written model of care framework to be followed by all the doorway locations statewide.

² Clarke, J., Davis, K., Douglas, J., & Peters, M.D.J. (2025) Defining nurse-led models of care: Contemporary approaches to nursing. *International Nursing Review*, 72, e13076. <https://doi.org/10.1111/inr.13076>.

Auditee Response:

We concur. Corrective Action Planned: Management will develop, approve, and implement a formal, written model of care framework that aligns with the recommendations from the 2023 Pacific Health Policy Group evaluation. This framework will be standardized and formalized in written Bureau policies as outlined in Observation No. 1.

Most aspects of the framework are already incorporated into all Doorway contracts to ensure consistent application of care statewide. Based on the contractual requirements outlined in DHHS contracts with Doorways providers, the model of care is expected to ensure that all Doorways services align with nationally recognized standards in ensuring access to care and providing appropriate substance use-related care. The model of care includes:

- providing low barrier access (no appointment needed, 24/7 coverage, etc.) followed by an American Society of Addiction Medicine (ASAM)-based assessment to determine the appropriate level of care for each individual on the same day they are requesting care;*
- individualized treatment plans that support each person's safety and recovery goals;*
- requiring Doorways staff have professional counseling competencies, case management practices, and overdose prevention tools;*
- clinical staff deliver services according to 12 core functions, ensuring consistent and ethical care;*
- throughout treatment, providers also incorporate the four recovery domains to promote a supportive, person centered and evidence-based recovery process.*

The model of care framework and related policy will be reviewed annually.

Observation No. 3

Establish Policies And Procedures For Formal On-site Contract Compliance Reviews

Program management did not establish formal policies and procedures to govern its on-site contract compliance reviews, the goal of which was to ensure compliance with contract terms. Although management stated they engaged in monitoring activities on a daily basis through routine interactions with the doorway locations, these monitoring activities were not equivalent to formal on-site contract compliance reviews.

Federal grant subrecipients, such as the doorway locations, were managed using contracts. During the four-year audit period, Program staff monitored contracts by completing formal on-site contract compliance reviews for four of the nine doorway locations. The Program had no policies dictating how many reviews should be completed and performed no other evaluation of subrecipient risk to establish the basis

for the frequency of conducting reviews. The DHHS Grants Office performed risk assessments primarily focusing on compliance with federal financial reporting requirements as part of the contract initiation process. Neither the DHHS Grants Office nor Program management identified or assessed risks for the program performance aspects of its contract compliance reviews dealing with clinical practices and case management.

The four on-site contract compliance reviews completed during the audit period examined subrecipient program, clinical, and data operations. During each compliance review, staff performed a clinical audit of six client charts and reviewed the following:

- screening,
- care coordination,
- evaluation and assessment,
- service planning,
- referrals to outside resources,
- staffing requirements,
- case management,
- service provided,
- releases of information and confidentiality,
- required policies and procedures,
- agreements, and
- data collection.

Contract compliance reviews were reportedly prioritized to address those doorway locations that had not been monitored during the COVID-19 pandemic. Program management was unable to provide auditors with policies, procedures, forms, or checklists demonstrating how the doorway locations were selected for review or how the reviews were conducted.

The federal *Grants Policy Statement* from the U.S. Department of Health and Human Services required recipients, such as the State, to monitor for program performance and compliance with federal award terms and conditions. Contract monitoring such as on-site reviews ensured the services intended to be provided under the contract were delivered. Without formal and timely program monitoring, there was little assurance the Program's contracts with the doorway locations operated as intended and program goals were achieved.

A similar comment on subrecipient monitoring was noted in the State's *Single Audit of Federal Financial Assistance Programs* for the year ended June 30, 2024.

Staffing Limitations

Program management reported its staff lacked clinical expertise, and the Program had extensive staff turnover during the audit period. The Program had six authorized positions including the SOR Coordinator, SOR Finance Manager, SOR Field Auditor, SOR Data Coordinator, SOR Contract and Program Specialist, and SOR Project Coordinator, and two of the program's positions went unfilled during State fiscal year 2025. Because the SOR Field Auditor position had been vacant for an extended period, the position was reclassified and the salary upgraded, but the Program still could not attract applicants and management stopped recruiting for the position.

Recommendations:

We recommend Program management:

- **establish formal policies and procedures for monitoring the program performance of the doorway locations as required by federal regulations, including procedures for:**
 - **selecting grant subrecipients for review using a data-informed risk assessment,**
 - **establishing the frequency of performing monitoring reviews,**
 - **using forms and checklists in conducting reviews, and**
- **increase the frequency of performing regularly scheduled formal on-site contract compliance reviews to improve contract compliance.**

We also recommend management consider reclassifying the SOR Field Auditor position to a Program Specialist position that requires clinical experience for reviewing clinical records of doorway clients on an ongoing basis according to priorities established by a data-informed risk assessment.

Auditee Response:

We concur. Corrective Action Plan: Contract monitoring activities include a range of structured compliance activities designed to ensure program quality and contractual compliance. These efforts include monthly monitoring meetings to evaluate progress and address emerging issues, as well as comprehensive invoice reviews to confirm accuracy and appropriate use of funds. The Department also conducts unscheduled site visits to observe operations firsthand and validate reported activities. To strengthen contractor performance, the Department also provides ongoing training and technical assistance, complemented by feedback collection from community members, including individuals served and partner organizations. Routine reviews of monthly data submissions support the identification of patterns, reporting concerns, and areas requiring additional support. Although only a limited number of on-site monitoring visits were completed during the audit period due to operational constraints, all other monitoring activities remained continuous and ongoing throughout the timeframe.

We agree that additional clinical expertise in record review may be beneficial. We will explore reclassifying the SOR Field Auditor position to a Program Specialist role that requires clinical experience. We will assess the required competencies, review applicable classification standards, and determine whether the recommended reclassification is feasible and appropriate.

As noted in the response to Observation No. 1, we will develop a policy on contract monitoring that includes frequency, checklists and scheduling site visits. We will aim to increase the frequency of site visits, though the actual frequency will always be dependent on availability of staff.

We would like to clarify that the work of the six staff positions funded by the grant extends beyond overseeing the Doorway contractors. Many contractors are funded by SOR and the doorway program represents less than half of the overall investment.

Observation No. 4

External Program Evaluation Recommendations Should Be Implemented

Program management did not fully implement the recommendations made in its two most recent external program evaluation reports. The first was an improvement plan regarding GPRA response rates completed by UNH, and the second, an evaluation of the Program conducted by Pacific Health Policy Group, both made available to Program management in September 2023.

As of November 2025, six of the 24 recommendations (25.0 percent) in the program evaluations had been fully resolved, 11 recommendations (45.8 percent) had remediation in process, and seven recommendations (29.2 percent) had not been resolved. The status of the recommendations in the external program evaluation reports as of November 2025 can be found in Appendix D.

According to GAO's *Standards for Internal Controls in the Federal Government*, management was responsible for remediating identified internal control deficiencies, such as evaluation findings, on a timely basis. This included completing and documenting the corrective actions taken.

Staffing Issues Reportedly Limited Ability To Make Improvements

The Program had six authorized, full-time equivalent positions but two of the positions (33.3 percent) went unfilled during State fiscal year 2025, which reportedly placed significant burdens on remaining employees. Due to the vacant positions, existing staff were required to take on additional responsibilities. The State's 2025 hiring freeze further complicated matters as federally funded positions needed to go through a waiver process and were not filled until late 2025. In addition, Program management reported extensive staff turnover during the audit period.

While vacancies appeared to have largely affected the Program's efforts to remediate deficiencies, the untimely implementation of recommendations could have prolonged the Program's inefficient and ineffective practices.

Recommendations:

We recommend Program management prioritize the timely implementation of all feasible recommendations made in the external program evaluation reports, including the development and implementation of corrective action plans.

Auditee Response:

We concur in part. We agree that timely implementation of external evaluation findings is important. We would add that upon delivery of evaluations and reports from external partners, it is prudent to evaluate the applicability and practicality of each recommendation individually, as external partners are not always aware of the context or operating environment and resources available for program delivery.

In response to the two reports referenced in the observation, the Department has already undertaken substantial work in response to these recommendations. Many action items have been fully addressed or are progressing appropriately within established operational timelines.

