Gary Tennis, Former Secretary
Department of Drug
and Alcohol Programs
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Initiatives and Accomplishments

JUNE 2016

Preventing & Reversing Overdose | Accessing Effective & Individualized Treatment | Supporting & Championing Recovery

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS
Saving one life at a time.

Pennsylvania, along with the rest of the nation, is experiencing the worst overdose death epidemic in history. Fatal drug overdoses are the biggest public health crisis to hit the Commonwealth and nation in the last 100 years. In 2014, nearly 2,500 Pennsylvanians died of overdose[1]. The total number of deaths for 2015 will be higher when the final number is tallied. We expect 2016 will be even higher.

In 2014, nearly 2,500 Pennsylvanians Died of Overdose (primarily heroin and other opioids).

To address the public health crisis, the Department of Drug and Alcohol Programs (The Department or DDAP) has undertaken many initiatives to prevent and treat substance use disorders, reduce deaths to drug overdose, and increase public health and safety awareness.

Equipping municipal police with naloxone. The Department led efforts to equip law enforcement and others with naloxone. Act 139, also known as "David's Law," made naloxone available to police, firefighters and family members and friends of those at risk of heroin or other opioid overdose. Naloxone rapidly reverses overdoses and has saved thousands of lives. As of May, more than 320 municipal police departments across the Commonwealth were equipped with naloxone through DDAP's efforts. Nearly 1,000 overdoses have been reversed. Additionally, 1,200 State Police patrol cars are equipped with naloxone in every county. Under DDAP's leadership, district attorneys and municipal police chiefs have developed naloxone programs. The Department has initiated and continues to oversee several initiatives to provide training, technical support and funding, as well as closely track those efforts, including the number of departments carrying naloxone and the number of overdoses reversed.

On March 1, 2016, Lt. Gov. Mike Stack, along with DDAP Secretary Gary Tennis, Physician General Dr. Rachel Levine, Pennsylvania lawmakers, and representatives from the Pennsylvania District Attorneys Association (PDAA), Pennsylvania Chiefs of Police Association (PCPA), Pennsylvania State Police (PSP), and health insurance providers recognized more than 300 municipal police departments, PSP and hundreds of individual police officers for their life-saving work resulting from the use of naloxone.

Overdose Task Force (OTF). The Department established OTF in July 2013.It is comprised of representatives from the national, state, county and local levels and continues to meet approximately quarterly. The initial goal of the OTF was to develop a rapid response mechanism to break down information silos so that law enforcement and emergency medical services could have real-time trends information more readily available to them.

Given the nature of this public health crisis, in June 2015, the OTF expanded its leadership to include Physician General Rachel Levine, MD, as co-chair of the group and simultaneously expanded its focus from its initial rapid response goal to include: 1) informing and driving public policy on the issue of overdose; 2) informing overdose response; and 3) strategizing and planning robust responses to the crisis.

"Warm hand-off" policy. With the assistance of OTF, the Department is implementing a warm hand-off process whereby overdose survivors are

1. Pennsylvania State Coroners Association Report on Overdose Death Statistics 2014

transferred directly from the emergency department (ED) to a drug treatment facility. The Department has incorporated contractual changes with the Single County Authorities (SCAs) in its 2015-2020 grant agreement that establishes the overdose survivor as a priority population and requires each SCA to create a process for direct referral from the ED. These new requirements went into effect in January 2016 and are expected to be fully operationalized by the end of 2016.

Police Intervention Efforts. The Department is researching various national police-assisted referral to treatment models to develop a Pennsylvania model. Once the model is complete, the Department will work with various interested police departments to encourage implementation.

Treatment bed capacity. Under guidance from OTF, the Department is reviewing treatment bed availability and a process for tracking it across the Commonwealth in real time. While this process is still under way, some initial barriers and strategies to remediate these concerns have been identified. The Department has also engaged partners, including the Hospital and Healthsystem Association of Pennsylvania (HAP) to identify solutions.

Prescription Drug Take-Back Program. Department leadership has led to a greatly expanded prescription drug take back program. Many young people who abuse prescription drugs are stealing them from medicine cabinets. Keeping unused opioids or other common drugs of abuse in a medicine cabinet is no longer safe or responsible. The Department, working in partnership with Pennsylvania Commission on Crime and Delinquency (PCCD) PDAA, the Attorney General's (AG) office and the National Guard, has continued to increase the availability of permanent prescription take-back boxes across the Commonwealth, with the goal of reducing the amount of prescription drugs available for potential misuse/ abuse. Since 2015, approximately 100,000 pounds of prescription drugs have been collected and properly destroyed. To date, this program has placed nearly 450 take-back boxes across 60 of the Commonwealth's 67 counties, primarily at municipal police departments So far in 2016, nearly 25,000 pounds of prescription drugs have been collected and destroyed.

Prescription Drug Monitoring Program (PDMP). The Department is working with health care providers to educate them on identifying those with substance use disorder through PDMP and effectively directing them to treatment.

