COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE
PUBLIC HEARING

STATE CAPITOL
HARRISBURG, PA

IRVIS OFFICE BUILDING
ROOM G-50

TUESDAY, MARCH 12, 2019
9:00 A.M.

PRESENTATION ON
BED REGISTRY AND WARM HANDOFF FOR ADDICTION TREATMENT

BEFORE:
HONORABLE GENE DIGIROLAMO, MAJORITY CHAIRMAN
HONORABLE STEPHANIE BOROWICZ
HONORABLE BARBARA GLEIM
HONORABLE JAMES GREGORY
HONORABLE DOYLE HEFFLEY
HONORABLE JONATHAN HERSHEY
HONORABLE MIKE JONES
HONORABLE NATALIE MIHALEK-STUCK
HONORABLE LORI MIZGORSKI
HONORABLE ERIC NELSON
HONORABLE TODD POLINCHOCK
HONORABLE JAMES STRUZZI
HONORABLE TARAH TOOHIL
HONORABLE ANGEL CRUZ, DEMOCRATIC CHAIRMAN
HONORABLE DANILO BURGOS
HONORABLE ISABELLA FITZGERALD
HONORABLE JOE HOHENSTEIN
HONORABLE KRISTINE HOWARD
HONORABLE STEPHEN KINSEY
HONORABLE MAUREEN MADDEN
HONORABLE DANIEL MILLER
HONORABLE MIKE SCHLOSSBERG

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*Pennsylvania House of Representatives*
*Commonwealth of Pennsylvania*

COMMITTEE STAFF PRESENT:

MELANIE BROWN
MAJORITY EXECUTIVE DIRECTOR

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

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1 P R O C E E D I N G
2 * * *
3 MAJORITY CHAIRMAN DIGIROLAMO: This goes in
4 session at 11:00, so we do have to finish up by 11:00.
5 And with that, instead of taking the roll, since
6 we have so many new Members that are here today -- and I
7 want to welcome all the new Members on both sides, Democrat
8 and Republican, to the Committee. This is our first
9 hearing. I thought we might just go around the room and
10 let everybody just say hello, identify themselves and let
11 everybody know where they are. And we might start off with
12 Kristine.
13 REPRESENTATIVE HOWARD: Hi. I'm Kristine Howard,
14 and I am from Chester County, the 167th District.
15 REPRESENTATIVE GREGORY: Morning, everyone. My
16 name is Jim Gregory, and I represent the 80th District,
17 which is most of Blair County.
18 REPRESENTATIVE GLEIM: Good morning, everyone.
19 My name is Barb Gleim. I represent the 199th, which is
20 Cumberland County.
21 REPRESENTATIVE MIHALEK: Good morning. I'm
22 Natalie Mihalek. I represent the 40th District. It's
23 Allegheny and Washington Counties.
24 REPRESENTATIVE POLINCHOCK: Good morning,
25 everybody. I'm Todd Polinchock. I represent the 144th

1 District, which is in central Bucks County.
2 REPRESENTATIVE MIZGORSKI: Good morning. I'm
3 Lori Mizgorski. I represent the 30th District. It's the
4 northern Allegheny County.
5 REPRESENTATIVE JONES: Mike Jones, 93rd District
6 in York County.
7 REPRESENTATIVE MADDEN: Maureen Madden, good
8 morning, 115th District, Monroe County, the Poconos.
9 REPRESENTATIVE HOHENSTEIN: Joe Hohenstein. I
10 represent the 177th District, which is the lower northeast
11 part of Philadelphia.
12 REPRESENTATIVE FITZGERALD: Good morning.
13 Isabella Fitzgerald. I represent the 203rd Legislative
14 District, northwest Philly.
15 REPRESENTATIVE BOROWICZ: Stephanie Borowicz. I
16 represent Clinton and a part of Centre County in the 76th
17 District.
18 REPRESENTATIVE STRUZZI: Jim Struzzi, 62nd
19 District, Indiana County.
20 MS. BROWN: I am Melanie Brown. I direct the
21 Committee.
22 REPRESENTATIVE HEFFLEY: Doyle Heffley, 122nd
23 District, Carbon County.
24 MAJORITY CHAIRMAN DIGIROLAMO: Gene DiGirolamo,
25 the 18th District in Bucks County.

1 DEMOCRATIC CHAIRMAN CRUZ: Angel Cruz,
2 Philadelphia County, 180th.
3 REPRESENTATIVE NELSON: Eric Nelson, 57th
4 District, Westmoreland County.
5 REPRESENTATIVE SCHLOSSBERG: Good morning,
6 everyone. Mike Schlossberg, 132nd District, Lehigh County,
7 city of Allentown. And it's good to see you, Layne.
8 REPRESENTATIVE KINSEY: Good morning. Stephen
9 Kinsey, Philadelphia County.
10 REPRESENTATIVE HERSHEY: And John Hershey, the
11 82nd District, Juniata, Mifflin, and Franklin Counties.
12 MAJORITY CHAIRMAN DIGIROLAMO: Okay. Before we
13 start with our testifiers, Representative Cruz, any
14 comments? Would you like to say anything before the
15 Committee?
16 DEMOCRATIC CHAIRMAN CRUZ: I just want to
17 apologize for being late, but I'm here.
18 MAJORITY CHAIRMAN DIGIROLAMO: Okay. Again,
19 Human Services Committee and this issue of addiction,
20 especially when it comes to the heroin and opiate epidemic
21 and crisis that we're experiencing all across Pennsylvania,
22 I mean, we've done an awful lot of work over the last few
23 legislative sessions. And even though this problem keeps
24 getting -- it appears to keep getting worse, although we're
25 getting some reports of the deaths being down in some of

1 the counties, the thing that keeps me going is that if it
2 wasn't for the good work that we have done up here in the
3 Legislature the past two or three legislative sessions,
4 that it would probably be two or three times worse than
5 what it is today. So that keeps me going.
6 And the hearing today is on two really important
7 issues and two bills that have been sponsored by my
8 colleague, Representative Doyle Heffley. So I am going to
9 let Doyle chair the Committee today since most of the
10 testimony will be on his two bills, which are warm handoff
11 and bed registry. So Doyle, I'm going to turn the hearing
12 over to you, and you can chair the rest of the hearing.
13 Thank you.
14 REPRESENTATIVE HEFFLEY: Thank you, Mr. Chairman.
15 Obviously, this is an issue that affects every county,
16 every part of the State, both rural and urban, and it is
17 something that we need to continue to address.
18 A few months ago we had the pleasure of sitting
19 down with Lehigh County officials and going over their Blue
20 Guardian program, and then we worked with staff to develop
21 a warm handoff legislation. And this is the first hearing
22 on that. So we're going to hear from all the testifiers.
23 I want to thank everybody for being here, and I want to get
24 right into our testifiers today. So if we could start with
25 Lehigh County, Julia --

1 MS. KOCIS: Kocis.
2 REPRESENTATIVE HEFFLEY: -- Kocis, Director of
3 Regional Intelligence and Investigation Center Office of
4 the District Attorney of Lehigh County; and Layne Turner,
5 Drug and Alcohol Administrator for Single County Authority
6 in Lehigh County. So if you could do your presentation.
7 Thank you.
8 MR. TURNER: Thank you. And thank you for the
9 invitation to be here.
10 The Blue Guardian program was developed to
11 include multiple facets and sectors surrounding substance
12 abuse disorder, specifically opioids and the impact to our
13 community. We looked at the issue as if it were an
14 ecosystem so that any change we made to one area would not
15 upset the balance elsewhere in the community. The Blue
16 Guardian is a collective impact approach that collaborates
17 across sectors to address these issues in unison. For the
18 purpose of this presentation, the scope of the common
19 agenda is limited to two partners: law enforcement and the
20 hospitals.
21 Law enforcement core functions are community
22 safety and community health. Through creative
23 collaboration, we have the ability to leverage these
24 partnerships. Supporting the core functions and leveraging
25 partnerships have created three unique programs: the city

1 of Allentown Police Department's outreach program, which
2 averages 250 monthly street-level contacts; Upper Macungie
3 Township's Police Department's evidence-based hub -- if a
4 disaster is identifiable, it may be preventable; and the
5 Certified Recovery Specialist Ride-Along program.
6 As the police departments across the Commonwealth
7 are participating in the naloxone program, fundamental
8 questions are asked. How can law enforcement be further
9 supported? How can we solve the data delay? And can the
10 individual and/or their family be supported? These answers
11 required us to know where the save occurred, when the save
12 occurred, where the individual is from, and which hospital
13 did they go to. Of these questions we had one easy answer.
14 We knew which hospital they were going to after the save.
15 The other answers proved more problematic.
16 Starting with which hospital that we knew and
17 building off the core function of community wellness,
18 healthcare partnerships were leveraged to create specialty
19 programs within the hospital setting that will target the
20 specific need of the individual who overdosed, received
21 naloxone, or required emergency medical attention because
22 of drug use. As a result, the programs listed here have
23 been established or are in the final planning phases.
24 As attendees are well aware, a warm handoff
25 process for opioid use disorder from the emergency

1 department to treatment is the benchmark across the
2 Commonwealth. The fundamental directive is for a warm
3 handoff to occur the referral must be made only from the
4 emergency department and it must be opioid-related. Lehigh
5 County has expanded this directive to include referrals
6 from all hospital departments and to include all substances
7 of use. Lehigh's expansion of the warm handoff directive
8 has allowed over 2,200 hospital-based referrals.
9 Because we eliminated the barriers of drug abuse
10 where the referral in the hospital had to come from and the
11 county of residence, we are a more meaningful partner to
12 our hospitals. A larger number of individuals are
13 accessing treatment, and we are collaboratively working
14 towards a healthier community. In a 24-month period over
15 850 individuals were provided the appropriate access to
16 treatment from the hospital.
17 Unfortunately, the 2,200 referrals represent
18 under 30 percent of the individuals entering an emergency
19 department because of a substance use disorder. Most
20 individuals refuse services and elect to return home. As
21 we know, returning home without addressing addiction can
22 have deadly consequences. However, as you will see later
23 in this presentation we are able to leverage the coroner as
24 a partner to further identify needed resources.
25 For those individuals involved with a police

1 naloxone reversal and refused treatment access while in the
2 hospital, the Blue Guardian was developed, a joint police
3 officer and certified recovery specialist home visit to
4 reconnect with the individual and/or provide family
5 supports but most important being able to offer immediate
6 access to treatment services. This program went live on
7 March 1st, 2018.
8 Of the more than 300 naloxone saves in that
9 period, 138 home contacts were made. Most individuals
10 saved through the naloxone program resided outside of
11 Lehigh County and therefore home contacts could not occur.
12 It is important to note of the 138 contacts the team
13 successfully met with 52 individuals. Of the 50 individual
14 face-to-face meetings, 34 individuals entered treatment.
15 The lessons learned when the face-to-face contacts are
16 made, over 60 percent of the time individuals enter
17 treatment. This speaks directly to the power of the joint
18 police and CRS contact.
19 There are six basic steps to the Blue Guardian.
20 First, the police administer the naloxone. Second, the
21 police enter the information into the Blue Guardian
22 application. From there, the data is sent to the PA ODIN
23 application, a naloxone use report is generated. We have
24 requested information be entered over and above what is
25 collected by PA ODIN into the naloxone use report. This

1 would include the incident number, the individual name, the
2 individual's address, location of the overdose, what
3 hospital and EMS group provided transportation.
4 Third, the SCA receives the notification of the
5 naloxone use report.
6 Steps four and five consist of the SCA submitting
7 a referral to the certified recovery specialist to
8 appropriate municipal police departments and arrange a home
9 visit within 48 to 72 hours. If, during this home visit,
10 the individual or family agrees to additional support
11 and/or treatment, immediate warm handoff occurs to the
12 Center of Excellence. If a family or individual declines,
13 it is noted in the police contact summary. This process is
14 critically important as it resolves the three previously
15 unanswered problematic questions: how to support the
16 police, who is the individual, and where do they live.
17 With this framework in mind, Julia is now going
18 to provide an overview of the application itself.
19 MS. KOCIS: All right. So we leverage the
20 technology that we had already developed by including the
21 Blue Guardian application as a component within our larger
22 illicit drug identification and tracking system. This
23 system tracks drug deaths, which you can see on the screen
24 here, which is entered by our coroner's office. It also
25 tracks our controlled drug purchases and drug-related

