COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE
PUBLIC HEARING

STATE CAPITOL
HARRISBURG, PA

MAIN CAPITOL BUILDING
ROOM 60, EAST WING

WEDNESDAY, OCTOBER 19, 2016
9:17 A.M.

PRESENTATION ON
WHAT TO DO WHEN A LOVED ONE
HAS AN ADDICTION PROBLEM

BEFORE:
HONORABLE GENE DIGIROLAMO, MAJORITY CHAIRMAN
HONORABLE RUSS DIAMOND
HONORABLE DOYLE HEFFLEY
HONORABLE TOM MURT
HONORABLE ERIC NELSON
HONORABLE JASON ORTITAY
HONORABLE TOM QUIGLEY
HONORABLE CHRIS QUINN
HONORABLE JACK RADER
HONORABLE BRAD ROAE
HONORABLE CRAIG STAATS
HONORABLE JUDITH WARD
HONORABLE RYAN WARNER
HONORABLE PARKE WENTLING
HONORABLE MARTINA WHITE
HONORABLE DAVID ZIMMERMAN
HONORABLE ANGEL CRUZ, DEMOCRATIC CHAIRMAN
HONORABLE JASON DAWKINS
HONORABLE MICHAEL DRISCOLL
HONORABLE STEPHEN KINSEY
HONORABLE JOANNA MCCLINTON
HONORABLE DANIEL MILLER

BEFORE (Cont'd):
HONORABLE EDDIE DAY PASHINSKI
HONORABLE MARK ROZZI
HONORABLE MIKE SCHLOSSBERG
HONORABLE BRIAN SIMS

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania

I N D E X

TESTIFIERS

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

P R O C E E D I N G S

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MAJORITY CHAIRMAN DIGIROLAMO: Good morning, everyone. Could I have everybody's attention? Good morning. Welcome to this voting meeting of the Human Services Committee. And as our tradition, I might ask everyone to rise for the Pledge of Allegiance to the flag.

(The Pledge of Allegiance was recited.)

MAJORITY CHAIRMAN DIGIROLAMO: Okay. Thank you. And for the voting meeting, I would like to ask Pam to take the roll.

(Roll was taken.)

MAJORITY CHAIRMAN DIGIROLAMO: Okay. Thank you all for being here. And again, we're going to start the hearing as soon as this is over, but there is one resolution on the agenda today, and it is an extremely, extremely important issue. It deals with the IMD exclusion.

And this is a little bit of a complicated issue, but IMD stands for institutionalized mental health disorder. And it was a rule of Federal law that was

implemented many, many years ago, and it's for mental health but drug and alcohol also got included for Medicaid patients, people who are on Medicaid. And this is for the people that are on the traditional Medicaid and also for the newly enrolled people on the expanded Medicaid.

And what the IMD exclusion says that if you have a mental health disorder or a drug and alcohol treatment, that you are only entitled if you're on Medicaid to 15 days of residential treatment in a facility that is greater than 16 beds. Now, this was initially implemented to keep the cost for mental health disorder under control. Unfortunately, drug and alcohol was included in it many years ago.

Up until this year, the States were able to apply for -- use of a better word -- a waiver for you to understand it. The actual term was "in lieu of." So you would be able to apply to CMS, the Federal Government, for a waiver to go past that 15-day limit. And this is really, really important for drug and alcohol, especially with the heroin and opiate epidemic that we have out there right now because 15 days for drug and alcohol in a treatment facility for a heroin or an opiate addiction is absolutely insufficient. You are never going to get better with only 15 days of treatment.

I was on a phone call with the CMS Director a few

weeks ago. They are adamant about implementing this rule, not quite clear when it's going to go into effect. I'm hearing January 2017, although our DHS is saying that it could go into effect in June or July of 2017, so we do have a little bit of time. They're taking the waiver away from the States, so this is not only an issue that affects Pennsylvania but it is going to affect every other State in the country.

And there's a lot of support around the country to do away with this. Actually 46 Governors have signed a letter to CMS not to turn this rule around. And we also have a letter from 29 United States Senators around the country to CMS also begging, imploring them not to do this. But it appears that they are adamant that they're going to make this change and take our waiver away from not only Pennsylvania but many of the other States.

What this resolution does, it's a resolution that's going to ask the President of the United States to get involved because it is our understanding that the President of the United States can overturn this rule simply by Executive Order. And my feeling is if we can get his attention that he will absolutely do that.

A copy of this resolution not only goes to the White House but it also goes to our Congressional Delegation, the Congressmen and the two United States

Senators, asking them to get involved. Some of them have already. But this is a critically, critically important issue. I'm telling you, your constituents are not going to get better if they've got -- alcohol, opiates, heroin, they are not going to get better with only 15 days of treatment in an in-house facility. And if they stay longer than 15 days, they lose their Medicaid, not only the behavioral health side of the Medicaid but the physical side of the Medicaid also. So if they stay longer than 15 days, they lose all the way to pay for their treatment not only on behavioral health side again but on the physical side, critically important issue. We're going to have a disaster here in Pennsylvania if they're allowed to implement this rule.

With that, I will ask for a motion to move and a second. Representative Staats and Representative Kinsey seconds the motion. Any questions or debate? And again, this is going to cost Pennsylvania -- this is taking from the Department of Human Services here -- in Pennsylvania's own documents, it's going to cost us $180 million in Federal funding in a fiscal year if this gets implemented, $180 million in Federal funding, in Federal match on Medicaid if this gets implements.

Any questions or comments on the resolution? Yes?

MALE SPEAKER: Thank you, Mr. Chairman. And, you know, I just want to applaud both yourself and I'm sure all the leadership who was involved in it. As always, and I mean this with a lot of respect, you know, I've talked to a bunch of Members coming in and coming out. We referenced how busy these last couple days are here. I know a bunch of people are making time, jumping in now because you rang the bell and you brought this issue up. And you also worded it in a way that is still respectful but at the heart of the issue.

So I actually just want to take a moment on it and just thank you for your attention to detail and your effort to always move this ball forward.

MAJORITY CHAIRMAN DIGIROLAMO: Thank you.

MALE SPEAKER: So it's been something that's been very noticeable, and I appreciate the leadership on both sides of the Committee for being open to push these matters in such a way. So I just want to thank you for my constituents as well who appreciate your work.

MAJORITY CHAIRMAN DIGIROLAMO: This is something me and Representative Cruz have worked on because he is very, very concerned about this issue also, as everybody should be, Democrats and Republicans. It's not a partisan issue. This is an issue that is going to affect every one of our constituents.

Any comments, questions moving forward?

Seeing none, we'll take a vote. Are there any negative votes on the resolution?

Seeing no negative votes, the resolution is passed out of Committee unanimously.

And I want to thank you, each and every one of you for your support. We really appreciate it. And hopefully, we'll get the President's attention on this because if we don't, there is actually a bill in Congress. Representative Hastings from Florida has a bill in Congress that would pull drug and alcohol out of this IMD exclusion, but I don't have a whole lot of faith in Congress getting anything enacted in a bipartisan way down there. So hopefully, we can get the President's attention.

Okay. Thank you. And I believe this is Representative Quinn's first meeting, so I want to, everyone, welcome Representative Chris Quinn from Delaware County to the Committee.

(Applause.)

MAJORITY CHAIRMAN DIGIROLAMO: And as I said to Representative Nelson when he first came on board, I don't know what you did wrong, but this is kind of like the purgatory of the Committee, so you must have done something

wrong already to get put on this Committee.

(Laughter.)

MAJORITY CHAIRMAN DIGIROLAMO: But we're glad to have you. Okay. And just about the hour of 9:30 so I'm going to call the hearing of the Human Services Committee to order. And this is a really, really important issue, especially with what we just did, and the idea behind the hearing is what to do when a loved one has an addiction problem.

And it's an extremely important issue, you know, and I've been very, very open about my son and his drug problem. And, you know, when me and my wife were first going through his problem, I mean, we were struggling to find out what to do, you know, how to get treatment, how to pay for it, where to go, what was the right treatment. So I struggled, and I was a State Representative and I struggled to find the proper place and the funding and how to pay for it and where to go and length of stay. So this is a really, really important issue for families across Pennsylvania, what to do when you find out that your loved one, most of the time your sons or daughters, has an addiction and they need help.

So this was an issue that was brought to me and

asked for the hearing by Representative Doyle Heffley, so I would like -- and I asked Chairman Cruz and he said he would be fine with it. I'd like to ask Representative Heffley to chair the Committee today since this is your idea and it's an issue that's been very, very important to you, as it is to a lot of the Members on the Committee.

So with that, I'm going to turn it over to Representative Heffley to chair the meeting.

REPRESENTATIVE HEFFLEY: Thank you, Mr. Chairman. It's an honor to be here and to chair the meeting on what is a very important subject. Folks come into our district office or approach us as we're out in our districts asking where they can find these services, and I commend you on calling this meeting together.

The first testifier is Deb Beck, President of the Drug and Alcohol Service Providers Organization of Pennsylvania. Deb?

MS. BECK: Thank you. How about Bill?

REPRESENTATIVE HEFFLEY: And Bill. And Bill Stauffer as well, Executive Director of the Pennsylvania Recovery Organizations Alliance. Thank you.