For clarity, the status of each item is summarized below:

September 2023 Doorway Program Evaluation Recommendations:

- 1. Enhance Doorway policies to support seamless statewide model of care, (Observation No. 2 in this report): To be completed upon corrective action.*
- 2. Define and align roles and creative incentives for collaboration across publicly funded system: This item represents an ongoing, long-term requirement and will remain active by design.*
- 3. Create a quality monitoring and improvement framework: In progress, with anticipated completion December 2026.*
- 4. Standardize data collection and establish benchmarks: In progress, with work continuing as planned.*
- 5. Enhance third party revenues to support Doorway model of care: Completed. Multiple Doorways have enhanced revenue. Continued enhancement is ongoing by design.*
- 6. Clarify and recognize Doorways as part of Medicaid Managed Care Organization care management obligations: Complete.*
- 7. Improve availability of Flexible Needs Fund: A continuous quality improvement activity, and therefore intentionally ongoing.*
- 8. Enhance Medicaid revenues and State Opioid Response funded transportation services: Ongoing, consistent with the nature and scope of the work.*
- 9. Improve access and enhance management of Department of Health and Human Services respite utilization: Being addressed through the new procurement process and embedded quality improvement efforts.*
- 10. In the absence of federal funds, explore expansion of Medicaid authorities and alternative reimbursement models for Doorway services: Not pursued at this time*

due to the continued availability of federal funds, rendering the action unnecessary.

11. Consider alternative delivery system structure for Doorway services: Completed.

We have similarly made substantial progress on the recommendations outlined in the UNH evaluation. Current status is as follows:

- 1. Restructure the Doorway system operationally and technologically, so all the doorways operate as one cohesive entity: Ongoing; this is understood to be a continuous improvement process.*
- 2. Ensure WITS Client IDs are in compliance with the Substance Abuse and Mental Health Services Administration's (SAMHSA) policies and data privacy standards, while still allowing for data entered in SPARS to be aggregated by site: Completed.*
- 3. Revise communication strategies to offer the Doorways and OSFVs timely and effective support, training, protocols, and information, including the most up to date SAMHSA guidelines: Completed.*
- 4. Develop clear, straightforward, and consistent contract language for the Doorways and OSFVs that requires completion of the GPRA intake, follow-up, and discharge as a deliverable of the contract for all clients receiving SOR-funded services: Completed.*
- 5. Increase GPRA awareness and education by communicating the importance of the GPRA, how the data is used, and how it supports the ultimate goal of improved client outcomes: Completed.*
- 6. Improve morale and relationships between the State, the Doorways, and other SOR-funded vendors to improve communication and the continuity of care: Ongoing; this is expected and appropriate given the nature of the work.*
- 7. Improve continuity of care and GPRA interview follow-up rates by subcontracting with an Administrative Services Entity such as advocates for human potential: Not feasible.*
- 8. To support the Doorways in operating as one cohesive system, develop and clearly communicate GPRA-related communication and action policies, and procedures: Completed.*
- 9. Develop and implement a streamlined client transfer process that improves continuity of client care and supports collaboration between the Doorways: The recommendation is not directly applicable, as we do not transfer in the manner described; however, movement between programs has been streamlined and is now more easily accomplished.*

10. *Formalize and universally implement client consent process for the Doorways and OSFVs that facilitates collaborative care coordination among the doorways and improves opportunities for ongoing client engagement: Ongoing, this is understood to be a continuous improvement as vendors change over time.*
11. *Establish and implement a protocol that details the training and professional development requirements for the Doorway and OSFV staff: Not feasible*
12. *Identify or hire a GPRA lead or GPRA data coordinator at each Doorway to organize and supervise GPRA data collection at the Doorway and review and clean GPRA data including intake, follow up, and discharge: Not feasible.*
13. *Establish and implement a protocol around regular supervision to support clinical and non-clinical Doorway staff who administer GPRA tools. Supervision should include supporting staff around secondary trauma: Completed.*

As demonstrated, a significant portion of the recommendations have already been met, while the remaining items are either continuous by design or advancing through appropriate implementation pathways. We will continue to monitor progress, maintain transparency, and complete outstanding items in a timely and accountable manner.

**State Of New Hampshire
Doorway Program**

Program Operations

The Doorway Program (Program) relied heavily on program *outputs* to provide trend data rather than program *outcomes* to measure program effectiveness. The U.S. Government Accountability Office (GAO) defined outputs as the direct products and services delivered by a program, whereas outcomes were the results of those products and services. Outcomes in the Program conveyed the measurable results of efforts to improve access, treatment, and recovery support for individuals with substance use disorders. We found the Program prioritized the collection of output data, rather than examining client outcomes. We also found the Program did not comply with federal Government Performance and Results Act (GPRA) data collection requirements due to low client interview response rates and incomplete monthly statistical reports submitted by the nine doorway locations statewide. Additionally, we identified an opportunity to improve the Program’s request for reimbursement process.

Observation No. 5

Federal Data Should Be Used To Measure Client Outcomes

Program management did not use GPRA interview data to measure client outcomes for formal reporting to stakeholders or to determine program efficacy, reportedly due to challenges with conducting interviews resulting in the low client response rate. The SAMHSA requirements included using the GPRA Center for Substance Abuse Treatment interview instrument to complete intake interviews with 100 percent of clients. New Hampshire’s data showed a 60.1 percent intake interview completion rate for federal fiscal year 2025.

Client Satisfaction Survey Results

To measure achievement of program goals, management used a client satisfaction survey consisting of five optional questions. The survey was not mandatory for clients and could be completed by providers and other non-clients, using a scannable code or smart device, which may have skewed results. The five questions were:

1. “How was your experience at the Doorway today?” (One to five stars)
2. “Would you be willing to answer a few more questions about your experience?” (Yes/No)
3. “How has your life changed since you’ve participated in the Doorway Program?” (Scale of 0 to 100)
4. “What services offered at the Doorway have been most helpful?” (Multi-select)
5. “Is there anything else you would like to tell us about the Doorway?” (Open comment response)

Tables 2 and 3 depict the survey responses for questions one and three from March 2024 through July 2025, when the survey was implemented to when our analysis of survey data was performed. Questions two, four, and five were not included below due

to their lack of relevance in measuring client outcomes – those results are presented in Appendix C.

Table 2 – Doorway Program Survey: Client Survey Experience

Question 1. How was your experience at the Doorway <u>today</u>?		
Answer Options	Count	Percent
★	4	2.5
★★	0	0.0
★★★	2	1.3
★★★★	10	6.3
★★★★★	144	90.0
<i>respondent answered question</i>	160	100.1
<i>respondent skipped question</i>	9	

Note: Totals may not add to 100 percent due to rounding.

Source: LBA analysis of Program survey data.

Clients were asked to rate their experience at the doorway location on a scale of one to five stars, with one star being the lowest rating, and five the highest. Although Table 2 showed a high percentage of respondents with a five-star rating (90.0 percent), the number of survey respondents was low compared to the number of program clients. In total, the client survey received 169 individual responses from March 2024 through July 2025, compared to an average of 1,805 unique clients served (9.4 percent response rate) during each year of the audit period. When clients were asked to rate how their life had changed on a sliding scale of zero to 100 with zero being worse than before, 50 being about the same, and 100 being better than before, 119 clients (87.5 percent) responded with a score of 80 and above indicating their life was better than before as shown in Table 3.

Table 3 – Doorway Program Survey: Change In Clients’ Lives

Question 3. How has your life changed since you’ve participated in the Doorway Program?		
Answer Options	Count	Percent
0-49	2	1.5
50-59	5	3.7
60-69	6	4.4
70-79	4	2.9
80-89	14	10.3
90-100	105	77.2
<i>respondent answered question</i>	136	100.0
<i>respondent skipped question</i>	33	

Source: LBA analysis of Program survey data, March 2024 through July 2025.

GPRA Results

We analyzed the responses to the quality of life (QoL) question within the GPRA interview dataset to determine QoL changes during the audit period.³ We examined pairs of intake and corresponding six-month follow-up interview responses to the QoL question. When we identified missing data between one or more interviews or when the client did not answer the question, we could not measure the QoL and discarded that pair of records from our analysis. We also discarded pairs when the six-month follow-up was conducted less than 150 days or more than 240 days after the intake interview date. After adjusting the initial dataset for instances where there was insufficient data to analyze, we examined QoL data for 404 clients. Because of the non-random nature of cases with data that could be analyzed compared to the entire population of individuals receiving services, the results could not be generalized to the entire population of individuals receiving services. Based on our analysis, 184 of 404 clients (45.5 percent) reported an improvement in their QoL, 81 of 404 clients (20.0 percent) reported no change in their QoL, and 139 of 404 clients (34.4 percent) reported a deterioration in their QoL.