1 complaints by our Drug Task Force.
2 And the coroner is actually a very important
3 partner in our collaboration because it's his data that
4 allows us to gain better insights into the substance use
5 disorder that's actually happening within our community.
6 So we capture information on decedent demographics, date,
7 time, and manner of death, as well as toxicology results.
8 This data is then used to populate the coroner's dashboard
9 within the application, and it allows us to see drug deaths
10 over time, the date and time of day that drug deaths are
11 occurring, as well as deaths across municipalities within
12 Lehigh County.
13 We were also able to incorporate what is called
14 an active metabolite database into the background of the
15 coroner's part of the application. This allows us to roll
16 up toxicology results to a parent classifier so we have a
17 better understanding of what are the types of drugs
18 involved in these deaths. So good example would be a
19 toxicology report will come back and list a substance
20 called 4-ANPP, and that actually is a fentanyl precursor
21 chemical. So we'll take that and we'll roll it up to the
22 parent classifier of fentanyl, and that way we have a
23 better understanding of how fentanyl may have contributed
24 to some of these deaths. We're also able to track the
25 migration path regarding a decedent's place of residence to

1 where they died.
2 And then the Drug Task Force section of the
3 application is where we will track all of the controlled
4 buys, drug complaints, and any identifiable markings of
5 heroin brands that detectives will confiscate during a drug
6 investigation or a naloxone administration event or even a
7 drug-related death.
8 So this is what the identifiable markings section
9 looks like, and this is where all the heroin brands are
10 listed that we find. We'll also list if there were
11 overdoses associated with a particular brand or deaths.
12 That way we can then alert our partners of what we're
13 seeing in the field in our area.
14 And we were able to incorporate some natural
15 language processing techniques into the Drug Task Force
16 section of the application, and what it does is it runs
17 over the police incident narratives to find new and
18 trending drug patterns across the region. So what --
19 REPRESENTATIVE HEFFLEY: Excuse me. Could you
20 just hold the mic just a little bit closer? Some people
21 have indicated they had a little bit of a problem hearing,
22 so -- thank you.
23 MS. KOCIS: So having this technique run against
24 police incident reports also gives us a deeper insight into
25 the substance use disorder that's occurring in our

1 community. And what you're looking at here is an example
2 of that technique that we put against police reports from
3 2015 and 2016. And I don't know if you can see it because
4 it's pretty small on the screen, but that's when we picked
5 up on K2 and synthetics that were trending in our region
6 back at that time.
7 Okay. So the Blue Guardian application allows us
8 to track who is administered naloxone, by which agency,
9 which hospital they were taken to afterward, and where the
10 individual resides. All police officers in Lehigh County
11 have access to enter this information in Blue Guardian
12 whether it's at their desktop at their home department or
13 within their patrol vehicle.
14 And the Blue Guardian system captures information
15 on date, time, and location of a naloxone event; victim
16 information -- name, address, demographics; any evidence
17 that may have been secured on scene such as drug
18 paraphernalia or identifiable markings which would be the
19 heroin brands that I had showed you earlier; the details of
20 naloxone usage, as well as pre-and post-naloxone symptoms;
21 and administrative details for inventory purposes. So all
22 of this information that's captured, it helps our Single
23 County Authority try to coordinate that Blue Guardian visit
24 with law enforcement and a certified recovery specialist so
25 they can do follow up with treatment options for the

1 individual.

2 And then once officers complete the Blue Guardian

3 form, a portion of that information is then sent up to the

4 Pennsylvania State Police ODIN system. And we feel that

5 our systems actually complement each other. So Blue

6 Guardian is more detail-oriented, and it also contains

7 clinical notes, which we need to do for treatment follow-up

8 and support, so we're more operational and tactical, and we

9 feel that the ODIN system has more of a strategic high-

10 level overview so you get an idea of where these naloxone

11 administrations and drug deaths are occurring across the

12 Commonwealth.

13 The Blue Guardian dashboard also shows a

14 migration path of where people are OD'ing, so we see a lot

15 of rural communities coming into our larger cities in

16 Lehigh County. We also see a lot of movement outside from

17 other counties moving into Lehigh County and other States.

18 The system also provides inventory management,

19 which shows naloxone distribution, who received what, when,

20 and the expiration dates, and it shows naloxone usage,

21 which is calculated automatically as law enforcement enter

22 the information in the naloxone event. And this

23 information can be exported into Excel, which is really

24 handy when we're doing our grant reports to the PCCD

25 because they are the suppliers of naloxone for Lehigh

1 County.
2 And lastly, there's a section in the application
3 that will track the treatment notes, so to show you this
4 part of the application we're going to actually walk you
5 through some case examples. And while the data has been
6 obfuscated meaning the personal identifying information has
7 been masked, the basic premise of the events have remained
8 the same.
9 Okay. So the first case is of Chauncey Stewart.
10 Chauncey was a young man who is given naloxone by police
11 and taken to the hospital. So if you look up on the screen
12 over on the right-hand side under activity history the
13 bottom event has a Blue Cross icon. That represents the
14 naloxone event. The next event above that represents a
15 Blue Guardian visit that was paid to his home. Chauncey
16 lived there with his parents. His parents were unaware of
17 their son's drug use. The son refused the services that
18 were offered. He actually became angry with our certified
19 recovery specialist for outing his drug use to his parents.
20 And then the next event that's listed above that with the
21 yellow icon, that represents that a few days later he was
22 unfortunately found dead in his bedroom by a family member.
23 When we look at the toxicology report for
24 Chauncey, it revealed morphine, 6-monoacetylmorphine,
25 codeine, 7-aminoclonazepam, and fentanyl. And it also

1 listed that his addiction started as recreational drug use.
2 So being able to cross-reference the Blue
3 Guardian information on Chauncey with the coroner report
4 like here helps us gain, again, better insight into the
5 problem. And then having additional information from our
6 Drug Task Force that might be able to link an overdose or
7 drug death back to a particular dealer that's associated
8 with a particular brand is even better. And that's why we
9 purposely work to integrate these systems together.
10 Our next case is of Marlice Patton. So Marlice
11 was a young woman who was administered naloxone twice by
12 law enforcement on two different occasions. Initially, we
13 were unable to locate her, but eventually she was found,
14 and she's actually been admitted into an inpatient
15 treatment program that provides MAT. And Marlice is still
16 in treatment and she's doing well.
17 So the information that's entered into this
18 section of the application, it may eventually have a status
19 of closed meaning the individual is in treatment, they did
20 well, they're released back onto the community, they're
21 healthy, but we will retain this information for if the
22 individual should ever go back to using drugs and police
23 need to administer naloxone again, the certified recovery
24 specialists have the ability to pull this information up
25 and see what we did with that individual last time around

1 getting them into treatment because maybe we can take a
2 different approach and serve the individual in a different
3 way.
4 And then our last case example is of Cassandra
5 Pope. She was a young pregnant woman who started out in
6 treatment, was later administered naloxone. She went back
7 into treatment and gave birth. She was administered
8 naloxone again, went to jail on a probation violation, went
9 back into treatment, and she recently died of a possible
10 drug overdose. Cassandra's toxicology report is still
11 pending, but it is noted that she started with prescription
12 drugs and progressed to illicit drugs.
13 So going back to the collective impact approach
14 of the Blue Guardian program, we, law enforcement and
15 healthcare, we really do have a common agenda in mind
16 because we have a shared vision for a healthy community and
17 our joint approach to treatment and support.
18 We have continuous communication between our
19 parties through the Blue Guardian application. It helps us
20 identify service delivery gaps and needs either from the
21 law enforcement end of the spectrum or from the healthcare
22 end of the spectrum. And the District Attorney and the
23 Regional Intelligence and Investigations Center actually
24 serve as a backbone organization for this program, and we
25 help coordinate the efforts across all partnerships. And

1 this is one of the reasons that we feel this program has
2 been so successful is because we have the District Attorney
3 as its champion supporter and his resources to help make
4 all this happen. We also try to leverage our individual
5 strengths so we're not duplicating efforts across our
6 partnerships, and this allows for us to make a greater
7 impact as a collective unit.
8 And then lastly, the Blue Guardian application
9 allows for data collection for consistent measurement to
10 help align participant efforts.
11 MR. TURNER: The philosophy behind the Blue
12 Guardian, its accompanying application and spinoff
13 specialty programs is meaningful across platforms. It can
14 be applied to volunteer fire companies identifying families
15 and needs and providing joint CRS outreach. It can be
16 applied to EMS groups. It can be applied to church groups.
17 It also has applicability with the mental health field.
18 The Blue Guardian process engages the strength of our
19 community to systematically work towards a system of shared
20 support, ownership, and outcomes. Thank you for your time
21 this morning.
22 MS. KOCIS: Thank you.
23 REPRESENTATIVE HEFFLEY: Thank you for your
24 testimony. And you will be able to stick around a little
25 while then for questioning afterwards? Thank you.

1 Everybody going to wake up now that the lights
2 are on?
3 Our next testifier is emergency room physician
4 Dr. Barbera. Thank you for being here today.
5 DR. BARBERA: Thank you very much. Thank you.
6 Ladies and gentlemen, on behalf of the
7 Pennsylvania College of Emergency Physicians, I thank you
8 very much for the opportunity to talk to you guys this
9 morning.
10 As you know, the emergency department is really
11 the frontlines of the opioid epidemic. There are very few
12 people that have an opioid addiction that do not wind up at
13 some time in the emergency department. So emergency
14 physicians have been very involved with the Commonwealth
15 and the local governments and the national even task force
16 on developing strategies to mitigate the opioid crisis.
17 Some include the warm handoff. Some include medical-
18 assisted treatment in the emergency department, and other
19 novel ideas such as inpatient observation for
20 detoxification, starting people on buprenorphine, getting
21 pregnant people that present to the emergency department on
22 medical-assisted treatment so that their children don't
23 suffer from neonatal abstinence syndrome.
24 So emergency physicians have been very involved
25 with this, and we wholeheartedly support the warm handoff.

1 There are some things that I think on behalf of myself,
2 Reading Hospital where I am the Chair at Tower Health
3 Reading Hospital, we actually have the largest emergency
4 department in the Commonwealth of Pennsylvania and a 24/7
5 warm handoff program that is funded through the community
6 with a certified recovery specialist 24/7 in the
7 department.
8 I want to tell you a little bit why that's
9 important to have it 24/7. We had a case several years ago
10 before we went 24/7 where we had a young lady come in. She
11 was 25 years old. She had two young children and she had
12 overdosed and one of her daughters had called 911 and she
13 had come in. And we had gotten her referral to treatment
14 the next morning. And we had sent her home. And about an
15 hour later she came back having overdosed again and was
16 deceased now. And we then had two orphans in our emergency
17 department.
18 And the ED staff sat around and we said, well,
19 what did we do? We didn't really do any good for anybody.
20 We felt like, oh, we got her an appointment tomorrow, but
21 tomorrow was too late in this case. And we see a lot of --
22 every day open the newspapers and you see tomorrow is too
23 late. These programs, to be effective, have to be 24/7.
24 And the only shot that you have is when that person is in
25 the emergency department and someone needs to be right

1 there and then able to take care of that patient. And we
2 see this.
3 So when we get a heart attack in, we don't send
4 them in and say, okay, go see your cardiologist tomorrow.
5 No, we don't. We take them right to the cath lab and we
6 put up billboards about them and say we are this good and
7 you see them everywhere about how great people are with
8 hearts. We are not that good at doing that with overdoses,
9 but we need to be because it's the same time sensitivity
10 there. Every hour somebody spends in the emergency
11 department and does not get treatment is one hour less that
12 they are going to be successful. The best shot at getting
13 somebody into treatment is right after they stop breathing
14 and right after they almost died. And I think that's
15 important.
16 The Single County Authorities need to be able to
17 provide 24/7 coverage. It doesn't need to be onsite. We
18 have about five overdoses a day. It makes sense for us to
19 have somebody onsite. But there needs to be a process that
20 there is an on-call system 24/7, and the Single County
21 Authorities need to be empowered and funded to do such
22 things.
23 The one thing that I would say that is a little
24 concerning is the warm handoff centers that are not in the
25 emergency department that is proposed, I would be a little

1 cautious about that because many times we will get
2 overdoses that have medical or traumatic injuries that have
3 not been picked up in EMS, and so what will happen -- and
4 this is not a ding against our EMS colleagues, but what
5 will happen is that they'll be called out for an
6 unresponsive -- somebody will feel that there is a drug
7 addiction and an overdose, and we'll find out after
8 evaluating them that there may have been an overdose but
9 there could also be a gunshot wound, there may be a
10 concomitant ingestion that there is heroin but there is
11 something else. More than likely it's alcohol or something
12 else.
13 We see medical problems. People that stop
14 breathing, that's a significant thing, so sometimes we see
15 anoxic brain injury, we see stroke, we see rhabdomyolysis.
16 We see a lot of diseases that go along with the overdose
17 that it's not really just a shot of Narcan and you're cool.
18 I think that we would really be putting patients in danger
19 if we said, okay, let's bring them somewhere where a
20 physician cannot evaluate them. So I would caution us to
21 do that. I think that at some point with the right
22 resources and those being structured well that will work
23 very well but not in 2019 at least not today.
24 The other thing about the legislation is the
25 mandatory education. While I think that's important, I

