COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE HEARING

STATE CAPITOL
HARRISBURG, PA

IRVIS OFFICE BUILDING
ROOM G-50

TUESDAY, APRIL 12, 2022
8:06 A.M.

PRESENTATION ON OPIOIDS IN THE COMMONWEALTH: LESSONS LEARNED AND NEXT STEPS

BEFORE:

HONORABLE KATHY L. RAPP, MAJORITY CHAIRMAN
HONORABLE TIMOTHY R. BONNER
HONORABLE VALERIE S. GAYDOS
HONORABLE KATE A. KLUNK
HONORABLE CLINT OWLETT
HONORABLE BRAD ROAE
HONORABLE PAUL SCHEMEL
HONORABLE TIM TWARDZIK
HONORABLE DAVID H. ZIMMERMAN
HONORABLE DAN FRANKEL, DEMOCRATIC CHAIRMAN
HONORABLE JESSICA BENHAM
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HONORABLE JASON DAWKINS
HONORABLE STEPHEN KINSEY
HONORABLE BRIDGET M. KOSIEROWSKI
HONORABLE BENJAMIN V. SANCHEZ

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania

I N D E X

TESTIFIERS

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

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REQUESTS FOR PRODUCTION OF INFORMATION

PAGE	LINE	DESCRIPTION
34	1-3	Medical marijuana program success/failure information
40	5-7	Cost specifics of naloxone
45	7-16	Drug use information

P R O C E E D I N G S

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MAJORITY CHAIRWOMAN RAPP: Good morning, members, ladies and gentlemen of the public, some of our testifiers are here as well. This is a hearing of the Pennsylvania House Health Committee.

At this time, just know that the meeting is being recorded, so please turn off your cell phones. And it's been quite a while since the Health Committee has had any type of hearing on the opioid issue.

I believe the last hearing that was held on opioids when my predecessor, Representative Matt Baker, was here. And it was a hearing where a lot of information was gathered regarding opioid use across the state. And, of course, with the COVID-19 hitting us all, it was sometimes difficult to schedule. And, of course, now we're hearing a lot of issues regarding opioids. I'm hearing about a couple drugs that I didn't even know about until they were brought to my attention. And I'm hearing also from news media that most of our deaths right now among certain age groups are because of opioid overdose.

So we're anxious to hear testimony today from our departments and others to share information with the committee so that we -- we don't always get the information that you have, all of your data and

information. So I appreciate very much our testifiers being here today, some within government and some who are not.

I'm just going to go ahead and invite the first panel to come up while Representative Frankel -- if you have some opening remarks, sir.

DEMOCRATIC CHAIRMAN FRANKEL: Thank you, Madam Chair.

And thank you to all the testifiers who are joining us today.

Over the past decade, we've taken incredible legislative and legal steps to combat the opioid epidemic. We've instituted a Prescription Drug Monitoring Program and seen a number of prescriptions and utilization of legal opioids reduce dramatically, with a 40 percent reduction in opioids dispensed at pharmacies between 2016 and 2021.

Meanwhile we've seen a corresponding increase in people seeking treatment, and we've worked as a state to make sure that treatment is available. We've instituted more oversight of recovery houses to regulate the quality of care. NARCAN is widely available for first responders, and almost 70,000 doses have been administered by EMS since January 2018, saving Pennsylvanians from overdose deaths. And just recently, the state extended

Medicaid postpartum for a full year so that moms who use treatment services can continue to receive them after birth, which supports both mother and infant.

But even with all these proactive policy steps, the situation is still daunting. Despite our efforts, annual overdose deaths have more than doubled since 2012, and the nature of substance use is changing.

Our most recent enhanced surveillance report shows that of the 2,000 opioid deaths that they tracked in 2021, more than 1,800 were attributable to fentanyl. We have a fentanyl epidemic. But we know that's also leading to increase in HIV and Hepatitis C. A study came out from the University of Pittsburgh just this month that about a third of people with opioid use disorder who gave birth were diagnosed with Hepatitis C that can be passed on to babies prenatally. There's clearly more work to do.

I look forward to hearing from the speakers today about how we can help people with substance use disorder to get and stay in treatment, help parents and infants get the best possible start, and how we, as policymakers, can help more Pennsylvanians be safe from death and disease linked to substance use.

Thank you, Madam Chair.

MAJORITY CHAIRWOMAN RAPP: Thank you,

Chairman Frankel. Thank you for that wonderful summary.

And at this point in time, our first panel is Jennifer Smith, who's the Secretary of Pennsylvania Department of Drug and Alcohol Programs; and Dr. Denise Johnson, who is our Pennsylvania Physician General. I don't have...

MS. SCOTTI: Roseanne Scotti, Department of Health.

MAJORITY CHAIRWOMAN RAPP: Okay. And when you speak, if you want to pull the microphones closer to you and you have to push the little button on the microphone to activate it.

So with all hearings now, people coming in to testify, we do have a new rule in the House that you are to be sworn in. So if you would please stand and raise your right hand, thank you.

Do you swear or affirm that the testimony you're about to give is true to the best of your knowledge, information, and belief?

If so, please indicate by saying "I do."

(Affirmative answers.)

JENNIFER SMITH, DENISE JOHNSON, M.D, FACOG, FACHE, ROSEANNE SCOTTI, called as witnesses, being duly sworn, testified as follows:

MAJORITY CHAIRWOMAN RAPP: Thank you. Thank you, ladies.

Secretary Smith, are you going first, ma'am?

SECRETARY SMITH: Yes.

MAJORITY CHAIRWOMAN RAPP: You may proceed.

SECRETARY SMITH: Thank you very much.

And I'm going to start by apologizing. It sounds a lot worse than it feels. I have seasonal allergies and lost my voice, so I'm going to talk really close to the microphone, but I'm sorry for people listening online. It might be painful for you.

Good morning. I am Jen Smith, Secretary for the Department of Drug and Alcohol Programs.

Thank you, Chairwoman Rapp, Chairman Frankel, and members of the House Health Committee, for this opportunity to speak to you today, or whisper.

It's my pleasure to speak on behalf of the Wolf Administration about Pennsylvania's opioid and addiction crisis and our efforts to combat overdose deaths.

The opioid crisis has had devastating impacts on individuals and families across Pennsylvania and our nation, hitting record numbers of overdoses in 2017. As a state, we responded swiftly and deliberately.

In January 2018, Governor Wolf took an unprecedented step to establish an opioid disaster declaration and combined 17 state agencies to combat the crisis.

As a result, my department, the Department of Drug and Alcohol Programs, has partnered with sister agencies to implement critical drug and alcohol prevention, rescue, treatment, and recovery programs. Before the COVID-19 pandemic hit, under Governor Wolf's leadership and utilizing the disaster declaration, we had made tremendous progress by lowering the overdose death rate 18 percent from the height of the opioid crisis in 2017.

Now as we near the ending of the COVID-19 pandemic, we understand the lasting behavioral health impacts that it has had for Pennsylvanians. The Wolf Administration is committed to continuing the fight to ensure all Pennsylvanians have access to necessary lifesaving resources.

After the expiration of Governor Wolf's emergency disaster declaration, my department took the lead in transitioning from the Opioid Command Center to the Interagency Substance Abuse Response Team, a new tool for collaborating across state government to combat the disease of addiction.

Evolving from the work of the Opioid

Command Center, this response team has shifted the Administration's focus from mainly opioids to all substance use disorders due to the increase of polysubstance abuse, stimulant use, and additional substance use disorders emerging in Pennsylvania.

During this transition, my department was able to reexamine the goals and format of the former group and move from meetings that included mostly informational-based presentations to action-based discussions related to policy, procedures, funding, and current events in the addiction landscape across the state.

Through the response team, we are conducting regional listening sessions across the Commonwealth to better understand the needs of each region in the aftermath of the pandemic. We are continually working to get naloxone into the hands of all Pennsylvanians. We are providing vital funding to local communities, and we're advocating for harm reduction strategies to minimize the negative consequences of drug use, save lives, and improve health outcomes while strengthening families and communities. I encourage you to review my written testimony to learn more about each of those initiatives.

Tragically, the co-occurring opioid

epidemic and COVID-19 pandemic resulted in Pennsylvania experiencing an overwhelming number of overdose deaths. According to the Pennsylvania Department of Health, 75 percent of the overdose deaths in Pennsylvania in 2020 involved fentanyl or fentanyl analogs. That number is alarming, and by contrast, has been consistently rising since 2017.