According to the GAO's *Standards for Internal Control in the Federal Government*, management should process relevant data into quality information. Quality information supports the internal control system and was essential for an organization to realize its goals.

Program staff reported the GPRA interview data was not used to track client outcomes because data on client progress was shared across all behavioral health programs in the continuum of care and it could not be efficiently separated for the Program exclusively.

The Program was unable to adequately or effectively measure client outcomes by relying solely on client satisfaction survey data. Undue reliance on survey data increased the risk of management making misleading or uninformed decisions, as the client survey could be susceptible to low response rates.

Recommendation:

We recommend Program management use federally-required interview data to more effectively measure client outcomes. If the client satisfaction survey is deemed useful to the Program, management should consider redesigning it. Management should also determine the best way to administer the survey to increase response rates.

³ Following the audit period, the GPRA was replaced by a new tool effective October 1, 2025, known as the Substance Abuse and Mental Health Services Administration Unified Performance Reporting Tool. Like the GPRA, the tool also asks the client to rate their quality of life.

Auditee Response:

We concur in part. Corrective Action Planned: We agree client outcomes should be measured. However, DHHS requires the use of evidence-based practices in the Doorways contracts. These are practices which produce outcomes that have been determined to be clinically effective and cost-effective when performed with fidelity. Utilizing Evidence-based Practices (EBP) relieves program managers from the obligation of re-evaluating outcomes for each client under the contracts. The program is regularly reviewing the national landscape of available EBPs to ensure EBPs utilized are updated as appropriate.

The GPRA intake interview contains approximately 105 questions and must be conducted face to face. The assessment typically takes at least 45 minutes to complete. Historically, the instrument has presented challenges for both participants and providers. Survey respondents are “self-selected,” meaning responses come from individuals willing to complete the surveys, rather than a random sample of participants. During the 2022-2024 state fiscal years, the GPRA database shows 4,774 responses, which was only 19.2% of the 24,857 individuals served. As pointed out in the observation, only 404 of 24,857 individuals (1.6%) engaged in a complete set of GPRA interviews.

Due to the low volume of returns, the Department complied with a Pacific Health Policy Group recommendation to create a simple, easy-to-administer survey for feedback on the client experience. However, neither the GPRA or the client survey provided enough consistent or thorough responses to draw conclusions on client outcomes that could inform substantive programmatic or policy changes.

The Department anticipates increased response rates for Substance Abuse and Mental Health Services Administration’s (SAMHSA) new SUPRT tool. Once these responses have been collected and analyzed, we will assess the utility of the information. We hope to be able to use the SUPRT tool responses to understand the client experience, measure client outcomes, and inform program practices.

LBA Comments:

While we agree that not every client's outcome needs to be evaluated, some evidence-based practice frameworks in the healthcare profession include the need to evaluate outcomes as part of the process. Sampling could be used by the Program to assess effectiveness.

The Program’s assertion that there were 24,857 clients served differs from the number of clients served in Figure 3 because the Program includes friends and family members that contacted the Program seeking information for a loved one in the total number of clients served by the Program. We believe the Program’s method of counting those served by the Program overstated the actual number of clients served.

Observation No. 6

Client Outcome Measurement Data Should Be Collected

The Program did not collect certain client outcome measurement data needed to determine effectiveness and ensure compliance with federal requirements. The Program tracked outputs including, but not limited to, the number of individuals seen and number of naloxone kits distributed. Outputs were the direct products and services delivered by the program while outcomes were the results of those products and services. Outputs themselves did not provide information on whether the provision of products or services were effective in improving client outcomes.

State-level Goals

To promote greater effectiveness in managing federal programs, the GPRA instituted a federal government-wide requirement that agencies set goals for their programs and use performance measures to assess whether those goals were met. Outcome measures were identified by the New Hampshire Department of Health and Human Services (DHHS) Bureau of Drug and Alcohol Services in the State fiscal years (SFY) 2024/2025 biennial operating budget document submitted by DHHS to the Governor. The budget contained the following three goals for the two-year budget period:

1. decreasing opioid overdose fatalities by ten percent;
2. “increas[ing] access to screening, assessment, and referral for individuals seeking” substance use disorder services by 15 percent; and
3. increasing referral of individuals with opioid use disorder to medication assisted treatment and other clinically appropriate services by providing 80 percent of clinically appropriate clients with access to these services.

Although there were three goals identified in the State budget, the Program achieved one, which was the decrease in opioid fatalities. This was a good example of an outcome measurement. Opioid fatalities in the State decreased 38.5 percent between calendar years 2023 and 2024. While the Program was able to show this outcome was achieved for calendar year 2024 using data provided by the New Hampshire Office of the Chief Medical Examiner, the decrease in opioid overdose fatalities may have been attributed to factors both related and unrelated to Program initiatives. The Program was unable to demonstrate it achieved the other two goals identified in the State budget. Additionally, performance measures were not included in Program contracts with the doorway locations to establish expectations and clearly communicate program goals.

To determine effectiveness, the Program could have measured the percentage of clients reporting an improvement in their QoL at three checkpoints: 1) at the start of the Program, 2) six months into the Program, and 3) at Program discharge. The QoL outcome measure was present in the GPRA interview dataset recorded by vendor staff. The data was automatically uploaded to the federal Substance Abuse and Mental Health Services Administration’s (SAMHSA) Performance Accountability and Reporting System on a nightly basis. Program staff had access to this data but opted not to use it for measuring client outcomes as reported in Observation No. 5.

Staffing Issues Reportedly Limited Ability To Measure And Report Outcomes

The Program had six authorized full-time equivalent positions and two of its positions (33.3 percent) went unfilled during State fiscal year 2025, which placed significant burdens on remaining employees and may have led to the Program's inability to properly report programmatic data, establish outcomes, and measure performance. In 2024, the program's previous data coordinator transferred to another position within DHHS and supported the Program as time allowed, while also managing new job responsibilities. A new data coordinator filled this vacant position late in calendar year 2025.

Without collecting data on client outcomes, the Program was unable to effectively determine whether desired program goals were met.

Recommendations:

We recommend Program management:

- 1. utilize data-driven outcomes, such as the QoL outcome, that are both measurable and attainable to assess whether the Program is achieving its programmatic goals;**
- 2. collect and track the data needed to assess all goals identified in the State budget; and**
- 3. include identified outcome measures in all contracts with the doorway locations to establish expectations and clearly communicate program goals.**

Auditee Response:

We concur. Corrective Action Planned: DHHS requires the use of evidence-based practices in the Doorways contracts. These are practices which produce outcomes that have been determined to be clinically effective and cost-effective when performed with fidelity. Utilizing EBPs relieves program managers from the obligation of re-evaluating outcomes for each client under the contracts. The program is regularly reviewing the national landscape of available EBPs to ensure EBPs utilized are updated as appropriate.

Additionally, the Department has created a publicly available Opioid Dashboard (available at the DHHS Data Portal: [NH DHHS Data Portal](#)) which reports on significant components of opioid use including emergency services and hospital admission/discharge data. The program area regularly reviews Statewide data that directly or indirectly impacts the individuals served through the Doorways contracts. We acknowledge that this process could be formalized with an established review frequency for program managers, data analysts, and leadership. This will be formalized in policy and procedure as outlined in Observation No. 1.

Furthermore, we acknowledge that not all datasets identified in the budget were reported. We will incorporate a process for reviewing and analyzing third-party data sources at least twice annually for reporting purposes and to inform both program

oversight and continuous quality improvement efforts. This also will be formalized in policy and procedure as outlined in Observation No. 1.

We currently collect client outcome data utilizing SAMHSA's new SUPRT tool. We anticipate the tool will lead to higher response rates which will be utilized for additional data collection, analysis and reporting.

LBA Comment:

While we agree that not every client's outcome needs to be evaluated, some evidence-based practice frameworks in the healthcare profession include the need to evaluate outcomes as part of the process. Sampling could be used by the Program to assess effectiveness.