1 think each county is different. So I'm part of a health
2 system and lead the emergency division for a health system
3 in four different counties. And each of our EDs are
4 different and we see different people. So our warm handoff
5 training is very different per our site. We have a
6 hospital in West Grove, Pennsylvania, that sees about one
7 overdose every three or four days, and their warm handoff
8 process is very, very different than Reading Hospital where
9 we see three a day.
10 So I think that it's incumbent on the Single
11 County Authority and the emergency department to develop
12 together what their training looks like because it's not a
13 one-size-fits-all. And I think that if we try to make it
14 so generic, we're going to lose the details.
15 What is important, though, obviously is treating
16 this as a disease, is avoiding the stigma, and as
17 empowering everybody from police, from prehospital, from
18 emergency responders, from addiction therapists to notify
19 or to address this as a disease and accept people as a
20 disease. And that was something at Reading Hospital that
21 didn't come that easily until there have been cases where
22 it has become evident that this is a disease. When someone
23 comes in and they have a heart attack and they continue
24 smoking, we don't say, well, we're not going to treat you
25 because you still smoke and that's your own fault. But for

1 some reason people will say that when someone comes in with
2 an overdose and say, well, that's your own fault.
3 So I think our education needs to be around the
4 fact that this is a disease, and whether or not we feel
5 that someone brings it on themselves, there are many
6 diseases that people bring on themselves be it tobacco or
7 eating or driving a motorcycle without a helmet, a lot of
8 different things, and yet we treat them as diseases. And I
9 would just advocate for that.
10 One more thing that I think is important and
11 where the warm handoffs sometimes fall out is the payers.
12 So what we've done at Reading is we have a payer-blind warm
13 handoff program because we find out that when we decide
14 when we get into insurance coverage, we're treating
15 everybody differently because some insurances will pay for
16 this and some will pay for this, and if you're not insured,
17 that's the easiest because then we can get somebody on
18 public assistance and they'll pay for things. And by the
19 time we're navigating through this system, what do you
20 think happens? People get tired of waiting. They're going
21 to go home. I'll come back tomorrow. Tomorrow doesn't
22 happen in 50 percent of the cases.
23 So what we've advocated for and what we do now is
24 we say, you know what, we're going to get you into
25 treatment, we've identified a need, we're going to get you

1 into treatment, and we'll worry about the payer on the
2 backend. And I think where this Committee can really be
3 powerful is to say, you know what, payers in the
4 Commonwealth of Pennsylvania need to treat this like the
5 emergency it is and really the preops and the, you know,
6 saying, oh, you've already gotten your X-number of days for
7 this year, you'll have to wait till January 1st before you
8 can go into treatment, well, that's a death sentence for
9 many people, and it's just not feasible.
10 Two more things -- I'm sorry, I'll be quick -- is
11 there does need to be a database that controls, you know,
12 and so we can see what our progress is. The one thing that
13 I would ask is that the database, if it's to be developed,
14 is developed much like the prescription drug monitoring
15 program. I think if you find that each hospital or each
16 EMR if they have to develop their own, you're going to have
17 a network of different databases that don't talk to each
18 other, that are very ineffective, and that create huge
19 administrative burdens. So if there is a database and
20 there needs to be a database, we need to be able to say
21 that Junior came in with an overdose and where can we send
22 him now? And we need to have that at the tip of our
23 fingers much like we can find a restaurant for lunch at the
24 tip of our fingers and say where can I get a reservation
25 for four. We can do that very easily. We can't find

1 whether there's an open bed somewhere to get somebody
2 detox. So I would advocate for that.
3 And finally, the legislation calls for a task
4 force, and I believe that emergency physicians really have
5 a powerful place on that task force and can be very, very
6 helpful as a member of that. And I thank you very much for
7 your time. Thank you.
8 REPRESENTATIVE HEFFLEY: Thank you, Doctor.
9 Dr. Gillian Beauchamp from Lehigh Valley
10 Hospitals, right? Okay. Come on and have a seat. Thank
11 you for being here.
12 DR. BEAUCHAMP: Good morning, Chairman
13 DiGirolamo, and the Members of the Human Services
14 Committee. I really appreciate the opportunity to speak
15 with you today, and I especially want to thank
16 Representative Heffley for inviting me to speak and for all
17 the important work you've done on behalf of those who
18 suffer from substance use disorder and in drawing attention
19 to how the Commonwealth might better respond to the opioid
20 crisis.
21 I'm Gillian Beauchamp. I'm an emergency
22 physician, toxicologist, and addiction specialist at the
23 Lehigh Valley Health Network where I've worked for the past
24 two and a half years. LVHN includes eight hospital
25 campuses, three in Allentown, one in Bethlehem, one in

1 Hazleton, two in Pottsville, and one in East Stroudsburg.
2 And with seven emergency departments treating approximate
3 314,000 patients per year, we are truly on the frontlines
4 of the opioid crisis in eastern Pennsylvania.
5 We are very fortunate to have in Lehigh County a
6 strong visionary single county drug and alcohol authority
7 that has worked hand-in-hand with our providers to find
8 solutions to better respond to the complex problems in our
9 community. Unfortunately, I'm not sure that that same
10 strength is currently available across the Commonwealth,
11 and for that reason I commend the motivation behind H.B.
12 424, the Warm Handoff for Overdose Survivors, which hopes
13 to bring best practices to all communities across the
14 Commonwealth, as well as efforts to help providers identify
15 available substance use disorder treatment beds throughout
16 Pennsylvania in H.B. 596, Detoxification and Addiction
17 Treatment Bed Registry.
18 Substance use disorder needs to be managed as a
19 disease, and that requires many partners working together
20 to provide a full continuum of care across many support
21 systems. And the warm handoff initiative is often the
22 first step in that continuum to make that connection
23 necessary to bring that patient to the full complement of
24 resources that lead to recovery.
25 Since 2017, LVHN has been utilizing the Lehigh

1 County-supported Hospital Opioid Support Team or HOST team
2 in conjunction with the services of our own addiction
3 recovery specialist to link patients to treatment for
4 substance use disorder. Our newer medication-assisted
5 treatment and connections program for pregnant women, also
6 county supported, initiated in 2018 have initiated
7 medication-assisted treatment for over 70 patients and have
8 linked over 60 pregnant women with substance use disorder
9 to treatment.
10 Altogether, these county-supported programs have
11 linked over 1,100 patients to treatment, and we've really
12 seen the difference that that makes in patients' lives as
13 individuals who are struggling with a substance use
14 disorder initiate their recovery journey and do the hard
15 work of rebuilding relationships, getting back to work, and
16 many of them returning to the community as recovery
17 advocates.
18 And despite the immense dedication of our Single
19 County Authority to collaborate on these programs, we
20 continue to face challenges in meeting the needs of our
21 patients with substance use disorder due to limited
22 resources throughout our region. Warm handoff programs
23 rely on the availability of treatment providers, as well as
24 inpatient detoxification and rehabilitation beds.
25 So again, I'd really like to commend

1 Representative Heffley for reaching out to the provider
2 community to ask for our input, listening to our
3 suggestions. LVHN firmly believes that if seamless warm
4 handoff processes were in place in every community across
5 the Commonwealth, lives would truly be saved.
6 I've been asked here today to speak directly
7 about Bill 424, and I'll offer a couple of general
8 statements, and then I'll be happy to answer any more
9 detailed questions you have about details of the warm
10 handoff, medication-assisted treatment, or any specific
11 language and provisions in the bills.
12 First and foremost, let me say I was pleased to
13 see the recognition of the level of complexity needed
14 across the many systems of care and responsibility that are
15 expressed in the proposed legislation. It's that same
16 level of complexity that gives me some pause about any rush
17 to implement a law until a few fundamental questions are
18 thoroughly researched and answered and then addressed in
19 the bill. The first one being the Commonwealth's role in
20 ensuring the necessary treatment and recovery support
21 capacity to address the need for all overdose survivors.
22 LVHN believes that this is the bedrock on which the success
23 of all warm handoff initiatives rest. For this legislation
24 to produce the outcomes it's striving for, we believe the
25 Commonwealth needs to seriously evaluate and quantify the

1 availability of treatment resources, as well as the
2 adequacy of Medicaid reimbursement rates for those
3 providing treatment for substance use disorder and
4 behavioral health services.
5 In light of the rising need, why aren't more
6 treatment services springing up or expanding the number of
7 beds? And what would a bed registry illuminate about the
8 availability of facilities that provide care to patients
9 under Medicaid or Medicare? We all know what the stats
10 would look like if we counted the number of dentists in
11 Pennsylvania and then compared that to the number who
12 actually accept Medicaid-covered patients. We're really
13 happy to see the legislation does reference reasonable and
14 fair reimbursement rates, but without further research,
15 evaluation, and detail, we're left to wonder how those
16 terms will play out in the final analysis.
17 LVHN wholeheartedly supports the creation of a
18 task force to study those requirements needed to implement
19 evidence-based treatments for substance use disorder, as
20 well as overdose stabilization and handoffs. As a
21 physician, I'm also acutely aware of other substance use
22 disorders that are ruining lives and need equal attention
23 to the opioid epidemic and could benefit from some of those
24 same treatments. We also believe that the work of such a
25 task force could better inform the mandates that are being

1 proposed in 424, protecting against the potential for any
2 unintended consequences and ensuring the desired outcomes
3 in keeping with the intent of the legislation.
4 I do want to take a moment to applaud the courage
5 shown by including a reference to harm reduction services
6 in House Bill 424. While sometimes considered
7 controversial, I believe many underestimate the potential
8 public health crisis that could result from inadequately
9 addressing the need to reduce harm. Both in our
10 Commonwealth and across the country, epidemics of opioid
11 overdose deaths and hepatitis C infection are happening
12 synergistically with combined influences related to
13 injection drug use. This is leading to increased
14 transmission and progression of disease. In Pennsylvania
15 acute hepatitis C incidents across the State has risen 233
16 percent in just the past four years. And further,
17 Pennsylvania ranks 10th in the U.S. for new HIV cases.
18 As part of a multipronged approach to addressing
19 these synergistic epidemics, harm reduction services are
20 needed to combine things like naloxone distribution,
21 linkage to treatment for substance use disorder, HIV and
22 hepatitis C testing and linkage to treatment for those
23 diseases, and referral to medical, social, and behavioral
24 health resources, all in conjunction with programs like
25 syringe services and associated education that help to

1 reduce the spread of HIV and hepatitis C. And I was very
2 happy to learn that the Pennsylvania Secretary of Health
3 referenced harm reduction syringe services in her budget
4 hearing testimony in front of the Senate Appropriations
5 Committee.
6 I do want to bring up just an example as a
7 physician on the frontlines of some of the patients that we
8 see to illustrate these thoughts. So the other day in
9 taking care of patients at the hospital we had a patient
10 who was brought in by our Blue Guardian certified recovery
11 specialist. He found the patient unconscious in his home
12 upon checking on the patient after recently receiving
13 naloxone by law enforcement, brought the patient personally
14 to the hospital, and we were able to link that patient to
15 treatment. That demonstrates the importance of programs
16 like Blue Guardian who directly address overdose patients
17 and members of our community in the field.
18 The second patient I saw was a patient who is a
19 very high-functioning member of our community who was there
20 for surgery, and he went into alcohol withdrawal on day two
21 after his surgery. Nobody knew he had an alcohol use
22 disorder problem, and that patient, we were able to link to
23 treatment, prevent further issues downstream, and get him
24 back to the life that he's used to living. And that
25 demonstrates that there are problems outside of opioids

1 that we want to address as well.
2 The third patient walked into our emergency
3 department because they'd heard about our hospital opioid
4 support team program. So without having overdosed, they
5 came to us to ask for help, and we were able through those
6 resources to link them to treatment. And that patient
7 demonstrates that even beyond patients who overdose there
8 are patients in the community who we'd like to help before
9 they get to the point of overdosing, before they get to the
10 point of needing naloxone.
11 The final patient that we saw that day had a
12 serious bacterial infection related to their injection drug
13 use. And by providing them the medical care that they
14 needed, the stabilization at a medical center, we were able
15 to meet them where they were at the bedside and to link
16 them to treatment. And that patient helps us to illustrate
17 how serious some of the sequelae are related to injection
18 drug use, including serious bacterial infections. Many of
19 those patients are positive for hepatitis C, and until we
20 can link them to treatment, promote abstinence, get them
21 the substance use disorder treatment that they need, we
22 aren't able to adequately address their hepatitis C, their
23 injection drug use-related infection, or to prevent
24 transmission through shared needles out in the community.
25 So in closing I'd really like to thank you for