Improving Licensure Regulatory Standards and Processes. The Department has developed a simplified and easy-to-understand template to guide treatment provider applicants in acquiring new treatment program licenses. Typical time for the Department's review and approval process has been reduced to a few weeks. The Department also is working on a new initiative that would extend licenses for exceptional program compliance, increasing the amount of time between inspections for the free-standing drug and alcohol facilities that for the previous two years have not had any citations in four critical areas (conduct or omissions that jeopardized the safety of any persons, compromised the quality of treatment provided, violated a client's con-fidentiality rights or resulted in treatment being provided without informed consent) and have reasonably and timely taken any remedial measure requested by the Department.

In addition, working with the Department of Human Services (DHS), the Department has begun to coordinate efforts to regulate programs that provide co-occurring mental health and substance use disorder treatment, eliminating duplicative efforts and making for a more efficient process. Along with DHS, the Department is also coordinating licensure application processing with PROMISe applications, reducing the amount of time before a treatment program can take Medicaid patients, making treatment beds available faster, and preventing waste at the government and provider level.

THE RX TAKE-BACK PROGRAM HAS COLLECTED AND DESTROYED APPROXIMATELY 100,000 LBS. OF PRESCRIPTION DRUGS.

Lastly, the Department's Licensure Division

processed 70 applications for new facilities or expansion of facilities in 2015 as evidence of the need and demand for new treatment facilities.

Workforce Development. Workforce development efforts are under way to provide new professionals entering the drug and alcohol treatment field a more effective and successful entry to employment while at the same time reducing treatment provider staff turnover by providing and maintaining a clear career path with concise objectives for candidates.

"Pathways to Pardons." Working with the Board of Pardons (BOP), the Department has initiated the "Pathways to Pardons" program. This program allows individuals with a substance abuse history who have been convicted of certain crimes to apply for a pardon from BOP. For those individuals who have fully committed to their recovery as evidenced by approximately five years in recovery and no criminal activity, "Pathways to Pardons" makes it possible for the crime(s) to be completely expunged from the person's criminal record. The number of applications for this program has nearly tripled since this initiative began.

Employment in Recovery. Two new projects are under way under direction from the Department. In collaboration with the Department of Agriculture, the Greene County Single County Authority and a Greene County recovery house are working to provide individuals in recovery with employment through a Penn State University program. As part of the program, those in recovery will have the opportunity to join the ranks of the agricultural workforce. Those in recovery will gain job skills while helping to address a workforce shortage. Additionally, the Office of Vocational Rehabilitation is working to expand payment for training for individuals in recovery to become Certified Recovery Specialists.

New Data System. The Department has begun the process to procure a new data system to enhance data collection efforts and allow for more detailed data analysis, while meeting its requirements under the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

Using State-owned Facilities for Use as Drug and Alcohol Treatment Facilities. In collaboration with the Departments of General Services and Human Services, the Department has identified a list of potential properties to potentially be made available for use as treatment facilities. All interested parties will work through the Department to use or acquire the properties.

Substance Abuse Treatment Funding and Federal Grants. The Department has engaged in an unprecedented level of grant-seeking initiatives, continually seeking major federal grants from SAMHSA as well as other partners. The Department's collaboration with Staunton Farm Foundation on a grant for prescription drug collection boxes is one example of these efforts.

Working at the federal level, Secretary Tennis has testified at Congressional briefings to urge Congressional support for the full continuum of treatment services, including long-term residential treatment (i.e., therapeutic communities). Secretary Tennis also has testified on behalf of NASADAD to increase SAPTBG funding. He also testified before a joint conference of the Council of State Governments and Department of Justice, Bureau of Justice Assistance on behalf of NASADAD to discuss the critical importance of clinically matching drug and alcohol treatment for criminal justice offenders to their level of need.

In addition to SAPTBG, which is the Department's main source of federal funding, the agency continues to pursue federal categorical grant opportunities for special initiatives. The Department's recent and still active federal grant opportunities include: the Cooperative Agreement to Benefit Homeless Individuals (CABHI), and the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) grants.

In collaboration with the City of Philadelphia and the Mental Health Association of Southeast Pennsylvania, the CABHI grant addresses the issue of chronic homelessness and increases the dissemination of best practice models. Additionally, a supplemental CABHI grant was awarded to Pennsylvania that focuses on homeless veterans with and co-occurring mental health and substance abuse issues.

For the SPF-PFS grant, the Department, as the lead agency, coordinates with five high-need counties (Blair, Bucks, Delaware, Lackawanna and

Westmoreland) to reduce underage drinking among 12-20 year olds and reduce prescription drug misuse and abuse among 12-25 year olds.

Most recently, the Department was awarded a Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The grant will assist individuals who suffer from opioid use disorder. The Department also received a Pennsylvania Screening, Brief Intervention and Referral to Treatment (PA-SBIRT) grant. The grant will enable implementation of SBIRT training and protocols in seven primary counties.