The rise of fentanyl in the illegal drug supply is one of the biggest concerns for individuals who use drugs. Fentanyl is undetectable through sight, taste, or smell. Unless a drug is tested, perhaps with a fentanyl test strip, it's nearly impossible for an individual to know if it has been laced with fentanyl.

According to various sources, we're hearing that fentanyl can be found in most heroin supplies, but also in some cocaine and methamphetamine supply streams.

We recently partnered with the Philadelphia DEA to raise awareness of the increase of fake prescription pills containing fentanyl. Criminal drug networks are mass producing fake pills and falsely as legitimate prescription pills to deceive the public.

Even more concerning, these fake prescription pills are widely accessible and often sold on social media and e-commerce platforms, making them available to anyone with a smartphone, most notably, our

youth.

And fentanyl is not the only danger out there. We know that drug supplies morph over time from mostly pure heroin in 2017 to fentanyl-laced heroin in 2020, and now the presence of a substance called xylazine. Xylazine is commonly used as an animal tranquilizer, and when used by humans, causes their respiratory system to be depressed. The results of xylazine cannot be reversed by naloxone the way that opioids can.

These dangerous substances are rapidly being introduced, and they constantly impact our ability and efforts to respond and save lives. As a department, we will continue to evaluate these emerging trends and work collaboratively with others at the state and local levels to direct resources where they're needed most.

Recent years have been marked by both progress and setbacks. While the setbacks can be difficult to digest, they have revealed new challenges and exposed how critical drug and alcohol prevention, treatment, and recovery programs are to the health and well-being of fellow Pennsylvanians.

That said, I would like to highlight some of the successes that we've seen across the drug and alcohol landscape.

We're assisting more Pennsylvanians than

ever in accessing treatment. In 2020 alone, we referred almost 12,500 callers to substance use disorder providers through our GET HELP NOW Hotline for a total of 38,000 referrals since 2016. The hotline has increased intakes from 40 percent in 2016 to 65 percent in 2021, indicating that more calls are resulting in connections to treatment and resources than ever before.

Additionally, in the coming months, we'll be announcing the launch of the Addiction Treatment Locator, Assessment, and Standards Platform, also known as ATLAS. This free tool will connect Pennsylvanians in need with appropriate high quality drug and alcohol treatment. We're continuing to increase access to awareness and distribution of life-saving naloxone, as the chairman mentioned in his opening remarks.

Since November of 2017, centralized coordinating entities across the state have distributed more than 130,000 kits of NARCAN. The Pennsylvania Commission on Crime and Delinquency distributed almost 55,000 additional kits of NARCAN directly to organizations serving high-need communities through its statewide portal. Using this state-purchased naloxone, more than 20,000 overdose reversals have been reported, more than 20,000 lives saved.

We're also aiding Pennsylvania in recovery

from the disease of addiction through the establishment of our recovery house licensure process. We're helping to ensure safe housing for individuals at an incredibly vulnerable time in their lives. As of this week, we have four licensed recovery houses and have received 30 additional applications for review. In the last state fiscal year alone, we awarded more than $8 million to various recovery community organizations to provide supportive services to individuals in recovery.

And we completed phase one of a project called Recovery Rising, which is an initiative to foster a resilient, diverse, and accessible recovery environment in Pennsylvania. Through that phase, we prioritized eight key areas on which the Commonwealth should focus to embed and expand recovery support services across the state. We are just beginning phase two which begins the first three priorities on that list of eight. We are also directly connecting more Pennsylvanians to treatment through our warm handoff process.

Since January of '17, warm handoff programs have been implemented in 160 Pennsylvania hospitals, accounting for over 95 percent of the total hospitals in the state. Through these programs, more than 24,000 individuals have been directly referred to treatment. A total of 6,931 warm handoff encounters took place across

these hospitals from January 2021 to April of last year alone.

Lastly, we are reducing barriers to treatment by combating the stigma still too often felt by individuals living with this disease. In the first year of our Life Unites Us campaign, we positively influenced public perception of treatment availability and the effectiveness. We also increased awareness about opioid use disorder as a disease and supported local treatment centers and harm reduction strategies.

I'd like to conclude my remarks today by offering that overdose death statistics that you heard from me, and likely will hear from others, are not just numbers; they are people. They represent faces and families that have been affected by a preventable medical disease. The numbers are an important part of understanding the issue that we are grappling with, but they do not tell the whole story. To know the whole story means you must mourn for those who have been lost, grieve with the ones left behind, embrace those still struggling, support those who have reached out and are receiving help, and celebrate those who have found recovery. Don't allow your knowledge of this disease to be reduced to numbers. Allow it to be about people and the hope that can come from recovery.

On behalf of my department, thank you so much for asking me to speak with you today. I look forward to continuing to collaborate with you to reduce the impact of the addiction crisis on Pennsylvania.

Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Secretary Smith.

And our next testifier is Dr. Johnson.

Dr. Johnson, before you proceed, I'd like to have the members go around and introduce themselves, starting with Representative Kinsey, please.

REPRESENTATIVE KINSEY: Good morning and welcome. I'm Representative Kinsey from Philadelphia County.

REPRESENTATIVE TWARDZIK: Representative Tim Twardzik, Schuylkill County, 123rd.

REPRESENTATIVE SCHEMEL: Paul Schemel from Franklin County.

REPRESENTATIVE ROAE: Good morning, Representative Brad Roae, parts of Crawford County and parts of Erie County.

REPRESENTATIVE ZIMMERMAN: Good morning, Representative Dave Zimmerman, northeast Lancaster County.

REPRESENTATIVE BONNER: Good morning, Representative Tim Bonner from Mercer and Butler Counties.

REPRESENTATIVE CEPHAS: Good morning, Representative Cephas from Philadelphia County.

REPRESENTATIVE DAWKINS: Good morning, Representative Jason Dawkins, Chairman of the Philadelphia Delegation.

REPRESENTATIVE SANCHEZ: Good morning, Ben Sanchez from Montgomery County.

DEMOCRATIC CHAIRMAN FRANKEL: Representative Dan Frankel, Allegheny County, city of Pittsburgh.

MAJORITY CHAIRWOMAN RAPP: Representative Kathy Rapp.

And with us virtually, we have Representative Valerie Gaydos and Representative Jessica Benham.

So thank you, members, for being here. I know it's an early morning, but we -- I thought we would have a lot to cover today, and we do. So I appreciate all of the testifiers who -- and members who -- came early to be with us.

So at this point, Dr. Johnson, you may proceed.

PHYSICIAN GENERAL JOHNSON: Great.

Good morning, Chairman Rapp -- Chairwoman Rapp and Chairman Franklin -- Frankel.

Thank you, House Health Committee, for

inviting me today to discuss other strategies to address the opioid epidemic.

As you've heard from Secretary Smith, this has been a devastating crisis for our Commonwealth and the COVID pandemic has made things even worse. Pennsylvania has made great gains addressing this epidemic, but we've had quite a setback with the pandemic.

We have to use every tool in our toolbox to address this crisis. As all of you know, many of us have been affected by a loved one or friends who have lost their lives due to drug overdose. These individuals do have an illness, and we want to make sure that they stay alive and have access to treatment so that they can realize the recovery. So we have to use every tool that we have.

And Secretary Smith talked about all the great work that DDAP is doing to address this epidemic, but there's still more that we can do. A few of the strategies that have been proven in many areas are harm reduction strategies. One of them, as you've heard, is fentanyl test strips.

So fentanyl, as you've heard, is contributing to a lot of the overdoses that we're seeing. It's also contained in a lot of the drug supply, and you can't detect it by taste or smell or other means like

that. So the fentanyl test strips are some small strips of paper that cost about a dollar. Individuals who use drugs can dissolve a small amount of the drug that is being used in water and test for the presence of fentanyl. We know from many studies that individuals, if they knew that there was fentanyl in their drugs, might not use at all, some might use less, or some might use in the presence of others. In any account, we can prevent overdoses and give that individual one more opportunity to survive and to enter treatment.

Many states have decriminalized fentanyl test strips, and the federal government does also help to fund these harm reduction strategies when that legislation has been passed in states. A diverse number of states are also taking on these strategies.

Another harm reduction strategy are the syringe services programs. Syringe services are public health services where individuals can return used syringes and receive clean syringes. We know from more than 30 years of operations of these facilities that these programs do save lives. They prevent overdoses. Individuals who use these services are five times more likely to enter treatment, and that's what we want. We want people to survive and have the opportunity to enter treatment and then realize recovery.

We also know that using contaminated needles increases our risk for Hepatitis and HIV. And we have seen that utilizing these programs can decrease the risk of Hepatitis and HIV by 50 percent. We also know that removing these contaminated needles from the surroundings can help to protect first responders. We also know that preventing these diseases, Hepatitis, HIV, also saves money.