1 the privilege of speaking with you today. I commend the
2 Committee for shining the light on this very important
3 topic, and I'm happy to stay around to answer any questions
4 you may have. Thank you so much.
5 REPRESENTATIVE HEFFLEY: Our next panel is the
6 Public Health Management Corporation, Dr. Karen Dugosh and
7 Dr. Adam Brooks. Thank you for coming here today with your
8 testimony.
9 DR. DUGOSH: Good morning, and thank you for
10 allowing us the opportunity to speak to you this morning.
11 I am Dr. Karen Dugosh, and I'm a Senior Scientist and
12 Director on the Center of Addictions, a Public Health
13 Management Corporation. I've been conducting addictions
14 research for almost 20 years. Much of my work currently
15 focuses on the opioid epidemic and developing and
16 evaluating strategies to reduce its impact, including warm
17 handoff initiatives. Through this work I've gained some
18 knowledge and insight about different factors that can
19 enhance or impede the success of warm handoff programs.
20 I'm very excited about the Warm Handoff to
21 Treatment Act as it recognizes the importance of connecting
22 overdose survivors to effective treatment and seeks to
23 develop standardized procedures and adequate funding
24 mechanisms to help ensure the success of warm handoff
25 programs. I would like to speak to you today about several

1 ways that I think the legislation could be improved.
2 As you know, there are effective medications for
3 the treatment of opioid use disorder, including
4 buprenorphine and extended-release naltrexone. Recent
5 studies have shown that emergency department patients who
6 receive buprenorphine prior to discharge are more likely to
7 engage in substance use disorder treatment after they leave
8 the emergency department. This research suggests that warm
9 handoff success rates would be improved by including
10 medications like buprenorphine in the warm handoff process,
11 something that's not addressed in the current bill.
12 Furthermore, because providers must complete a
13 comprehensive training and receive a special waiver to
14 prescribe buprenorphine, it's important to consider
15 providing resources to help offset the additional costs
16 that EDs experience. It is also critical to emphasize the
17 importance of connecting individuals to facilities that
18 provide medication-assisted treatment, given that it's the
19 gold standard for treating opioid use disorder.
20 Furthermore, the legislation seems to equate
21 detoxification services with formal opioid use disorder
22 treatment. However, research indicates that detoxification
23 alone is not an effective treatment and that providing
24 detox alone may actually put individuals at higher risk of
25 relapse and overdose. As such, the bill should include

1 mechanisms to help ensure that patients successfully
2 transition to the appropriate level of care following a
3 detoxification episode.
4 Like many others today, I believe that the bill
5 could be improved by enhancing the monitoring and oversight
6 of the warm handoff process. This includes increasing the
7 number of target behaviors that are reported to the
8 Department, as well as the frequency with which reporting
9 and feedback occurs. My work has found that the warm
10 handoff process can break down at several points along the
11 continuum from individuals refusing to be transported to
12 the emergency department to a patient leaving substance
13 abuse treatment against medical advice.
14 The legislation as written does not capture
15 several of these key elements. Collecting the full range
16 of data will allow the Department to identify where gaps
17 occur and where additional efforts need to be directed.
18 And I would agree with the previous speaker that following
19 a system, implementing a system like the PDMP approach
20 would be highly successful.
21 And, furthermore, I believe the bill focuses on
22 bidirectional annual reporting by providers in the
23 Department and that this reporting would benefit from
24 increasing. I think it should occur more frequently,
25 possibly on a quarterly basis. This is of particular

1 importance during the early phases of program
2 implementation and would allow the Department to identify
3 performance gaps when they can more easily be addressed
4 early on. In addition, collecting these data in more
5 regular intervals could allow the Department to reinforce
6 high performers through some form of recognition or a type
7 of an incentive program.
8 The stigma surrounding addiction and the general
9 lack of provider knowledge and training about addiction is
10 a significant barrier to the success of warm handoff
11 programs. The proposed legislation has taken several steps
12 to overcome these barriers. First, it mandates training
13 for both EMS and ED providers and provides financial
14 resources to offset training costs. The work that I have
15 done suggests that these trainings should be delivered on
16 an ongoing basis with frequent booster trainings.
17 Second, the warm handoff centers to be
18 established through this legislation will likely be staffed
19 by individuals who have more experience with and less
20 stigmatizing attitudes about individuals with addiction,
21 which is likely to further support successful transition to
22 treatment. Regardless of where the person is being
23 treated, it's critical that members of the care team have
24 expertise in addictions and that they are sensitive to the
25 experience and needs of overdose survivors.

1 Finally, it's essential that the entire program
2 be rigorously evaluated to determine its effectiveness and
3 to identify important mechanisms of action. Given the
4 magnitude of the current opioid epidemic, it's clear that
5 there is no one single strategy to address it. We need to
6 identify various points at which we can intervene with
7 individuals to prevent, identify, and treat opioid use
8 disorder.
9 The time immediately following an opioid overdose
10 represents a teachable moment to connect opioid overdose
11 survivors to treatment. I believe that the proposed
12 legislation has the potential to increase the success of
13 Pennsylvania's warm handoff mandate, and I thank you for
14 offering me the opportunity to provide you suggestions for
15 how it can be improved. Thank you.
16 DR. BROOKS: So my name is Dr. Adam Brooks. I'm
17 a Senior Scientist and a Director of Research at the Public
18 Health Management Corporation's Research and Evaluation
19 Group. I work closely with Dr. Karen Dugosh. Prior to
20 joining PHMC, I also worked as a scientist at the Treatment
21 Research Institute. My focus and work has been on
22 developing tools to equip the addiction treatment providers
23 with tools to track patient outcomes and also to deliver
24 evidence-based counseling interventions around counseling
25 and medication.

1 So I'm really pleased to be able to offer you
2 some comments on House Bill 596. I really commend you on
3 this bill. It's very needed. The bed registry is going to
4 make it simpler for evaluators at crisis response enters
5 and intake units to identify which detoxification programs
6 or residential facilities a patient can be referred to and
7 to find one that is ready to actually receive patient the
8 moment that the patient is ready to get the care.
9 So I'm going to just make three suggestions that
10 you might consider adding to the bill or to make it a
11 little bit more expansive, informative, and patient-
12 centered. So first off, I'd suggest that you widen the
13 scope of the registry to include outpatient and methadone
14 treatment. The bed registry's currently limited in its
15 formatting to tracking and informing intake workers about
16 the availability of residential and detoxification
17 placements, and this is a really important step forward.
18 We can't dismiss that. But one byproduct is that the bed
19 registry might reinforce the mindset amongst intake workers
20 and patients that being admitted to an inpatient or
21 residential facility is the preferred way to be treated for
22 addiction treatment. And meanwhile, methadone maintenance
23 programs, intensive outpatient programs, and partial
24 hospital programs have made great strides in formatting
25 their programs to address opioid use disorder and to meet

1 those urgent needs for people who aren't required to be
2 housed or don't have to be in a controlled environment.
3 So the legislation should be expanded to include
4 a listing of the outpatient treatment programs and service
5 providers, as well as current MAT slots available at that
6 facility. This is going to assist intake workers and
7 patients to think flexibly about all the treatment options
8 when deciding on the best referral, so suggestion 1.
9 Suggestion 2 would be to shift the focus away
10 from detoxification to the concepts of withdrawal
11 management. So my second suggestion on the legislation is
12 to try to promote that new terminology and a new mindset
13 away from the mentality of detoxifying a patient towards
14 managing the withdrawal symptoms that they're going to
15 experience. Withdrawal management is a more encompassing
16 term that's descriptive of how addiction medicine is being
17 practiced anyway currently for opioid use disorder.
18 So, for example, a patient might check into a
19 residential program and be placed on a maintenance dose of
20 a legal FDA-approved medication with methadone or
21 buprenorphine to manage their withdrawal. One patient at
22 that facility might be maintained on that dose throughout
23 their entire residential stay while another patient might
24 be slowly tapered off that dose pending their withdrawal
25 symptoms and what their provider thinks as they're going

1 through the process. And so that patient might then be
2 discharged opioid-free. Furthermore, some patients and
3 providers might decide that opioid-free patients, when
4 they're being discharged, should be given an injection of
5 slow-release naltrexone to prevent relapse and to prevent
6 overdose risk when they leave after discharge.
7 Now, as these three small little examples
8 illustrate, the course of care around medication really
9 differs based on the patient's needs and the provider's
10 willingness and capacity to meet those needs around
11 withdrawal symptoms. So withdrawal management can be
12 accomplished in methadone maintenance in outpatient
13 settings as well and including that in the bill language
14 would support that. Therefore, each participating agency
15 in the registry should also disclose what their withdrawal
16 management capabilities and philosophy are so that intake
17 workers and patients can make patient-centered informed
18 decisions about where they want to be referred for their
19 care.
20 So my third suggestion on the bed registry
21 legislation would be to augment the registry with some
22 patient-centered information to inform their care
23 decisions. Now, because withdrawal management can take
24 numerous paths for a patient, it's important that mandated
25 treatment providers who are listed in the registry should

1 also provide some up-to-date statistics indicating typical
2 course of care related to their withdrawal management and
3 their patient outcomes. This information should be made
4 available to a patient whose considering complying with the
5 referral at the listed facility. The information could
6 include things like their completion rates, as well as
7 retention rates at 30- and 90-day thresholds. In addition,
8 the treatment providers should disclose what percentage of
9 their patients who qualify for medication are actually
10 offered the medication and choose to receive the medication
11 because that speaks to the climate of what's going on at
12 the facility, and this could be broken down by what
13 percentage of patients are offered medication to taper off
14 of an addictive substance of what percentage are offered
15 ongoing maintenance doses of FDA-approved medications to
16 manage their withdrawal.
17 And finally, what percentage of patients are
18 discharged on agonist medication and what percentage are
19 discharged on antagonist medication. This information is
20 important information that are quality indicators that
21 could impact a patient's willingness to receive a referral
22 and paint a clearer picture of what a patient can expect
23 when they're referred to a treatment facility. The
24 information should be available to a treatment seeker and
25 updated at a minimum of every six months.

1 Thank you for the opportunity for PHMC to
2 represent and to testify on the bill, and we're pleased to
3 be part of the conversation and of course we'll be around
4 for questions.
5 DR. DUGOSH: Thank you.
6 REPRESENTATIVE HEFFLEY: Thank you very much for
7 your testimony. And our next testify or will be Deb Beck
8 from a treatment provider's perspective.
9 MS. BECK: Oh, Lord, lots of stuff. I want to
10 start by thanking this Committee. You've done some very
11 concrete things. Hi, good morning. I haven't seen you for
12 a while. I haven't seen you. You've done some very
13 concrete things in the past that have made a huge
14 difference. And for those of you who are new, this is the
15 Committee where Narcan got its start and your actions
16 started here, 20,000 lives have been saved in Pennsylvania.
17 That's just the ones that they can keep track of. You've
18 saved lives by that. So I don't want the new Members to
19 think, oh my goodness, this is so complicated and there's
20 all these high-tech complicated phrases.
21 I'm not going to read, so you can, you know, look
22 at testimony later. First of all, thank you very much.
23 I'm looking at the Chairman. We have three Chairmen today
24 I think. We've got DiGirolamo, Cruz, and we got a new
25 Chairman here on this issue, Representative Heffley.

1 I am Deb Beck. I'm with the Drug and Alcohol
2 Providers Association. We have a statewide organization of
3 prevention and also all kinds of drug and alcohol addiction
4 treatment. And it's available in most of your districts.
5 If I can help you later, absolutely promise I will linger
6 in the halls if you have any specific questions in your
7 area or if I can help because I know you're going to
8 disappear like magic of onto the Floor.
9 First, I want to start by expressing our
10 appreciation as the drug and alcohol addiction treatment
11 field to the emergency responders in all of our counties
12 that are saving lives every day. This is incredibly hard
13 work. I'm surprised that they're not all going for
14 psychological counseling to support what they have to do
15 every day. We are so grateful to the police and the EMS
16 and the emergency room personnel that save lives.
17 I wanted to also thank you for the opportunity to
18 be here to testify in regard to 424 and to thank Heffley
19 for your ongoing interest in this crisis that we must
20 address and your continued commitment.
21 I think it's appropriate that you are focused on
22 overdose survivors. Overdose survivors are high risk to
23 die later from addiction if we don't do something about it.
24 And in one and four families in your communities, in my
25 neighborhood and yours today is wrestling with how to get

1 an untreated loved one into an addiction treatment program.
2 And I don't know if Representative Struzzi is here today.
3 I haven't met him yet. That's you. You're right. We
4 don't have enough beds. Flat out, you're right. You can
5 have a registry, but if you don't have enough beds, what
6 are you going to do? We don't have enough beds that are
7 immediately available when the patient makes a decision to
8 go for help.
9 This is a disease of urgency. If you fool around
10 and you delay, which all of us have done in the past, the
11 patient could die or could do damage to my family. So
12 5,456 people died in Pennsylvania in 2017 of overdoses,
13 5,456. Imagine the grief going on. Imagine the pain out
14 there. I listen to it every day. I hear from the
15 families.
16 So two provisions of your bill really strike us
17 as really important and a lot of important stuff was said
18 here today. But first the law, you're requiring that
19 overdose survivors go immediately on the special
20 populations list for treatment through the Federal drug and
21 alcohol block grant money that comes into the State,
22 absolutely imperative. There are other populations on that
23 list. Who are they? Pregnant addicted women, oh, my gosh,
24 kind of an obvious one needs to be there. So are homeless
25 veterans. But let's add overdose survivors to that list.