Life Skills Training (LST). An evidence-based program, LST reduces drug, alcohol and tobacco use by 60 percent to 70 percent among 6th, 7th and 8th grade students. During 2015, the Department continued collaboratively working with the Pennsylvania Department of Education (PDE) and PCCD to raise awareness and encourage school superintendents to use this program. Through Pennsylvania's Evidence-based Prevention and Intervention Support Center (EPISCenter) and Blueprints/University of Colorado, free training, supplies and technical support, including covering the cost of substitute teachers while teachers are being trained, is provided to any Pennsylvania school district that wants it. More than 60 school districts participated statewide in this grant throughout 2015 and that number greatly exceeds the total number of school districts participating in any other state that was eligible for this grant.

Building Bridges to Recovery (BBTR). This Department initiative encourages increased collaboration of our recovery community with medical providers. BBTR programs take place in September during National Recovery Month to raise awareness around substance use disorders and recovery from the disease. In 2015, BBTR efforts included a press conference in observation of International Overdose Awareness Day.

Get Help Now: Let's Work Together! In 2015, the Department launched a first-of-its-kind mobile website that offers a new starting point for individuals seeking drug and alcohol recovery and support services over their mobile phone or other mobile device. The mobile website gives Pennsylvanians the ability to find addiction treatment services for adolescents and families statewide and offers treatment information resources. The Department led a collaborative effort as part of the Mobile PA Challenge by partnering with a student team from Harrisburg Community College and the Office of Administration.

Driving Under the Influence (DUI) Treatment Compliance Project. With this project, the Department is working to ensure that quality, pre-disposition assessments and treatment services with clinical integrity are being provided for DUI offenders with substance abuse disorders in every county in Pennsylvania and accurate and complete reports are being made, as required by statute and best practice standards of public administration.

The Department, in collaboration with PennDOT, is auditing compliance with existing laws, identifying and troubleshooting obstacles to compliance and promoting innovative local practices in substance abuse treatment/criminal justice program development and improvement. The Department and other key DUI compliance stakeholders have a commitment to continuous improvement to treatment, working together toward a more integrated case management approach and communicating and collaborating with other key DUI compliance stakeholders.

To date, the Department has conducted a survey of all 67 district attorneys, and 37 of 67 counties report that they are in full compliance with the statute. Of the 30 counties reporting noncompliance, the Department thus far has met with county criminal justice advisory boards in more than 20 percent of those counties and those counties are either now in full compliance or are working to achieve compliance. The Department has worked with treatment providers and the information technology experts at PennDOT to identify the source of the reporting gap and proposed a change in reporting and analyzing the required data. The Department has assisted in recruiting a wide array of treatment and criminal justice experts as an oversight committee and regularly communicated with treatment and criminal justice professional groups. The Department staff have conducted site visits to seven counties and currently are confirmed to visit an additional 10 counties by the end of May. The current goal is to complete more than 50 percent of the

counties visits by mid-August.

Maximizing Medicaid Funds for Offenders. A portion of state and federal funds being administered through the Department to the Commonwealth's Single County Authorities (SCAs) are being used effectively to transition offenders to residential drug and alcohol treatment facilities immediately following their release from county prison, thereby bridging a treatment gap that exists in Pennsylvania. At its inception, four SCAs participated in this program and reported an estimated $950,000 of Medicaid funds used for offenders entering drug/alcohol treatment facilities. Since then, the Department has required all 47 SCAs to participate in this program. During SFY 2015-2016, 1,077 offenders received various levels of residential treatment services: 326 went to long-term inpatient rehab; 363 went to short-term inpatient rehab; 132 went to short-term inpatient to be treated for mental health and substance use disorders; 56 went to a halfway house; and 194 went to long-term inpatient to be treated for mental health and substance use disorders, where the average length of stay was 32 days.

Compulsive and Problem Gambling Program. Outpatient problem gambling counseling services continue to be enhanced and expanded with new treatment providers. There are more than 100 provider locations currently. With money provided to them from the Compulsive and Problem Gambling Treatment Fund, SCAs provide problem gambling needs assessments, prevention programs, outreach, educational programs and other Department-approved services. Client treatment retention has increased from an average of 17 treatment sessions used in 2012 to an average of 23 treatment sessions used in SFY 2014-15. Nearly 75 percent of clients discharged from treatment during SFY 2014-15 achieved or partially achieved treatment goals. Of the clients discharged from treatment during SFY 2014-15, 67 percent were no longer gambling or reported reduced gambling.

Problem Gambling Prevention Program. A new two-year Problem Gambling Prevention Program (PGPP) funding initiative is providing comprehensive, evidence-based problem gambling prevention programming across the Commonwealth. Forty SCAs applied for funding and were awarded a total of $4,373,021 in SFY15-16 and $4,358,916 in SFY16-17.

In SFY 2014-15, through the PGPP funding initiative, 16 SCAs expanded their student assistance program (SAP) services, including SAP consultations, core team meetings, training, parent/consultant/teacher meetings and educational groups.

In addition, the Department collaborated with PDE and PCCD to develop the next Pennsylvania Youth Survey (PAYS), a survey of school students in the 6th, 8th, 10th and 12th grades aimed at learning about their behavior, attitudes and knowledge concerning alcohol, tobacco, other drugs and violence. Additional gambling questions were included in the 2015 PAYS, allowing for more information to be collected about student gambling activities. During the spring of 2016, the SCAs began to analyze the PAYS data. Plans are under way for them to use the data to identify gambling trends and communicate the need for problem gambling prevention pro-grams and services within their local communities.