There has been a recent study that shows that in Philadelphia, over 10 years of utilizing these syringe services programs, they were able to decrease HIV and Hepatitis and save up to $2.4 billion over 10 years.

We know that individuals who use drugs are deserving of our care and compassion. We need to use every tool in the toolbox to make sure that they have an opportunity to survive, but also to access treatment and recovery. And these strategies can help with that.

A diverse number of states have syringe services programs, and I believe at this point, Pennsylvania is one of only 10 states that don't. Both the Biden and Trump Administration have recognized the importance of these programs and have strongly supported them.

We know that syringe services programs, again, will save lives and help to preserve the health of

individuals. And at the Department of Health, we strongly support these programs.

My testimony has been submitted, but I would be happy to answer any questions that you might have.

Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor, for your testimony.

Did you have any comments, ma'am?

MS. SCOTTI: I did not have prepared testimony, Chairwoman. I'm here for any technical questions around syringe service programs or other harm reduction.

MAJORITY CHAIRWOMAN RAPP: All right. Thank you so much.

I do believe we have some questions from members. I believe Representative Brad Roae has a question.

REPRESENTATIVE ROAE: Thank you, Madam Chairwoman.

It's actually a question for both Secretary Smith and Dr. Johnson.

Fentanyl does seem to be a really, really big problem, and it seems like reducing the amount of fentanyl out there would help. That area that's in the

vicinity of Mexico and the United States -- I hesitate to call it a border because a border implies, you know, it's hard to get from one side to the other. You know, anybody can go across the southern border just as easily as any of us could walk across this room right now. And it's well documented a lot of fentanyl is coming into the country from the southern border.

Have your departments considered writing a letter to the Biden Administration asking them to better secure the border to help reduce the flow of fentanyl coming into the country? I mean, in addition to all the other good things you're thinking about doing and doing to ease the crisis a little bit. If we reduce the amount of fentanyl, that would help.

Have you considered contacting the Administration to ask them to secure the border to prevent as much illegal fentanyl from coming in?

SECRETARY SMITH: So apologize again for the voice, so we are not the experts on how the supply of drugs flow. We get information from different entities that advise us.

You're actually going to hear from a great expert next. Jerry Daley is on the phone. He's a part of panel two. He is going to be able to talk to you all about where they see the supplies coming from, whether

it's being manufactured in the United States, whether it's being shipped in. And really, the last time I had heard from him, it's really coming from a lot of different sources. It's not just coming over the borders. It's also being sent through the mail.

It is just so readily, easily available even within our own United States that it doesn't necessarily mean if we close off a border that it's going to fix the problem. Drug users are very resourceful individuals, and particularly, synthetic opioids that can be manufactured, they will find ways to manufacture them regardless of whether they have them shipped in from another country or not.

So that's why it's really important that we look at addressing this from lots and lots of different perspectives. So we've got law enforcement entities working on, sort of, that supply chain issue, and then we've got folks, like Dr. Johnson and I, working on the prevention, intervention, treatment, and recovery support strategies.

REPRESENTATIVE ROAE: Yeah. Those are good points.

I guess what my point is there's no single thing that's going to prevent this crisis that's going on, but if we can, you know, treat some people, get them to

stop using heroin that might be laced with fentanyl, if we could close the border to prevent that source of fentanyl coming in, if we could arrest people that are manufacturing fentanyl in Pennsylvania, if we can -- you know, doing multiple different things, we can chip away at the problem. I don't think one single thing would solve the problem. But I think, you know, securing that border would really go a long way.

And I would hope that the administration of all 50 states would ask the President to secure the border just to help reduce the flow of fentanyl into the country.

Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

The next question we have is from Chairman Frankel.

DEMOCRATIC CHAIRMAN FRANKEL: Thank you.

Thank you for your testimony.

I must say, you know, one of the things that I find disturbing is the fact that we lag so far behind on these harm reduction strategies, and I would hope that maybe, you know -- we have legislation that's sitting in our committee and other committees to move forward with some of that stuff, particularly as other -- we're an outlier, not kind of, you know, leading the way

here.

But one of the other problems that I understand is that there is kind of constraints around providers providing medically assisted treatment. And so I'm curious, are you seeing, you know, this as an issue? And what other barriers there might be to seeking medically assisted treatment?

PHYSICIAN GENERAL JOHNSON: Sure. Thank you, Chairman.

SECRETARY SMITH: You can start.

PHYSICIAN GENERAL JOHNSON: I can start, and I think Secretary Smith has quite a bit to add.

Certainly, Secretary Smith talked about the stigma. So there is a huge stigma associated with people who use drugs but also accessing treatment. And so many individuals are reluctant to seek treatment because they don't want to be identified, but also they're afraid of the way that they would be treated. So the Department of Drug and Alcohol Programs has done a lot of work to address this stigma.

We also do need to help to recruit providers by training them how to administer medication-assisted treatment. So not everyone is educated or empowered to do this. And so there has been a lot of work to make sure that providers understand how to

administer this treatment and that they're enrolled to be able to provide it.

So expanding providers who are knowledgeable and who are able to treat, those are strategies that we're involved in as well.

And Secretary Smith?

SECRETARY SMITH: Yeah, I'll add to that.

We've done a lot of work in this space over the last five years to improve access to medication-assisted treatment.

And just, you know, so everyone is clear, medication-assisted treatment that we're referring to is specifically for individuals with opioid use disorder. So it would not necessarily apply to individuals with a stimulant use disorder, okay? So this is for opioid use disorder.

Some of the things we've done, we contract with what are called Single County Authorities. Those are local entities that receive our dollars and federal dollars to pay for the under/uninsured populations in their counties. We have a grant agreement with them and impose certain requirements on them in order to receive those funds. So several years ago, we instituted a requirement that they contract with providers who offer these medication-assisted treatment therapies.

We also worked with the Department of Health several years ago to establish what are called PacMAT programs which stands for Pennsylvania Coordinated Medication-Assisted Treatment. These are "hub and spoke modeled" programs where you have, for example, primary care physicians at the spokes who might have patients that might have a substance use disorder. They're not experts in treating addiction, so they work closely with an addiction medicine specialist located within the hub of that network to consult with in order to prescribe the appropriate medications and get those patients connected to treatment. So we've expanded services to thousands of Pennsylvanians through that model alone.

We've also worked with our Department of Corrections to ensure that individuals in the state correctional facilities have access to those medications. So if an individual is on the medication before they enter the system, they're permitted to continue and able to continue those medications. And for those that enter the criminal justice system and are determined to have a substance use disorder, they are offered those services as part of their treatment regimen. So we've taken a number of steps to expand how many providers offer this service and to really center on the fact that it is a gold standard of care for individuals with opioid use disorder.

With that said, we still have some work to do, particularly at the county criminal justice level. There are a number of judges, probation officers who will not allow their clients to be on medication-assisted treatment because they don't understand that it's a medication and not a drug that feeds their substance use disorder. So there was recently a letter from the Department of Justice specifically to Pennsylvania sort of calling us out, talking about the need for our court systems to embrace medication as an acceptable mechanism for the treatment of opioid use disorder.

So we still have some work to do there.

DEMOCRATIC CHAIRMAN FRANKEL: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you.

I have just one quick question, then I'll go back to the members.

We have two bills in the Health Committee that address two drugs that we're totally unfamiliar with -- well, I am and several of the members. One is kratom and the other is psilocybin.

I'm a little familiar with psilocybin because there was a case in Venango County --

SECRETARY SMITH: Okay.

MAJORITY CHAIRWOMAN RAPP: -- where there was a person who was actually killed because he was so high

on psilocybin that he was just totally out of control.

Is your agency looking at those two drugs?

Kratom, I've seen, is now a component in some of the vaping devices, and it's openly advertised in vaping devices.

Can you tell us a little bit about those two drugs?

SECRETARY SMITH: I can tell you a little bit about kratom. I'm not familiar with the other substance.

MAJORITY CHAIRWOMAN RAPP: It's magic mushrooms is basically what it is.

SECRETARY SMITH: Okay. So in terms of kratom, kratom is unregulated. It is marketed as a natural herbal substance that individuals could take to assist with pain, anxiety, depression, all kinds of issues. And it is marketed as sort of a natural supplement.

And so there is a number of people across the state who are beginning to use this substance in ways that, perhaps, it wasn't intended to be used. Because it's not a regulated substance, there really is no way for us to control the appropriate or inappropriate use of the substance aside from educating people.

