New Hampshire Gov. Maggie Hassan put forth a proposal on Thursday to resolve the state budget impasse. Hassan last month vetoed the $11.3 billion budget that was approved by legislators, faulting the budget for, among other things: lowering the rates of the state's two main business taxes, not including money for state employee pay raises, and failing to reauthorize Medicaid expansion beyond 2016. The "compromise" Hassan proposed Thursday offers up concessions in two of those three areas: She agreed to lower the business taxes and dropped her insistence that continuing the Medicaid expansion program beyond 2016 be part of the budget. Ordinarily, that might be good enough to get a deal done, but there are two obstacles in the way.

The first is that the governor wants to offset the tax cuts by raising the cigarette tax and increasing motor vehicle registration fees by $5. "Proposing $100 million in new taxes and revenues is not going to work for the Senate," said Senate President Chuck Morse, R-Salem. "Clearly, there's no way that we could get the taxes she's proposed through the House," said Republican House Speaker Shawn Jasper, of Hudson. "It was very difficult to get anything through the House, even in the way of adjustments that could be seen as just keeping up with inflation. To talk about a 21-cent increase in the cigarette tax and $5 on the registration fee - those are just issues that simply there is no support for within the House."

Jasper and Morse both noted that much of what Hassan proposed was included in the governor's original budget - and has already been rejected. That's true, but Hassan's proposal still represents a genuine attempt to solve the deadlock, and Republicans should respond in kind. If they don't, it could well be because of the second obstacle: politics. "There was no sincere attempt to work with us here; this is strictly politics," said Jasper, who faulted the governor for not sharing her proposal with his office until Thursday morning, when she held a press conference to lay out her plan. Morse said the governor was trying to "negotiate in the press."

Perhaps Hassan's decision to hold a press conference surrounded by a group of Democrats - without giving Republicans a heads-up - created the impression that she was overly partisan. We think she was acting in good faith. We'd also like to believe that Republicans weren't just looking for an excuse not to make a budget deal to do the governor political harm. Politics, it seems, is a sword with two edges. But even if the governor made a tactical error by not informing legislative leaders of her intention ahead of time, that's another issue for another day. It shouldn't prevent Republicans from coming back with a compromise plan of their own that moves the state closer to a final budget agreement. The people of the state deserve at least that much.

A lack of strong leadership at the top is plaguing New Hampshire’s approach to the opioid epidemic.
The state has a drug czar, Jack Wozmak, whose position is funded by a $91,000 grant from the New Hampshire Charitable Foundation. Last week, Gov. Maggie Hassan’s office released a list of nearly two dozen recommendations compiled by the drug czar to “combat the opioid and substance misuse crisis.” Though it had some good recommendations, it was an unfocused hodgepodge of a list that has no hope of being fully implemented.

Just how disorganized is the governor’s approach? Her press release announced 22 recommendations but listed 23. This is a small error, but it is a sign that things are being thrown together without much attention to detail. The list of recommendations did not suggest any order or prioritization. Rather, it was a laundry list of actions that could be taken if the state had unlimited resources, which it obviously does not. This was not very helpful. Instead of an action plan that can be aggressively and swiftly implemented, the state got a bunch of bullet points with no plan for enacting them.

Another bad sign came in mid-July, when Hassan’s office told WMUR-TV that Wozmak had been in touch with law enforcement agencies around the state, including Manchester’s. To that, Manchester Police Chief Nick Willard replied on Twitter, “I have yet to see any coordination on the issue, in spite of my repeated request for action.”

The governor has proposed spending more money on substance abuse treatment. But aside from that, her leadership has been disappointing. A lack of focus (she was not even aware the state had been awarded a five-year extension of a federal grant to fight substance abuse earlier this month) has plagued her administration’s approach to this deadly epidemic. We do not doubt the governor’s concern regarding this issue. But getting a handle on the problem takes more than good intentions. It takes strong, disciplined leadership focused on building consensus for quick, effective action. That has not come from this administration.

