STATEMENT

OF

HEIDI MORAN

CLINICAL ADMINISTRATOR
SOUTHEASTERN NEW HAMPSHIRE SERVICES
272 COUNTY FARM RD.
DOVER, NH 03820

BEFORE THE
UNITED STATES SENATE
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS

"ALL HANDS ON DECK: WORKING TOGETHER TO END THE TRAFFICKING AND ABUSE OF PRESCRIPTION OPIOIDS, HEROIN, AND FENTANYL."
SEPTEMBER 14, 2015

Chairman Johnson, Ranking Member Carper, and distinguished Members of the Committee:

It is my privilege and honor to address you today on behalf of my agency and all those New Hampshire residents who are struggling with the disease of addiction and would like to access treatment.

Southeastern NH Services is a private, nonprofit agency dedicated to helping people recover from addictive disorders. Since being established in 1979, this agency has helped tens of thousands of individuals and families find recovery. We provide a full range of services to those in need. Services we offer include Outpatient Counseling, Intensive Outpatient programs, the Strafford County Drug Court Program and a women's program, as well as Impaired Driver Intervention programs, 28 day residential and a 90 day half way house. We also offer a weekly Family Education Program for the families of those clients who are in the 28-day residential program. Families attend 4 three-hour educational sessions to assist them with understanding the disease of addiction and how it affects the entire family.

Relapse prevention, self-help and support, as well as the biological, psychological and social aspects of the disease of addiction are discussed during the family program.

We run a very structured residential program with rules, schedules and boundaries that are closely monitored. The population we serve can be quite diverse. However, for the most part we have seen a staggering number of young people between the ages of 18 and 30 enter our residential programs these last few years. Previously we had seen more of a mixed group age wise. We still get the occasional older client, 35 – 55 years of age, but the majority remains younger. Many of our clients come from jails across the state and other legal referrals, like probation and parole. "No" is not a familiar word in the vocabulary of many young

clients and to be made to follow rules, get up in the morning and participate in their recovery are new concepts to them. Many clients come from the street and are homeless, couch surfing or living in shelters or tents. We have always been known as "The House of Hope" and that place that would help anyone, regardless of their ability to pay. Although we are structured and strict with our rules, we are fair and compassionate. The mixture of fairness, caring and structure instills a feeling of trust and safety in our clients. That feeling is one we hear about time and again from clients who have completed treatment and moved on to live a life of recovery, as well as those who relapsed and were able to pick up the phone and call us for another chance at changing their life. Although many hate the rules, they admit that knowing what to expect and having an understanding of what comes next, allows them the safety and environment they need to get well.

As I write this, I have tears in my eyes. I can't say enough about our programs and the fantastic work we all do to help our clients find their way back to life.

I have cried with clients who have come into treatment scared to death that they won't be able to "do it". I assure them they can, as long as they are willing to follow our suggestions and those they receive from other people in recovery. I have cried with parents who want to "fix" their children and can't let go. I have cried at funerals of those who couldn't stop. My tears have flowed freely for over 20 years.

Prior to 2013 Southeastern had not had to worry about billing or revenue sources. We were provided with our primary budget from the NH Board of Drug and Alcohol Services (BDAS) Block Grant, some funding from Federal Probation and Parole contracts, private pay resources from various DWI programs and some private donations. The Block Grant was dispersed at the rate of 1/12th of the budget each month. The 1/12th payment schedule allowed us to budget and monitor expenditures. Our residential services have

always remained full, or close to full on a regular basis. Due to the population we serve, it is difficult to maintain out patient services at the same level as residential. We have a very high no call/no show rate.

In 2013 BDAS changed their way of determining payment and went to utilization. We were given % numbers for our various programs and had to meet those numbers in order to get "full utilization" which meant full payment. Each program was given an amount from the 1/12th previous budget and we had to meet the new requirements to get the full benefit of our budget. We were always over the amount for utilization for residential, but could not meet the requirements for out patient. Consequently, we lost over $85,000 from our budget that year. Then BDAS changed the rules again and went to a Fee for Service way of payment.

Without trying to explain the painful in's and out's of this, it should suffice to say that the game changed frequently and without much notice or direction for staff who had never had to deal with billing, tracking or monitoring.

The building we are located in is owned by Strafford County. We rent our space and have been at this location in the Strafford County Complex for over 30 years. Our building is the oldest in the complex and was built in the early 1900's. The building is fully sprinkled and is maintained by the county. As I stated previously, we received state funding since the beginning of time. In October 2013, I received a call from BDAS asking if we could provide Access to Recovery (ATR) beds for ATR clients. ATR was a Federally funded program for a specific population comprised of Veterans, DWI offenders, and people coming out of jails. We said yes, we would provide beds. An application was filled out and I received a call asking for our DHHS License number. We have never had a license and had never been asked to provide one. After some discussion BDAS got back to me and said it was fine to accept the ATR clients without a license.