Observation No. 7

Complete Intake And Follow-up Interviews As Required

Program management reported the Program was not in compliance with GPRA data collection requirements because of low client interview response rates. The SAMHSA required grantees to collect and report GPRA data, including client intake and follow-up interview data. The SAMHSA requirements included using the GPRA Center for Substance Abuse Treatment interview instrument to complete intake interviews with 100 percent of clients. New Hampshire's data showed a 60.1 percent intake interview completion rate for federal fiscal year 2025.

The SAMHSA also required a follow-up interview rate of 80 percent at the six-month mark. New Hampshire's six-month follow-up rate was 4.9 percent for federal fiscal year 2025, approximately 16 times lower than mandated by SAMHSA. In response to a UNH Institute for Health Policy and Practice (IHPP) recommendation, the Program amended and issued new contracts during SFY 2025 to improve GPRA compliance at doorway locations

Program and doorway location staff reported GPRA interview questions were invasive, the intake interview was lengthy, and some clients were transient and difficult to reach by phone. According to the UNH IHPP 2023 *New Hampshire State Opioid Response Grant GPRA Improvement Plan*, five doorway locations stated, "clients frequently arrive at the Doorway seeking help with transportation, housing, and/or crisis intervention, but after receiving assistance, the clients never return for the GPRA interview or have little further contact with the Doorway."⁴

⁴ Peoples, S., Swanson, B., Plante, E-L., & Costello, A. (2023). *New Hampshire State Opioid Response Grant GPRA Improvement Plan: Findings and Recommendations*. Durham, NH: University of New Hampshire.

The Program risked fully or partially losing grant funds as a consequence of not meeting the expected GPRA interview compliance rates. Additionally, as reported in Observation No. 5, if GPRA interview data had been collected, Program management could have used it to determine whether the Program was effective in achieving Program goals through its QoL measure. Without completing the required GPRA interviews, the Program had no other broad-based method it could use for measuring client outcomes and determining program effectiveness.

Recommendations:

We recommend Program management comply with the SAMHSA requirements for collecting and reporting data.

Auditee Response:

We concur. Corrective Action Planned: The GPRA intake interview contains approximately 105 questions and must be conducted face to face. The assessment typically takes at least 45 minutes to complete. Historically, the instrument has presented challenges for both participants and providers.

The Department made steady, deliberate improvements to GPRA processes throughout the audit period to strengthen response rates and overall compliance. These efforts included:

- conducting interviews with Doorway staff to better understand workflows and challenges in administering the tool,*
- consulting with other states with strong completion rates to learn from their models and staffing structures,*
- completing a review of available technology systems to assess limitations of the existing WITS platform, and*
- distributing a survey to additional SOR-funded vendors to gather broader perspectives on barriers and opportunities for improvement.*

Despite these efforts, GPRA rates remained below performance requirements, in New Hampshire and in most states nationwide. Due to the nationwide difficulties in GPRA administration and response rates, SAMHSA has pivoted to a new data collection tool, the SAMHSA Unified Performance Reporting Tool (SUPRT). As a result, while we remain committed to data-driven program improvement, GPRA compliance is no longer applicable to the current grant requirements.

Observation No. 8

Improve Accuracy And Completeness Of Monthly Statistical Reports

Monthly statistical reports published by the Program were incomplete and prone to error. Nearly every monthly report published during the audit period included errors or

omitted certain program data. Program staff reported the process was complex and required a great deal of manual work.

Although not required by laws, rules, regulations, or policy, it was common practice for the Program to publish certain statistical information, such as the number of individuals seen, number of naloxone kits distributed, and number of treatment referrals, on its website monthly. Publicly reported outputs provided information to stakeholders, ensuring the Program was transparent.

We reviewed 48 monthly statistical reports published by the Program from July 2021 through June 2025 and identified the following issues primarily caused by data entry errors:

- incorrect date ranges for monthly statistical reports,
- missing or incorrectly linked reports, and
- incorrect totals.

The GAO's *Standards for Internal Control in the Federal Government* stated management was responsible for generating and using relevant, quality information to support the functioning of its internal control system. Reporting unreliable information could lead to operational inefficiencies or reputational harm and could undermine trust. Additionally, using inaccurate information to make management decisions could lead to adverse consequences on individuals or communities.

Recommendation:

We recommend management improve the accuracy and completeness of monthly statistical reporting by establishing policies and procedures for compiling, reviewing, and reporting output data. In addition, management should consider automating the process to eliminate mistakes caused by human error.

Auditee Response:

We concur. Corrective Action Planned: We will strengthen internal controls around statistical reporting by establishing written policies and procedures that outline the process for data collection, data quality management, data analysis, reporting requirements by audience, and program management review. Policies will include the criteria management will use for evaluating data, what data will be used for contract management, when data will be escalated to leadership, and when data will be used to inform policy.

Policies will require a mandatory, documented supervisory review. Procedures will also define clear segregation of duties to ensure that the individual preparing a report is not the same person who approves it, with review and approval steps scheduled to occur early enough in the reporting cycle to meet all federal submission timelines. We anticipate having these policies completed June 30, 2027.

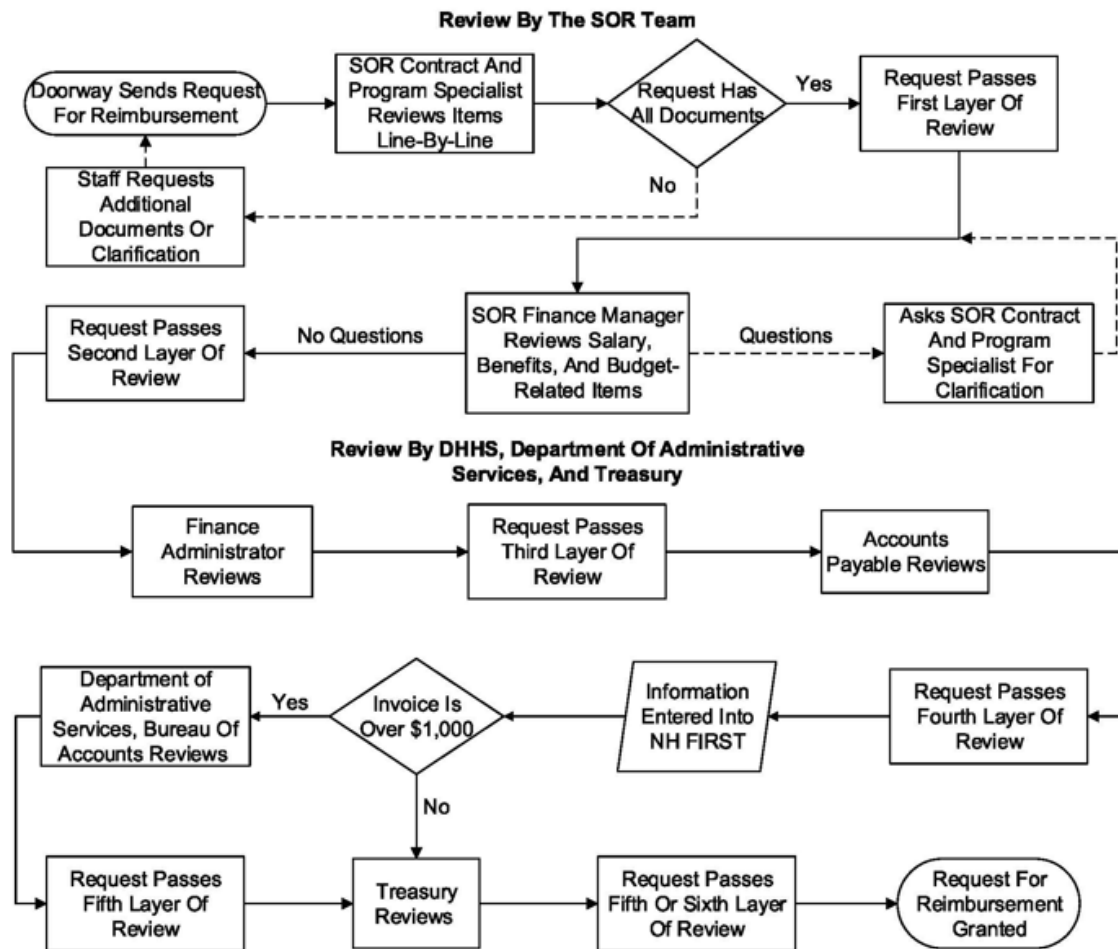
Observation No. 9

Reimbursement Process Should Be Reviewed

The Program did not have controls in place to ensure it received complete and accurate requests for reimbursement with all supporting documentation for timely processing. Program management stated the cause of processing delays was due to untimely, incomplete, and error-prone submissions of documentation supporting requests for reimbursement.