MS. BECK: Good morning. Thank you. I just had a little red-white-and-blue moment here watching a very -- your agreement on the IMD is so important. I don't know how to begin to tell you -- how to thank you. I just feel

a little choked up about that because I've worked with patients who've struggled to get help and need the structured living environment of a rehab, and that rule will certainly destroy that.

Also, I saw you two on television the other night with Gary Tennis. It was actually quite a good teaching seminar on addiction. I thought you did a really good job.

But, excuse me, I just had a Democratic -- it's a small D moment, that was, to see what you're doing. I wish Congress would work together on issues like this and put this stuff aside and get down to what matters. They can fight over other things but, you know, let's talk about something that's affecting one in four families.

I want to thank you for the opportunity. My name is Deb Beck. I'm with the Drug and Alcohol Service Providers Organization. By the way, 230 rehabs and detoxes will be affected by that rule you just voted on. They're in everybody's county in large numbers.

What to do when you think a loved one has an addiction? Well, number one is if you think someone in your family has a problem, unless you are a totally drug and alcohol-free family for generations, they do have a problem because typically you don't see it until it's pretty late. People are embarrassed and hide it from you. So if you think you got someone with a problem, they got a

problem and you want to explore that.

The first, most important thing you want to do is get an education on addiction. This is not in the parents' manual when the child is born. No parent is prepared for what's about to happen. You really want to get an education.

Now, we've attached materials for you. I would highly recommend -- because I hear from many of your offices and certainly from yours Representative Heffley. I would take a thumbtack and put it by the phone with your staff. There's a resource list attached here that you can give to families. The first part of the resource list is DDAP, the Department of Drug and Alcohol Programs. You -- it will teach you quickly online how to locate a treatment program in your own county. That would be the first place the family may want to call. The second place is Alcoholics Anonymous, Narcotics Anonymous, or the support groups for families, Al-Anon and Nar-Anon. Their websites are listed in the attachment.

But also, and really important, is to understand the State structure. In Pennsylvania, the Department of Drug and Alcohol Programs runs this stuff at the State level but gives out the planning for prevention and treatment locally through the Single County Authorities. And if you don't know what a Single County Authority is,

it's okay. They know they need a new name. But the phone number is there listed by county. There are 48 of them. Some of them are joinders. And that would be a place you want parents to call because you don't want people calling blindly or responding to 800 numbers on television. There have been some very odd things going on with those 800 numbers.

I would call the Single County Authority and some of those other resources. Talk to people. Talk to people in recovery. Now, you as a family member are going to get different ideas from different people on what treatment should look like. If you think there's a problem, first, learn about the illness and then learn about treatment and then call these resources to find out about treatment. Get to the family groups to support you. Most of the treatment systems have family groups around them. You don't have to go through the treatment center to tap into their family group. So these are resources you want to get your staff to know how to use for your constituents.

Getting an education is just like cancer. If you have cancer in your family, you would learn everything about cancer, and you wouldn't expect the same treatment to be recommended by everybody you speak to. It really starts with that individual assessment, and the assessment will figure out what the person needs and what resources are

needed.

I do want to say to you as a matter of great urgency that if you think you've got somebody in the family with a problem that you do something and you do something in a hurry for this reason: Alcohol and other drug addictions are progressive, always fatal illnesses if they go untreated. They are progressive and always fatal. This doesn't get better by itself. If I got the problem, you're going to have to get me some help.

And as you know, we're in the middle of a huge epidemic right now, prescription drugs, heroin, but we also included in our number that the alcohol overdose death rate here in the State, and that gives you a death rate of 3,662 people in 2014. The 2015 numbers haven't been calibrated fully yet. We added alcohol because only a third -- that's a big only -- of the patients coming in are opiate addicts. The rest are alcohol and other drug addiction.

The comments I'm making are a little scary about death and dying, but there's good news here as well. This is a highly treatable illness. In fact, the recovery rates are much higher than for diabetes and heart disease and other life-threatening things, highly treatable illness, but that hinges on being able to get treatment that's appropriate for me and long enough to give me a chance to get clean. Witness the IMD comment; 15 days ain't going to

cut it, friends, for people who need rehab.

There's more good news here. The good news is that almost everybody has healthcare coverage in the State of Pennsylvania for this now of some sort or through the Single County Authorities, the little bit of money they get for the in-betweeners. The Affordable Care Act has required all health plans to have some coverage. And Governor Wolf moved forward and endorsed and embraced the Medicaid expansion, which picks up a group of people who didn't have it before.

So the good news is that virtually everybody has coverage. The bad news is it's darn hard to fight through the insurance methods and procedures of paying for the very coverage you already paid for. I hope that this pisses you off. This coverage is already paid for by the premium dollar, by your employer, by you, the government, and don't try to get it. It's very hard to get it, a little more about that in a minute.

And I think Pennsylvania really needs to step up and deal with enforcement of all of the health plans in regard to drug and overhaul it if we're serious about addressing the epidemic. If were not, we'll just send them all to jail, or worse yet, a number will end up in our graveyards, not a good thing.

Second step for families -- first step is learn

everything you can about addiction and about treatment, and the second step is the families must insist to their health plans, hey, I know I have coverage for this. Don't give me any BS about that. Now, you really need to tell families, insist upon it, they all have the coverage. The problem is how to access it. The families may have to fight their own insurer. The treatment community will assist with that as we can, but the families are going to have to fight for that. Delays and denials with a disease that kills you are simply unacceptable. This is unacceptable. People have got to fight it.

Pennsylvania's Insurance Department is now auditing the insurers for compliance with some of these laws, but that's only part of the picture. There's some other legislation that I hope we will get to at some point that should assist with that as well.

Addiction can't wait. Keep in mind the addict has a brain disease so I'm not thinking too well. How do you expect me to fight through the insurance problem? And if I'm a family member, I'm at sea. I'm racked with guilt. I think I did something wrong as a parent. Parents don't have a manual on how to deal with addiction. So for this reason, we really do urge you to look for ways to enforce these laws and enforce transparency and accountability to the General Assembly.

It's going to have to be dealt with in a kind of systemic way. The person with the addiction isn't going to be able to fight for himself or herself, nor is the family because they feel smitten with guilt. That is if we're serious about the epidemic, we'll seek those remedies.

There's a quick description of the laws I'm talking about. Pennsylvania has a commercial insurance law. I think you all are under it. A PA policy purchased in PA, group health insurance law, has comprehensive addiction treatment benefits and the method of access is a physician certification and referral to a licensed drug and alcohol program. The insurers didn't like that and they took the law to court. And I'm very proud to say that the Attorney General's Office of Pennsylvania years ago was under Mike Fisher and then Jerry Pappert and then finally at the very beginning of Tom Corbett's stay I think in the AG's Office they went to court and defended Pennsylvania's Act 106. The Supreme Court has upheld this law. This law is now upheld by the Supreme Court.

And over on the Medicaid side there is a reference here at Act 152, 1988. It provides comprehensive treatment as well. You access it through the Pennsylvania Client Placement Criteria, which was developed by the Department of Drug and Alcohol Programs. It works pretty good. These two laws work pretty good. There are some

fights, but they work pretty good.

Now, I'm going to give you where we have some problems. Patrick Kennedy got through the Parity Act for drug and alcohol and mental health, and there is a struggle going on nationally to get them enforced. One of the reasons is it's kind of hard to measure it. It says if you have any coverage, which everybody now does in Pennsylvania one way or another, it has to be provided in parity with med-surg benefits. And nobody's quite figured out how to measure that, and that is something the Insurance Department is now auditing the insurers on, which I think is good news. It'll help shape that.

The Parity Act applies to something State law does not apply to. The Parity Act applies to State laws but also to big self-insured multi-State plans like a plan that McDonald's holds or Walmart holds or McDonnell Douglas. State laws can't touch those. So this auditing by the Insurance Department is important.

The next benefit is Federal employees. We've got 200,000 of them and their dependents in the State, and we are in a big battle there. For whatever reason, they have set up an authorization process that people literally could die by the time they get through the authorization process. There is now a class-action lawsuit -- you can read more about that from the testimony -- pending in PA to force a

more sane authorization process. This means your U.S. Postal Service workers. That means your IRS workers. It means, you know, Social Security Administration staff, Department of Defense are all affected by this.

And finally, the biggie was the one that Gene DiGirolamo and Representative Cruz started with is the IMD exclusion. This new Federal rule -- and there are attachments describing this weird thing in the back; you can read about it -- would limit Federal matching money in the State of PA for residential rehab under Medicaid to 15 days a month. Secretary Ted Dallas's office estimated preliminarily it's $180 million lost to the State a year if this is implemented. So we've got to stop it.

Let me tell you who it will affect primarily. It will affect primarily pregnant addicted women and long-term residential rehab who are poor -- these are all poor people -- to get a commercial insurance plan. I guess you're going to do okay. It will affect people coming out of jail. It doesn't give anybody a cash grant. It gives them a Medicaid card so I can continue to care for my schizophrenia, my drug and alcohol addiction, or whatever. And I think under this Administration they work pretty hard to hook people up on Medicaid so there is no break in the service, but now the service is going to be pulled away when they get to the outside. It's dramatically going to

affect pregnant addicted women, women with dependent children, and low-level drug offenders who are trying to get back to start.