So we have begun to do that. We have put together some materials. We have been sharing some things

on social media specifically about the potential dangers. Because it's not regulated, there are still some safe uses for it. But when you're using it in combination with certain substances or in excess, it can be very dangerous.

So certainly would be happy to partner with you on reviewing some language that you have.

MAJORITY CHAIRWOMAN RAPP: Thank you, Madam Secretary.

Our next question is from Representative Paul Schemel.

REPRESENTATIVE SCHEMEL: Thank you, Madam Chair.

In the previous hearing that we had on this, which has been a number of years ago, as sort of -- we were beginning to learn the parameters of the opioid epidemic. It seems as though the genesis, at least of a number of the cases of addiction, came from individuals who really sought pain relief from back pain, were given prescriptions to opioids, and those spiraled out of control.

So I have just a few questions on that and where we are today. And I've seen that in my own community, with people I know and constituents.

First, are we seeing a difference in the way physicians prescribe? So although we're still trying

to deal with a number of people who have an opioid addiction, do we believe that the number of new individuals becoming addicted through prescription drugs, you know, through regular prescriptions, is on the decrease?

PHYSICIAN GENERAL JOHNSON: Secretary Smith will have some numbers for you, but we certainly have seen a significant decrease in prescribing narcotics. We have seen a decrease in the amount of opioids people are getting, the length of time that they're getting the opioids, as well as multiple prescriptions and prescriptions from multiple providers. So the work that Pennsylvania has done has made a significant impact there.

We still are doing work in terms of making sure that individuals who have their pain appropriately treated with opioids get the treatment that they need. And so that work is ongoing to make sure that providers are educated, that individuals are educated as well. But we have made a significant impact in decreasing those large quantities and extended periods of opioid prescriptions.

SECRETARY SMITH: And I'll plug Dr. Johnson's department. They have a wonderful dashboard on their website where you can actually look at all that information county by county or at a state level.

In terms of overall opioid prescribing, that's dropped. The last I looked, it was 37 percent since we instituted the Prescription Drug Monitoring Program. If you look specifically at high dosage opioids, those have dropped, I think it was 47 percent. It was right around the 50 percent mark.

So certainly we see the prescribing dropping. And folks from the Department of Health do a great job of monitoring, even at a detailed level where they see prescribers with unusual habits. You know, if they had been traditionally low prescribing and they see big jumps, they will do outreach and discuss specifically with those providers.

So I do believe we're seeing fewer numbers of individuals becoming dependent on opioids through the prescription drug process. Excuse me.

REPRESENTATIVE SCHEMEL: All right. Thank you.

At the same time, the medical marijuana program was introduced as a means of also sort of combating opioid addiction as a much milder and less addictive product for dealing with pain.

Do we have any hard data on the program success or failure of it, and meeting the needs of folks that have chronic pain without the use of opioids?

PHYSICIAN GENERAL JOHNSON: I don't specifically know if we have that data, but that's something that we could take back to the program to let you know what information we do have, specifically the medical marijuana for individuals with opioid use disorder are people who have been refractory to treatment with other means. But we could get you more specific information.

I don't know how much we have on that population.

REPRESENTATIVE SCHEMEL: Okay. Thank you, all.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

Thank you, Dr. Johnson.

Our next question comes from Representative Kinsey.

REPRESENTATIVE KINSEY: Thank you, Madam Chair.

And good morning, again.

Secretary Smith, a few minutes ago you talked about services that were offered to individuals who were incarcerated. I think I read somewhere that about 10 percent of those individuals who are leaving facilities die from a drug overdose as well.

So is there a continuum outside of the

prison walls that allow for these individuals to receive services as well?

SECRETARY SMITH: Yeah. Generally speaking, what happens -- and this is something that happens really at the county level -- is our Single County Authorities, those folks I was mentioning to you earlier that receive dollars from us, in addition to receiving funding, they also have a responsibility to do a needs assessment and strategic plan for each of the counties that they oversee. And that includes identifying where there are gaps in the system at any part of the continuum, and that would include working with criminal justice.

So what happens in most cases is those counties develop programs either where they have individuals that go into the county jails and work with individuals prior to release, or they have places for individuals after they've been released to connect to either treatment resources, if they need housing services, if they need connection to other medical care.

So it happens at a county level. I would say most SCAs have some process for doing that, but some do a much better job than others.

REPRESENTATIVE KINSEY: Great. Thank you for sharing that.

And, Dr. Johnson, just quickly, I think

you've talked about the stigma that, sort of, the individuals might feel or have, you know, once they are entered into a program. Do you have a standing order for naloxone, I believe?

PHYSICIAN GENERAL JOHNSON: Correct.

REPRESENTATIVE KINSEY: What's the process for individuals -- and I'm thinking somebody who might have been addicted, they don't want to have the stigma, but what is the process in regards to the standing order?

Because I think I read in your testimony that any individual is able and encouraged to obtain naloxone at their local pharmacy.

Is a prescription needed, or how do they go about getting naloxone at their local pharmacy?

PHYSICIAN GENERAL JOHNSON: Yeah. So there are many ways to get naloxone, and one of them is utilizing the standing order.

So the standing order is available through our website. You can print it out or show it on your smartphone and take it to the pharmacy, and so you don't need an additional prescription. That is a prescription that will allow you to get naloxone at any pharmacy.

Secretary Smith also mentioned that you can get naloxone in the state by delivery. So you can get home delivery of naloxone.

And many first responders also offer leave back naloxone. So when they have responded to an emergency and there are individuals at risk, they have the ability to leave naloxone. And we also have some individual groups that are distributing naloxone. We also recommend dispensing or giving naloxone at emergency departments when individuals leave, people who might be at risk.

So many areas to get it, but you don't need to get a different prescription. You can get it from the website for the pharmacy.

REPRESENTATIVE KINSEY: Okay. Thank you, both.

Thank you, Madam Chair.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

Our next question comes from Representative Zimmerman.

REPRESENTATIVE ZIMMERMAN: Good morning and thanks for the testimony.

So I'd like to hear just a little bit more on naloxone. So is it used as an injectable or is it the nasal spray or both? What are the costs? How much has the department put into, invested in our state in that? And who's actually getting it, our emergency responders,

is it fire companies, police? Who ends up getting it?

SECRETARY SMITH: Let me start? Okay.

So naloxone actually comes in three different forms. One is an injectable form. It looks like a syringe, and it can come with an atomizer, which is a little piece that you can put on top of the syringe to make it usable for nasal purposes. Then there is what is called an auto-injector which operates more like an EpiPen kind of situation, where you would put the device against the skin and a needle is injected from the device. And then the third version, which is the version that the state dollars are being used to fund for the free naloxone, that is the nasal version, and it looks just like a Flonase or an allergy nasal spray. You simply depress the device into the nostril, very easy to use, very safe.

In terms of the methods that Dr. Johnson was mentioning around the standing order, that's one way to obtain naloxone from the pharmacy. There are other ways that we have from a state perspective where you can request dosages from the Pennsylvania Commission on Crime and Delinquency to distribute those to different entities across the counties. And we have a website called NEXT Distro which allows any member of the public to go to the website, look at a brief training video, answer a

question, and then input their mailing address and naloxone will come free of charge directly to your home.

So we have distributed through the statewide distribution over 220,000 kits of NARCAN. The state pays $75 per kit, and the kit includes two doses. The doses are four milligram doses each.

Currently there is only one manufacturer of that four-milligram nasal spray, so that's why we have a contract with one entity. We are hearing that there are more generic products coming to the market soon. So perhaps that will help improve some of the cost and the prices.

In terms of folks who present with the standing order at a pharmacy, they may have to pay some kind of co-pay in order to receive the naloxone. So we are working on a program that would pay for the co-pay portion so the individual could also present at a pharmacy and receive free naloxone.

Does that -- did I get your questions? I can't remember them all.

REPRESENTATIVE ZIMMERMAN: Yeah. I'd like to hear just a little more on cost as well. That's very good information.

SECRETARY SMITH: So I can get you -- I don't have it with me, the exact amount of money we've

spent over the last few years. We have it readily accessible, I just don't have it with me.

Most of it we have used with federal -- it's all been federal grant dollars, but some of it has come from different federal grants. It's in the millions of dollars, though, that we have spent on naloxone distribution over the last three years.

REPRESENTATIVE ZIMMERMAN: Yeah, if that's available and if you could get that to our chairman --

SECRETARY SMITH: Yeah, I'd be happy to.

REPRESENTATIVE ZIMMERMAN: -- that would be wonderful.