DHHS was a direct recipient, and doorway locations were subrecipients, of State Opioid Response (SOR) federal grant funds. On a monthly basis, each doorway location prepared a request for reimbursement by collecting supporting documentation, such as individual invoices, receipts of payment, and employee timesheets, and completing a spreadsheet summarizing spending by expenditure type. The summary spreadsheet and supporting documentation were then submitted electronically to DHHS for review before being entered into NH FIRST, the State's accounting system. Figure 6 depicts the State's review process upon receiving requests for reimbursement from the doorway locations. Once requests for reimbursement were reviewed and approved, the Program reimbursed the doorway for the expenditures incurred using SOR federal grant funds.

Figure 6 – SOR Invoice Review Process



Source: LBA interviews and analysis of requests for reimbursement.

Reimbursements To Doorways Were Not Paid Timely

Contracts with the doorways required the State to, “make payments to the Contractor within 30 calendar days only upon receipt and approval of the submitted invoice and required supporting documentation.” In our random sample of 65 of the 662 invoices submitted to the Program during SFYs 2022 through 2024, we found it took an average of 39 days to process the invoice from the date of the doorway location’s initial submission to the date paid.

Because some requests for reimbursement may have been incomplete at the time of submission to DHHS, we also calculated the time it took to process the invoice after the first layer of review was completed to the date paid, which averaged 29 days (one day less than the 30-day requirement in the contracts).

However, of the 63 invoices that had complete data, 18 (28.6 percent) took more than 30 days to process, including one which took 113 days, 83 days beyond the contracted

time limit. Additionally, the number of days elapsed between the first and second layers of review depicted in Figure 6 averaged 16 days, which accounted for more than half of the total 29-day average review process time for our sample. Given the small sample size, our results may not be representative of the whole population of reimbursement requests submitted to the Program during the three-year period reviewed.

Recommendations:

We recommend DHHS management:

- **evaluate its process for reviewing reimbursement requests submitted by the doorways, with a goal of determining the root cause of payment delays and ensuring compliance with the 30-day payment terms;**
- **provide vendor training to communicate and reinforce compliance requirements and documentation needs; and**
- **explore whether future contracts could be structured with different payment terms that would help to increase efficiencies while maintaining compliance with federal requirements.**

Auditee Response:

We concur. The Department has provided a vendor training that addressed key financial and grants management topics, including Roles and Responsibilities of the Procurement Process, Budgets, Indirect Cost Rates, Budget Revisions and Ratio Requirements, Subrecipient Monitoring, and Invoicing and Supporting Documentation. Training Cohort 3 expanded the curriculum to include Uniform Guidance and a full-day Nonprofit Financial Management workshop. The sessions ran as Cohort 1 (Jan–Mar 2024) with 181 attendees, Cohort 2 (Jul–Dec 2024) with 212 attendees and Cohort 3 (Jan–Jun 2025) with 350 attendees. Participant satisfaction across cohorts averaged 92.5%. We are in agreement that this training should occur with regular frequency to ensure vendors better understand the components of their contract payment terms. However, this is dependent upon adequate resources being available to the Department. Implementing further trainings in the current biennium would be very challenging under existing constraints.

The Department has also reviewed the invoice process flow to identify additional efficiencies, including implementing a Teams-based approval workflow for Budget Revision Requests to help reduce delays with that component of the invoice payment progression. The Department also agrees with the need to explore different types of contract payment terms. This aligns with the [DHHS Roadmap 2024-2025](#), Commitment 3 – Improve Customer Service; Initiative 5: Streamline payment methods to ensure more efficient and effective delivery of services. The Department is committed to working collaboratively with providers to identify approaches that maintain compliance while minimizing unnecessary administrative burden.

Governor's Commission On Addiction, Treatment, And Prevention

The Governor's Commission on Addiction, Treatment, and Prevention (GCATP) funded the Doorway Program's (Program) unmet needs, which were for client services that fell outside the scope of State Opioid Response (SOR) grant funding, such as those related to alcohol use disorder. Unmet needs funds were used by clients to facilitate recovery-related medical appointments, treatment programming, or other supports as approved by Program professional staff. During the audit period, funding for the GCATP came from the currently named Addiction, Treatment, and Prevention Fund as required by RSA 176-A:1, III.

The GCATP was comprised of government leaders, stakeholders, and public members. Statute dictated the Executive Director of the GCATP, "shall be the director of the appropriate division responsible for alcohol and drug misuse prevention and recovery..." thereby designating the Director of the New Hampshire Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) as the GCATP Executive Director. The GCATP contracted via DHHS to provide additional administrative support, such as report writing, as the GCATP did not have the authority to contract on its own. DHHS used an existing Project Coordinator position to support the GCATP.

Staff reported the GCATP followed the same payment process and internal control procedures for its unmet needs requests for reimbursement as all other DBH requests, regardless of funding source. Requests for reimbursement relating to unmet needs were received by GCATP staff for review and approval, and were also reviewed by Program staff to ensure expenditures were not eligible for reimbursement under the SOR grant. Expenditures were always funded by SOR grant funds if eligible. If not, unmet needs funds were used to pay requests for reimbursement. After Program staff performed its review for SOR grant funding eligibility, the centralized DHHS finance office additionally examined whether the correct NH FIRST account was charged. DBH's *Internal Invoice Processing Guidance* policy established timelines for contractor requests for reimbursement submissions and DBH staff review and approval processes.

Observation No. 10

Develop Comprehensive Policies And Procedures

Management of the GCATP did not establish comprehensive policies and procedures to support its operating, reporting, and compliance objectives. In particular, the GCATP lacked written policies and procedures for the following:

- the determination of funding allocations,
- guidelines for processing reimbursement requests, and
- statutory reporting requirements as reported in greater detail in Observation No. 11.

According to Government Accountability Office’s (GAO) *Standards for Internal Control in the Federal Government*, management was responsible for designing control activities through the establishment of policies and procedures. Policies and procedures helped to establish clear expectations, ensure compliance, promote consistency, and mitigate risks of not achieving the entity’s objectives. Without written policies and procedures, institutional knowledge at the GCATP could be lost when key staff members leave the organization.

Recommendation:

We recommend GCATP management establish comprehensive policies and procedures to support significant GCATP-related processes that are not already adequately covered by DHHS policies and procedures.

Auditee Response:

We concur. Corrective Action Planned: GCATP management will develop, approve, and implement comprehensive policies and procedures that clearly define and support all significant GCATP operational processes in coordination with the Department. These policies will supplement existing Department policies where gaps exist and will ensure consistent, compliant, and well-documented program practices. Policies and procedures will be substantially completed by June 30, 2027.

Observation No. 11

Follow Statutory Reporting Requirements

The GCATP did not comply with some key reporting requirements in its governing statute. By not reporting as required, the Governor, the Legislature, and stakeholders may not have had the information needed to make informed decisions. Table 4 outlines the noncompliance issues we identified based on the GCATP’s release of one required annual report in 2024 and other miscellaneous reports during our four-year audit period.

Table 4 – GCATP Noncompliance With Statutory Reporting Requirements

Statute	Statutory Requirement	Description Of Noncompliance
RSA 12-J:3, VII	Develop a handout describing the risks of opioid use and how to mitigate them.	No handout was found on the GCATP websites or provided by the GCATP.
RSA 12-J:4, II	Submit an annual report to the Governor and legislative leadership.	No annual reports were submitted in 2022, 2023, or 2025.