1 I think that's absolutely imperative.
2 The second part of the bill that got our
3 attention was you're asking for the elimination of
4 preauthorization requirements. Please do that, but don't
5 just limit it to the commercial insurance side. Do that
6 for the rest of the system as well. You do not want our
7 patients caught up in a lot of back-and-forth with insurers
8 and managed-care entities both on the public side or
9 private side while the patients dying sitting out front.
10 You don't want to do that. Whoever came up with that,
11 brilliant, do it. Put your checks and balances later in
12 the process, never at the front door.
13 This isn't like -- people don't go sign into drug
14 and alcohol treatment because it's fun. This isn't
15 something where you have to protect the world from the
16 addict getting treatment. But sometimes I think our system
17 has been designed to protect the world from the addict
18 getting treatment instead of getting the addict into
19 treatment. More on that in a minute.
20 We do want to raise one major concern, and I
21 already hinted at it. Overdose survivors are fragile,
22 fragile, fragile, fragile. They are not going to recover
23 through stabilization and detox, which was already
24 mentioned. Stabilization and detox are not treatment.
25 It's the beginning to get the cobwebs out of the brain so

1 people can begin to engage therapy on some level. They're
2 not going to recover. And the odds of somebody coming from
3 a detox to an outpatient clinic and surviving is not great
4 in terms of staying clean. Again, if I'm sick enough to
5 end up in a detox, I'm probably going to need the whole
6 array of residential, outpatient like crazy, halfway
7 houses, the whole thing, not likely that I'm going to
8 survive going from detox to outpatients. It's probably not
9 going to happen.
10 Now, by the way, most people with addictions
11 don't need residential. Most go to Alcoholics Anonymous,
12 Narcotics Anonymous. They go to outpatient, whatever, and
13 do fine. But for people who have managed to end up in an
14 overdose in a hospital, probably not going to make it.
15 That's why the bed issue becomes so terribly important.
16 And it must be available when I need it. It can't be
17 available two weeks for now or in Erie when I'm in
18 Montgomery County. They need to be locally available, and
19 that's an issue.
20 I would have concerns about licensure in terms of
21 stabilization units. A lot of those concerns have been
22 raised earlier.
23 We are very much in support of Representative
24 Gregory's resolution that calls for pressing empty State
25 hospital buildings into this service because they're kind

1 of located around the Commonwealth in places that might be
2 available to fill some of these gaps, so I would add that
3 to the list of things to consider.
4 And frankly, friends, if we really wanted to do
5 something about the drug crisis here in Pennsylvania,
6 there's a lot of stuff we could do in addition. There are
7 many other things. For example, eliminating all the
8 admission stuff that gets in the way and hinders admission
9 into drug and alcohol treatment. It's an incredibly
10 bureaucratic process at the front door that catches our
11 clinicians when they'd rather be doing clinical work.
12 On the insurance side, why wouldn't we tell
13 insurers you must tell your subscribers what their coverage
14 is for addiction treatment and how to access it. You know,
15 we've had flus and viruses. One-page flyers weren't out of
16 the question. And I certainly know my insurer sends me
17 that one-page flyer when they want me to know that there's
18 a premium increase, so why not a one-page flyer that says,
19 hey, Deb, here's your drug and alcohol coverage. This is
20 how you access it. If you can't access it, call your
21 Single County Authority. People can't find it in the books
22 many times.
23 Finally, in closing, I'm sure you're sitting here
24 thinking, oh, my God, this is going to cost a lot of money,
25 right? You're worried about cost, and you got to be. But

1 I want to tell you what the research shows us in terms of
2 cost. The cost of untreated addiction, untreated drug and
3 alcohol addiction to America has been conservatively
4 estimated as $428 billion a year, an annually renewing $428
5 billion a year. We call that the price tag of denial,
6 America's price tag of denial. We would rather pay for car
7 wrecks and burying people and putting them in jail than to
8 deal up front with the illness, $428 billion. Pennsylvania
9 prorate is $17.1 billion. We're wasting $17.1 billion.
10 Now, by the way, that Federal number is just the
11 easy-to-measure stuff, just the stuff like car wrecks and
12 criminal justice costs. No one has found an ability to put
13 a price tag on the broken heart of a mother whose kid has
14 died. We haven't begun to talk about the measures and
15 costs that could be in here.
16 What about the other side of the equation moving
17 from the price tag of denial? The research is conclusive.
18 By the way, I've been in the field since 1971. Can you
19 imagine? Think about all the human beings and going to
20 treatment that come through our doors since 1971. I just
21 want you to know I've been around awhile, kind of seen
22 this, the ebbs and flows of this problem for many years.
23 There are things we could be doing better. And again, you
24 started in the first place, Narcan, to save the lives.
25 But what does the research show you about the

1 cost of addiction treatment? It's a very interesting
2 illness. It turns out that it costs large amounts of money
3 in healthcare on the untreated, large amounts of money in
4 criminal justice, and large amounts of money in the
5 workplace. If you treat it, if you treat the addiction,
6 it's always cost-beneficial. It always pays to treat this
7 illness, and your savings will be realized in the area of
8 healthcare, in the areas of reduction in crime, and also
9 workplace difficulties. The research is overwhelming.
10 So it's kind of interesting. You know, if you
11 put the accountant's eyeshades on here and think I can't
12 stand these people, I can't stand people with addictions, a
13 lot of people feel that way. Well, even if you don't like
14 people with addictions, why the heck wouldn't we do the
15 right thing financially? And I discovered there's
16 something bigger than denial and stigma around addiction,
17 you know -- I mean, excuse me, about -- something bigger in
18 America I thought was money. I thought if we could
19 demonstrate it was cost-beneficial, we could get by the
20 stigma. I've been wrong. All these years in the field
21 I've been wrong. We would rather pay for the mayhem than
22 pay upfront for the illness.
23 So I think it's a nice opportunity to do the
24 right thing, and at the same time it's going to realize
25 some savings for the Commonwealth and certainly heartaches

1 of families. Five thousand four hundred people lost their
2 lives to this illness last year. The numbers aren't in.
3 Excuse me, that's 2017. The numbers aren't in for 2018.
4 We think it's going to be around the same.
5 So I thank you for your time. I promise I will
6 linger if any of you have any questions that are specific
7 to your area. You're Representative Gregory. You're the
8 guy with the State hospitals. Thank you. And you're
9 Representative Struzzi, and you're the guy who's figured
10 out we don't have enough beds. And, Doyle Heffley, thank
11 you so much. I think we really particularly would like
12 those two provisions and wonder if we could even move them
13 separately. Thank you.
14 REPRESENTATIVE HEFFLEY: And thank you, Deb, and
15 thank all the testifiers today.
16 I'll speak briefly here. House Bill 424, the
17 significance of the bill, the young lady Gabby Green,
18 daughter of one of my staffers, had passed away last April
19 from an overdose, and that's why we chose that number for
20 the warm handoff bill. And I do believe that we could save
21 many lives if we can develop this warm handoff.
22 I know one of the first hearings I sat in on this
23 Committee was on the Prescription Drug Monitoring Program
24 back in 2011, now that is up and running. The naloxone
25 that we had worked on and passed on the Floor, to get that

1 out into the public, and also provide family members of
2 loved ones with addiction to have that in their house.
3 And now, you know, we hear from a lot of folks
4 and, you know, we are reviving people, we're saving lives,
5 but what's the next step? And through all these
6 initiatives and everything that we've done it's been the
7 next step, the first thing is saving lives with the
8 naloxone. Now the next step is how do we get those folks
9 with nonfatal overdoses into the treatment that they need?
10 And that's what the warm handoff legislation is for, and I
11 don't believe we could have a warm handoff legislation
12 without a bed registry to identify where those beds are.
13 There's definitely a shortage of beds. I think,
14 you know, a lot of the suggestions that we heard here today
15 were great, and that's what this is all about. House
16 Resolution 659 from I think it was 2016 or '14 put together
17 the Opioid Task Force, and we moved a great package of
18 legislation, including the PDMP. We have the seven-day
19 limiting for prescribing in ERs, and I think one of the
20 main things was the medical society coming out with the
21 prescribing guidelines for opioids.
22 So we are making a lot of progress, and I think
23 this is naturally the next step. We needed it two years
24 ago. We need it this year. So we still have a lot of work
25 to do. And I thank everybody for coming and testifying

1 today and want to invite everybody up. And we have a
2 number of Members that have questions for the panelists
3 today, so I don't know if everybody can kind of filter up
4 to the front at the table or if that would be possible, all
5 the testifiers.
6 MALE SPEAKER: We can move some them chairs
7 around, too?
8 REPRESENTATIVE HEFFLEY: Yes, we can move some of
9 the chairs around as well. And I also want to thank all
10 the Committee Members for being here and Chairman
11 DiGirolamo for allowing this hearing and the Subcommittee
12 Chair to be here and part of it. Chairman DiGirolamo?
13 MAJORITY CHAIRMAN DIGIROLAMO: Yes, okay. Okay.
14 We're going to open it up for a few questions, but just one
15 comment because I've heard it from almost all the
16 testifiers. I mean, I've put an awful lot of people in
17 treatment, people who call my office, and I'll tell you,
18 over the last few years trying to find a detox bed over the
19 weekend anywhere in the State of Pennsylvania is a
20 challenge. A lot of times you cannot find a detox bed.
21 And I'm a firm believer that people that want to
22 get into treatment and their families ought to have options
23 of what type of treatment they want to get into. And, you
24 know, if they want to get into residential rehab, they
25 should have that opportunity and option to do that.

1 And Deb Beck mentioned Representative Gregory's
2 piece of legislation to do a study on these closed-down,
3 shut-down State office buildings around the State, and I
4 really think that there are buildings out there that we
5 could open up and get treatment people to go in there and
6 run those buildings if we can get them rehabbed. Because
7 everybody knows you got an addict in the family, want to
8 get them into treatment, and you're sitting there on a
9 Thursday and Friday and they want to get in and you can't
10 find a detox bed and you're going to tell them to call back
11 on Monday or Tuesday. That's not going to work a lot of
12 times because they're just going to go right back out on
13 the street, keep using, and you're not going to find them.
14 When somebody needs to get into treatment, you've got to
15 have a place to put them and a way to pay for a lot of
16 times.
17 I mean, so, you know, treatment beds, we've got
18 to get more treatment beds open in this State. It's
19 critical because people are dying because they can't get
20 into treatment. And make sure that we have a way to pay
21 for it, too.
22 So with that, I'm going to open up for questions,
23 and first, Representative Cruz.
24 DEMOCRATIC CHAIRMAN CRUZ: Thank you, Chairman.
25 First of all, thank you all for giving us the opportunity

1 to give us your feedback and your information. The concept
2 that I believe in is that in order for you to come to a
3 solution, you've got to talk about the issue, so this is
4 what we're doing, okay?
5 Number one is that everything that we do to help
6 folks get treatment is costly, but one of the solutions
7 that we talked about in this Committee that we need to
8 bring back is how do we tax the opiates, pharmaceutical
9 industry, okay? They are responsible for giving these
10 medications and these drugs to people that become addicted.
11 The second part is how do we come after them
12 legally and hold them responsible, file charges against
13 them? What is the difference by an actual drug dealer in
14 the street and a pharmaceutical industry that is selling
15 and giving away drugs that are addictive and not being held
16 responsible?
17 We are a legislative body. We legislate the law,
18 and I think it's time for us to do both, do attacks where
19 we use the monies to help people that became addicted to
20 their product, but we also find a way how to hold them
21 responsible legally so this doesn't occur.
22 Yes, we're running out of beds, okay? And the
23 testimony that I heard was from Allentown, Lehigh Valley,
24 and Reading, but you haven't talked about Philadelphia, the
25 city of the first class, okay, where we have all these