In Conclusion. The problems and solutions underlying the current overdose death epidemic are complex.

Without the necessary resources brought to bear, no solutions for the effective prevention and treatment of addiction will work. As we shift public policy toward fully funding the actual need for drug and alcohol prevention and treatment in our communities, we will dramatically reduce the suffering felt by one in four families in Pennsylvania.

Pennsylvania will have safer and healthier families and communities when these goals are fully realized, resulting in reductions in health care costs, less crime (resulting in the need for fewer jails and prisons), less domestic violence, less child abuse, safer highways, and a safer and more productive workforce. It's time to move forward. We know what works. Let's work together!

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pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS
Saving one life at a time.

Governor Tom Wolf
Secretary Gary Tennis

DDAP Interdepartmental Collaborative Projects
Pennsylvania State Government Plan

Overview

We are in the midst of a nationwide overdose epidemic and our treatment system is only funded and equipped to treat one out of eight people in need. Pennsylvania is uniquely positioned to model how state government responds to drug and alcohol problems and their consequences. Securing funding, building infrastructure and increasing access for all evidence-based modalities are essential to repairing our treatment system. Over the past few decades, our treatment providers have borne the consequences of overprescribing, scant funding and short-sighted managed care practices reducing level of care and length of stay (LOC/LOS). The treatment programs do not bear it alone; so do our court systems, jails, child protective services systems, emergency rooms, highways, workplaces, schools, and each and every one of us as members of our communities. Just like with giving half a dose of antibiotic, undertreatment leads to poor outcomes in which the person continues to suffer, and the disease is passed down to the next generation. Children of substance abusers share their parents' genetics and become the next generation of substance abusers. This is our opportunity to take the needed, effective action to end the cycle of substance abuse, at the level of both our families and our communities.

Undertreatment primarily is a consequence of chronic and severe underfunding. This underfunding has created a cost shift. Every dollar invested in treatment with the clinically appropriate level of care/length of stay (LOC/LOS) translates into a $7 return to state coffers, primarily in reduced criminal justice costs. On the other hand, underfunding guarantees that we will spend more on DOC, children and youth services, domestic violence, and health expenses for hepatitis C, HIV, etc.. While treatment is DDAP's primary focus, our interdepartmental collaboration includes four additional major areas of endeavor: Prevention, Intervention, Overdose Abatement and Recovery Supports.

Pennsylvanians deserve a comprehensive treatment system that works. Our work requires most of our state agencies, not just DDAP, DHS or DOH. The following agencies will also play critical roles: the Departments of Agriculture, Community & Economic Development, Corrections, Education, Insurance, Labor, Military & Veterans Affairs, State, Transportation, as well as State Police, PCCD, Pardons Board, AOPC, Juvenile Court Judges Commission and the Board of Probation & Parole.

The list of collaborative projects follows. Many projects require the work of multiple agencies; you will find them listed in order of the size of their role. Projects that are in progress will include a status report.

The Statutory Mandate of Act 50 of 2010

Act 50 of 2010 requires the Department of Drug and Alcohol Programs to develop a comprehensive state plan that provides direction to all state government agencies to ensure the full continuum of coordinated, research-based, robust statewide efforts (prevention, intervention, treatment, recovery supports, and overdose abatement) to reduce the problem of drug and alcohol abuse in the Commonwealth. The pertinent provisions of Act 50 are attached. This plan reflects the interdepartmental coordination of the comprehensive state plan.

Prevention & Intervention

1. **Department of Education** Robust school-based prevention programming is more critical than ever, since we know drug traffickers are targeting ever younger children.
   a. **Reinvigorate and Sustain Student Assistance Programs (SAPs)** throughout the Commonwealth (D.Ed., PCCD, JCJC, DHS, DDAP). SAPs are a statutorily-mandated evidence-based practice in which students at risk are identified and provided critical resources to prevent their descent into mental illness, substance use disorders, violence and juvenile justice involvement. With the elimination of federal Safe & Drug-Free School funding, the state's SAP system has significantly been reduced over time. *Curriculum requirements for alcohol, chemical, and tobacco abuse are required by section 1547 of the School Code.*
   b. **Botvin Life-Skills Training (LST) Offer** There is a time-limited offer for fully-funded training, materials, technical assistance, and payment of substitute teachers during training, for 6th-8th grade LST for any school district that applies. The research shows 60%-70% reduction in drug, alcohol, tobacco abuse and violent behavior among middle-schoolers where LST is provided.
   c. **SAMHSA Prevention Videos for Parents (Talk, They Listen)** This acclaimed video helps encourage parents to be able to talk with their children about drug and alcohol abuse. Parental engagement is an evidence-based component of any comprehensive prevention program (it is a "protective factor" for children). These videos are well done, free and available to any parents we can get them to, through PTOs, and other avenues.
   d. **Preventing Drug/Alcohol Abuse on University & College Campuses (PDE, DOH, DDAP, PCCD)** Widespread alcohol abuse has been tolerated on campuses for decades, and has resulted in unacceptably high rates of accidents, sexual assaults and other violence. Today, this is exacerbated by increased use of prescription amphetamines ("study drugs") and opioids, including heroin. Secretary Murphy has

suggested a Governor's Conference of University Presidents to educate them about best prevention practices for campuses.