Now, by way of comparison, if you look at treatment for doctors, we looked at the sufficient health programs nationally. In 49 States, doctors get 60 to 90 days' residential rehab followed by outpatient, very intense and then less and less and less. They follow them for five years. Their recovery rates are over 70 percent in one study and over 90 in another following them for five years out. So obviously, people we value we provide the care. I just think this IMD rule is outrageous.

The same Federal Government that has this IMD rule out, that's the Medicaid bureau. And another bureau published statistics on how much money we save if we treat addiction. It's just kind of interesting to watch that juxtaposition.

You already heard from Gene and saw his resolution, which laid out very clearly 29 Senators are opposed to this. Forty-six Governors, including Pennsylvania's, are on record opposed. Casey is one of the Senators, by the way, opposed.

So I'm going to come back now and say in summary, what does the family need to do? Educate themselves like crazy about the disease. That's number one. Educate

themselves about what is the treatment and the treatment options. I gave you a list of resources there. And then the next step is insist that your treatment is covered under whatever health plan you're under because it is. Insist on it. You may have to fight the insurer, but insist on it. It's there.

That's a lot of information in a hurry. I appreciate your time. I apologize. I'm going to have to slide out in a minute. Thank you for your time.

REPRESENTATIVE HEFFLEY: [inaudible]. Bill?

MR. STAUFFER: Thank you very much. It's a little daunting coming after Deb Beck but --

MS. BECK: Oh, wait until you hear him.

MR. STAUFFER: My name is Bill Stauffer. I'm the Executive Director of the Pennsylvania Recovery Organizations-Alliance. We're the statewide recovery organization in Pennsylvania. I'm going to read actually my written testimony.

Before I do that, I want to thank Representative DiGirolamo for the leadership on the IMD. I agree wholeheartedly that it will be devastating for the State of Pennsylvania. We are grateful for your support. This is absolutely something that we need to do. As a shout out as a constituent of the 132nd District, thank you very much, Mike, for your support on that.

So it's an honor to be here today to testify in front of your Human Services Committee. I first want to acknowledge that publicly funded treatment saved my life. And as of tomorrow, I will have 30 years in recovery.

(Applause.)

MR. STAUFFER: Continuous recovery. And what that has allowed me to do is to have a full and productive life. I've had a normal life because I got help. And we need to make sure that that's available for other Pennsylvanians because treatment works, recovery works, and this is something that we need to have absolutely as a reality for people across Pennsylvania. It makes sense in all ways.

I want to emphasize how important this topic is to us here today. Substance use disorders impact at least one in four Pennsylvania families. Accidental overdoses -- and you've heard these things before -- they're the leading cause of death in some age groups, and this drives government costs in multiple areas, including criminal justice, health care, lost productivities, workplace accidents, auto accidents. The list goes on and on. You are so aware of that. Arming our families with information and making it easier to get help for a loved one is of

paramount importance in saving lives and healing shattered families.

As Deb Beck had said, it's not an easy task for a family member to get help for a loved one. We kind of expect this kind of resistance from someone suffering from a substance use disorder. After all, as it was mentioned, they have a brain condition. Our brains are not working right when we're under the influence. On the other hand, it's a public disgrace in this day and age that in the midst of the largest epidemic in human history that we face the kind of insurance discrimination and limits on care. And it's all too common for families to have to fight the fight that Deb Beck mentioned in her comments before me.

As an advocate for families seeking help for their loved one, we seek the elimination of discriminatory practices and disparate services, including things like exclusionary criteria, exorbitantly high fees, unnecessary information requirements, lengthy preadmission administrative review processes, limited provider networks, medical necessity review exceeding 48 business hours between the persons in the care wholly intended to prevent access to lifesaving help. These things get in the way of getting people help.

Once in care, these arbitrary time limits on reviews for authorizations, denial of any retro-

reauthorizations, and other heavy administrative burdens on those seeking help just get in the way of saving lives. Can you imagine having to wait 48 business hours for your insurance company to review care to decide how they're going to treat a heart attack?

You know, Deb mentioned the Parity Act. This is the kind of things that families face. Can you imagine how terrifying it is for a family member to be sitting there as they're waiting for their insurance company 48 business hours -- that's six business days, right? So you're waiting there six days as your insurance company decides whether or not to help your family member or how to help them. And those things to do and can occur out there in this day and age. We deserve better.

When care is authorized, it is often for far lower levels and shorter durations than is clinically indicated. I have known many people who have lost their lives as a result of these machineries of denial. They are very much with me here in the room today.

And departing from my written testimony, which I put together a few weeks ago, Saturday morning I was sitting in the kitchen of the mother of someone I went to kindergarten with as we're trying to figure out why her son was dead. And this was alcohol; this was not opiates. And could she have done something different given the

circumstances that she was in? These are things that people in the recovery community, we deal with all the time these kind of losses. These are very, very real and they're happening every day and they're happening in your districts.

For family members out there who are trying to get help for a loved one, please trust your gut. Addiction is like an iceberg. As a family member, you only ever see a small portion of what is going on under the surface. Far too often, I have seen people who had a growing awareness of a loved one who had a problem but discounted this instinct and hoped that either they were wrong or that somehow the person was just going to moderate their use and get on with their lives. There's a prevailing and incorrect notion that a person with a substance use disorder has to want to get help to get better before you can help them. It's not true. But as a result of this misconception, far too often people sit around waiting for this moment to occur on its own, and it can be a horrific mistake.

We would not do this with any other medical condition. While it is true that at some stage in the recovery process a person needs to take the reins of the recovery process, it is often later on in the process after the person has gotten help and they've begun to heal that

this occurs. Very few people, including myself, wake up one day and decide to get help on their own. And a short burst of care is all too often not enough to break the chains of addiction. Like any other medical condition, it takes a lot of work. Pressure from family, an employer, a caring medical professional, or a run-in with law enforcement are typically the kinds of things that it takes to get loved one help.

This is worth repeating: We should remain cognizant, like any other medical condition, early intervention is important for reversing the condition, and so families should seek help for a loved one at an early stage of the condition and not delay care. It is important for us to advocate for aggressive treatment, just as we would do if confronted with any other medical condition that can be fatal when untreated or undertreated.

As I mentioned, I have 30 years in recovery. I was 21 years old. I don't think I would be alive here today had I not gotten help. And actually, for the record, my help started with a DUI so it was a legal intervention.

We need to make it easier for families to know what coverage they have and the laws that protect them. Deb Beck covered that so well. I am recommending that every insurance policy in Pennsylvania have a minimum of a once-a-year, plain-language -- not written by the lawyers

-- description of available substance use services and to delineate what Federal and State laws apply in a mailer sent out to each subscriber. Far too often, Pennsylvania families who are covered by insurance don't know what their plans cover and if they're covered by Act 106.

I'm going to read to you from the Pennsylvania Bulletin in 2003 after that State Supreme Court decision that Deb Beck mentioned earlier.

"The act specifies that all group policies, contracts, and certificates subject to the act providing hospital or medical/surgical coverage shall include within that coverage certain benefits for alcohol or other drug abuse and dependency. Under the act, the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. It is the Department's determination that the same prerequisite applies for inpatient detox coverage. The certification and referral in all instances controls both the nature and duration of treatment. The location of treatment is subject to the insuring entity's requirements regarding the use of participating providers."

This means that a doctor can write an order for treatment and it is not permissible under the law in

Pennsylvania for an insurance company to apply preauthorization criteria. It's just that doctor's authorization. This typically covers up to seven days of detoxification per admission, a minimum of 30 days of residential treatment services, a minimum of 30 days of outpatient coverage, family and counseling intervention services, and at least 30 outpatient partial hospitalization benefits after that.

It's my understanding that the Mental Health Parity Act extends these benefits, as Deb Beck mentioned before me. In regard to MHPAEA, this is landmark legislation, but since its passage in 2008, we have not come nearly far enough in the enforcement of the law or education to the public to the important safeguards it contains. I am heartened by recent movement to examine plans offered in Pennsylvania for compliance. We need to educate families about this and make sure that they understand what is present in their benefits and assist them in fighting for them.

Historically, our treatment system has had a difficult time for persons to navigate when they're seeking help. When a person enters care is dependent on a variety of conditions, including the type of insurance they have, if any, and where they live.

As Deb Beck mentioned, the place to start is our

Department of Drug and Alcohol, and they have a section on their website that I've included hyperlinks in my testimony that you have showing where people can get help, where there are open beds, and with their very limited staff and resources, they're doing yeoman's work to make sure that families can get help across Pennsylvania.

Finally, I would want to say you want to get help for yourself. It can be really disorienting to have a family member with a substance use disorder, and it's important to get help for yourself. It is a family disease, after all, and professional help can be crucial for your own well-being as well as that of a loved one.

We know that substance use disorders affect the whole family. A family is thrown out of balance when a member becomes addicted. And it can be disorienting and a profoundly difficult experience for all family members. Counseling can assist a person in reestablishing their own balance and help all members as they move towards recovery and healing. In my nearly 30 years of work, I have seen countless examples of people with substance use disorder getting better when their family got help.

Speaking of this, as entitled above, Act 106 of Pennsylvania requires coverage for family and intervention services, but for some reason this provision seems to not be utilized in the way that it should. There are support

networks and family groups across Pennsylvania for family members who have been down this path and are willing to help others in their recovery journey.