So I just want to also just comment, I have friends and family that are involved with, as EMTs and so forth. And what they've become very concerned about is that so many that, you know, they treat with this product, within days or weeks they're back doing the same thing.

And is there anything being done or can be done?

SECRETARY SMITH: Yeah --

PHYSICIAN GENERAL JOHNSON: Well --

SECRETARY SMITH: Doesn't matter.

PHYSICIAN GENERAL JOHNSON: Thank you. I would just like to make a comment on that.

Certainly individuals who are revived after

a possible overdose can be at risk again, but it's the same as with any medical condition. So an individual who has diabetes and their blood sugar goes high or low, we continue to provide treatment until they can get that under better control.

And so we really need to think with compassion for individuals who use drugs in the same way, that one episode will not necessarily prevent them from having another one until we get them into treatment and recovery. So, yes, it's expected for individuals to be at risk still after one episode, but our job is to support them until they're ready to realize recovery.

SECRETARY SMITH: And if I may just add to that. To your question of, is there something that can be done, there are some things we can do.

So there are some counties who use the warm hand-off process even with their EMS first responders, so not just at the hospital, but also with police or EMS. And what that does is connects the overdose survivor directly with someone who has lived addiction experience, so a person who has a substance use disorder themselves but is in recovery. And we find tremendous success in those kinds of models, in being able to convince the overdose survivor to either go to the emergency room for further treatment or to be connected to resources. And

sometimes that doesn't happen the same day or immediately. Sometimes a week will pass and the person will reach back out and say, "Hey, you know, I've been giving this some thought, can you connect me somewhere?"

So we do know some models that have more success, but I don't think we'll ever get to a place where we'll have a 100 percent success rate in getting people connected to treatment right away.

REPRESENTATIVE ZIMMERMAN: Thank you, very informative.

Thank you, Madam Chair.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

We have time for two more questions, Representative Dawkins.

REPRESENTATIVE DAWKINS: Thank you, Madam Chair.

Quick question, I want to talk a little bit about the evolution of addiction and the drug use, the uses that we are seeing around addiction.

Can you talk a little bit about the increase of synthetics and how they have replaced traditional measures of getting high?

So, you know, in the 80s you had the crack epidemic. You move that into cocaine and then you move

that into -- so now we're at the point of synthetics, where fentanyl and synthetic opioids is now the choice that most folks go to.

Can we talk a little bit about the increase of opioids, synthetic opioids, and fentanyl in terms of the death rate and the user rate and what that looks like? Like a snapshot, so we can kind of see, almost a grid or a graph to see, are we trending in the right direction or the wrong direction as it pertains to addiction?

SECRETARY SMITH: Yeah. That's a great question.

And the first point you made really sums it up, right? Drug use is cyclical. And when you look at it over long periods of time, not just over the last five years, but over decades of time, you see that it moves in cycles. And we certainly see that now. It also differs based on the geography. So even within Pennsylvania, you can't simply say, "We have a fentanyl problem," because that's not true.

There are parts of northeastern Pennsylvania where methamphetamines rule the day and they see very little opioid use disorder.

And so that's why part of treating this disease is so very difficult because the treatment methods for each substance use disorder can be very different.

The substances that they're using are different. And so the ways that we attack the supply issues are different, the way we address treatment issues are different. And that's really challenging for us in Pennsylvania.

I think you're going to be really impressed with what you hear from a data perspective from Jerry Daley in the next panel. He's going to talk at length about the trends in drug use and where these supplies are coming from. So he has much better information than I do.

What I can tell you is that -- and we found this with the prescription opioid issue that the Representative mentioned earlier, when you turn off the spigot in one area, they simply turn on a spigot in another area. So, you know, this isn't about just addressing prescription opioids or just addressing opioids or drugs coming in from other countries, it's really an all hands on deck, you have to try to turn all the faucets at the same time. And that's really, really difficult.

Law enforcement doesn't have the bandwidth to do all of that, like we don't always have the bandwidth for all the treatment needs that exist in every part of the state.

So it really is a big challenge. If you don't get the information that you're looking for, kind of specifically with numbers from Jerry, he and I will work

together to get that information for you.

REPRESENTATIVE DAWKINS: Thank you.

So for both you and Jerry, this is just something you can kind of jot down and you can send to the committee, is if you have that data broken out per capita of every county of where we have the highest concentration of drug use, what's the drug of choice in those different counties. And if you can break it down by demographic -- race, age, et cetera -- I think that will be really helpful for the members of this committee and also the members of the House to really get a true snapshot on what addiction looks like.

Because addiction doesn't have a race, it doesn't have a certain location where it's more prevalent than others. I think this is how we start the conversation of how do we fix this issue, because we have lost the -- arrest our way out of this situation, of addiction, that's never going to work. So we have to come up with new solutions. And I think this will, at least, provide the data to, like, have informed, driven legislation coming out of this.

So thank you.

SECRETARY SMITH: Yeah. We'll see what we can do to get to you.

MAJORITY CHAIRWOMAN RAPP: Thank you.

Our last question before we move on to our next testifier is from Representative Twardzik.

REPRESENTATIVE TWARDZIK: Thank you, Madam Chair.

Thank you for coming. It's been very informative.

You talked about faucets, and it's come to my attention that businesses are offering Groupon discounts for various items, including consultations for medical marijuana cards, consultations for medical marijuana cards with diagnosis, and renewals of medical marijuana cards.

Has the department looked at these providers to ensure that they are following the parameters of the law, such as the patient is under the practitioner's continuing care, accurate medical records are being kept, the Prescription Drug Monitoring Program is being accessed?

SECRETARY SMITH: I think this falls under your purview, I'm sorry.

PHYSICIAN GENERAL JOHNSON: Thank you for that question.

Yes. We certainly are concerned to make sure that patients are getting appropriately diagnosed and treated, and treated according to the regulations and

parameters.

I know that the medical marijuana program does have specific criteria for certifying physicians. And so there are criteria that need to be met for individuals to be certified, which does require ongoing monitoring and supervision.

REPRESENTATIVE TWARDZIK: Okay. So someone is checking into these medical marijuana providers that are going through Groupon offering discount coupons to gather more customers?

PHYSICIAN GENERAL JOHNSON: So they're individual requirements for each prescriber who would be certifying individuals. Yes.

REPRESENTATIVE TWARDZIK: Okay. Thank you.

PHYSICIAN GENERAL JOHNSON: Yes.

MAJORITY CHAIRWOMAN RAPP: Thank you, ladies, very much for your information.

As we continue to look at, especially the fentanyl crisis that we're hearing about and all the other issues, we have a lot more questions but no time right now to gather answers from you.

But thank you for being here so early in the morning. I truly appreciate it, and so do the members of the Health Committee.

So thank you very much.

SECRETARY SMITH: Thanks for having us.

MAJORITY CHAIRWOMAN RAPP: I wanted to recognize, before I introduce our next testifier, Representative Kosierowski and Representative Bonner. Thank you for being here, members.

Our next testifier is Jeremiah Daley who is the executive director of Liberty Mid-Atlantic High Intensity Drug Trafficking Area.

Jeremiah, Mr. Daley, you are with us remotely. Even so, sir, could you please raise your right hand?

Do you swear or affirm that the testimony you're about to give is true to the best of your knowledge, information, and belief?

If so, please indicate by saying "I do."

MR. DALEY: I do.

JEREMIAH DALEY, called as a witness, being duly sworn, testified as follows:

MAJORITY CHAIRWOMAN RAPP: Thank you, sir, and thank you for being with us today. And you may proceed, sir.

MR. DALEY: Good morning, Chairwoman Rapp and Chairman Frankel, members of the committee.

As stated, I'm Jeremiah Daley and I am the executive director of the Liberty Mid-Atlantic High Intensity Drug Trafficking Area, or HIDTA program, which is a program of the Office of National Drug Control Policy. We're one of 33 HIDTAs around the country and one of two that have responsibilities for portions of Pennsylvania.

There's five HIDTA counties that are designated in southeastern Pennsylvania, which is our area of responsibility -- Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties, along with four other counties in New Jersey and Delaware. The Ohio HIDTA, based in Cleveland, has five counties in western Pennsylvania, Allegheny, Beaver, Erie, Washington, and Westmoreland.

And all of our missions are to disrupt the market for illegal drugs by dismantling drug trafficking organizations, money laundering organizations, and addressing some of the consequences of drug trafficking, including drug-related violence.

So to do this, we provide mission critical resources to law enforcement agencies who actually do the investigations in specialized multiagency task forces. We provide intelligence support and specialized training to them as well. We have an information sharing network and data systems that facilitate the advancement of

investigations to disrupt and dismantle these drug trafficking organizations. And we draw from many law enforcement agencies throughout our regions. Federal, state, and local agencies are involved in our drug enforcement task forces.