2. Department of Health

a. **Prescribing Guidelines (DDAP-DOH)** (Leadership of Guidelines Group has been transferred from Gary Tennis to Dr. Levine). Three sets of guidelines are accomplished: Opioid Prescribing for Chronic Noncancer Pain; Emergency Department Prescribing Guidelines; Prescribing Guidelines for Dental Pain. The Group has identified the need for additional guidelines for Opioid Prescribing Guidelines in Geriatric Medicine; Opioid Prescribing Guidelines in Obstetrical Medicine (pregnant, and post-delivery) and orthopedic/sports medicine.

b. **ABC-MAP** The first 48 states experienced serious heroin spikes when first implementing their Prescription Monitoring Programs. Pennsylvania stands to be the first state in the nation to mitigate this impact by developing a robust warm handoff component to its ABC-MAP program.

c. **Continuing Education for Health Care Professionals (DOH-DOS-DDAP)** These agencies are working with PA Med Society to create a free, online four hour CME for physicians, with one hour each for (i) Prescribing Guidelines, (ii) ABC-MAP, (iii) Naloxone co-prescribing and (iv) Warm Hand-Off (identification and referral to specialty care of patients with SUDs).

d. **Medical School Curriculums in Addiction (DOH-DDAP) Even though addiction afflicts one of our four American families,** few medical schools in the nation have a required course in addiction. DDAP has been working with SAMHSA over the past 18 months to develop and implement a strategic plan to encourage PA's medical schools to include a responsible level of education about addiction, intervention and treatment in their curricula. Dr. Levine and Secretary Murphy will partner with DDAP on this initiative, beginning with a joint letter to all PA medical school deans.

3. Department of Human Services.

a. **Medicaid-Funded Opioid Prescribing.** Using Medicaid payer system to ensure safer and more responsible prescribing of opioids and other addictive drugs. DHS-OMAP Medical Director Dr. David Kelley has been part of the Prescribing Practices Workgroup since its inception, and has been working on payor issue.

4. Attorney General's Office.

a. **Pharmaceutical Industry.** I've met several times with the Attorney General's Office to encourage them to consider following the response of a few other state Attorneys General in ensuring that the industry fairly compensates the taxpayers for costs caused by over-marketing and misrepresentation of safety of other Rx drugs.

b. **Take-Back Rx Drug Disposal (AG, DMVA, DDAP, PCCD; PDAA, PSP).** DDAP has successfully collaborated with other agencies to have over 200 Rx drop boxes

installed across the Commonwealth, resulting in 16,000 pounds of prescription drugs being collected in 2014 alone. However, although the DEA is once again starting up its semi-annual take-back days, it's not clear that it will once again begin taking away the drugs from our permanent boxes. This leaves, leaving this program in peril. DMVA has offered to transport these drugs to incineration sites already under contract with the Attorney General.

5. **PA State Police.**
   a. **Rx Drug Take-Back Boxes in State Police Stations (Barracks).** Since the beginning of the Take-Back program three years ago, there have been District Attorney requests (always denied due to purported safety and disposal concerns) for PSP to also permit take-back boxes in PSP barracks. This can be especially important in rural areas, where municipal police stations may be few and far between. Acting Commissioner Brown has indicated that he is amenable to PSP doing this.

6. **PA Commission on Crime & Delinquency.**
   a. **Executive Prevention Council (PCCD, D.Ed., DHS, DDAP, JCJC).** PCCD Executive Director Linda Rosenberg has proposed establishment of an Executive Prevention Council of the above agencies' leading prevention experts to ensure that state funding only goes to prevention programs that are either evidence-based or contain promising practices (innovative new practices containing the components identified with evidence-based practices).

Treatment

Currently, in Pennsylvania, treatment is funded at about 13-14% of need (better than the national rate of 10%), causing wait lists, clinically unsound levels of care/lengths of stay (LOC/LOS), and other scaling back in evidence-based treatment offerings, as well as the catch 22 of lack of resources to gather data. Our mission is to build a treatment system in place that offers the full continuum of care for *all* Pennsylvanians with drug and alcohol addiction. There are three prongs that must be put into place contemporaneously in order to build a treatment system to serve Pennsylvanians: 1) Funding; 2) Infrastructure; and 3) Access. Each of the initiatives discussed below will addresses at least one of these prongs.