Finally, I would tell families not to give up. This is not an easy journey but it is a worthwhile one. Recovery is a reality for many of us, and for many of us, it did not occur in a simple and linear fashion. It happens because people are behind us and supportive.

Thank you all very much for the opportunity to testify here today.

REPRESENTATIVE HEFFLEY: Thank you, Bill, for your testimony. Are you able to stick around until the end --

MR. STAUFFER: Sure. Absolutely.

REPRESENTATIVE HEFFLEY: -- for some questions?

MR. STAUFFER: Yes.

REPRESENTATIVE HEFFLEY: All right. And thank you very much.

Our next testifier is Dr. Stephen Kearney, the Medical Director for the State and Local Government.

DR. KEARNEY: Thank you very much. And I'd like to thank the Committee for having me here today.

My name is Steve Kearney, and I am the Medical Director for State and Local Government at SAS Institute. SAS Institute is the largest privately held software

company in the world. We actually do the biosurveillance for the CDC. We are in actually every State in the U.S. and all the territories where if there is a public health epidemic, if there's a challenge with any type of bioterrorism, we help collect that information, do the analytics on that. We're in almost every industry sector, so think any type of large data from how you swipe your credit card for fraud to telecommunications to applying data and analytics to any type of large data system.

And so you might ask then, why are you here today? My background is actually I, for 17 years, worked in health outcomes research for Pfizer and worked with State and local governments, policymakers, insurers, all providers, integrated delivery networks to try to answer questions on health outcomes. And so just the way that we would approach cardiovascular disease, the way we would approach behavioral health, the way we would approach an antibiotics program, that's the same type of approach that we've taken now to the opioid epidemic and the challenges that we've seen.

Prior to that, I had a practice at Duke where we looked on things like diabetes and how do we collect information on that, what does that look like, how do we make the best decisions on the data that we have, and how do we follow national guidelines? I remember distinctly

sitting in Grand Rounds at Duke and hearing about the fifth vital sign and the new guidelines where we're going to apply opioids to that, that it was a great opportunity for us to treat patients that were suffering. And the unfortunate consequences of that are the reason that we're here today and trying to help folks with addiction.

And so what we have learned over the past 10 months -- I've actually been to 25 States. I've met with folks in Washington. I talked with Chairman Hal Rogers, who actually started the Prescription Drug Monitoring Programs with the House Appropriations Committee to talk to them about what does it look like in regard to a systematic approach to not only the epidemic with opioids and prescription opioids but how do we get out in front of this? What is it look like for heroin? What does it look like for fentanyl? What does it look like for all the other challenges that we're seeing?

And so what we've been doing is truly taken that same systematic approach. How do you make data actionable for providers? How do you make data actionable for individuals such as yourself? We go into systems right now that unfortunately make it very difficult at times to apply the principles that we learned in regard to prevention and what does it look like as far as being able to identify these patients at risk?

And so before we can talk about the addiction, then we actually have to start prior to that, right? We know that if a patient receives three months of therapy on an opioid that they're going to be at higher risk, but we don't have systems right now in place that actually help us identify those patients.

We also understand that if an individual had to receive naloxone or have an ER visit or hospitalization, right, for an opioid problem, that currently they can go the next day to get a prescription filled for an opioid. So there are tremendous issues with the system that we have in place.

And so what we have been doing is talking with each State, learning best practices, working with folks like yourself to say what are things that we can do working together and how can we share best practices? And that's really what my group is about. We work in a space where we talk about data for good and how can we apply that data for good that everyone has available and how do we get agencies to share that information?

So I was very fortunate for the past two years to work with Project Lazarus in North Carolina. I don't know if all of you have heard of Project Lazarus, but Project Lazarus took a communitywide approach where they started with local initiatives working with everyone from law

enforcement to the clergy to their local Representatives to bring coalitions together and start saying how do we approach this epidemic and how do we get good treatment? And the biggest challenge that we had in all of that space and really in my 17 years in health outcomes research was how do we get that data into the hands of people that can make a difference, right?

I commend you on your current efforts. I know that there has been a lot of work to enhance the Prescription Drug Monitoring Program, to get that information gathered. The challenge that we see in all of these is how do we then provide value to the system and providers and how do we make that data actionable?

If you're a provider and you look into the system and you see that there's a specialist or someone else that is taking care of that patient, that actually delays intervention many times because you'd say, all right, that patient is seeing this specialist and it's very difficult to discern whether you should intervene at times. However, if you're a provider and are taking care of a patient with heart failure or cardiovascular disease or have a stroke and you receive information that they were admitted to the hospital, then you change your treatment plan. You change action. So to take care of the addiction, we actually need to intervene and find the opportunities to intervene where

we have the highest chance of being successful.

We have a couple of questions that have come up as we work with agencies. One is can we share information, right? And so the biggest challenge with that usually is are we following HIPAA guidelines? Are we following the HIPAA rules with that? And what we would say is that if you continue the data process of a patient-doctor relationship, patient-provider relationship, then that information follows through multiple agencies. So if we think of everything from law enforcement to if you're working with health information exchanges, if you're working with child welfare, all of that information, if it maintains the relationship with the patient provider and confidentiality can be used to intervene.

And so one of the questions that we would have, everyone asked today, is are there policies in place now that could impact or could make data actionable for everyone is involved in the system, whether it's law enforcement, whether it's child safety, whether it's the addiction treatment facilities.

So one of the things that we look at when we see large amounts of data is that there's an opportunity. So we know that there's a certain number of beds that treatment facilities can fill. There's a certain number of patients that can receive medical-assisted treatment from

providers. And so there's systems available where we could actually identify that patient as soon as there was an opportunity for intervention and provide a path for treatment. But unfortunately, as you've heard, it's delayed for a number of times. Sometimes we have three or four or five opportunities to intervene and we don't take those opportunities. So that's the one challenge is how do we make policies so that then we can intervene in these instances.

The other question is with active Committees that we've seen that really are focusing on this project the same way that we are, this epidemic, the same way that you would for any other type of biosurveillance is they meet and they have actionable items when they leave. The problem that we see is, unfortunately, there's not the opportunity to share data the majority of the time because it takes -- from the time that you would request a report until the next time of the meeting, the staff to put that data together, the task is onerous. The data systems are not readily available.

And so just as we learn from banking and telecommunications and other areas, that data can be available, actionable in the dashboards and in other ways that you can actually have it accessible whenever you would need to make choices or decisions on policy. And so we

worked with other groups to do that and we'd like to share that with you as well.

Some examples, in North Carolina we actually worked with the Government Data Analytics Center there. And we've spent a few years now trying to get that information available to all the stakeholders. This year, we're actually bringing the prescription drug monitoring data into that system so that all the folks that have the opportunity to intervene with these patients where we worked with Project Lazarus will have the information there.

We also have another system that's called CJLEADS, which is a real-time system on the dashboard for all the law enforcement so that when they pull up an individual and we know that the -- I'm sure you've heard this on the Committee -- we can't arrest our way out of this problem. We need to get these folks into appropriate treatment and have them have the best opportunity to be successful. Then they can pull that out and identify ways to get this person in treatment versus taking them to the local magistrate, to take them into drug courts and that type of thing.

Currently, we actually do the work in California where we actually analyze all of their data with the Prescription Drug Monitoring Program. I bring that up just

because of the sheer volume of California and what that looks like.

And then other States like Massachusetts where we've had to work with five agencies and 10 data sets to bring this information together but to protect every agency so if you have credentials to log into that agency, you can only see that information so that you can protect that, but that the models are in place that we can then begin to look at where are the next instances for heroin? Where are the next instances for par fentanyl or some of the other agents that are out there that are really causing the problems in this space? And then how can we get out in front by -- whether it's appropriations or resources or policies to actually make decisions on this information?

There's some information in your packet here that talks about the way that we have helped States approach this. It's very similar to the way we approach most of the projects that we do with CDC or other State and public health departments. I'd encourage you to read that. We are available to share any of that information.

My job as the Medical Director is to go -- I was just in Arizona yesterday sharing information of what other States are doing. How do we share best practices? And then last Friday, I was on with the Office of National Drug Policy and they were asking us questions on where do States

need help? Do they need help from CMS? Do they need help from SAMHSA? What does it look like as far as the current funding and how can we help with data and analytics to get out in front of this problem?

So I would submit to you today that I know you hear all of this from your constituents. I, like all of you, have had family members impacted by this. Unfortunately, right now, we're fighting behind. We look at the information in hindsight. It's very difficult now to get all that information together in the current systems and even have insights currently on the problem. And being able to have the foresight to move to where the problem is going to go or skate to where the puck is is truly challenging right now.

And so we would make all of our resources available to the Committee to share what other States are doing, to share what we've learned from other industries. And I will close now and ask if there are any questions.

REPRESENTATIVE HEFFLEY: Thank you, Doctor, and fascinating. Before I was elected, I worked in the trucking industry and risk management was a lot of what we did, managing that risk, looking ahead to identify the issues. I mean, this is really interesting information, and thank you for your work.

If you could stick around for a little bit, we're

going to get to questions as soon as all the testifiers are done, but I do have a couple of questions for you myself.

DR. KEARNEY: Great. Thank you.

REPRESENTATIVE HEFFLEY: Thank you.