1 encampments. And someone came up with a solution saying
2 that that's have a safe needle injection site. That does
3 not work. If these people do not feel safe, they're not
4 going there. We'd rather have more beds and more treatment
5 to help the people, okay, than starting resolving and
6 creating other things that are part of the problem.
7 So I thank you for talking about the issue. Now,
8 it's our responsibility to roll up our sleeves and do the
9 people's business that they sent us up here to do, which is
10 to protect our citizens in the Commonwealth of
11 Pennsylvania. Thank you, Mr. Chairman.
12 MAJORITY CHAIRMAN DIGIROLAMO: Representative
13 Nelson?
14 REPRESENTATIVE NELSON: Thank you, Mr. Chairman.
15 Complex and broad testimony today, and my initial
16 question is focused on the Blue Guardian program. And I
17 also just wanted to comment a little bit on some of those
18 roadblocks for individuals. Particularly somebody had
19 mentioned in their testimony about individuals struggling
20 with alcohol addiction. And it's difficult for somebody
21 who's not drunk to be able to get in. Like when they are
22 recovering and they're sober and then they try to reach
23 out, they don't qualify to be able to get back in again.
24 And I've had multiple people struggle with being able to
25 get into a program because they had hit a trough, were

1 sober, and then not able to get into active treatment.
2 So I don't know if -- you know, these bills don't
3 touch that, but as we get into roadblocks -- another
4 roadblock that I hear from private treatment providers is
5 that they are struggling to be approved to treat those
6 lower-income individuals at least in Westmoreland County
7 where they have a desire to -- they're private practice and
8 they have a desire to expand into there, but there are some
9 roadblocks in allowing them to get access to be able to
10 provide that treatment, and they're willing to do that over
11 the weekends, you know, with those registries.
12 But could you touch on a little bit specifically
13 for the -- we don't have in Westmoreland County a Blue
14 Guardian-type program, and we're looking to try to
15 integrate and develop. How, from a confidentiality
16 standpoint, does all of that information between names,
17 addresses, you had mentioned some mental health -- you
18 know, from the DA, toxicology, individuals struggling, how
19 does that -- you know, is it an app, is it a computer
20 program that's provided? And what is an approximate cost
21 of implementation of that program? It sounds very
22 effective, but can people really share all of that
23 information? Because it seems to be a struggle point,
24 particularly from physical and mental health side.
25 MS. KOCIS: So, yes, it is an application. It's

1 a web-based application. We have over 1,200 users across
2 two counties. Everything is handled through role-based
3 security, so only individuals that would -- the coroner,
4 for example, would allow it to see his information. Only
5 those individuals can see that information. We can see
6 summary reports that he wants to present to us, but for the
7 purposes of this presentation, I wanted to show you what it
8 would look like when his staff enters it, same with the
9 clinical notes.
10 So Layne and his staff, the Single County
11 Authority and the certified recovery specialists, they can
12 see the clinical note information; law enforcement cannot.
13 Just like the clinicians, they can see their information
14 but they cannot see the law enforcement information if that
15 makes sense.
16 REPRESENTATIVE NELSON: So within our hospital
17 system they have their own Meridian I think it's called or
18 they have their own system that they're using to enter in
19 billing. Is this an additional system like where the --
20 was there pushback from the hospital providers, you know,
21 that there's now another database that they would be
22 entering in information?
23 MR. TURNER: No, the hospitals aren't entering
24 any of this information into the database. That's all done
25 either by police creating the naloxone report, which is a

1 report that they're required to fill out anyway for PA
2 ODIN. So instead of doing the handwritten report, faxing
3 it into PA ODIN, they're able to access it from their
4 cruisers, type in the information, hit submit. Part of
5 that report that's appropriate goes to PA ODIN. The rest
6 of it comes to my office as the SCA. So the SCA's office
7 really drives the boat on this. We then contact the
8 certified recovery specialist. They go out and do the
9 house call. We get the clinical notes. The SCA's office
10 puts the clinical notes into the system. So the hospitals
11 don't do any of the data input.
12 But what we've done is we have a different system
13 that again is maintained in my office that manages all
14 those 2,200 warm handoff referrals. It's called REDCap.
15 It's a free web-based application. Confidentiality is part
16 of it. It's role-based access, so St. Luke's can look at
17 St. Luke's. Lehigh Valley can look at St. Luke's, but they
18 can't look at each other's patient data. But they're able
19 to share information that way in aggregate totals. We're
20 able to take that information, do a data export, and then
21 run it through the REDCap so we can further develop what
22 does the drug trend really look like per ZIP Code or per
23 city block in the county of Lehigh.
24 REPRESENTATIVE NELSON: Thank you. Thank you,
25 Mr. Chairman.

1 MAJORITY CHAIRMAN DIGIROLAMO: Representative
2 Polinchock.
3 REPRESENTATIVE POLINCHOCK: Thank you, Mr.
4 Chairman.
5 This is more of an offer that a question. You
6 know, obviously we know the opioid epidemic touches all
7 demographics, rich, poor, urban, suburban, rural. It
8 certainly touches my district in central Bucks County as
9 well. And this issue I think it's just too important to
10 move slowly on, so with regards to the testimony from Dr.
11 Beauchamp representing the hospitals and specifically the
12 Lehigh Valley Health Network -- and with your permission,
13 Mr. Chair, I'd like to take the lead in getting the ball
14 rolling on forming this task force, the overdose recovery
15 task force. I'd ask that my colleagues jump on board and
16 that anybody that has a willingness or expertise in this
17 field to please get your information to Melanie so that we
18 can get up and running immediately with this.
19 Thank you, Dr. Barbera for having the emergency
20 room physicians want to jump on board with that as well, so
21 it's much appreciated and everyone that traveled so far
22 today to brief us.
23 Ms. Beck, no doubt your passion has saved lives,
24 and thank you for the work that you're doing. So thank
25 you, Mr. Chairman.

1 MAJORITY CHAIRMAN DIGIROLAMO: Representative
2 Gregory?
3 REPRESENTATIVE GREGORY: Thank you, Mr. Chairman.
4 And thank you all for being here, for your testimony today.
5 This is an all-encompassing subject.
6 Representative Heffley, thank you very much for
7 putting this bill forward.
8 And the opportunity to talk to you today is why I
9 ran for this position. Anonymity is a big part of what we
10 do as addicts, and living in long-term recovery for nine
11 years and having lost a brother to overdose 30 years ago,
12 if I get nothing else out of this, the opportunity to be a
13 representative here to talk about this today, then I would
14 be fine with that because this is a huge problem for the
15 State of Pennsylvania.
16 And for the opportunity to repurpose State office
17 buildings, to find spaces that we don't have barriers to
18 people who need the help is crucial. It is absolutely
19 crucial. In the late '70s we closed mental health
20 hospitals in Pennsylvania and turned them into veterans
21 homes. Our veterans benefited from that. So what are we
22 willing to do for our addict community to make those spaces
23 available for them now?
24 So I really appreciate the opportunity to put
25 that proposal forth and the staff that's helping with that,

1 and I would encourage my colleagues to sign on and also add
2 their cosponsor names to that resolution.
3 So just a couple of quick questions. First of
4 all, when it comes to the cost, in Blair County, Blair
5 County raised taxes two years ago, and one of the reasons
6 they raised taxes was because for those people that have
7 not lost somebody to addiction, they should count their
8 blessings, but they're paying for it. You wanted to know,
9 Deb, about cost. Parents who are parenting, grandparents
10 who are parenting foster kids in Blair County, in Blair
11 County we had the largest number of foster kids that we've
12 ever had last year. That's a cost to taxpayers. Autopsy
13 and toxicology reports increased. That's another cost, an
14 increase that you're paying for. So with that in mind I
15 would just encourage you to also include that in
16 conversations about those that look at stigma and are
17 taking people and not being willing to recognize how we can
18 help them.
19 For those in the healthcare field in hospitals,
20 when we're looking at areas where we need to address
21 possible holes in the system, can you explain to me whether
22 or not we have a HIPAA problem in our system whereby
23 emergency room visits for those who are on naloxone,
24 Suboxone are coming in, and the PDMP does not recognize
25 those that are currently receiving it because of therapy.

1 They are protected by privacy, that those folks when they
2 come in are being given an opportunity to either relapse or
3 receive treatment and not use it there but take it with
4 them. Can we recognize whether or not we need to look at
5 our HIPAA policies? Maybe it's not a State; maybe it's
6 more a Federal issue, but if we need to recognize where the
7 holes are in a system where, when you come into the
8 emergency room, that you are not recognized on the PDMP.
9 Is the PDMP fully helping the situation? And I'll just
10 throw that out as one question first of all, anybody that
11 would like to answer.
12 DR. BARBERA: I would say that the PDMP is
13 helping --
14 REPRESENTATIVE GREGORY: Okay.
15 DR. BARBERA: -- and I'd say that at least at our
16 -- I don't want to get arrested, but we decided that HIPAA
17 is last. We decided that we're going to treat patients for
18 the best of patients, and we would fight the HIPAA battle
19 if we needed to if the physician felt that it was in the
20 best interest of the patient to look at someone's past
21 medical history. And that's what we are calling this, the
22 past medical history for their treatment. And so I think
23 that's very important.
24 And I would offer one suggestion to all of us
25 with regard to stigma. We've learned that the word addict

1 itself is not a positive connotation, so when you come into
2 the emergency room and the triage nurse says oh, we have an
3 addict in room 5, that is very different -- all of a sudden
4 all of us, all of us have this preconceived notion of what
5 that patient is, so we've changed our terminology and we
6 say, well, we have a person with an addiction, person with
7 an addiction, much like a person with diabetes or a person
8 with a heart attack or a person with a laceration because
9 we've kind of found that we were taking this disease and we
10 were segregating it. We were saying, well, okay, addiction
11 is here and all the other medical problems are over here,
12 and we're going to treat all the other medical problems
13 because if you have a stroke, we don't really care about
14 HIPAA, we just do our stroke stuff, right? And then we
15 figure everybody wants to get help for a stroke, right?
16 So we struggled a little bit with our Single
17 County Authority with regard to what information we can
18 release after the visit, but during the visit at least for
19 us it's not an issue.
20 REPRESENTATIVE GREGORY: Thank you. And as far
21 as -- I'll be brief. I want to allow other questions. But
22 as far as the behavioral health issue, the mental health
23 issue, we didn't hear too much about how that plays a role,
24 but then we also get into a workforce issue. And in my
25 county we have a difficult time finding certified recovery

1 specialists. We have a workforce issue in just about every
2 industry that we have in Pennsylvania. Can you talk about
3 what we need to do as the State, the Commonwealth, to be
4 able to recognize how to encourage more folks to be a part
5 of wanting to be participating in helping this from a
6 workforce issue? Thank you.
7 DR. BROOKS: Well, I mean, you know, just one
8 point would be the salaries, pay.
9 REPRESENTATIVE GREGORY: But workforce is an
10 issue, correct?
11 DR. BROOKS: Oh, it is a major issue, and I think
12 one of the issues that I find in the work that I do is the
13 turnover rate is people enter the field, they're
14 enthusiastic young people with degrees in counseling or,
15 you know, want to do good, but it does not pay, and the
16 paperwork is crushing. And so those two things together
17 drive people out of the field really quickly. And I think
18 you've probably seen it, too, Deb, in your perch.
19 We really need to be starting to think about
20 paying for addiction treatment the way we pay for other
21 health services. And right now, the rate for
22 reimbursements for services is low enough that we just
23 can't keep addiction treatment agencies staffed at
24 competitive salaries, so people leave to go do other
25 things. And we wind up training people who may not be as

1 qualified and just hoping we can train them well enough to
2 do the job and that we can retain them long enough to stay
3 in the field.
4 Deb, do you want to add anything?
5 MS. BECK: Yes, I do. Thank you for asking that.
6 I think when you've got -- there's a workforce problem
7 everywhere, you're correct, but I'm sorry, our folks are
8 dying. I think if I prioritized where I'd want to see
9 workforce dealt with, it would be here. You have in the
10 audience Bill Stauffer from the Recovery Organization who
11 works on workforce papers, and he's done surveys and he'll
12 correct me if I'm making an error here.
13 I ran treatment programs. I ran a skid-row
14 program for a number of years. Easily the best counselors
15 were recovering addicted people who also then had gotten
16 training and counseling, easily. The social worker types,
17 and I is one -- and the human services types after a while
18 the stigma around the illness becomes overwhelming. And
19 the salary is one of the issues, but the other is the whole
20 field is stigmatized. And it's like why are you working
21 with those people and why don't you go do something with
22 people who we care about? And they eventually leave.
23 Also, the undergraduate training -- and I have
24 both a bachelor's and master's -- is incorrect in health
25 and human services on drug and alcohol. It doesn't teach

1 it's a disease. It's still teaching it as though it's
2 something to do with your mother or your father. And when
3 you have someone having a seizure, you figure out, well,
4 gee, that probably didn't have anything to do with his
5 mother or his father. The training is not very good in the
6 colleges. There's some improvements. There's some
7 colleges that are beginning to do this.
8 Loan forgiveness is what we ought to be doing
9 frankly. People who are in the field and stay, Bill
10 Stauffer's surveys have shown -- my own experience working
11 in the field -- is that people who stay day in and day out
12 are usually in recovery or family members of people in
13 recovery, but it's usually a second career. There may be
14 criminal charges for some. They're raising families, have
15 a house, they're going to need support and time to get out
16 to school. The loan forgiveness is imperative. And given
17 this is who's going to be there on the frontline, that's
18 who many of the certified recovery specialists are, I think
19 we need to spend the bucks there.
20 REPRESENTATIVE GREGORY: Thank you. And I'll
21 just finish that by saying as we look to try and limit the
22 barriers, looking for more space, looking for more money,
23 we can do all of that. But when an addict comes in and
24 they don't have somebody to talk to, it's a barrier, and so
25 we need to address that. So thank you.