1. **Department of Drug & Alcohol Programs.**
   a. **Rate-Setting (DDAP, DHS, SCAs, BHMCOs, Treatment Providers).** Decades ago, a rate-setting system was established in which treatment programs could provide documentation of their costs in providing treatment, as a basis for rate-setting. But due to severe underfunding, SCAs and Medicaid Health Choices behavioral health

managed care organizations (BHMCOs) have been setting treatment rates below providers' costs, causing a deterioration in our treatment infrastructure. DDAP will lead a rate-setting task force to restore fiscal integrity to Pennsylvania's rate-setting system. DDAP and DHS should collaborate to ensure that SCAs (DDAP) and MA-HC BHMCOs (DHS) are paying treatment providers the true cost of the services being provided (these have been cut below cost due to funding shortages and conventional managed care practices).

b. **Robust Case Management by SCAs (ensuring appropriate funding, developing collaborative working relationship with CAOs, etc.) (DDAP, DHS, SCAs).** Because of ACA, funding drug and alcohol treatment will be more readily available through Medicaid and private health insurance. DDAP must continue to drive SCAs to assume more of an overarching role to facilitate funding of treatment under the ACA, in addition to referral to appropriate treatment. *DDAP is working with SCAs to see that the proper level of care with the proper length of care is provided.*

c. **Licensure Reform** We have completed the first of three major rounds of licensure reform, so that our regulations are streamlined, program-supportive, and up-to-date. Additionally, we are about to do a regulation change providing for extended (two year) licenses for programs that consistently have excellent inspection results.

d. **Co-occurring Treatment (PTSD/Addiction) for Veterans (DDAP, SCAs, Drug Court Judges, DMVA, VA).** Too many times, SCAs simply tell Veterans seeking treatment that they should just "go to the VA." However, sometimes services in the VA are not clinically appropriate or worse, may not be available at all. We are working with our SCAs to ensure that they carefully case manage our veterans until they have "landed" in clinically appropriate treatment, whether in the VA or in our community based system.

e. **Prohibiting Onerous County Residency Requirements** Currently, county residency requirements vary widely, creating gaps in funding coverage (due to lack of meeting residency requirements at the new county) for a Pennsylvania citizen who moves from one county to another. We will contractually prohibit the current widely varying residency requirements as applied to those moving from one PA county to another, for DDAP-funded treatment. This will eliminate unnecessary delays in access to care.

f. **Establishment of an 800 Number for Treatment Access.** Often, citizens in the general public do not know how to access care. DDAP will seek to implement a toll free telephone hotline that individuals can use to reach professional support to connect to care. This will help individuals to navigate the complex system of funding streams, and access a treatment program that is appropriate for their individual needs.

2. **Department of Human Services.** Most public funding for D & A treatment in PA is through Medicaid, administered by DHS.

a. **Eliminating Delay between MA application and MA Health Choices Enrollment.** Treatment during this delay period is 100% *state* funded. Once enrolled with the Health Choices BHMCO funding is *federally funded* at the rate of either 55% (pre-ACA Medicaid population) or 90% (expanded population). Moreover, the funding for the delay period is insufficient to meet the need.

b. **MA Health Choices-Funded Treatment for County Jail Releasees. (DDAP-DHS-county criminal justice and drug & alcohol stakeholders).** Having releasees signed up and taken to Health-Choices funded treatment at the time of release, is a subset of the preceding item. Counties are getting millions of dollars in additional federally-funded treatment with this project. This is being implemented so that more inmates will be released with continuing substance abuse care. This is a critical connection for this vulnerable population to access the treatment needed to prevent SUD relapse and criminal recidivism.

c. **MA Health Choices-Funded Treatment for State Prison Releasees (DDAP-DHS-DOC)** With the Wolf Administration, we're finally starting to get some releasees into this pilot program, but are operating at a small fraction of what is possible. Our newly hired Prevention & Treatment Bureau Director is well-positioned to work through the bureaucratic obstacles we've been dealing with. Adjustments have been made to the program model to expand eligibility of the pilot and increase enrollment. By increasing the number of counties participating in the project, and expanding eligibility requirements, there is an improved implementation of the project.

d. **Ensuring Appropriate Treatment Coverage Under MA Health Choices (DHS, DDAP).** BHMCOs are legally required to approve clinically sufficient LOC/LOS in accordance with the PA Client Placement Criteria (PCPC). The research consistently shows that getting the clinically-needed intensity and duration of treatment is *the* most critical component for successful outcomes, yet managed care has a decades-long practice (for public and private insureds) of attempting to shorten the care far below clinical need. Improving proper authorization of care may require increased payment or "pay for success" incentive payments to facilitate authorization of good quality care. This will leverage payment through federally-matched funds. Also, DDAP's Dr. Ken Martz has completed trainings of MA-HC BHMCO utilization review staffers on the 3rd Edition of the PCPC. Dr. Martz' trainings have resulted in some improvements in this area, and a second round of these trainings will be planned to reinforce the material. However, we still must insist on BHMCO's compliance with both contractual and statutory requirements to approve the correct LOC/LOS.

e. **Increase Use of D&A Therapeutic Communities for Addicted Mothers** (DDAP, DHS, PA Supreme Court). Mothers in recovery can avoid losing their children to foster care. Instead of placing children in foster care the research shows that the foster care system results in children ending up in the child welfare system and ultimately, the criminal justice systems at rates far greater than the general population. Given the

tremendous outcomes being realized Pennsylvania's relatively strong network of women and children's drug & alcohol therapeutic communities, in which addicted women can bring their young children into treatment with them, we need to continue working with our court system, DHS Office of Children, Youth & Families, and other stakeholders, to encourage placement of addicted women and their children. These programs typically have lengths of stay from 6 to 9 months followed by a combination of recovery housing, outpatient treatment, and other recovery supports. Dr. Martz has been working closely with Justice Baer's Children's Roundtable workgroup to implement more humane and functional handling of these cases, and progress is being made. Improvements have been implemented in cross agency collaboration, communication and identification of training needs.