Our next testifier is Kenneth Martz, Special Assistant to the Secretary, Department of Drug and Alcohol Programs.

DR. MARTZ: Good morning. Thank you. Thank you for taking the time for this important issue.

One of the challenges that we know regularly is that when someone is found to have a substance use disorder, there's not time, and folks are not looking around to know in advance what to do if a loved one has a challenge because people think it will never happen to me. And so this has really moved and changed over time. This is not about "those" people. This is about our brothers and mothers and sisters and children that we're talking about. So this is a critical element to be able to understand what to do and have that information.

So I want to take a second to say thank you, by the way, for the legislation's bipartisan support and foresight in advance, thinking through to foresee the need for the Department of Drug and Alcohol Programs with Act 50 and having the need for a coordination of these efforts, as well as recent efforts for Act 139 for naloxone. This has

been lifesaving, critical to this element, particularly for family members. And we're continuing to get the word out and to grow those initiatives.

One of the first things to know is that the Department of Drug and Alcohol Programs, as was described earlier, shares the Federal funding down through the Single County Authorities. And so they're a key element and key partner in this issue. So often, folks will not know what an SCA is and that's okay. We'll support and get people connected with where they need to be.

But one of the first things to know, one of their roles, is a couple of things: to know what the local resources are, you know? So, for example, if I'm calling the insurance company on the number on the back of my card, they're going to say this person, Smith, Jones, and Tyler here. Which one do you want? And I'm going to say I have no idea.

The Single County Authority, one of their roles is they will know the providers in their area. They will contract with the providers in the area. They will help to get the initial assessment and help to coordinate that, you know what, you are someone with this particular background, with this particular need. This program fits well with that need. I know this program and it's a better match for you than this program, which would not be a good match for

your need.

So this case management role and coordination role is a critical function, and they also take that role not only for case management and ongoing support but also to make sure that they're required to contract with a range of services so that whatever is needed who comes through the door, they have it available and they know who to get it from even if it's not in the county but needs to be coordinated a little further away. So knowing the local resources are critical.

One of the other things, again, is that often you don't know where to go, what to do, and so one of the first places folks will turn up is the ER either because of Narcan or they got sent there for one reason or another. And so we have directed the SCAs to reach out to all the ERs to begin to develop policies and procedures so that the ERs know what an SCA is, they know that I have someone coming into the door and how to connect them and what the procedures are, that there are six different procedures they can set up for warm handoff, which can look differently in Potter County than in Philadelphia, for example. So there's different options for what will work in your locales. So, again, there's a lot of work and where it needs to come from is the grassroots and from the local areas.

So key areas for them to know to try and prevent there from being a wrong door, whatever they start with, folks will be able to connect you and support you to the next step. So key steps for the family members to do and to know right away, as some themes are starting to emerge already today, you need to know how to educate yourself as it is a family disease, not only about the person that you care for but also about yourself and how we play a part in this or how we can play a part of the solution is a critical element. How best can I help my loved one and what supports can I do for the stress and strain that is on me being around those with an addiction and the concern?

Also that, you know, a tragedy, when someone is lost, but even those who are still active in addiction very often the loved ones are struggling day in and day out, worried about their loved one, waiting, when are they going to get that call they have passed. So it's a lot of stress and strain and support the loved one as well as for the person with addiction. So it's critical to engage in getting personal supports.

Other couple things to know to do, critical elements we've been working on, make safety plans. Think about if you have medications in the house, you can get a lockbox, maintain those drugs safely, maintain those medications safely, and for those that are used, return

them to the drug takeback places. DDAP has the website, DDAP.PA.gov. You can look up there. It will find your local drop boxes that are available to return the medications at any time.

One of the other things to work out is that, again, often, when you're in an emergency situation trying to get a loved one into care, you may go to the Internet and you may find some things out there that are highly marketed and occasionally you have to be careful about scams or unlicensed facilities that are posing as licensed facilities or as good-quality treatment. And so, again, this is where it's really valuable to be using some of the resources that we're describing today either through DDAP or through the local county SCAs who will know who is a licensed program, what's a legitimate program versus somebody that we don't know in Costa Rica or somewhere else that you may find on the Internet.

So we heard mentioned today, as a family member, you also need to know about the key insurance protection. I can't say enough about them. We've heard them already testify earlier today. Pennsylvania has some of the strongest insurance support in the country. We have some State laws that really support the Federal laws, really helps the opportunity to make sure that I can get the services that I am entitled to that I have already paid

for.

The other thing to think about in terms of personal support for the family member is to remember that they may benefit also from some personal counseling for the stress and strain and the challenges but also other resources for support such as Al-Anon, Nar-Anon, Smart Recovery, faith-based supports, et cetera. So there's a number of ranges there, as well as intervention services so that you can get some professional support to go and have a conversation with your loved one that, hey, I'm worried about you and this is where I want to support you to get to the next level in your treatment.

Now, think for a moment about what's going on with substance use disorder. It's not unlike other illnesses. So, for example, if I have pneumonia and the physician tells me you need to take this penicillin for 10 days, and I start taking my penicillin and two days later and three days later I start feeling better. And what does the doctor always tell you? You're going to feel better after three days; keep taking it anyway. Okay. So I take it the fourth day. I start getting stomach upset. No, no, keep taking it anyway. You've got to take the full 10 days. What do they tell you is going to happen if you don't take the full 10 days? It's going to come back, it's going to be worse, and you can get a treatment-resistant

form.

It's the same for substance abuse. You know, I have an opioid disorder. I have an alcohol use disorder. I go into treatment and 10 days later somebody maybe says you're cured or 15 days later somebody says you're cured, go home, you don't need residential treatment anymore. And what do you think is going to happen? You're feeling better. You're not in withdrawal anymore. Well, just like with penicillin, you need to take the full course of treatment if you expect to get better.

If I only took two days of penicillin and the infection came back, would you start to blame the patient and say, you bad patient you, you got the flu again, you got the pneumonia again, what's wrong with you? But isn't that what we do with substance abuse? We blame the patient rather than saying, oh, I'm sorry, I didn't give you the appropriate clinically expected medical care. I gave you a half a dose.

We know that length of stay and intensity of treatment is the number one predictor of outcome. You know, just like penicillin, you have to have the proper length of dosage as well as the intensity. If I take a half a piece of the Tylenol, it's not going to cut my headache. You know, you have to take the appropriate intensity and duration if you're going to have any effects

of support.

So this gives us the opportunity to -- when you have proper lengths of stay in treatment, you have the opportunity to do the work that needs to happen in treatment to deal with the coping skills, to deal with the family relationships and broken family relationships that have occurred over the course of time because of the lying and cheating and stealing and other things that go along often with addiction, time to deal with the trauma and learn relapse prevention skills and get your head thinking clearly that you can't do when I'm a day or two into recovery when I'm still in withdrawal.

So for a family member, the person in recovery and the person in addiction is not going to know about the length -- all the variations, so they need to know for the family member that there are a range of intensities just like there's a range of intensities for my heart disease. So, for example, I may go to -- at a certain stage of heart disease, I'm going to walk in and the doctor's going to say, well, you should try some diet and exercise. Other times, you're going to walk in to the doctor and say, no, you're going upstairs into the operating room right now.

So you need the intensity that is appropriate for the severity of where you're at. So if I'm very early on in substance use disorder, I may only need something a

little bit less. If I'm more severe, I need to go to the operating room right now. I can't wait three weeks until authorizations are done and then get a half an operation. You need to be treating folks as clinically as appropriate, as we do with any other chronic condition.

Know that this is a disease that is chronic, progressive, and sometimes fatal. This is an issue that is very serious and so we need to treat it with that same level of severity.

Important thing for families to know also is that this is a brain disease. Somebody's not just sitting there saying, you know, just -- you know what I want to be when I grow up? I want to be addicted to heroin and live under a bridge somewhere. No. This is a disease. This is not a chosen choice or bad people. Based on the disease model, there will be a severity where once dependent, it engages the fight-and-flight response. So, for example, if I started to say that I was going to take away something that was very valuable to you, you'd immediately start to tighten up. This is not about being stubborn. It's about fear that you're going to withdraw something from me that I know is going to put me into withdrawal and it's scary, okay?

So understand the brain disease aspect that also I can't think clearly at that moment because the moment I'm

there, it's not about getting high and feeling good, feeling high. It's about not feeling bad. It's about avoiding that withdrawal, which is a terrifying thought. And so really understanding that, having that sensitivity there so that you can have the strength and courage to support them without shaming and help them into the next step.

Understand that these lies and manipulates are common, as is denial. The individual may not be willing to admit even to themselves or to others that they are in an issue. We know that this is the case even within treatment. I've seen both -- sometimes for six months, but where we're developing a relationship and there's a time where they're sitting there trying to figure out who's going to find this out? It is safe to share this? Is it safe for me to share this information with you? I've had patients that I have worked with for six months and then they finally walk in one day and say, okay, I've got to tell you something. And I know it's coming that day, that there's going to be a talk about something else that is what they really needed to be talking about but they weren't ready to feel safe to share yet.

So think about from this context of the first day they're not going to be ready to walk in and talk at the same level about what they need to work on, so this is --

again, the length of time in treatment has to have a sufficient time to do the work of treatment to build the relationship and build the trust.