1 Thank you, Mr. Chairman.
2 MAJORITY CHAIRMAN DIGIROLAMO: Representative
3 Hohenstein.
4 REPRESENTATIVE HOHENSTEIN: Thank you, Chairman.
5 I want to start by saying that I, along with
6 Representative and Chairman Cruz, represent Philadelphia
7 and we have 20 percent of the overdose deaths in the State
8 according to the last measure. We are living with a little
9 bit of a different reality. I was listening to the Blue
10 Guardian program, wonderful, but a lot of our people living
11 in addiction are living on the streets as well.
12 So one program I want to note that the
13 Philadelphia Police Department has started is a police-
14 assisted diversion, which is essentially the triage version
15 of what we just heard described by the Blue Guardian
16 program, which I think also is really good.
17 I have two questions, one regarding House Bill
18 424 for Dr. Dugosh. Did I pronounce that right?
19 DR. DUGOSH: Dugosh.
20 REPRESENTATIVE HOHENSTEIN: Dugosh, okay. I'm
21 Hohenstein, so I'm sensitive to issues of pronunciation of
22 my name. So when you reference MAT as a gold standard, I'm
23 a Philadelphia Eagles fan, and gold standard makes me very
24 uncomfortable as a phrase. It's not exactly something that
25 I'm comfortable with. But what I'd like to ask you to do

1 is just describe that because I've heard it described from
2 the Secretary of I think Health, Secretary Levine, as
3 medically assisted treatment wrapped around with counseling
4 and therapy and then intensive case management. And I'd
5 like you to just make certain that that's the description
6 that we're talking about when we talk MATs.
7 DR. DUGOSH: Okay. That is what I'm talking
8 about. Research consistently shows that these medications
9 are most effective when they're provided within the context
10 of comprehensive psychosocial treatment and service
11 provision. Medication alone is better than nothing at all,
12 but people tend to have the best outcomes when they receive
13 comprehensive wraparound treatment along with medications.
14 REPRESENTATIVE HOHENSTEIN: And that requires a
15 deeper initial investment into the person's treatment,
16 correct?
17 DR. DUGOSH: Absolutely.
18 REPRESENTATIVE HOHENSTEIN: Yes.
19 DR. DUGOSH: Because you find that individuals
20 who have opioid use disorder, that's not the only problem
21 they have. They tend to need housing often, especially in
22 Philadelphia. They tend to need -- they have family issues
23 that need to be resolved, so providing comprehensive
24 wraparound treatment is really important.
25 REPRESENTATIVE HOHENSTEIN: And what would be

1 your opinion of how we should handle the Department's --
2 what they call the Center of Excellence? They have about
3 40 or so of them around the State. We didn't talk about
4 those in this context, but when you were talking about only
5 sending people to facilities -- or not sending people to
6 facilities that would do abstinence only, how do COEs fit
7 into that?
8 DR. DUGOSH: I think that the COEs, at least the
9 COEs that I've worked with tend to have more comprehensive
10 treatment available, and they tend to have better outcomes
11 for patients. In the work that -- I did a comprehensive of
12 evaluation of Bucks County's warm handoff program, and we
13 found that when hospitals have an associated Center of
14 Excellence, individuals who received the warm handoff were
15 more likely to have more positive outcomes. And the work
16 that I've done in Philadelphia seems to suggest the same
17 thing, so I do believe that the Centers of Excellence are
18 having an impact.
19 REPRESENTATIVE HOHENSTEIN: Right.
20 DR. DUGOSH: Again, I think it's important with
21 all of these initiatives to comprehensively evaluate
22 whether or not that's the case by looking at the numbers.
23 REPRESENTATIVE HOHENSTEIN: Right. Thank you.
24 And I just have one further shorter question on House Bill
25 596 for Dr. Beauchamp and I think also for Ms. Beck.

1 Relating to the concept of how the registry treats whether
2 a facility will accept Medicaid or medical assistance in
3 any way, how do we improve that or what do we need to do
4 with the bill to make certain that that's clear?
5 DR. BEAUCHAMP: That's an excellent question. We
6 do find that at least in our treatment program the vast
7 majority of the patients are covered by Medicaid or our
8 program helps them to apply for medical assistance and then
9 during that transition period we rely on county support for
10 the treatment until that coverage comes through.
11 So while I don't have the perfect answer here, I
12 think what is absolutely key is that we have access to
13 treatment providers who are willing to accept patients in
14 that very tenuous period, so there can be four to six weeks
15 when the patient has no coverage at all when they're
16 uninsured and when medical assistance is pending, and
17 that's where county support has come through in our region.
18 But once the patient is covered, does have Medicaid, where
19 there is a treatment provider who accepts that coverage, we
20 are able to engage that patient in treatment. So the key
21 really is finding adequate numbers of treatment providers,
22 facilities who accept Medicaid.
23 And I do want to be clear that that doesn't
24 necessarily mean that those all have to be detox or
25 inpatient rehab beds. In our program, because we use

1 medications like buprenorphine, so medication-assisted
2 treatment, we are able to stabilize patients without them
3 necessarily needing an inpatient stay. So we actually have
4 a cost-effective approach that involves avoiding that very,
5 very medically challenging detoxification period, and
6 instead, rather than putting the patient through that,
7 we're able to put them on a medication that actually makes
8 them feel relatively normal, allows them to engage in
9 treatment, and they can then participate in something like
10 a partial program, intensive outpatient. So maybe one,
11 three, or five days a week rather than relying on the
12 availability of an inpatient bed.
13 REPRESENTATIVE HOHENSTEIN: Okay.
14 DR. BEAUCHAMP: And so we've worked closely with
15 the county to work with those limited resources.
16 MR. TURNER: If I could jump in and clarify
17 something, though?
18 REPRESENTATIVE HOHENSTEIN: Sure.
19 MR. TURNER: From the Single County Authority's
20 perspective, I have contracts with many, numerous providers
21 for both detox, residential beds. I have seven beds on
22 hold tomorrow. I have five beds on hold for Thursday. So
23 what is a -- I'm not sure from my perspective what a bed
24 registry is going to do because I know what the capacity of
25 my treatment providers are because I have those contracts.

1 I work in close relation with them. They know how many
2 individuals are in detox. They know, as they're going
3 through the continuum, day four, day five, they're stepping
4 down. I'm already reserving those beds two days out. So I
5 don't know if a patient bed registry is ever really going
6 to catch up and give us a real-life number what's available
7 this morning. Most of our treatment providers do send us
8 an email every morning around 6:30, 7:00 in the morning
9 giving us an idea of what their forecasted capacity is.
10 Now, if there is an AMA or therapeutic discharge, they
11 already have somebody on hold or standby that's filling
12 that bed, and they'll never update that registry.
13 So I think it's a great concept. It's something
14 that allows us to continue these conversations, but
15 practically speaking, it's not going to provide Lehigh
16 County any assistance whatsoever because we already have
17 them booked out for two or three days.
18 REPRESENTATIVE HOHENSTEIN: All right. One last
19 thing I'll mention in Philadelphia when I talked to the
20 mayor and I asked him, you know, if there's one thing you
21 want to make sure people in Harrisburg understand, and he
22 said, yes, beds, beds, beds. So we need them. But you're
23 right; we do need to adequately track them. We have a
24 different problem of volume in terms of the tracking, and I
25 think a registry I think would help us. But thank you for

1 giving me so much time, Chairman.

2 MS. BECK: Representative Hohenstein, I'm

3 learning all these new names. I'm working on it. Back to

4 the State hospital idea, you know that the State's already

5 paying to maintain empty buildings. They got to. You

6 know, they're sitting there empty. You know, you're

7 already paying for it. And you have State hospital beds

8 and programs like that in Philly, and I think you ought to

9 open the doors. I mean, what are we doing? Are we serious

10 or are we playing here? You know, even if you don't like

11 addicted people, it's like a virus. You want to stop it

12 before it gets any bigger. You need to open the doors, get

13 the treatment in there, hire lots of recovering people,

14 make mistakes, but get people off the street.

15 We've had a natural experiment with that back in

16 the '80s where there was an opening of beds in

17 Philadelphia, and what happened is a crime wave, the crime

18 went down in the area where the beds were opened up. Well,

19 no kidding. If I'm involved in crime -- and most addicts

20 aren't, by the way, they're more like Betty Ford. I always

21 have to say President Ford's wife now that I've gotten

22 older because kids in school don't know who I'm talking

23 about -- don't commit crime. Our people just die quietly

24 of desperation more often than not, but gee whiz, in

25 Philadelphia, why wouldn't you open those doors? Open the

1 doors. Let's make some mistakes. Let's get the people in
2 there. You're already paying for it.
3 And again, one of my fears about your bill,
4 Representative Heffley, is I'm afraid it'll work. You
5 know, we can't handle what we got now, so dealing with
6 where we're going to put them is just imperative. Thank
7 you.
8 MAJORITY CHAIRMAN DIGIROLAMO: Okay. Just a
9 quick comment on these MATs, and I'm not anti-MAT. There's
10 an absolute place for MATs. And I think in the State, as
11 far as methadone goes, we're doing a really good job with
12 methadone maintenance treatment. And I think there's a lot
13 of docs out there with the Suboxone that are doing a really
14 good job as well, and they're including, as you mentioned,
15 counseling along with the Suboxone. But I want to tell you
16 what. We've got this Suboxone all over the street down in
17 southeastern Pennsylvania and in other parts of the State.
18 And you know how it's getting there? It's getting there
19 because it's being diverted from people that are going to
20 these doctors, are getting no counseling, they're in and
21 out of the office in five minutes, taking home their
22 prescription, they're diverting the drugs. And you know
23 addicts are the most entrepreneurial people that there are.
24 They've figured out they can sell their 30 strips or pills
25 of Suboxone on the street and make money and continue to

1 use their drugs.
2 And it's really out of control. And the doctors
3 are taking cash. They don't want to accept insurance.
4 They're charging $150 to $200 a pop and seeing 100 or I
5 don't know how many they're up to right now, 100, 150
6 patients a month, hiring doctors that are retired to come
7 in for a day or two a week so they can see more patients,
8 and they've got a great business going on.
9 So if you're going to do the Suboxone without any
10 counseling, I mean, we've got to get our hands around this.
11 It's all over the street. Addicts are telling me to get
12 all the Suboxone you want, and it's being diverted because
13 they're going to their docs, getting a prescription, and
14 going out in the street and selling it. We've got to get a
15 better handle on what's going on with the Suboxone around
16 the State.
17 Okay. We've got about 15 minutes left.
18 Representative Struzzi, then Representative Gleim for
19 questions.
20 REPRESENTATIVE STRUZZI: Thank you, Mr. Chairman.
21 I'll try to keep this brief.
22 First of all, thank you for being here. I
23 appreciate the work that you're doing. And there are
24 professionals around the Commonwealth doing great work.
25 And I think it's important that we understand what