3. Department of Transportation.

a. **Compliance with DUI Treatment Requirements (DDAP, DOT, State Supreme Court, AOPC, PCCD, Sentencing Commission, County & State Probation, Parole Boards, SCAs, DUI Association, Supreme Court).** Most counties are not enforcing our DUI statute, which requires completion of clinically correct treatment as a condition of parole for addicted/alcoholic offenders, and full reporting to DOT. Success rates in the Restrictive Intermediate Punishment treatment for DUI offenders are over 95%, and recovery for these individuals results in safer highways and less domestic violence (5,000+ inmates in DOC had a prior DUI). DOT is providing $100,000 (plus DDAP's $60,000) to fund a project manager (started 8/10/15) to bring all counties into compliance. Former National Drug Court President, Judge Michael Barrasse, is chairing the Oversight Committee. Sixty percent of DUI offenders have private health insurance that covers treatment costs.

b. **Posting Prevention Flyers (Rx Drug Abuse, Alcohol Abuse, etc.) at Highway Stops (DDAP, DOT, Turnpike Commission, SCAs, Commonwealth Prevention Alliance).** Changing attitudes of the public at large about drug and alcohol abuse, stigma, and the need for seeking help, is an important component of an effective prevention infrastructure. Both DOT and the Turnpike Commission have agreed to let us place prevention flyers at these highway and Turnpike rest areas and service areas.

4. Department of Corrections.

a. **Ensure Clinical Integrity and Optimal Use of *Prison* Behind-the-Walls Treatment (DOC, DDAP).** DDAP and DOC need to collaborate to ensure that behind-the-walls treatment is clinically sound, both in treatment provided and length of stay. We also need to ensure that inmates receiving behind-the-walls treatment are released immediately following completion of treatment (placing them in the general prison population after treatment undoes the benefits of treatment). Dr. Martz has run

seven behind-the-walls programs in the Maryland State Prisons and is well-versed in evidence-based practices for this specialty population.

b. **Develop Pre-Release Program for those in need of residential D & A rehab (DOC, DDAP, PCCD, PBPP).** The General Assembly will be amenable to legislation reinstating pre-release for those in need of treatment. We can realize reductions in prison population by releasing at 60% to 80% (negotiable) of the minimum sentence, into community-based treatment funded by Medicaid. To be eligible, inmates with SUD would first have to complete available behind-the-walls treatment.

c. **Begin Transitioning Release System so that Current CCC and CCF "Residents" in Need of Treatment, Are Placed in Licensed Treatment.** There are reports of widespread drug use in DOC's Community Correction Centers and Community Correction Facilities (used to house parole violators, for the most part). We need to transition (building infrastructure and funding) so that all in need of drug and alcohol treatment are getting the LOC/LOS that they require clinically, instead of simply being housed.

5. State Board of Probation & Parole.

a. **Increase Cross-System Collaboration Between Probation & Parole Officers and D & A Treatment Counselors (DDAP, PBPP, County Probation/Parole Officers Association, Treatment Providers)** Close collaboration between Probation/Parole Officers and treatment counselors enhances outcomes by ensuring that probationers/ parolees are constructively engaging in the treatment process. Cross-training sessions with both officers and counselors together will lead to more effective collaboration and better outcomes in both systems.

6. Department of Insurance

a. **Enforce Federal Mental Health Parity and Addiction Equity Act and Act 106** (DOI-DDAP) DOI currently enforces Act 106 complaints brought to the Department. DDAP should educate treatment providers, insurers and the public at large about consumer rights under MHPAEA and Act 106. DDAP needs to partner with DOI to train *and require* treatment providers to advocate for their clients to be funded for clinically necessary services.

7. Department of Military & Veterans Affairs/Department of Aging

a. **Full continuum of Drug and Alcohol Treatment for Seniors and Veterans (DDAP, Aging, DMVA).** Medicare does not cover any non-hospital residential rehab at all. This is devastating to treatment funding for older adults and also for Veterans, since the Veterans "Choice" program (VA funding for community-based treatment) is modeled on the Medicare benefit.

8. Attorney General's Office

a. **Enforcement of Act 106 and Mental Health Parity & Addiction Equity Act (MHPAEA).** The federal government is relying upon states to enforce MHPAEA, which requires health insurers to treat addiction in the same manner (meeting clinical standard of care) that it treats physical diseases. Given that standard of care under PA's Act 106 is determined by the physician or licensed psychologist, the Attorney General's Office is well-situated to ensure that privately insured Pennsylvanians needing addiction treatment get the care they need. We have been meeting with the Attorney General and her top staff to ensure that these laws are enforced.