The number one reason why folks don't get the help that they need is funding. The number two is the shame and stigma attached. We know that folks are afraid, deathly afraid that not only will my drug be taken away, I can lose my job, my children, I'll go to jail. I was testifying with a woman in recovery recently who testified that after many years in recovery she was afraid to move. She couldn't move from her apartment because she would fear that she wouldn't be able to get another apartment because she'd been told we don't want your kind here, we don't want people like you here. This is someone in long-term recovery who is a pillar of the community these days but having that history, there's such a stigma out there that is terrible.

Know that the Department is working on all cylinders trying to find resources and work through these. I'm not going to go through all the details, but we've been working on the warm handoff, which I've mentioned, not to forget about the Student Assistance Program. That is for student-age helping identify and refer folks early on, before it becomes this severity.

The Get Help Now resource, if you go to our

website, it will connect you with where are the drop boxes, where are the treatment programs, where is your local SCA.

Open Bed Projects, we know that we've got a challenge right now is that we have a lack of available beds, particularly for detox. We recently did a survey that about two-thirds of our beds, two-thirds of our programs were full six to seven days of the week. That means that anybody that would walk to their door would be turned away. We need to be able to have sufficient infrastructure and funding for sufficient infrastructure to support all that's needed.

Also, not least again is naloxone. We have had over 1,500 saves. Think about that in context. We've lost 3,500 individuals. Think about what those numbers would be if we didn't have those additional 1,500 saves.

So again, thank you, thank you, thank you for the work that you've been doing to support in this process and giving us the tools that we need to do our part in this process from takeback boxes to naloxone to supporting anything that's needed.

In closing words, for those that are in recovery and those who are family members, please, please remember that you are not alone. Resources are available and treatment does work. And recovery is not only possible but is an expectation and we'll do whatever we can to help you

get there. Thank you for your time.

REPRESENTATIVE HEFFLEY: Thank you. And we will have time for questions afterwards.

Our next testifier is Kathleen Birmingham, the Program Director for the Lancaster Freedom Center. Thank you, Kathleen.

MS. BIRMINGHAM: I would like to thank you for the opportunity and the privilege to talk to you here this morning. And I would like to reiterate everything that's been said by the testifiers before me. I agree with everything they've been sharing with you.

My name is Kathleen Birmingham, and I'm the Program Director at the Lancaster Freedom Center in Lancaster, which is an outpatient substance use and mental health treatment facility. I am a registered nurse, a licensed clinical social worker, and am certified as a co-occurring chemical dependency therapist. Probably most significant of my credentials here today is that I am a person in long-term recovery from alcoholism. And I grew up in a family in which both of my parents suffered from alcoholism.

Over the 40-plus years that I have been involved in the human service field, I have been invested in working with family members and concerned others of clients suffering from substance use disorders. I have been

running a weekly group for family members at the Lancaster Freedom Center for many years.

When I learned that I would be speaking with you today, I asked the current and past members of family group, "What is it that you think they need to hear?" My remarks are a composite of their responses and my experiences.

Primarily, family members and concerned others need to understand that they are dealing with someone who has a disease, an illness, not a moral failing. It is a very difficult concept for family members and addicts, too, I might add, to accept. Most have been experiencing guilt and shame for such a protracted period of time that telling them that substance use disorders are a disease like diabetes and cancer is a disease seems way too easy. It feels like a cop-out. They need to learn that the medical information that is available regarding neuropathways, dopamine receptor sites, and genetics that put the individuals that they love at risk for this devastating illness, a disease characterized by craving, a craving which causes them to accept the catastrophic consequences of their addictive behaviors and continue to use drugs despite them.

Family members and concerned others need to learn how to stop feeling guilty and giving in to the behaviors

which encourage the destructive patterns to continue. They come into the group without a clue as to how and why it is imperative that they begin to recognize and change enabling and codependent behaviors on their part. Like the addict in denial that he or she has a problem, family members and concerned others do not realize that they have become very sick in the process. They too are angry, defensive, and guilt-ridden. It takes time and education for them to accept that substance use disorders impact every member of the family system and those who care about the well-being of the addicted person.

In addition to education, these individuals need the support of other family members and friends who are going through or who have gone through the process and can empathize with their grieving the loss of how life should have been. All family members have expressed how important it is to see that they are not alone in this process. Inviting concerned others to attend Al-Anon family groups can be extremely helpful, but they are reluctant to do that if they have not experienced some initial feelings of acceptance and openness from others who have been involved in the process. It is as difficult for family members to venture through the doors of an Al-Anon meeting as it is for the addict or alcoholic to breach the doors of AA or NA.

In weekly family group, they listen to other parents, spouses, or concerned others speak openly about how they came to this situation and how they have dealt with the shame of having a loved one with an addiction problem. Some of the stories speak about addiction to alcohol, some speak about substances such as marijuana, opiates, methamphetamines, and other addictive prescription drugs. All of their stories include consequences of loss of control resulting in loss of jobs, education, marriages, children, physical and mental health, and a myriad of other costs that the client and concerned others endure at the same time they're battling this disease. Family members are relieved to hear that they are not unique, that there is a place for them to come and share about what is going on without fear of judgment or condemnation.

The past and present members of the family group wanted you to know that they feel strongly that this experience should be made available in every treatment setting. Sadly, it is unusual for an outpatient facility to offer this opportunity. Most residential facilities provide a separate family component. Outpatient facilities do not.

The Lancaster Freedom Center has always recognized that since everyone in the family suffers when one member has an addiction problem, all family members

should be offered the opportunity to receive education and support. At LFC, we do not add an additional cost for this group because it may present a deterrent. It has been our experience that having family members and friends attend family group and becoming a part of the recovery process helps the client to move forward more successfully in their own sobriety.

In my experience, family members and concerned others all feel some type of guilt, guilt for having done something or guilt for not having done something. They feel that it was their responsibility to have prevented this tragedy from happening. They all benefit from hearing repeatedly that they did not cause this problem, they cannot control it, and they cannot cure it. The more information they receive, the better able they are to respond in an informed way to the drug-induced behaviors of the addict. Treatment helps them to stop reacting with guilt and shame and supports their change to becoming responsive in a more positive manner.

I would like to conclude my remarks by sharing statements from two sets of parents from whom I requested feedback in order to make this presentation today. Both are couples who were involved in family group some years ago at different times, and I have maintained contact with them because they are very generous in their willingness to

come in and share their experience, strength, and hope with the current members of family group. They speak openly about their fears, their guilt, and their frustrations in navigating this rocky period in the journey of their lives. They also share their hope because both of their sons are now living successful, productive, and sober lives.

The first couple, Tom and Ellen, shared that: "The Family Counseling Program helped us to look at addiction in a completely different way. It allowed me to give up my anger at my child. One of the best things we learned was that nobody chooses to be an addict. Don't be afraid to make your loved one's life miserable in order to save it. Be willing to take away privileges and endure their anger. This may mean eventually kicking them out of your house and removing financial support. Emotional support is given unconditionally. We got to the point that we were okay with the prospects that he might hate us forever, but if he lived in spite of that, it was worth the risk.

"As a family, we had to be willing to sacrifice our own comforts in order to put his health and sobriety first, just as a family would if their loved one had cancer or diabetes. Carrying through on your ultimatums is a must. Tell your loved one that you expect them to be whole again, not simply that you hope they will stop using."

The second couple, Tim and Nancy, shared: "We are strong advocates of the holistic approach to treatment since the addict's illness pervades every member of the family on myriad levels. Treating only the addict is akin to concentrating on one tree in a forest fire. Family members are not equipped to deal with the addict, let alone the interpersonal and conflicted emotions inherent in these situations. Family group sessions were critical for our healing process since they provided not only some education on how we got to this point, but also a crash course in the behavior of substance abusers, what to look for, what not to fall for, where you need to go, and how to try and get there.

"Our success with our son would not have been possible without the family group sessions helping to guide us. Amateur psychology, especially in dealing with substance abuse, is like an amateur bomb squad, it will, more than likely, blow up in your face. Family group, led by trained professionals, is the best approach for the most effective treatment."

Thank you for letting me share my remarks.

REPRESENTATIVE HEFFLEY: Thank you. And if we could get the testifiers to come back up if the Members have any questions. I just wanted to acknowledge that several Members had to step out. This is a very busy time

in Harrisburg right now. There's a lot of other Committee meetings and voting meetings to attend, so I know that not everybody can be here for the entire meeting. But if anybody has any questions?

Eddie Day Pashinski.

REPRESENTATIVE PASHINSKI: Thank you, Representative Heffley. Thank you all for your testimony, just riveting explanations of what we're facing here not just in Pennsylvania but throughout the entire country.

I have a couple comments that I want to make and then I do have a question. This is not the first time we've had hearings on this subject, and it seems as though we're on this roadway and we have an area where the road is smooth and is well taken care of and then all of a sudden the road ends and there is no road. And then down the road about another mile, the roadway starts up again, very nice and smooth. Once we get to that area, we're moving along forward and then we have another break in the road. Can we picture that? Because that's what I see between detox, rehab, outpatient, you know, family concerns, lack of funding.

My question first is, is there a State that has a program that is actually fully functional and working, number one? If so, what kind of dollars are they putting into it to make it work? Because there's a series of

things that we have to address when dealing with this addiction. It's like any other addiction. Just the myth itself that this is an illness, you know, because most people think an addict is just, you know, a lost soul and a you're a bum, et cetera, et cetera, which is totally wrong, totally wrong.