Statute	Statutory Requirement	Description Of Noncompliance
RSA 12-J:4, II(a)	In the annual report required by RSA 12-J:4, II, “[i]dentify alcohol and other drug misuse and problem gambling prevention..., treatment including reduction of societal and individual harm, and recovery services and programs provided by [S]tate departments and agencies or funded in whole or in part by [S]tate or federal funds.”	No identification of services and programs was included in the 2024 annual report.
RSA 12-J:4, II(c)	In the annual report required by RSA 12-J:4, II, “[r]ecommend any revisions to the statewide plan....”	No recommended revisions to the statewide plan were included in the 2024 annual report.
RSA 12-J:4, II(d) RSA 12-J:4, II(e)	In the annual report required by RSA 12-J:4, II, “[i]dentify and prioritize unmet needs for prevention, treatment including reduction of societal and individual harm, and recovery” and “[i]ndicate the progress, or lack thereof, in addressing the unmet needs.”	No identified and prioritized unmet needs were included in the 2024 annual report.
RSA 12-J:4, II(f)	In the annual report required by RSA 12-J:4, II, “[r]ecommend initiatives and/or policy considerations to the [G]overnor and the [G]eneral [C]ourt to address the unmet needs.”	No recommended initiatives or policy considerations were included in the 2024 annual report to the Governor and the General Court.
RSA 12-J:4, II(g)	In the annual report required by RSA 12-J:4, II, “specify the resources and any legislation necessary to support existing programs for prevention, treatment including reduction of societal and individual harm, and recovery and to develop, implement, support, and evaluate the initiatives recommended by the [GCATP].”	No resources or legislation specified as necessary to support prevention, treatment, and recovery programs were included in the 2024 annual report.

Statute	Statutory Requirement	Description Of Noncompliance
RSA 12-J:4, II(i)	In the annual report required by RSA 12-J:4, II, “[i]ncorporate the findings and recommendations of the report required [in RSA 12-J:4, II-a] and make specific findings and recommendations regarding public awareness, education, and legislation to address the dangers of synthetic drugs.”	No findings or recommendations regarding public awareness, education, and legislation to address the dangers of synthetic drugs were included in the 2024 annual report.
RSA 12-J:4, II-a	“[P]repare a report, including recommendations for policies to be implemented for coordinating public awareness of and education in the importance prevention and health promotion, as well as the dangers of synthetic drugs and other emerging or designer synthetic drug substances. The report shall include substantive input from the [GCATP]’s member agencies...” and submitted to the Governor and legislative leadership annually.	No reports were submitted in 2022, 2023, 2024, or 2025.
RSA 12-J:4, III(b)	Submit a mid-year report to the Governor and legislative leadership, “regarding the current state of drug misuse, prevention, treatment including reduction of societal and individual harm, and recovery.”	No mid-year reports were submitted in 2022, 2023, 2024, or 2025.
RSA 12-J:4, IV	In the reports submitted by the GCATP under RSA 12-J:4, “include outcome data and/or research citations about the efficacy of funded programs based upon evidence of program results.”	Reports submitted during our four-year audit period included output data but did not include outcomes that were based upon evidence of Program results.

Statute	Statutory Requirement	Description Of Noncompliance
RSA 12-J:5, I	Issue a report annually on, “currently funded programs and including findings relative to cost-effectiveness, outcomes, and evidence of effectiveness of programs funded in whole or in part by the [GCATP].”	No reports related to cost-effectiveness, outcomes, and evidence of program effectiveness were issued in 2022, 2023, 2024, or 2025.

Source: LBA review of GCATP reporting requirements and produced reports.

Commission management had no written policies or procedures guiding the GCATP’s production of required reports. Some required information was found scattered among other GCATP reports, including dashboards, statewide plans, State action plans and updates, and funding crosswalks, but formal reporting to the Governor and legislative leadership as required by statute was not performed.

Recommendations:

We recommend the GCATP comply with all reporting requirements in its governing statute, RSA 12-J. We also recommend GCATP management develop written policies and procedures to ensure compliance with its reporting requirements, including:

- **identifying and tracking reporting requirements,**
- **setting production schedules and internal deadlines,**
- **assigning responsibilities among the responsible staff, and**
- **updating GCATP members periodically on reporting statuses.**

Auditee Response:

We concur. Corrective Action Planned: The Department will review all reporting requirements in RSA 12-J and work with the GCATP to ensure compliance. We anticipate coming into compliance with reporting requirements as reports come due, over the course of the next 18 months.

Observation No. 12

Website Content Should Be Hosted On A Single Domain

The GCATP had its website content dispersed between two different websites, one operated by DHHS, and one operated by a contractor. Neither website clearly referred to or linked to the other website, causing confusion for users trying to find information and increasing the risk of publishing duplicate or conflicting information. There was also a risk of information not being reported on either website due to lack of coordination.

We found duplicate information posted on both websites, primarily reports and notices for upcoming meetings, but there was also other information published that was unique to each website. For example, agendas and minutes were posted on the DHHS website but not on the contractor's website. Contract provisions required the contractor to post the approved meeting minutes on the web page it managed. We also found that the 2024 funding crosswalk, *2022 Community Voices for Strategic Planning Data Report*, and *Stimulant Workgroup Strategy Recommendations* were posted on the DHHS website, but not on the contractor's website.

Management was responsible for selecting appropriate methods for communicating externally. GAO's *Standards for Internal Control in the Federal Government* stated "[m]anagement evaluates the entity's methods of communication on a periodic and ongoing basis so that the organization has the appropriate tools to communicate quality information throughout and outside of the entity on a timely basis."

According to GCATP management:

The two websites serve different but complementary purposes. The site hosted by the contractor...is designed to support the operations and programmatic work of the [GCATP], including meeting materials, initiatives, and [GCATP]-related resources. The site hosted by [DHHS] serves as the official [S]tate government webpage for the [GCATP], ensuring compliance with [S]tate web standards and providing formal public-facing information within the [DHHS's] website structure.

However, it was not clear what information published on the contractor's website could not be published on the DHHS website.

Recommendation:

We recommend the GCATP consolidate all website content on a single domain. When deciding where to have its website hosted, the GCATP should assess the pros and cons of using a State run versus private sector host, including associated costs to the GCATP and whether a State entity can use non-State hosting services.

Auditee Response:

We concur. Corrective Action Planned: The Department and GCATP management will evaluate options for consolidating all GCATP-related website content onto a single domain and determine the most appropriate hosting solution. The Program will then develop and implement a plan to consolidate website content accordingly. The Department will migrate web content by July 31, 2026.

Appendix A

Scope, Objective, And Methodology

In May 2024, the Fiscal Committee of the General Court approved a joint Legislative Performance Audit and Oversight Committee recommendation to conduct a performance audit of the Doorway Program (Program). We held an entrance conference to discuss the audit with the New Hampshire Department of Health and Human Services (DHHS) in September 2024, and the audit scope was approved by the joint Legislative Performance Audit and Oversight Committee in December 2024.

Scope And Objective

We designed the audit to answer the following question:

Did the Department of Health and Human Services, Division of Behavioral Health, effectively monitor the provision of the Doorway Program during State fiscal years 2022 through 2024?

Our original audit period was State fiscal year (SFY) 2022 through SFY 2024; however, due to the timing of audit progress, we also included SFY 2025. As we learned more about Program operations, we also examined the Governor’s Commission on Addiction, Treatment, and Prevention (GCATP), formerly known as the Governor’s Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery, as it related to the Program.

Our objectives were to: 1) determine the number of citizens directly participating in the program, 2) determine how long it took for clients to access services, and 3) evaluate the Division of Behavioral Health’s contract management and monitoring functions as they pertain to the Program. We were unable to achieve the second objective due to a lack of Program data.

Methodology

To gain a general understanding of the Program and address our audit objectives, we:

- reviewed relevant federal and State laws;
- reviewed contracts, grant agreements, policies, and procedures;
- reviewed evaluations of similar programs in other states;
- interviewed and corresponded with Program and DHHS management and staff;
- interviewed and corresponded with DHHS staff supporting the GCATP;
- documented and evaluated the request for reimbursement process;
- interviewed doorway providers to obtain perspectives from stakeholders;

- reviewed roles and responsibilities of Regional Public Health Networks and Certified Community Behavioral Health Networks and compared them to Program roles and responsibilities;
- reviewed reports of external program evaluations conducted by third parties;
- reviewed federally-required reports;
- reviewed contract compliance reviews of Program subrecipients and related materials;
- compiled and reviewed results of the Program's client satisfaction surveys;
- reviewed the Substance Abuse and Mental Health Services Administration Notices of Funding Opportunity, grant proposals, and Notices of Award;
- reviewed supplemental job descriptions and organizational charts;
- determined Program data reliability and analyzed Program statistics;
- reviewed risk assessments performed by DHHS;
- identified leading contract management and monitoring practices and compared them to Program practices;
- identified grant requirements and leading grant management practices and compared them to Program practices;
- identified prior external program evaluation recommendations and determined their status as of November 2025; and
- determined the non-payroll costs of operating the Program by funding source during the audit period.