9. PA Commission on Crime & Delinquency.

a. **Pilots for *Pre-Arrest* Diversion by Police to Treatment (PCCD, DDAP, DHS, county & municipal stakeholders; PSP).** Seattle, Santa Fe, Knoxville, and other cities are beginning to implement Law Enforcement Alternative Diversion (LEAD) projects (modeled after a British program) in which police are trained to screen for drug and alcohol problems (we could also include mental illness), and to take individuals who've been caught committing minor offenses to a center for assessment to treatment, rather than booking them for the minor offense. We could combine this with a program modeled after that in Gloucester, Massachusetts, in which anyone in the community needing treatment can go to any officer and ask for help; the officer will then transport them to the center for assessment to treatment, without risk of charges. We might also attempt an expedited sign-up on Medicaid Health Choices for these individuals. I've discussed this with PCCD Chair Josh Shapiro, who seems interested in moving forward. We should also explore implementation of this model with PA State Police.

10. Federal.

a. **IMD Exclusion (HHS-CMMS, Congress, NASADAD, DOH).** I'm working at all levels (Patrick Kennedy, Bob Brady, National Drug Court Judges, etc.) to eliminate application of the IMD exclusion to drug and alcohol treatment. If successful, this will result in billions of dollars more Medicaid-funded treatment across the nation, and will preserve the Federal match Pennsylvania is apparently getting. This is my highest priority right now.

b. **SAPT Block Grant Restoration (Congress; ONDCP; NASADAD).** Adjusted for inflation, the Substance Abuse Prevention & Treatment federal block grant has been cut by 25% over the past decade; this coincides with the worst drug overdose crisis in the nation's history. (About $60M of DDAP's roughly $100M is from the SAPT block grant.) Once the IMD matter is resolved, restoration of these funds will be our next federal priority.

c. **Medicare/VA Drug & Alcohol Benefit (Congress, HHS, Patrick Kennedy). See 7(a) above.**

Overdose Abatement

1. Department of Health.

a. **Expanding Use of Naloxone. (DDAP, DOH, DHS, PSP, PBPP, PCCD).** The Department of Health and DDAP have been working very closely together to pull in resources for, and expand the use of naloxone among all first responders (police, basic EMS, family members, any others who might be in a position to reverse an opioid overdose). This has been, and must remain, a top priority for both of our departments while the current opioid overdose epidemic continues to plague our communities.

b. **Epidemiology Data for Drug and Alcohol Overdose** Drug and alcohol overdose (fatal and nonfatal) reporting is woefully inadequate throughout the nation and Secretary Murphy and Dr. Levine are undertaking a robust review of current practices and how to revamp our system to gather more up-to-date and accurate data. DOH & DDAP must also continue its vigorous efforts to have best practices for warm hand off to treatment of OD survivors in our hospital emergency departments

2. PA State Police.

a. **Narcan.** Monitor and continuously increase quality of work in Narcan administration by PA State Police. It appears that PSP has one overdose reversal so far; municipal police officers have about 200 saves.

Recovery Supports

1. Department of Community & Economic Development.

a. **Use of Some HUD and other Housing Funding for Recovery Housing** Starting with Allegheny County pilot. (DDAP, DCED, Allegheny County Human Services Dep't). This pilot may involve the establishment of a revolving fund, such as that used in the Oxford House programs.

2. Department of Labor & Industry.

a. **Engagement of Office of Vocational Rehabilitation** (OVR to assist those coming out of treatment to become trained and prepared for meaningful work. (L & I, DDAP, DHS). Over ten years ago, OVR offered very strong vocational rehab

supports for those coming out of drug and alcohol treatment, but this no longer is the case. We will work with OVR to restore this programming.

3. Department of Education.

a. **Recovery Schools (DOE, DDAP, DOH).** Students in early recovery who return to their old schools after completing treatment have very high relapse rates due to overwhelming peer pressure to return to substance abusing behavior. Recovery schools, on the other hand, provide for a positive, pro-recovery peer pressure and overall environment. Recovery schools have the dual benefit of a staff that understands substance abuse as well as fellow students who form bonds helping each other through as each student faces similar paths and challenges towards sobriety. Rep. John Taylor and prevention stakeholders have met twice with DDAP (DOE and DOH participated in the second meeting as well), to seek input on his legislation to create pilot two or three recovery schools.

4. Department of Agriculture.

a. **Link Treatment Programs in Rural Areas of Dept. of Agriculture Initiatives to Train New Workforce in Agricultural Work** A large portion of current agricultural workforce is retiring. We've been approached by Mark Critz about connecting those coming out of treatment in our rural areas with training and careers in agriculture, which we are working on.

5. Board of Pardons.

a. **Streamlined Pardons Process for Those in Sustained Recovery for Drug & Alcohol Addiction. (Board of Pardons, DDAP).** In addition to developing a streamlined process for this population, we need to conduct training of all treatment programs and other possible stakeholders so that they provide key information to those who complete treatment about when and how to seek a pardon. This is critical to enable recovering "ex-offenders" to clear their records and not be hampered in attaining meaningful employment, housing, etc.

b. **Support Expungement Legislation that Provides for Automatic Expungement of Low-Level Misdemeanors.** This legislation was nearly enacted last session.