1 legislation means to you on a day-to-day basis before we
2 enact anything. This discussion for me has been very
3 painful, and every time we talk about this subject I see my
4 brother in his coffin because it was only four years ago.
5 And I think that we're talking about some of the key links
6 that are missing in the entire treatment and recovery
7 process. And the process is what we need.
8 So I applaud the Guardian. I think that the step
9 by steps that you showed, the linkage between Narcan and
10 treatment is fundamental. I see it in our county in
11 Indiana County. And Narcan is saving lives, but we've got
12 to get to the point where we don't need to continue to
13 provide Narcan. I think we need this discussion to -- you
14 know, let's start talking about prevention as well. I
15 think that's where we need to be at some point. But 5,000,
16 5,400 lives lost every year is -- to me there's no cost
17 that we should have to be worried about to cover this
18 because the cost to our communities, the cost to families,
19 I know what it did to my parents, I know what it did to our
20 family. Representative Gregory, I understand Jim's point
21 as well and everyone who suffers through this. So it's
22 very pertinent that we have this discussion. I applaud
23 Representative Heffley for pushing these legislations
24 forward.
25 But I have a couple of questions I think

1 pertaining to first of all Blue Guardian. And I want to
2 keep this brief because we're running out of time, but how
3 has that program been received in the community?
4 MS. KOCIS: It's been received very well
5 actually, and since we've incepted the program, we've seen
6 a shift in perception from the community about law
7 enforcement. They see them there as now to help, not to
8 arrest. And we see a shift in perception from law
9 enforcement with regard to what addiction is. It's not the
10 face you think you used to know. It's constantly changing.
11 So there's been some very positives that's come out of
12 that.
13 REPRESENTATIVE STRUZZI: And is it funded through
14 the District Attorney's Office or through -- go ahead.
15 MS. KOCIS: It is a combination of the District
16 Attorney's Office for his staff and support, but it's also
17 funded through Single County Authority.
18 REPRESENTATIVE STRUZZI: Okay. Okay. The stigma
19 is still a big concern for me, and I think the stories that
20 you told some of you today in your testimony -- and you've
21 got to put a face to this because these are people who
22 simply made a bad decision or, like my brother, had a
23 sports injury that led him down the wrong path. So I think
24 if we want to erase the stigma -- and the stigma is a big
25 thing. I really think we need to change that. And you

1 mentioned it, Dr. Barbera. In the emergency room and as we
2 talked about the warm handoff, which, again, I think is
3 essential, it needs to be warm, right? We can't have
4 nurses and doctors who don't understand this as well. And
5 I've heard that story as well back in my home county, so we
6 need to make sure that, as we push this legislation
7 forward, I think all the items in here are so important.
8 I think that's the only couple of questions that
9 I had. And just one more related to the registry, I did
10 share that with some of our treatment professionals in
11 Indiana County as well, and they sort of agreed that there
12 isn't a lot of value in it if it's not accurate, so that's
13 just something that I think we need to bear in mind moving
14 forward. So again, thank you all for being here. Thank
15 you.
16 MAJORITY CHAIRMAN DIGIROLAMO: Representative
17 Gleim.
18 REPRESENTATIVE GLEIM: Hi. It's Barb Gleim --
19 MAJORITY CHAIRMAN DIGIROLAMO: Gleim.
20 REPRESENTATIVE GLEIM: -- from Cumberland County.
21 I want to thank everybody for being here. I just have a
22 real quick process question to sort of piggyback off of
23 what Representative Struzzi was asking. I come from more
24 of a rural area, and so this is going to be, you know,
25 hopefully passed for the whole State. And I know that Blue

1 Guardian's presentation talked about the rural community
2 little bit. And I just got out of a meeting in my district
3 on S.R. 6 and how the EMS are really short-staffed right
4 now. So do you suggest or do you have any suggestions on
5 possible consortiums with the EMS in the whole process of
6 this or is it really the police departments who are
7 actually the ones that are more important here?
8 MR. TURNER: I believe it's a combination. I
9 believe it's whoever that meaningful partner is for your
10 community. For us we had the data with the naloxone
11 program with law enforcement. We had all 17 police
12 departments actively involved. The next step of the
13 migration is to obviously look at volunteer fire companies.
14 What if we train those volunteer fire companies to learn
15 how to make that phone call to that person in the community
16 they know is struggling? And by them making that phone
17 call and having the family agree to a quick meeting,
18 there's no confidentiality issues. We now have become
19 invited into that home. So that volunteer fire company
20 member brings the CRS into the member's home and provides
21 the support and that same linkage.
22 So we are able to use it with police as necessary
23 because I think police give us that emphasis that we need
24 that this was a law-enforcement-involved naloxone event so
25 it's event-specific, but I also think that this can be a

1 very proactive instead of a reactive program as well where
2 we train churches, community members, EMS, volunteer fire
3 companies, families, community members. How do you make
4 those cold calls or make that uncomfortable conversation
5 with your neighbor saying I know you're struggling. You
6 know what, I know a guy. The guy would love to hear your
7 story. And we bring that CRS in. I mean, when you put a
8 CRS in those environments or put him in a police cruiser
9 doing car therapy with a cop, it changes people's lives,
10 you know, and that's what we're looking for. We're looking
11 for a relationship to be built that we can then springboard
12 access to treatment and these other, you know, issues that
13 we need to talk about. But if we don't have that
14 relationship, we're never going to get the people to stay.
15 REPRESENTATIVE GLEIM: Thank you. That's all.
16 Thank you.
17 MAJORITY CHAIRMAN DIGIROLAMO: Representative
18 Heffley for follow up.
19 REPRESENTATIVE HEFFLEY: Yes. Back to Layne
20 Turner, one of the issues we have in Carbon County, a very
21 rural district that I represent, is with the beds. And
22 we're hearing from the ER -- I heard from my emergency
23 rooms about the need for a registry, a need to find those
24 beds. And so I'd like to work with you on that so we can
25 accommodate in many rural parts. And that's another

1 comment that was made earlier about the Centers of
2 Excellence, but the SCAs are providing many of those
3 services already, so I don't want to duplicate a lot of
4 services. I want to make sure that we're getting the
5 biggest bang for the buck for every dollar that we're
6 spending and definitely working to get those folks in --
7 you know, find those beds that are out there and especially
8 in the rural areas where we don't have those treatment
9 facilities, inpatient treatment facilities in those
10 counties.
11 MR. TURNER: Well, absolutely. And that's where
12 I believe a regionalized approach really comes into play.
13 You know, SCA should no longer think that this is just my
14 county. We need to think regionally. We have a partner
15 with Lehigh Valley Health Network. They're located in
16 multiple counties, so I can't say that my work with the
17 Lehigh Valley Health Network or the hospital stops at the
18 border. But we also have the ability to learn from our
19 hospital partners because many individuals that are
20 languishing in the hospital system are more appropriate for
21 the substance use disorder treatment system, but because of
22 endocarditis or because of ambulatory issues our treatment
23 system will never accept them. So what would it look like
24 if we start identifying these patients sects, the pregnant
25 women, create a designated program for pregnant women,

1 okay? We did that. We just took care of 110 pregnant
2 women.
3 Now, what if we start licensing SNIFs, skilled
4 nursing facilities, for outpatient treatment, take the
5 endocarditis patient out of the hospital, put them in a
6 SNIF who only operates at 60 percent capacity, bring
7 treatment into that facility, and start leveraging the
8 ability of skilled nursing with treatment? Now we don't
9 need to rely -- put all of our eggs in that treatment bed
10 basket, but we are creating other competencies and
11 modalities that's going to strengthen our system across
12 because, remember, we're looking to maintain the balance of
13 that ecosystem. By putting all of our eggs in that one
14 treatment bed balance, we're still going to have an upright
15 system. We need to look at all of those opportunities. So
16 leveraging the abilities of skilled nursing, our hospital
17 partners, we're really seeing more of an impact and less of
18 a need to rely solely on those beds.
19 REPRESENTATIVE HEFFLEY: Just a couple of follow-
20 up questions. I think I have a couple minutes yet. The
21 PDMP is providing a lot of information to doctors. Would
22 it be beneficial if the PDMP could also identify nonfatal
23 overdoses if that was tracked in the PDMP? And also if
24 there was a form of a registry or availability for beds
25 listed in conjunction with the PDMP?

1 MR. TURNER: Can I jump in first? It's an
2 absolutely yes, but one of the missing populations in the
3 the PDMP is our veterans. So if you're receiving care
4 through the VA, the VA, federally, they do not endorse the
5 State's PDMP. So we have an outpatient veterans center in
6 Lehigh County. If the veteran is there receiving
7 medication through the Veterans Affairs association, it's
8 still able to access a community-based provider. That
9 community-based practitioner has no idea that that veteran
10 is receiving methadone for pain management.
11 REPRESENTATIVE HEFFLEY: Okay.
12 MR. TURNER: That veteran is not telling them.
13 They're able to then prescribe a double dose of methadone
14 in this instance because the Federal system will not
15 participate in the PDMP. So I think that's one of the
16 things we can begin rebalancing with this, especially with
17 the number of veterans that are in Pennsylvania. We need
18 to have that system fully automated, fully talking to each
19 other, fully integrated so doctors can then do their job
20 and really do the opioid stewardship reviews that they're
21 doing so well.
22 REPRESENTATIVE HEFFLEY: And that's why these
23 hearings are so important to pull that information out,
24 and I thank you for being here. I would just say, because
25 we're going to run up against the time, that I would ask

1 for everybody that was here today or that submitted
2 testimony if you could do markups on the bill and get that
3 information over to myself and Melanie with the Human
4 Services Committee so we can continue to have this
5 discussion and develop this legislation going forward. And
6 I thank you all for being here.
7 MS. BECK: Representative Heffley, can I make one
8 more outrageous comment before I let you go?
9 REPRESENTATIVE HEFFLEY: Sure.
10 MS. BECK: We're talking about money, and I very
11 much ring to what Angela Cruz said earlier. I just want
12 you to know that where there is litigation going on they
13 have found smoking guns from the opiate industry. There is
14 actually a profit-to-increase-dose-chart smoking gun. We
15 will increase our profits by X amount if you increase the
16 dosage of OxyContin. There's a profit-to-dose chart if you
17 want to see it in the middle of one of the lawsuits. You
18 want to look at that, if you're looking for funding for any
19 of these things, I think Angel Cruz is really onto
20 something.
21 REPRESENTATIVE HEFFLEY: And I think funding and
22 the resources is very critical, and I think it's something
23 that the Legislature over the last few years and coming out
24 of D.C. with this current administration has really stepped
25 up funding to a lot of these programs. And we can look for

1 other avenues as well, but I think we also need to make
2 sure that we're using every dollar that we spend to get the
3 biggest bang for the buck, and that's why I really wanted
4 to highlight the Blue Guardian program and how that links
5 -- it's like a connection. It's like a link in the chain.
6 It connects everything from the overdoses to the treatment
7 and everything else.
8 So thank you all for being here.
9 MAJORITY CHAIRMAN DIGIROLAMO: One more. We got
10 two minutes left, and I had a question for Deb Beck just
11 real quick, two minutes. Your membership, you represent
12 members who do residential, do outpatient, and MAT. If you
13 were king or queen of the world, in two minutes what are
14 the biggest problems that you see, and what would you like
15 to see the Legislature do to help people get into
16 treatment?
17 MS. BECK: I think I would die of the opportunity
18 first. Oh, man. I think we give out treatment of all
19 kinds like thin gruel to a starving child. That's got to
20 stop across the system. If we really gave a damn about
21 this problem, we would look at policy with that in mind and
22 look at the pain that not dealing with it causes oodles of
23 families and the cost. So I would open the doors to
24 treatment, floodgates. I'd put lots of resources in the
25 Department to make sure there's no rip-offs. But how do

1 you rip off treatment when people don't want to go? I
2 mean, this is insane.
3 We have set up edifices to keep people out of
4 treatment. It's time to take them down, open up the doors,
5 and let's get serious about this. If this was a smallpox
6 epidemic, we wouldn't be setting up these barriers. There
7 are barriers everywhere you look, insurance, Medicaid, not
8 enough beds. This is just crazy. I think we almost look
9 like we have an investment in not dealing with the problem.
10 It's like scary.
11 And at the same time you've got free market -- we
12 got the free market industry. I did believe in the free
13 market. It works. But what has happened, it has worked to
14 market these drugs in a way that drug dealers never have in
15 America. We have thousands of people sitting out there
16 with their brains sensitized to addiction, they're born in
17 withdrawal. We have created a problem. The good news is
18 we created it. It means we can fix it.
19 MAJORITY CHAIRMAN DIGIROLAMO: And Representative
20 Cruz touched on this because everything you talked about, I
21 mean, having additional money to try to take care of these
22 problems if it's law enforcement or treatment,
23 Representative Cruz mentioned it, make these drug companies
24 that created this mess come in to Pennsylvania and every
25 other State and help clean up the mess that they started

1 with these opiates. That's what we ought to be doing.

2 Okay. With that, I want to thank everybody for

3 being here, and this meeting of the Human Services

4 Committee is now adjourned. Thank you all very much.

5

6 (The hearing concluded at 10:59 a.m.)

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