The audit period was SFYs 2022 through 2025 (July 1, 2021 through June 30, 2025), except for our review of Government Performance and Results Act (GPRA) data. GPRA data was incomplete for SFY 2025, so our review of this data covered only SFYs 2022 through 2024. We examined managerial Program controls and other relevant matters outside of the audit period when they affected program operations during and after the audit period.

Request For Reimbursement Process Review

To gain an understanding of the Program's request for reimbursement process, we interviewed DHHS employees involved in the first three layers of review shown in Figure 6, reviewed policies and procedures related to the reimbursement process, and reviewed documents utilized by staff during processing.

We also selected a random sample of ten percent of the 662 invoices processed by the Program during the audit period, resulting in 66 sample selections. We searched for each invoice in the NH FIRST State accounting system by transaction number and collected dates documented on the invoices that were significant to the request for reimbursement process. These dates included:

- date invoice was signed by the contractor,
- signature dates from key DHHS employees in steps one through three of Figure 6, and
- date of payment.

The number of invoices referred to in Observation No. 9 was reduced from our initial sample of 66 invoices to 65 invoices because one invoice selected in our sample did not contain the vendor signature date needed to calculate the number of elapsed days during different phases of the invoice processing cycle. The number of invoices was further reduced to 63 because two additional invoices did not contain DHHS signature dates. The number of days elapsed between significant dates was calculated via Excel's DAYS function.

We chose a random sample design because it provided us with an efficient way to test how long it took a reimbursement request to travel through the invoice processing cycle. While our sample results cannot be projected and may not be representative of the entire population, we believe our work was sufficient to be able to identify inefficiencies in the reimbursement process.

Data Output Analysis

We analyzed monthly output statistics data reported by the doorway locations to the Program to determine the total number of individuals seen, number of naloxone kits distributed, and the number of clinical evaluations and treatment referrals provided to clients during our audit period. The Program published this monthly data on its website. Clients may have been duplicated from month to month, so it was not practical to add up the number of clients who received clinical evaluations and treatment referrals during each fiscal year and arrive at an unduplicated count of clients who utilized the Program's services. An average number of clients who utilized the Program's services each month during State fiscal year 2025 was used to gauge typical utilization. Despite some missing values, we determined the data we analyzed was reliable by conducting various analyses and deemed it sufficiently reliable to use to provide background information on the Program. The monthly output statistics data was not used to materially support any findings, conclusions, or recommendations.

Quality Of Life Outcome Analysis

We obtained certain GPRA data which was based on client interviews performed by the doorway locations at Program intake, six months after Program intake, and at Program discharge. While clients were required to participate in the GPRA interviews, they could decline to answer individual questions, so data was not available for all questions asked.

GPRA data for SFY 2022 through 2025 were obtained from the Program. However, data for SFY 2025 was determined to be incomplete and; therefore, was not used for our analysis. The remaining SFY 2022 through 2024 data was analyzed to determine the number of unique clients utilizing the Program and self-reported changes to the client's quality of life (QoL) as a result of participating in the Program.

The data in our dataset contained one consistent variable throughout all years of the audit period, "LifeQuality." The LifeQuality variable was conducive to gauging program effectiveness. The GPRA question relating to the LifeQuality variable was, "How would you rate your quality of life over the past 30 days?" Answers selected could be "Very

Poor,” “Poor,” “Neither Poor nor Good,” “Good,” “Very Good,” or the client could refuse to answer the question (coded as “Refused”). The answer could also be coded as “Missing.” Microsoft Visual Basic for Applications was used to cleanse and prepare data for QoL analysis. Our analysis evaluated changes in a client’s reported QoL between Program intake and its subsequent six-month follow-up. If QoL increased from Program intake to a subsequent six-month follow-up interview (ex. QoL was reported as “Good” to “Very Good” or “Very Poor” to “Poor,” etc.), we recorded it as an improvement to QoL. If QoL decreased from Program intake to a subsequent six-month follow-up interview (ex. “Very Good” to “Good” or “Poor” to “Very Poor,” etc.), we recorded it as a deterioration in QoL. When we identified missing data between one or more interviews or when the client did not answer the question, we could not measure the QoL and discarded that pair of records from our analysis. We also discarded pairs when the six-month follow-up was conducted less than 150 days or more than 240 days after the intake interview date. Because of the non-random nature of cases with data that could be analyzed compared to the entire population of individuals receiving services, the results cannot be generalized to the entire population of individuals receiving services. The QoL data was reported as shown in Figure 4.

Compilation Of Doorway Program Client Satisfaction Survey

Program management launched a client satisfaction survey on March 26, 2024. The Program received 169 survey responses from the launch date through July 14, 2025, when our analysis of the survey responses was performed. The survey was available at the doorway locations via QR code, laptops, or tablet and completion was not restricted to clients only.

We did not create the survey, nor did we survey the Program’s clients independently. The compiled results of the survey are shown in Appendix C.

Internal Controls

Internal controls were defined as a process effected by an entity’s oversight body, management, and other personnel, designed to provide reasonable assurance that the objectives of an entity will be achieved. Internal controls were comprised of the plans, methods, policies, and procedures used to fulfill the mission, strategic plan, goals, and objectives of the entity. *Government Auditing Standards* required that we determine and document which, if any, internal control components and principles are significant to the audit. We identified the following components of internal control and underlying internal control principles that we considered to be the most significant to the audit objective. The observations associated with those internal control components and underlying principles that we identified during the audit are also noted below.

Control Environment

1. Commitment to Integrity and Ethical Values – required the oversight body and management to demonstrate a commitment to integrity and ethical values.

2. Exercise Oversight Authority – required the oversight body to oversee the entity’s internal control system. We found DHHS management had not established adequate internal controls to ensure the program achieved its objectives (Observation Nos. 1, 2, 4, and 10).

Control Activities

3. Implement Control Activities – management should implement control activities through policies and procedures. We found Program management did not establish policies and procedures (Observation Nos. 1, 3, and 10).

Information And Communication

4. Use Quality Information – management should obtain or generate relevant, quality information and use it to support the functioning of the internal control system. We found the Program needed to improve its collection and reporting of its programmatic data (Observation Nos. 5, 6, 7, and 8).
5. Communicate Internally – management should internally communicate relevant and quality information, including objectives and responsibilities for internal control, necessary to support the functioning of the internal control system. We found the Program needed to improve the information it collected and reported to internal stakeholders (Observation Nos. 5 and 8).
6. Communicate Externally – management should communicate relevant and quality information with appropriate external parties regarding matters impacting the functioning of the internal control system. We found the Program needed to ensure it reported complete and accurate information to external parties (Observation Nos. 4, 5, 6, 7, 8, 11, and 12).

Monitoring

7. Perform Monitoring Activities – management should establish and operate monitoring activities to monitor the internal control system and evaluate the results. We found the Program needed to improve its subrecipient monitoring policies and procedures (Observation Nos. 3 and 4).
8. Evaluate Issues and Remediate Deficiencies – management should remediate identified internal control deficiencies on a timely basis. We found the Program had not resolved the recommendations made in external program evaluations (Observation No. 4).

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State Of New Hampshire
Doorway Program

Appendix B
Agency Response To Audit



Lori A. Weaver
Commissioner

Katja S. Fox
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION FOR BEHAVIORAL HEALTH

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
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June 9, 2026

The Honorable Ken Weyler
Joint Legislative Fiscal Committee
Legislative Office Building
33 N. State Street
Concord, NH 03301

Dear Chairman Weyler:

On behalf of the Department of Health and Human Services, I would like to extend our sincere appreciation for the efforts of the LBA during the recent performance audit of the Doorways Program. The thorough review and thoughtful analysis provide us with valuable information that will guide the continuous quality improvement of this important program.

The Doorways initiative plays a critical role in serving some of our most vulnerable residents, individuals and families affected by substance use disorder. We remain deeply committed to supporting their health and well-being. Treatment works, and recovery is possible. Every improvement we make strengthens our ability to connect people with effective care, enhance recovery supports, and ensure that those seeking help are met with compassion, dignity, and timely access to services.

As noted in our formal response, a number of improvements are already underway. The insights and recommendations offered through this audit will be instrumental in continuing to shape these enhancements and will help us strengthen our processes moving forward.

We thank the auditing team for their time, professionalism, and collaboration throughout this process. Your work supports our shared commitment to effective program oversight and high-quality services for the people of New Hampshire.