Nashua Telegraph – July 26, 2015
‘Drug czar’ wants to bring opioid training to hospitals
By KATHRYN MARCHOCKI
There used to be four vital signs in medicine: pulse, respiration, blood pressure and temperature. This changed sometime in the 1990s and early 2000s. Health care providers were encouraged to pay lots of attention to pain. "Now pain is a fifth vital sign," Catholic Medical Center Chief Medical Officer Dr. William Good-man said last week.

Patient surveys even ask people if they felt their pain was addressed during their hospital stays, he added. The United States now consumes more than 80 percent of the world's narcotics, Goodman said. And it suffers from a crippling epidemic of addition to opioids and its cheaper, illicit cousin - heroin - which drove most of the record 326 drug deaths in New Hampshire alone last year. Several years into what is widely regarded as a crisis, the medical community is striving to get a handle on the complicated, multifaceted issues of treating those who come to them with opioid-related issues or whose opioid addiction complicates their treatment for other conditions.
They said they are getting support from Gov. Maggie Hassan's so-called "drug czar," Jack Wozmak, who has made it his mission to help develop internal protocols that will change the way opioids are dispensed. Wozmak wants to bring the award-winning Boston University School of Medicine training program in the safe prescribing of opioids for chronic pain and alternatives to pain management to every major medical center and hospital in the state.

It's called the Safe and Competent Opioid Prescribing Education (SCOPE of Pain), and Wozmak says it can make a difference. "If it could reduce by 50 percent the number of prescriptions being written, then I've gone a long way toward ending the pattern of creating addicts, because what's fundamental to dealing with the opioid and heroin crisis is we have to stop creating addicts," Wozmak said in a July 12 interview. "I would like to think we could roll out a couple by fall," he added of the BU programs.

No sessions have been scheduled to date. Wozmak has contacted substance abuse specialists at Southern New Hampshire Medical Center in Nashua and met last week with Catholic Medical Center's Goodman and directors of various departments. "They can't wait for this to happen, because it builds on their efforts to have these changes take place," said Wozmak, whose formal title is senior director for substance misuse and behavioral health. "This builds on a certain energy within most facilities. Most doctors understand there is a problem."

The BU program would provide hospitals already developing or revising internal protocols for safe opioid prescribing and alternative pain management resources, guidance and support, he said. "We're looking at it," said Lori Magoon, senior addictions clinician at SNHMC. She said she and Wozmak spoke earlier this month about the BU initiative and will discuss the program with hospital administrators. Magoon, who also is president of the New Hampshire Alcohol and Drug Counselors Association, said she likes the BU program's focus on medical professionals training their peers in best practices. "I just want the appropriate people make the appropriate decisions on the amount of medication that should be prescribed," she said.

Catholic Medical Center already convened an internal working committee to develop protocols for responding to the multiple aspects of opioid addiction hospital staff face daily. "We want to develop best practices so we don't have to keep reinventing the wheel each time, because it is so complicated," Goodman said. So complicated, in fact, that CMC plans to host a daylong conference in early November on opioid addiction, its impact on society and best practices for responding to it. It will be open to first responders, health care providers, social workers and police across the state. Goodman said he expects CMC will have developed its internal protocols by then and hopes to share its experience with other medical professionals.

Goodman said he intends to contact BU program officials to tap into their expertise and resources. "We are going to leverage what they do," he said. Wozmak said he hopes to bring the SCOPE of Pain program to the state's more than 12,000 licensed physicians, nurse practitioners, physicians assistants, dentists
and veterinarians authorized to prescribe opioids. "I want to encourage them to change the way they pre-
scribe opioids so that it is responsible ... (and) they make those changes voluntarily, and not in
response to legislation," Wozmak said.

The SCOPE of Pain program, which received the 2014 National High Inten-
sity Drug Trafficking Area
award for outstanding prevention effort, provides continuing medical and nursing education training in
safe opioid prescribing practices. Since the program started in 2013, more than 10,500 clinicians across
the country have been trained through its online and live sessions hosted in collaboration with federal
and state partners, such as New England HIDTA, according to the BU School of Medicine website.