Beyond that, though, we also have an overdose response strategy that we participate in, in which we provide a drug intelligence officer and a public health analyst from the Centers for Disease Control Foundation. We work across the Commonwealth with agencies like Secretary Smith, the Department of Drug and Alcohol Programs, the Physician General Johnson's Department of Health, county and local health and prevention and treatment agencies to identify what are some of the better practices and promising strategies that may address the terrible toll of overdose deaths in the Commonwealth.

Our HIDTA program is proud to partner with these agencies and organizations, and we want to, you know, emphasize, I guess, that this is truly a partnership between public safety and public health that would make the difference in how we respond to the overdose crisis.

I'm going to focus my testimony mostly on the supply side of the controlled substance issue and how they're coming into Pennsylvania communities.

Opioids, of course, is the topic of this

committee's hearing today. But we have to look at some of their close cousins, the novel psychoactive substances that are appearing from time to time, as well as the stimulants that were mentioned earlier, cocaine and methamphetamine being the most prominent among them. Let's recognize up front exactly how great of a toll all of these substances are taking.

The CDC estimates that 105,000 or more Americans died over the last 12-month period studied between October 1st of 2020 and September 30th of 2021, and a 16 percent increase over the same period one year earlier. Pennsylvania which -- in Pennsylvania, the CDC projects over 5,500 deaths during that same period.

This is an enormous loss of life. And primarily, the synthetic opioid classes, fentanyl and fentanyl-related substances, account for nearly three-quarters of these fatalities.

The voluminous flow of fentanyl and fentanyl-related substances into the United States is increasing steadily. The United States Customs and Border Protection seized over 16,600 pounds of heroin and fentanyl at our nation's borders, whether at the ports of entry along the southwest border or in places like the New York JFK Airport mail sorting center or other places where drugs may come into the country. That's a 282 percent

increase from fiscal year 2017, so the problem is escalating in a very significant way.

But even for all those drugs seized, they represent only a fraction of the deadly substances that made it past our borders and into the drug marketplaces of the United States, including in Pennsylvania.

This incredible proliferation is coming in waves, I guess is the best way of describing it. At first it was the prescription opioid pain medications that were dispensed for therapeutic use, but too often diverted for nonmedical consumption that began in the 1990s, what I call the first wave of this opioid crisis. That allowed what was a somewhat localized problem with heroin, that began a quarter century before, to explode into a statewide heroin crisis, the second wave of the opioid crisis.

That wave took thousands of Pennsylvanian lives itself but has only gotten worse, as if pouring gasoline onto a fire, with the introduction of fentanyl and fentanyl-related substances to the illicit drug market beginning in about 2016. That became the third wave. And during that time period, these substances, which are 50 to 100 times as potent as morphine is, became the drug of choice in the marketplace. A few grades of fentanyl and fentanyl-related substances, like carfentanil, can kill a

person who is opioid naive.

When we get now into the last few years, particularly since the beginning of the pandemic, we've entered what I term the fourth wave. The fourth wave is the polydrug where opioids are being combined with stimulants like cocaine, methamphetamine, synthetic cathinones, and other substances like Valium, Xanax, and traditional prescription medications for treating anxiety cases.

The casual users are often caught off guard by this introduction of the fentanyl and fentanyl-related substances. They are not tolerant of opioids at all. They think they're taking cocaine when, in fact, they're taking cocaine mixed with fentanyl, and they're overdosing. This is becoming increasingly problematic in communities of color around the Commonwealth.

And then to add to that, substances such as xylazine, which was mentioned earlier, is a veterinary tranquilizer and anesthetic known on the streets as trank, is being introduced as well. And this substance does not respond to the overdose reversing drug naloxone, as Secretary Smith mentioned before. As with all other substances, the lethality of drugs increases with the combination of substances, and we're seeing much more of this polydrug use going on around the Commonwealth.

On top of all this now, we're seeing the form of fentanyl and fentanyl-related substances being more likely to be in pill form than in powder form. An increasing number of counterfeit pill milling operations are developing, primarily from Mexico, but also being produced domestically, including here in Pennsylvania. Our HIDTA task force has investigated several instances where pills were being pressed from pill presses that were obtained through the internet and right into our communities.

These counterfeit pills are comprised of synthetic substances like fentanyl, etizolam, methamphetamine, a host of adulterants, diluents, and pining materials which may vary from batch to batch greatly, exacerbating the risk to consumers of these substances.

Recently our Delaware County Task Force Initiative in conjunction with the Pennsylvania State Police and the Drug Enforcement Administration investigating the trafficking organization operating there. Search warrants were executed and some 68,000 counterfeit pills, replicas of legitimate pharmaceuticals, were seized along with a kilogram of raw fentanyl and 11 firearms. These pills were likely manufactured in Mexico, but other investigations have located the pill

presses, binding material, and bulk fentanyl used to manufacture these pills locally.

In this internet connected world that we live in where almost everyone has access to a mobile phone, tablet, or computer, drug trafficking is facilitated through electronic means as often as not. Dealers of retail to wholesale quantities of psychoactive substances, some traditionally used and other novel compounds with unknown potentials to incapacitate or kill their consumers, now lurk behind keyboards instead of in the shadowy corners in distressed neighborhoods. Deliveries can be made by parcels, brought to the consumers' doors by UPS, FedEx, and the postal service.

And that was the case this past week when, in Montgomery County, an announcement was made from one of our initiatives, along with the homeland security investigation state police and DEA dismantled a polydrug trafficking organization that used USPS, FedEx, and UPS parcel shipments to receive drugs, primarily methamphetamine, from a source in Los Angeles and send the proceeds back by way of Cash App, a mobile application encrypted that enables anonymous transfers of funds. It is but one of a myriad of these applications that can be used to transfer value without ever stepping into a bank or meeting a person face-to-face.

The impact of the COVID-19 pandemic caused many Americans to self-medicate to relieve their anxiety, their isolation, and depression resulting from either governmental-imposed or self-imposed quarantines, and the endless media coverage that raised these anxieties, along with the separation from loved ones and loss of employment caused many people to turn to drugs for relief, whether alcohol or some controlled substance. Nonetheless, many people's substance use disorders were exacerbated by this isolation.

In addition, we saw a release of a number of persons from Pennsylvania correctional facilities and county jails, many of whom suffer from substance use disorders. And without the benefit of in-custody treatment programs for those inmates, the pandemic became an opportunity for them to relapse. Likewise, treatment programs in the general community had to reduce services or eliminate in-person support groups, leaving many folks to fend for themselves early on in their recovery process. And those are the folks that are at the greatest risk of overdosing and dying because they have, to some degree, lost their tolerance for the opioids that they had previously used and are not finding themselves encountering drugs laced with fentanyl and other potent opioid substances.

This is a rather gloomy assessment of where things are, but there are things we can do to turn this corner on the opioid crisis and the polydrug crisis overall.

First, better coordination between law enforcement and public health and public safety officials and entities such as were dealing with the overdose response strategy. Secondly, consistent and continuous data collection and sharing that information by all of these disciplines to report both fatal and nonfatal overdoses as close to the time of occurrence as possible, using statewide tools like the Pennsylvania State Police Overdose Information Network and the interstate tools like the HIDTA program's Overdose Mapping and Analysis Program to detect clusters of overdose events in near real time, enabling public safety and public health to respond to these areas that are at greatest need immediately.

Pennsylvania Senate Bill 1152 was recently introduced and addresses this to require all law enforcement and emergency medical service agencies to make reports through either the Overdose Information Network or the Overdose Mapping and Analysis Program to ensure that we do have this real-time information available to us.

Accelerating and enhancing forensics analysis of seized drug samples to know what is in the

drug marketplace by either state, local, or privately operated forensic laboratories that are interconnected through data sharing systems to provide both public safety and public health officials with more timely and concrete information about what drugs are circulating in the environment.

We are blessed in Pennsylvania to have multiple forensic laboratories operated at the governmental level, but also the NMS Laboratory in Willow Grove, Pennsylvania, is one of the leading privately operated forensic laboratories in the world.

Substantial commitment to substance use prevention efforts that will curb the demand for these deadly substances in our schools, workplaces, and our recreational activities, and our homes is essential to turning the corner here.