Sincerely,

A handwritten signature in black ink, appearing to read 'K. S. Fox'.

Katja S. Fox
Director

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

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**State Of New Hampshire
Doorway Program**

Appendix C

Doorway Program Client Survey Results

The Doorway Program (Program) launched an ongoing client satisfaction survey on March 26, 2024. The information below contains the results of the survey as of July 14, 2025, when our analysis of the survey responses was performed. The Program received 169 survey responses. The total number of survey respondents who skipped a question was calculated by subtracting the number of respondents who answered the question from 169. The survey did not require an answer to every question and, as a result, a client was able to answer or not answer any or all of the survey questions.

For question one, clients were asked to rate their experience at the doorway location on a scale of one to five stars, with one star being the lowest rating, and five the highest. For question two, clients were asked to provide a yes or no answer as to whether or not they wanted to answer more questions. For question three, clients were asked to rate how their life had changed on a sliding scale of zero to 100 with zero being worse than before, 50 being about the same, and 100 being better than before. The categories shown in the compilation under question three were established by the auditors to summarize the survey data. For question four, the categories shown were created by the Program and the respondent could select one or more choices. The fifth question was a free response, and respondents could write in their response to the open-ended question resulting in multiple comments about the doorway location. The categories shown were the result of auditor content analysis of the respondent's answers. The number of responses to questions four and five could be greater than the number of respondents because respondents could provide multiple answers to each question. Totals may not add to 100 percent due to rounding.

Question 1. How was your experience at the Doorway <u>today</u>?		
Answer Options	Count	Percent
★	4	2.5
★★	0	0.0
★★★	2	1.3
★★★★	10	6.3
★★★★★	144	90.0
<i>respondent answered question</i>	160	100.1
<i>respondent skipped question</i>	9	

Question 2. Would you be willing to answer a few more questions about your experience?		
Answer Options	Count	Percent
Yes	160	95.8
No	7	4.2
	<i>respondent answered question</i>	167
	<i>respondent skipped question</i>	2
		100.0

Question 3. How has your life changed since you've participated in the Doorway Program?		
Answer Options	Count	Percent
0-49	2	1.5
50-59	5	3.7
60-69	6	4.4
70-79	4	2.9
80-89	14	10.3
90-100	105	77.2
	<i>respondent answered question</i>	136
	<i>respondent skipped question</i>	33
		100.0

Question 4. What services offered at the Doorway have been most helpful?	
Answer Options	Count
Having someone to listen	78
Connection to treatment	76
Help with housing	73
Connection to other services	67
Recovery coaching	59
Medication access	54
Connection with mental health services	52
Help with transportation	51
Help with insurance	45
Naloxone/Narcan	30
	Total
	585
	<i>respondent answered question</i>
	142
	<i>respondent skipped question</i>
	27

Question 5. Is there anything else you would like to tell us about the Doorway?	
Answer Options	Count
Positive comment about staff	67
Positive impact on life/ recovery journey	14
No	9
Good/ helpful experience at the Doorway	7
Asset to the community/ great resource	5
Negative comment about staff	4
Good as-is/ loved the program	4
Transportation/ housing help	3
Needs more resources, funding, or attention	3
Thankful for program	2
Great groups	2
Help with medication	2
Got help elsewhere due to complications	1
Would have nowhere else to go without the program	1
Total	124
<i>respondent answered question</i>	113
<i>respondent skipped question</i>	56

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**State Of New Hampshire
Doorway Program**

Appendix D

Status Of External Program Evaluation Recommendations

The Doorway Program (Program) underwent two external program evaluations during our audit period, the results of which were reported to Program management in September 2023. A copy of the Pacific Health Policy Group’s September 2023 *Doorway Program Evaluation* report can be accessed at the Program’s website:

<https://www.thedoorway.nh.gov/sites/g/files/ehbemt566/files/documents/2023-12/nh-doorway-finalreport.pdf>

A copy of the University of New Hampshire’s Institute for Health Policy and Practice can be accessed at:

https://www.thedoorway.nh.gov/sites/g/files/ehbemt566/files/documents/2026-05/gpra_improvement_plan_sept_2023_final.pdf

We reviewed both external program evaluation reports and provide a summary in Tables 5 and 6 of the status, as of November 2025, of the recommendations contained in those reports that are relevant to our performance audit.

**Table 5 – Status Of External Program Evaluation Recommendations,
Pacific Health Policy Group**

September 2023 Doorway Program Evaluation

No.	Recommendation	Status
1	Enhance Program policies to support a seamless statewide model of care.	Remediation in Process
2	Define and align roles and create incentives for collaboration across publicly funded system.	Remediation in Process
3	Create a quality monitoring and improvement framework.	Remediation in Process
4	Standardize data collection and establish benchmarks.	Unresolved
5	Enhance third-party revenues to support Program model of care (e.g., immediate face-to-face engagement and care management for hard-to-reach clients).	Remediation in Process
6	Clarify and recognize doorway locations as part of Medicaid Managed Care Organization care management obligations.	Remediation in Process
7	Improve availability of Flexible Needs Fund.	Remediation in Process

Status Of External Program Evaluation Recommendations _____

No.	Recommendation	Status
8	Enhance Medicaid revenues and State Opioid Response (SOR) funded transportation services.	Remediation in Process
9	Improve access and enhance management of Department of Health and Human Services respite utilization.	Remediation in Process
10	In the absence of federal funds, explore expansion of Medicaid authorities and alternative reimbursement models for Program services.	Unresolved
11	Consider alternative delivery system structure for Program services.	Resolved

Status	Count
Resolved	1
Remediation in Process (action beyond meetings and discussion)	8
Unresolved	2
Total	11

Source: LBA analysis.

Table 6 – Status Of External Program Evaluation Recommendations, University Of New Hampshire Institute for Health Policy And Practice

September 2023 GPRA Improvement Plan

No.	Recommendation	Status
1	To best serve clients and improve continuity of care across the State, restructure the Program system, operationally and technologically, so all the doorways operate as one cohesive entity.	Remediation in Process
2	Ensure Web Information Technology System Client IDs are in compliance with Substance Abuse and Mental Health Services Administration (SAMHSA) policies and data privacy standards, while still allowing for data entered in SAMHSA’s Performance Accountability and Reporting System to be aggregated by site.	Resolved
3	Revise communication strategies to offer the doorways and other SOR funded vendors (OSFV) timely and effective support, training, protocols, and information, including the most up to date SAMHSA guidelines.	Resolved

Status Of External Program Evaluation Recommendations

No.	Recommendation	Status
4	Develop clear, straightforward, and consistent contract language for the doorways and OSFVs that requires completion of the Government Performance and Result Act (GPRA) intake, follow-up, and discharge as a deliverable of the contract for all clients receiving SOR-funded services.	Unresolved
5	Increase GPRA awareness and education by communicating the importance of the GPRA, how the data is used, and how it supports the ultimate goal of improved client outcomes.	Resolved
6	Improve morale and relationships between State, the doorways, and OSFVs to improve communication and the continuity of care.	Remediation in Process
7	Improve continuity of care and GPRA interview follow-up rates by subcontracting with an Administrative Services Entity, such as Advocates for Human Potential.	Unresolved
8	To support the doorway locations in operating as one cohesive system, develop and clearly communicate GPRA-related communication and action policies, and procedures.	Resolved
9	Develop and implement a streamlined client transfer process that improves continuity of client care and supports collaboration between the doorways.	Unresolved
10	Formalize and universally implement client consent process for the doorways and OSFVs that facilitates collaborative care coordination among the doorways and improves opportunities for ongoing client engagement.	Remediation in Process
11	Establish and implement a protocol that details the training and professional development requirements for the doorway and OSFV staff.	Unresolved
12	Identify or hire a GPRA Lead or GPRA Data Coordinator at each doorway location to organize and supervise GPRA data collection at the doorway location and review and clean GPRA data, including intake, follow-up and discharge.	Unresolved
13	Establish and implement a protocol around regular supervision to support clinical and non-clinical doorway location staff who administer GPRA tools. Supervision should include supporting staff around secondary trauma.	Resolved

Status Of External Program Evaluation Recommendations _____

Status	Count
Resolved	5
Remediation in Process (action beyond meetings and discussion)	3
Unresolved	5
Total	13

Source: LBA analysis.