Wozmak noted the BU program was offered in Portsmouth in May 2014. He said his goal is to offer the
"first organized approach for re-education across the entire medical community in New Hampshire."
The program is funded by New England HIDTA, he said. The concept of retraining health care providers
in safe prescribing habits was listed as one of the 22 recommendations Wozmak released Tuesday to
help combat opioid and substance abuse.

The BU program grew out of the Federal Drug Administration's concerns over the rise in opioid
over-doses and lack of uniform standards for prescribing opioids, said Dr. Seddon Savage, an expert in
pain and addiction medicine and director of the Dartmouth Center on Addiction Recovery and Education
at Dartmouth College in Hanover. As part of its Risk Evaluation and Mitigation Strategy, the FDA
convened pain and addiction experts across the country to develop a curriculum blueprint based on best
practices, she said. The BU program is one of a small number of approved programs and the nearest
available to New Hampshire, she said.

 Manufacturers of long-acting or sustained-released opioids were required to fund development of the
REMS curricula, but had no control over or role in developing its content, said Savage, who has been a
speaker at BU SCOPE of Pain training sessions. "People are hungry for information," Savage said. "People
want to do the right thing in treating people with pain, and they don't want to contribute to harm.
"Having a curriculum that has been so well reviewed is a strength of this curriculum, because it has the
input of diverse pain professionals already, and it has a long history of being well received by clinicians."

The Daily Freeman – July 26, 2015

Brain center’s closing sends ripples nationwide

By KATHLEEN RONAYNE, Associated Press

CONCORD, N.H. (AP) — When Tyler Richardson’s son hit puberty, the combination of hormones and new
strength from a growth spurt added an element of danger to a long history of unpredictable behavior
because of autism and severe anger problems. He wandered outside one day after his aides left his
grandmother’s home, where he was living. Grandma tried to bring him back inside, and he eventually
followed. But once in the kitchen, he attacked her, latching on and taking her to the ground. Then, he bit
off her finger.
Richardson loved his son, but something had to give. After a long, nationwide search and episodes of trial and error, the northern Colorado man contacted Lakeview NeuroRehabilitation Center in Effingham, New Hampshire, an 88-bed facility near the Maine border for people with traumatic brain injuries and other developmental disabilities. It was the only such center he could find with an available bed that would take his son. “It’s probably one of the toughest things that I think anyone has to go through,” Richardson said. “Just to find somebody to help us find a program was really hard.”

About a year later, Richardson is back where he started. Lakeview is preparing to close after months of scrutiny over allegations of abuse and neglect, including a client death and reports of chronic understaffing. The paucity of such centers for people with extreme brain disorders and related behavioral problems means the closing is sending national ripples through the industry and stressing out families who need to move their love ones from Lakeview, as well as others who have lost yet another option.

During the past year, 19 states and Washington, D.C., sent people to Lakeview, a private facility which has been home to male and female residents ranging from age 8 to their late 40s. Just a quarter of the 140 people who have lived there in the past year came from New Hampshire. As of 2013, 13 states had shut down state-run developmental centers, and many more are on the path to closure.

The shutdowns are partly a reflection of a trend of states moving away from placing people in institutions and focusing instead on caring for them within their homes and communities. But sometimes, like with Richardson’s son, institutionalization makes more sense. Lakeview and only a handful of other centers serve people who exhibit high-risk, often violent behaviors coupled with developmental or intellectual disabilities, meaning they require constant care, often from multiple people.

Community care, such as a home with a few other residents and caregivers within a neighborhood, works for most people with developmental or intellectual disabilities, said John Finn, a former treatment expert for the New York government who now does consulting work for New Hampshire agencies. But that type of setting doesn’t work in the most extreme cases, in which five or six aides might need to control a violent outburst.