In the summer of 2011 -- I'm sorry, 2021, Drug Enforcement Administration launched it's "One Pill Can Kill" campaign nationwide to educate and alert young people to the dangers of counterfeit pills, while our neighbors in Camden County, New Jersey, launched the "Don't Die To Get High" campaign also to raise awareness particularly among the casual users of drugs, not the persons who have substantially advanced substance use disorders, but the person who tends to use drugs on

weekends only.

The point being in both of these campaigns is we don't know what are in some of these counterfeit pills or bags of what appear to be cocaine. We only know that many people are dying from them.

As mentioned by Secretary Smith and Dr. Johnson, the widespread distribution and access to naloxone is essential to reversing opioid overdoses in emergencies and ensuring that first responders and public places, as well as citizens at large, have naloxone available. It's noteworthy and encouraging that in a recent survey our public health analysts conducted that 88 percent of 612 police -- Pennsylvania municipality policy agencies who responded to the survey stated that their officers carry naloxone, while another 5 percent stated that their officers would be doing so within the next three months. However, 12 percent of the respondents do not and do not have plans to issue naloxone to their officers, plus over 400 agencies did not respond to the survey, and we suspect that many, if not most of them, also do not carry naloxone.

It's important for us to emphasize the need for first responders in particular, but also a wider population, have access to naloxone to reverse overdoses in these overdose situations.

More accessible and more affordable substance use disorder treatment opportunities are also part of the answer as well. Secretary Smith addressed this issue, but I'd just like to point out that the recent financial settlement and the civil litigation achieved from the opioid manufacturers, distributors, and retail pharmacy chains make over $1 billion available for this need. And close attention needs to be paid to ensure that Pennsylvanians with substance use treatment needs are referred to only well-qualified and responsible treatment providers and recovery supports.

We should also expand programs such as the Pennsylvania Attorney General's Law Enforcement Treatment Initiative and similar county-based programs that enable police to divert and deflect those with substance use disorders who commit low-level offenses to treatment rather than to courtrooms and jails.

The sooner we can get persons who are afflicted with addictions into treatment, it will not only benefit them, but it will also benefit our communities at large by reducing low-level crime that's often associated with substance use disorders.

Tangible supports to those in recovery who are seeking to regain control of their lives following treatment, such as housing, employment, counseling, all

are essential to lasting positive outcomes.

I'd like to point out to the committee some of the -- one of the areas where I'm invested, and that's with the St. Joseph University Center for Addiction and Recovery and Education. And the recovery forum that they have established on campus there. It is one of the first in Pennsylvania that has recognized that the college-age population is very susceptible to substance use disorders, and they are taking proactive measures to ensure --

MAJORITY CHAIRWOMAN RAPP: Thank --

MR. DALEY: -- that those who have, do not engage, are not put in positions to engage in additional substance use.

MAJORITY CHAIRWOMAN RAPP: Thank you --

MR. DALEY: I want to thank the committee for your attention and appreciate this opportunity greatly.

MAJORITY CHAIRWOMAN RAPP: Thank you, Mr. Daley.

We are running a little short of time, but I do have a question. Just kind of an observation and I guess a conclusion I'm making for myself, that when we look at the manufacturing of fentanyl, we like to, you know, in our minds -- those of us who watch, you know, crime shows -- you know, we know that the drug dealers want to make money. But it also appears to me that they

know exactly, that they're selling drugs that actually kill people. And it's almost, in my mind, that it is a deliberate sale of a product that is actually going to kill Americans.

One of my members talked about what's going on, you know, at the border. We know there's massive amounts of fentanyl coming in from the border. It is disturbing to see that they are using the mail system, whether it's FedEx, UPS, post office.

But do you think that's a wrong conclusion for me to deduct, that one of their goals is to actually kill people? It's hard not to come to that conclusion in my mind.

MR. DALEY: Chairwoman, I think you're not entirely off base in coming to that conclusion. You are not the first person who's postulated that this is essential chemical warfare being waged against the United States by drug cartels.

That said, as you said up front, the main motivation for persons to manufacture and traffic drugs like fentanyl and others, methamphetamine and cocaine as well, is profit. Money is the objective.

MAJORITY CHAIRWOMAN RAPP: Well, then it's the only business -- if you want to call it a business that wants to kill off their customers.

MR. DALEY: I think they --

MAJORITY CHAIRWOMAN RAPP: It's just my conclusion.

MR. DALEY: I think they recognize that, you know, there will be many, many dollars exchanged before persons die from the substances. And they're going to take advantage of every one of those dollars they can get.

MAJORITY CHAIRWOMAN RAPP: Absolutely. Thank you, sir.

Representative Frankel, did you have any comments, questions, sir?

DEMOCRATIC CHAIRMAN FRANKEL: I was -- the same exact thing. This does not make a lot of sense, particularly with the counterfeit pills. I mean, already, you know, for the casual users, it doesn't really make sense. I mean, you're already profiting from selling the legal drugs, the regular cocaine, that's unadulterated or methamphetamine. I mean, it just doesn't make sense to why these additives are being put into these other substances.

I completely agree with my counterpart here. It just doesn't make a lot of sense, why are there counterfeit illegal drugs that add these more deadly substances?

MR. DALEY: Thank you, Representative Frankel.

It is, I guess in our thinking, you know, we don't understand this. But keep in mind that this is a business in which costs are contained just like you want to contain costs in any business that anyone else would operate. And it's cheaper to produce synthetic substances, like fentanyl, than it is to grow opium poppies and then process it into heroin and traffic it that way.

Same with methamphetamine versus cocaine. As a stimulant, you have to, you know, grow coca leaves and harvest them and process them and so forth. Whereas in a laboratory with the right precursor chemicals, you can make pounds and pounds of methamphetamine in a relatively short period of time with very little labor costs.

As to when the, for instance, fentanyl is being introduced into cocaine or into the heroin supplies and so forth, it's more likely occurring here in the United States at the mid-level or retail-level distributors that are adding it in order to create addictions to these opioid substances to continue to keep a hold on the consumer of those substances.

MAJORITY CHAIRWOMAN RAPP: Thank you.

I did catch your comment that this is like a chemical warfare, and I believe that's -- after hearing

your testimony and department, I would agree this is a form of chemical warfare.

I have time for one question.

And, Representative Frankel, if you have someone on your side who wants to ask a question, but we are running behind.

Representative Tim Bonner.

REPRESENTATIVE BONNER: Thank you, Madam Chair.

Thank you, Mr. Daley, for appearing here today.

Mr. Daley, do you know what percentage of fentanyl in the United States is manufactured in Mexico?

MR. DALEY: I don't have an exact figure, but I can estimate that probably 90 percent of the finished fentanyl or fentanyl-related substances is produced in Mexico.

Heretofore, going back two or three, four years now, China was a leading source of fentanyl itself coming into the United States. However, through the State Department and Drug Enforcement Administration negotiations with the Chinese government, they have restricted the production of fentanyl entirely to pharmaceutical needs. And only rogue chemical operations are producing it.

But what they are producing are the precursor chemicals that are then shipped to Mexico where the fentanyl is actually synthesized.

So I would estimate about 90 percent of all the fentanyl is being produced in Mexico, but often involving precursor chemicals from China, and a few other countries as well that they are dependent on getting to make the fentanyl.

REPRESENTATIVE BONNER: How prevalent is the fentanyl problem in Mexico, Central America, and Canada?

MR. DALEY: Let's start backwards. Canada has a substantial problem with fentanyl, particularly on the west coast in British Columbia and Alberta and Saskatchewan and in the western provinces. That is likely due to connections to the Mexican cartels, as well as some importation directly from Asia, including China.

With respect to South or Central America, there's very little fentanyl in circulation there. And in Mexico, there is a growing problem with opioid addiction attributable to fentanyl in the population area.

I just read something a couple weeks ago how the federal government in Mexico is somewhat alarmed by the increasing level of overdose deaths there. But without question, America suffers the greatest from opioid use disorders and overdose deaths attributed to opioids,

especially fentanyl, of any of the counties in the western hemisphere.

REPRESENTATIVE BONNER: My last question, do you believe the criminal penalties in Pennsylvania are adequate for this problem?

MR. DALEY: I think when we're talking about trafficking, to be clear, we're talking only about trafficking drugs, not the, you know, the individual using substances. They need treatment, not incarceration.

But persons who are trafficking drugs, particularly drugs of this lethality, I would say anywhere, you know, up to a life sentence is appropriate in those instances. The question is whether or not all, you know, are being prosecuted as vigorously as they should be.

REPRESENTATIVE BONNER: I believe the penalty right now is a maximum of 15 years in Pennsylvania.

MR. DALEY: Sounds about right.

REPRESENTATIVE BONNER: Okay. Thank you, appreciate your testimony.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative Bonner.