You know, so we have a problem of trying to change the image of exactly what not only the addict goes through but what the family has to go through. And again, the family is shackled because they don't know what to do. So it's like you need a -- there is that break in the road that I'm talking about. So while working on the addict, the family is struggling, trying to deal with this. So you have to have a program that affects the family at the same time that you're trying to help that addict. Do you see where I'm going about the broken-road syndrome? I don't know if it makes sense, but to me it does. It's splintered and I want to try and connect that.

So the question is, first of all, is there a State that has a functioning program from detox all the way to, you know, complete sobriety and maintaining that sobriety throughout their lives?

MS. BIRMINGHAM: Go ahead.

MR. STAUFFER: I'm not aware of a State that has a fully functional system. You know, we have -- there's a

recovery movement taking place in America where people are standing up all around the Nation to recognize that we don't treat substance use disorders like we do other disorders. And there's a growing body of research. I mean, we know that if we can get somebody to five years of recovery, just like cancer actually, the likelihood of them staying in recovery just dramatically improves. That's the market we should be reaching for.

We have providers -- I mean, as a former treatment provider, I had to make conscious choices about what I did or did not provide even when I knew this body of research saying I should do it all just based on --

REPRESENTATIVE HEFFLEY: Could you just make sure your mike is turned on.

MR. STAUFFER: Oh.

MS. BIRMINGHAM: You can use this one.

REPRESENTATIVE HEFFLEY: Green light.

MR. STAUFFER: Sorry about that. Can you hear --

REPRESENTATIVE HEFFLEY: There you go.

MR. STAUFFER: Could you hear what I was saying --

REPRESENTATIVE HEFFLEY: I could.

MR. STAUFFER: Okay. So we have a recovery movement that is bringing recognition to the fact that we don't treat substance use disorders like we do other

medical conditions. If you get cancer, you know that you're going to get surrounded by services. They're going to be pitfalls and things that happen, but eventually, you're going to get a lot of services and care and follow-up to get you to the point where you're five years in recovery. And we kind of approach it like that. We do not approach substance use disorders that way in this nation.

So there's a movement to move in that direction and get us towards what the science says. So I actually think that we have some really, really good providers and we have some good leaders in both systems here that are just trying to do this, forgive me, but with duct tape. We're just trying to do it without adequate resources.

It is the leading public health issue in our country. It also drives your costs. So the money is there. I mean, I've looked at estimates that say to get somebody to five years' recovery would be about the equivalent of putting a stent, a heart stent in someone. Like so in the medical side we don't blink when we spend the kind of resources that it would take. There's something about that stigma that says, you know, if you have this kind of problem, we're not going to treat you the same way. And we're paying exorbitant amounts of money in our criminal justice, lost health care, and all over the place in that. So I wish I could point towards a model

that worked, but I'm not aware of one.

DR. KEARNEY: I'm not aware of a model program either, but I do know actually Pennsylvania is one of the leaders in this area because -- I've mentioned earlier -- we have some of the strongest insurance laws, which is a critical element to make sure that folks can get the treatment that they need with the coverage that they already have.

And so many other States are struggling with that issue, that they can't even get the initial access. They're told they can't even get to detox, go try 12-step instead, don't come here until you fail first at something else, et cetera. So that's why it's such a critical element.

To the issue -- to piggyback a bit that we know that we've had a 26 percent cut in our Federal block grant for substance abuse over the last 10 years because inflation adjusted, et cetera. This is a time when we've got an opioid epidemic escalating rapidly. So to the issue about having sufficient resources is a critical issue. We also know that that's multiple levels of infrastructure but also a workforce issue.

SAMHSA has published a workforce study within our region that substance abuse providers are the lowest paid of all disciplines, of all allied health disciplines and

the lowest of all States in our region except for West Virginia.

So in terms of this issue of as you cut and cut and cut slightly, one of the things that gets cut is -- at a key time my role was always as a provider to make sure that I carry my person forward and I see them through to the next step. They could refuse something -- that's another conversation -- but I would always work to have that coordination of care. But again, as we get squeezed and squeezed and squeezed, there's challenges that occur. So it's not a simple dollar number, but the vision is there and a lot of it is happening right here in Pennsylvania.

MS. BIRMINGHAM: And I would add that despite the fact that Pennsylvania has the 106, 107 largely -- to Deb Beck -- it is still difficult for us. We hear back from insurance companies on a daily basis. Intensive outpatient, this person has to fail at the level of outpatient before they can access intensive outpatient. They have to fail at the level of intensive outpatient even though I know, because I've done the evaluation, that they are not appropriate for our level of care, which is outpatient. They need to go to residential treatment. But we can't put them in residential treatment if they have not first failed at intensive outpatient or outpatient treatment. That's deplorable. We don't do that for

someone who needs open-heart surgery.

DR. KEARNEY: And I would say from our work across the country we found really good pockets of groups that are working together. Even with Project Lazarus, for the two years that we worked on that in North Carolina, we had all 100 counties covered. We trained over 1,500 providers. Every meeting that we had, we had individuals come forward that could help with treatment, but we needed beds, we needed funding, and we needed an infrastructure to share that information.

And so in talking with Washington, they know that they woefully underfunded all of these projects and that it's going to cost a lot of money, but they're also looking at how do they measure that and how do they get these folks into the right places because, like all the great work being done here in Pennsylvania, it is very difficult to then move that forward with insurers and share that information.

REPRESENTATIVE PASHINSKI: Well, I truly appreciate all of your responses. And you've already identified some policy gaps and you've identified the fact that you are underfunded, which doesn't allow you to do what you need to. And of course in government we never have enough dollars for everything, but it seems to me that if we were to address this thing appropriately and invest

wisely in the long run, we can certainly make this work and save some dollars.

There was one other point that was made, and I'm going to hold that and give the other people a chance to ask questions, but I'd like to come back if I could, Mr. Chairman. Thank you.

REPRESENTATIVE HEFFLEY: Sure. Thank you, Representative.

Representative Zimmerman?

REPRESENTATIVE ZIMMERMAN: Yes, my question is just a little bit different, but I first want to thank all of you for your testimony. It's very helpful, and I appreciate your time.

In some conversation with EMS and law enforcement, it's my understanding that, whether it's Narcan or naloxone that has been used, that they end up finding the same individuals days or weeks later and using the same drugs again to kind of, you know, keep them from dying. And so does that not bring, you know, a whole new conversation to, you know, what we do about that and if there's, you know, anything else we can do as well? But even hearing that maybe some of these individuals are kind of emboldened by that and just assume that with these kinds of drugs that they can, you know, use even more powerful drugs or do an overdose and just assume that somebody will

kind of bring them back. So just, you know, things I've been hearing from both law enforcement, as well as EMS.

DR. MARTZ: Yes, I mentioned earlier about the warm handoff. That's one critical element. One of the challenges is that you can't require someone to engage in treatment in certain ways. So, for example, even if I have cancer, I can say I'm not going to stay here, I'm not going to accept this treatment. And so when I wake up from an overdose and the first thing I see is an officer standing over me after my -- it was substance use -- as I've talked before about the fear and anxiety.

And so it's a little bit easier as we're connecting into EMS and connecting to the hospital and we're working very closely with a number of procedures to get funding and additional certified recovery specialists, folks who have been there with lived experience who in some or all of our counties will call and meet them at the hospital and have a face to wake up to and help engage them. We know that that's a challenge across the country. Folks aren't going out and using more because of that. We are just way ahead of the country in the use of naloxone, I mean, light-years ahead when I talk to our national counterparts. And so we're also well ahead of research on this. I've been asked to speak on this for IRETA, and when they heard about it, they wanted to put the training

national because this is light-years ahead here in Pennsylvania.

We're also looking even within our State to see where the best practices are and we're finding in Berks County they're doing some excellent work getting -- I've heard different numbers -- about two-thirds to 75 percent of folks who are revived at the ER connected directly into care, and that's a critical element, that warm handoff there, that it's not just here is a number, go call this. It's I'm going to help you to close that gap in the road to get to the next piece of care, which is exactly what we would do with any other medical condition. And we have those challenges there to support and we're working that.

REPRESENTATIVE ZIMMERMAN: Good. Yes, thank you. That's encouraging. I appreciate it.

MR. STAUFFER: I would just briefly add to that. You know, I teach at a social work school and I would want to make sure that people understand that when somebody's in this condition, our brains aren't working right. It affects executive function. I can weigh things out now and decide: bad idea. When somebody's under the grips of a substance use disorder, it's not working that way. We really need to get people help at that time or we are going to see them go round and round. They're not emboldened kind of in the way you say. They come to from withdrawal

and their brain is screaming to use drugs, and that's really like on a physiological level what's happening. And I don't think a lot of people, even paramedics and even some medical professionals may understand that.

DR. KEARNEY: And I would commend Pennsylvania on all the work that they've been doing. As we learned working with our Harm-Reduction Task Force with Project Lazarus, it was a challenge as far as getting folks with the warm handoff. The other challenge is that then the system does not help them with this information. So, for example, if you have an overdose, receive naloxone, that information is many times not shared with the provider or the health system that they're in, and so it's a real challenge as far as making sure that information is available so that then they can reinforce getting them into treatment. And so that's a challenge across the country as well.