“As they close those developmental centers, if they don’t create an alternative place for those really high risk people … then the problem the parents have becomes very real,” said, Finn, who couldn’t offer an exact number of centers that serve such patients. New Hampshire Gov. Maggie Hassan put a moratorium on sending new clients to Lakeview after a damning investigation from the Disability Rights Center, the state’s federally designated protection and advocacy system for people with disabilities. Hassan initiated daily monitoring of Lakeview and hired a consultant to examine licensing for similar facilities. The state education commissioner also ordered the school at Lakeview shut down in part because it lacked a curriculum and failed to meet other state requirements.
The state did not order Lakeview to shut down. That was the decision of its owner, who said it would be too costly to keep it running with the school closed and the moratorium on new patients. It costs about $800 to $1,500 a day to send someone to Lakeview, a cost covered primarily through Medicaid. The rates for residents in other states vary. State health officials said Lakeview was also at risk of losing its license as administrators struggled to correct problems.

Lakeview has made strides in care quality, and news reports have been preoccupied by a handful of extreme problems in the past, said Tammy Baxter, who was hired eight months ago to improve quality assurance. She worries that some of Lakeview’s clients could end up in psychiatric wards or jail if they don’t find a new home base. “You didn’t make it to Lakeview because you had a negative outcome in the community one time,” Baxter said. “People had to fail in multiple group homes and multiple facilities before they ever became a client at Lakeview.”

Since the announcement, residents have been trickling out on their way to other placements in New England and across the country. The tentative closing date is Aug. 1, but administrators say they plan to stay open until everyone has somewhere to go. Just 10 clients remain. Richardson’s son is one of them, and he’s been looking for another placement for nearly three months. “What’s the worst-case scenario? I ask that question all the time, and no one can really tell me what the worst-case scenario is,” he said. “He has to have intense help every day for every area, and there’s just not a lot of places that can do it or are willing to do it or want to do it.”

Kimie Hirabayashi, of Honolulu, sent her teenage son to Lakeview after trying a number of placements at public and private schools in her home state. He has attention deficit-hyperactivity disorder, Asperger’s syndrome, high anxiety and intermittent explosive disorder, she said. The family needed to hire a private transportation company to fly him to New Hampshire because he can’t travel on a commercial airline. Hirabayashi, like Richardson, describes her son’s experience at Lakeview as positive. His behavior had improved there, and she was preparing to move him to another school with bigger classrooms and more interaction with other students when news came that Lakeview would close. After submitting at least 20 applications, she found an all-boys school in Massachusetts to take her son.

Although some parents describe positive experiences at Lakeview, official reports conclude the facility faced chronic understaffing, and investigations support allegations of abuse and neglect. Reports from the state health department found an instance of a resident wandering away from the facility unattended in January, after Lakeview was already under scrutiny. It was not the first time such a misstep had been reported.

State health officials say there are better options than Lakeview and the focus should be on helping people live and participate in their communities rather than reside in institutions. “I don’t believe that Lakeview is the last resort,” said Marilee Nihan, deputy commissioner of New Hampshire’s Department of Health and Human Services. “I do believe that they take a lot of complicated clients that other facilities won’t take. It is my hope and desire that every single client that goes to a place like Lakeview
gets enough treatment and supports to be able to move through the continuum of care so that they become more community-based in their living.”

Families say it’s not easy. Jennifer Cote has been a vocal critic of Lakeview after her son lived there for just a month. He has Crohn’s disease and autism and can’t speak. Cote began looking for a new placement when her son, then age 11, fared poorly at a facility in her home state of Maine. Facing rejections from programs across her state, she turned to Lakeview. She was impressed during her initial visit, but her reaction changed the day she dropped her son off. The facility was dirty and the staff members seemed indifferent to her son’s special needs, she said. Cote’s son lived at Lakeview for a month until a Maine hospital that he used to live at in times of crisis agreed to readmit him. He now lives at Easter Seals in Manchester, New Hampshire. When it comes to home and community care for someone like her son, she said, “the supports are not there.”