At the same time that this was happening there was a lot of discussion about Medicaid expansion and movement away from the Block Grant. I started to look into what would be required from us to be able to bill Medicaid and other insurances. DHHS Licensure was obviously something we had to get. No license is required for outpatient, however there are strict requirements for residential. I reached out to the state Safety Code Specialist and received the codes for compliance and instructions regarding what I needed to do next. I hired an architect to come and investigate the building and to look at what needed to be done.

In March of 2014 I met with BDAS and gave them an update as to what we needed to do. I asked why no one had ever required this in the past and was told it had not been necessary previously. That is the start of our journey towards licensure.

Since that time we have worked with State, County and Local agencies in an attempt to get the needed renovations done to comply with the codes for licensure. Some people will say "why not just buy another building?" We rent, we don't have the funds to buy and renovations for compliance would need to be done in any other structure as well. Plus, we are in a location that suits the population we serve by being close to the courts, probation, Strafford County Jail and on the bus route. It has taken all this time to get the necessary agencies together so the architectural plans and safety plan can be completed and approved. We are still waiting for final approvals and no hammers have swung as of yet. The County is doing all they can to work with us and to help us get the work done. However, we are looking at approximately $500,000 worth of work that we will be responsible for. The County will assume half of all the safety requirement costs. We will have to pay for the other half of safety costs and for all renovations to bring things up to ADA code compliance. If the County were to rent the space to anyone else and it not be used as a residential

facility, they would not have the same requirements and codes to meet because a license would not be needed.

We have always had two beds in the residential rooms. According to code we must have a minimum of 160 sq. ft. to have 2 beds. Most of our rooms are 122 sq. ft. We have lost 8 beds as a result of this sq. ft. requirement. We understand and agree with safety first thought processes. However, in our facility clients sleep and change their clothes in their rooms and that is all. Clients are not allowed to take naps or "hang out" alone in their rooms. We tell clients "being alone in their head is a very dangerous neighborhood to be in". Addicts spend a lot of time in early recovery thinking about using, plotting and planning and convincing themselves that they don't need to be in treatment. We require that clients stay out in the community and speak with their peers. We have groups and activities going from 8 am until 10:30 pm so clients don't have a lot of time to "think" themselves out of treatment. In a nursing home a resident lives in their room and needs space, which is not the same in my facility.

In addition, it has been our experience that having a roommate can be a great detour for any unhealthy behavior. Last winter a woman brought heroin into the half way house and used it in her room. She was in a room that had a bed removed. Fortunately it was 10:30 at night and quiet in the house. Another client could hear her gurgling from the hallway. Staff performed CPR and she was revived. There would be less of a chance for those types of incidents when people have roommates.

Then came Medicaid. Since Medicaid expansion became part of our outpatient billing reality we have had to hire additional staff and hire a billing agent. We have had very little training and assistance to figure out how to track and monitor our money. Our budget is very difficult to figure out since we don't know how much we will be paid or by whom from week to week. Our rates have been cut by BDAS for residential (by $30 a day per bed) treatment until we can

bill Medicaid, which won't happen until we get a license. That comes to about a $100,000 deficit for this year.
All the while trying to get a loan to help us with the $500,000 cost to fix our building so we can remain open and treating the Heroin epidemic!

My final thought is related to what I feel are unrealistic expectations placed on the addicts who need our help. I have heard over and over how wonderful Medicaid expansion is and how "everyone " will be able to get treatment. That is not true. Maybe they will be eligible, but that isn't the same thing. An opiate addict who is living on the streets or from couch to couch, doesn't have an address. He/she may be carrying a backpack or trash bag and the chances that they will have their Social Security card, income tax return, ID or other information they may need to prove the information they give on their Medicaid application in that bag is slim to none. If they are given some direction by a social worker or someone in another agency to get insurance they may follow through, but more often than not they get frustrated, are sick and can't think straight.

They don't follow through, they give up and get high.

My agency and others in NH need help. We have not had the guidance, financial support or time to do what needs to be done. NH cannot afford to lose any beds. We have been working on a shoestring for many years and providing quality treatment to the population in greatest need. We are all passionate about our work and are here to promote change and increase the possibilities for a life without drugs for those who continue to struggle. BDAS has given us until June 30, 2016 to get our license or have all support pulled from our residential programs. That would be a disaster. I have 10 short-term residential and 15 long-term residential beds. Can NH afford to lose 25 beds? How many kids would die? We need people in our corner who will help us get done what is needed to stay operating.

I thank you for the opportunity to appear before the committee today to share some of the challenges we are facing in trying to help treat those who are suffering from addiction.

I will be happy to address any questions you may have.