REPRESENTATIVE HEFFLEY: Thank you.

Representative Ward, did you have a question?

Okay. I have just a couple of things. One of the things that I heard twice in the testimony -- and I appreciate everybody for your time today, and we have, I think, a few minutes left. We do have to adjourn by 11:00.

One of the things I heard twice from two different testifiers was potential for scams and unlicensed

centers, 800 numbers, TV advertisements. I guess I never really -- we do scam seminars throughout the district on different things that are out there, but I don't know if anybody can elaborate on that a little bit. I mean, I know it's a little bit off, but since I heard it twice, the last thing we want to do is have a family or somebody finally reaches out for help and then gets scammed.

DR. MARTZ: Well, just a simple example, there are -- when you go through a web browser, there's ways that it can pop up with ads, and the ads can appear as though it belongs to that actual website so it appears as if it's a part of what you're looking at as a legitimate website but it's actually an advertisement that popped up.

And so, for example, if you are in Pennsylvania and the program says it's a licensed program or there are certain regulations that we have around -- you can't advertise as a substance use treatment without being licensed, which means that they're following certain regulations and being monitored. If I get a pop-up that takes me to Florida or somewhere else, it may or may not advertise in the same way or it may be, for example, a hotel that says you can also go downstairs and there's something over here. If there's not a regulation on it from another State in the same way that we regulate what you can advertise, there can be some issues there where

they -- we've had patients who have thought that they were one type of program and it was not. So they thought they were getting this residential service, for example, but it was not. So making sure that it needs to be carefully advertised and properly advertised, we have some support and control over that within Pennsylvania, but outside of Pennsylvania, we have no way of intervening with how it's advertised.

MS. BIRMINGHAM: One of the things that's going on because of the opiate epidemic is the numbers of recovery houses that are coming about, which are good things. They provide support and structure for people newly in recovery. They are now being licensed in Pennsylvania, but they are not licensed in other States. And unfortunately, there are scams associated with them. And it's an unfortunate thing, and it's an unfortunate thing for family members to be paying for them.

And, you know, other States that -- people go down to Florida, for example, and I have heard horror stories about what's going on when people get kicked out of recovery houses and people who are there ready to pick them up and getting a bounty perhaps for putting them in other recovery houses. So the recovery house movement needs to be licensed and credentialed just like the rest of us who are licensed.

REPRESENTATIVE HEFFLEY: Thank you. And I know we had a task force that was adjourned to review recovery house regulations here in the State of Pennsylvania, and we are moving forward in that regard. Just a note, I had a gentleman come to me in my district. His daughter was in a recovery house and she had overdosed in the recovery house. And I think one of the things that we're working on the regulation is to require Narcan in recovery houses.

I have a lot of questions we could take off on, but I do want to get back to one of the things that I found fascinating and I've been doing a little bit of reading on it and trying to understand it better is the Lazarus project. I know you talked about that quite a bit, and just taking the information, that data you're looking at and managing that risk.

I know some of our schools that I represent, we have an afterschool program where we identify people that are, you know, struggling academically and get them into these afterschool programs and that works. And I think, you know, as we go through this, we're not going to see the light at the end of the tunnel for a long time. There are so many people that are struggling with addiction. As we try to turn off the spigot of the prescription drugs that we feel is fueling this, there are still a lot of people in recovery. So I think looking at the data and drilling down

and finding out what best -- and I really want to explore that a little bit more with you, Dr. Kearney. So I really appreciate your testimony and everybody here.

One other thing is -- what I hear quite a bit is not enough beds available. And I would say that because I would think -- can somebody give us a number? How many more people are seeking recovery treatment now than last year? And do we have a projection what that's going to be next year? Because I think the system is just going to be overwhelmed in a sense. How can we build out this infrastructure? How do we get enough beds available? I think the State is looking at the possibility of a bed registry.

DR. MARTZ: I can get back to you with some of the exact numbers. I don't know them off the top of my head. I do know that we -- one of the challenges that we've had historically has been funding, and so what would happen is while there will be many people who would need treatment, by March or whenever -- it would be different for each county -- they would run out of funding and so people would know and they would stop knocking on the doors. So it makes it really difficult to know the actual numbers of folks that are in need because somehow when there's nothing available, people don't come in the door.

We do know that there has been a substantial,

substantial increase which is going to continue to alter the numbers, which is why it's a bit of a moving target, because of the Medicaid expansion so that now there has been funding. There has been a significant influx in the numbers of folks that have been coming in because there are more folks who are eligible for coverage. We normally only have 10 new programs apply each year for program expansion. We've got over 100 this year already. So the programs are scrambling to try and grow, and grow that infrastructure as quickly as possible to keep up, so it's changing very rapidly to try and grow to keep up with the numbers.

REPRESENTATIVE HEFFLEY: And following up to that, one of the things that I've heard from some of the providers that are looking at getting into, you know, treatment and recovery services is the regulatory process. Is there a way -- you know, I mentioned earlier about the scams. We want to make sure that it's done right. But is there a way that we could help with some kind of regulatory reform so that the folks that are looking at expanding into these services are able to do that in a regulated manner, in a more efficient manner? I mean, right now, just for the simplest projects sometimes take two or three years to get a shovel in the ground.

You know, how can we expand that or how can we reform the regulatory process as now you've mentioned we

have more people with insurance? I think there's going to be a continued increase in people seeking recovery services. How do we meet that need in a way that -- we want to have that accountability, but at the same time, you know, make it a quicker process to get these places up and running?

DR. MARTZ: A key issue there is that there's a number of steps in opening a new program. From our department's perspective, we license the program, so one of the things that can happen before that is zoning, and these local regulations which we don't have any control over which can take some period of time.

Historically, our role has taken quite a bit of time. We've gotten our application process down from six months to two weeks to a month, so we're streamlining wherever we can internally. Then, there are other steps, though, that will need to occur. So, for example, once you now are licensed to go forth and open your program, you will want to get funded for it. So then there's a process for developing contracts for funders and for insurance panel applications, et cetera, et cetera. So there's a number of steps that occur over the process of developing and implementing a program. And so we're looking closely at whatever we can do to support these practices to streamline.

REPRESENTATIVE HEFFLEY: I definitely would be interested in working on a process to do that. Thank you.

And Representative Pashinski has a few more questions.

REPRESENTATIVE PASHINSKI: Thank you very much, Mr. Chairman. And again, this always happens. You know, we're starting to really get down to the point where we're actually identifying things that we can do to help solve this problem and then we run out of time. So if you would, I would very much appreciate if you could stick around. I'd like to give you my card because I'd like to continue the conversations.

But two things I might want to share with you: One, can we put together a financial analysis of your typical addict, what they go through, the process that happens, the cost involved in that as opposed to if we had the system in place what the cost would be to take that addict through the proper system to make them well? This place runs on money, and the only way we can sell things is to demonstrate if we do plan A, it's going to save the taxpayers money in the long run, all right? So it's important that we get a financial number on it.

The second thing, are you all familiar with White Haven Center, White Haven Center in Luzerne County? Many, many years ago that was developed as a place for people

with tuberculosis. That's where they would sequester the people. They have four to five considerably large buildings that were in place for the various stages of med that they needed and they had to go through. So the shovel in the ground, we already have some buildings, and I think if we went throughout the State, we can find others.

You are identifying an epidemic no different than tuberculosis. We have the buildings. Let's explore White Haven to see if that's a possible place for them to start. One building is detox. I don't want to simplify this but I'm just making this statement. One building is detox, second building is rehab, third building is outpatient. You see what I'm saying? And it's all already there. Of course, it will take X amount of dollars. Is it worthwhile exploring? I don't know. You're the expert. I just offer that to you for consideration.

DR. MARTZ: That's an excellent idea. We have been working closely with other departments to identify other buildings that are already -- I don't know that particular one, but we've been looking at what are buildings that are available, already owned, that could be repurposed or used in such a way and trying to work together with providers that could take those steps because those are some of the steps along the way, as I mentioned, about --

REPRESENTATIVE PASHINSKI: Yes.

DR. MARTZ: -- developing and opening a program.

MR. STAUFFER: I just want to add, you know, the idea of looking at the costs, there was a center -- the National Center for Addiction and Substance Abuse, CASA, in New York did a study the other way, and they looked at State cost for addiction, and they said that Pennsylvania spends about 97 cents of every dollar on shoveling up the problem, about a penny-and-a-half on treatment, and the remainder on prevention.

REPRESENTATIVE PASHINSKI: Yes.

MR. STAUFFER: So there is some data out there on that already, but we're certainly --

REPRESENTATIVE PASHINSKI: Okay.

MR. STAUFFER: -- spending a lot of money.

REPRESENTATIVE PASHINSKI: Well, I'd appreciate anything that you could offer --

MR. STAUFFER: Sure.

REPRESENTATIVE PASHINSKI: -- the Committee. I think the Chair would appreciate that as well. But I'll stick around at the end and share cards. Thank you so very much. Thank you, Mr. Chairman.

REPRESENTATIVE HEFFLEY: And thank you, everybody, for your testimony today. I thank the Committee Members for being here. We do have to adjourn right now as

we are getting ready to go into session. Thank you very much.

(The hearing concluded at 10:58 a.m.)

I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.

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