MR. DALEY: Thank you, sir.

MAJORITY CHAIRWOMAN RAPP: Thank you, Mr. Daley. Your testimony was very informative. We pray

that you will keep up the good work in investigating the manufacture, sale, and everything that you're doing to curb fentanyl and synthetic fentanyl and other drugs in the state of Pennsylvania and across the United States.

Thank you very much, sir. It was very informative.

MR. DALEY: Thank you, Chairwoman.

Thank you, members of the committee.

MAJORITY CHAIRWOMAN RAPP: Members, our next panel is Cathleen Palm, who is the founder of Center for Children's Justice, and Dr. Jeanmarie Perrone -- I hope I pronounced your name correctly -- director of Penn Medicine Center for Addiction, Policy, and Medicine.

You are here virtually -- both?

MS. PALM: Morning, Chairwoman.

MAJORITY CHAIRWOMAN RAPP: Good morning. And if you would kindly raise your right hand to be sworn in.

Do you swear or affirm that the testimony you're about to give is true to the best of your knowledge, information, and belief?

If so, please indicate by saying "I do."

MS. PALM: I do.

CATHLEEN PALM, called as a witness, being duly sworn, testified as follows:

MAJORITY CHAIRWOMAN RAPP: Thank you. You may proceed.

MS. PALM: "One Month, Twelve Days, Died Suddenly," that's how the 2014 obituary for a Pennsylvania infant reads. The infant's mother would plead guilty to involuntary manslaughter and be sentenced to prison for a period of 15 to 60 months. Brayden and his mother would be featured in a December 2015 Reuters investigation along with 109 other infants from across the United States. The journalists were spotlighting infants born withdrawing from prenatal opiate exposures. More than a third of these infants, like Brayden, died from asphyxiation related to hazardous sleeping conditions while their parent caregiver was under the influence.

Fast forward to this month and a criminal complaint filed in Franklin County, Pennsylvania. Six-day-old Xander died on May 26th, 2021, having been discharged from the hospital a day earlier. Today, his mother is facing a criminal charge of involuntary manslaughter.

Law enforcement alleged that the infant and his mother experienced withdrawal issues at the time of

his birth. The criminal complaint also notes that hospital staff advised the mother against the use of illicit narcotics while caring for the victim, with the hospital noting that such use would affect the mother's cognitive abilities and decision-making. On the day the infant died, police alleged the mother used illicit narcotics, particularly scramble, known as heroin and a mixture of fentanyl. A blood sample from the mother was positive for fentanyl and other drugs. The infant's autopsy revealed he died from positional asphyxiation.

A former member of the Pennsylvania House of Representatives who went on to lead in Congress, Congressman Greenwood, enacted a law in 2003. Pennsylvania then responded with its own law in 2006, updating it in 2014 and 2018, to ensure that infants born affected by prenatal drug exposure had a plan of safe care.

A frustrated Greenwood would tell Reuters journalists that the implementation of federal and state laws has proven to be a national disgrace.

I begin in this space of citing what are, frankly, horrible and preventable outcomes for children not with any intent to demonize parents or caregivers affected by an opiate or substance use disorder.

Stigma related to persons living with an

opiate use disorder is so overwhelming and so unlike any other well-researched health condition or disease. Stigma and how it undercuts a person's access to clinically appropriate treatment is quite literally killing not just some people living with OUD, but also some infants and children born to persons with an OUD.

Let's be clear: These infants' death fall outside any metric currently being measured by the Commonwealth.

How, then, does Pennsylvania have a reliable sense of whether the epidemic is improving or worsening. The bottom line is that if our main source of gauging the epidemic's impact is the number of overall overdoses, we can't have anywhere near a reasonable reality check about how expansive the epidemic is and how tough its toll is on children.

Fatalities beyond overdoses provide one tangible discussion point, look at the DHS summaries of child abuse and neglect fatalities and near fatalities and you find a five-month-old died in Lackawanna; two-month-old, Armstrong County; three-month-old, Bedford County; two-month-old in Bucks County. These are some, not all, of the fatalities in those quarterly reports, and all died from hazardous sleep incidences. They don't include the children who died from ingestions or physical

abuse.

Recently, the Center for Children's Justice filed a Right-to-Know request asking the Department of Human Services for multiyear records and/or information that would reveal the number of children reported to ChildLine as a newborn affected by prenatal substance exposure, who then were later reported as a victim of a fatality or near fatality suspected or substantiated as child abuse or neglect.

The Department of Human Services denied this Right-to-Know request, stipulating that the department has no records that could be responsive to this question.

The fact that this data doesn't exist is as revealing as it is alarming about the prioritization of children in the midst of an unrelenting public health crisis like the opioid epidemic.

Our Right-to-Know request was one of many steps taken to pursue what seems like baseline information. During an April 19th, 2019 confirmation hearing for the DDAP and DOH secretaries, Senator Street and Senator Schwank raised concerns about whether we as a Commonwealth were appropriately examining the role that substance use disorder might be playing in the number of unsafe sleep deaths. No one has answered that question

yet today.

I want to say again that pursuit of data and intentional strategies that include the lens of a child must not be misconstrued as any attempt to demonize or stigmatize parents and caregivers. Rather, we remain deeply concerned about how little the Commonwealth and all of us know about the toll of this epidemic on children.

Getting reliable fatality data in itself is complicated. You have three different agencies -- the Department of Human Services, the Department of Drug and Alcohol, and the Department of Health with their own type of fatality review. One is related to child abuse and neglect, one is related to general public health, and one's related to medication incidents that relate to medication-induced incidences.

And yet, we don't know how aligned or connected these reviews are, and then, also what their recommendations and strategies are for prevention and intervention. That in itself is a problem, particularly given, kind of, how tangible fatality is.

And so we know -- particularly, as we know, last week, we regularly convene folks monthly around the issue of children and the opiate epidemic. And one of the pediatricians last week said they've seen a four times increase in the rate of ingestions. So we know that these

incidents are happening particularly with children getting access to medication-assisted treatment. And so that is one of the things that we need to be talking about.

There's another pool of data that confuses us, and that also reveals that we don't know enough about the impact on children. The Department of Health produces an EMS data report. Inside that data report for 2020, it talks about 15,000 or so encounters with unique patient encounters where EMS provided naloxone and administered naloxone. But if you look and dig deeper, you find that that same report says that no children were administered naloxone. But turn to a report of the Department of Human Services and you'll find that you can find a child in Berks County, a child in Montgomery County, all who were administered naloxone in the field.

Now, granted, some children get naloxone upon being delivered to a hospital in what is a suspected overdose, but some children also are administered in the field, and we seem not to know to what degree that's happening at this point in time.

I want to be sure that it's understood that we're not calling out medication-assisted treatment. It is absolutely an evidence-based treatment pathway for adults. It is absolutely worthwhile and something we need to connect more people to. We need to remove the stigma

upon it. But we also need to be sure that people understand it doesn't mean -- that that doesn't mean there's not other use still going on given the conversation around polysubstance use. And I also think it's really important that we understand that what we are doing for adults, very wise, evidence-based pathways to treatment, may have unintended consequences for children if they get access to those drugs.

Recovery from a substance use disorder is far from linear. Relapse is part of the disease, just like Dr. Johnson talked about the diabetic with high sugars or low sugars. If a person can't navigate and access clinically appropriate treatment, peer recovery services, or connection to fundamental basic life things, like housing, health care, and food, it becomes hard to remain in and stay in treatment and recovery, let alone to parent in that same space.

We see this as so evident in the maternal mortality report when 50 percent of the pregnancy-associated overdoses relate to accidental poisoning overdoses, that's a clarion call to action, not just on behalf of women, but also on behalf of their children.

In 2016, March of 2016, the center asked for the creation of a time-limited, state-level task force

to explore the effects of this crisis on children. Recently, thanks to each of you and your votes and the leadership of Representative Clint Owlett, that task force, the Opioid Abuse Child Impact Task Force, was created and the task force held its first meeting last month. I just want to say, though, more than 2,000 days, a huge spectrum in the life of a child, passed until that task force was created.

And in the meantime, a co-occurring crisis happened, the pandemic. So we saw greater overdoses. We saw Philadelphia and other counties record higher levels of overdoses. We saw children at home with access to medication-assisted treatment and other drugs that even the attentive parent might have had trouble keeping out of the hands of children. We saw children die from hazardous sleep conditions.

There's been some tangible and promising steps, including when the Governor created the executive order making NAS a reportable health condition, something we asked for in March of 2016, that now allows hospitals to voluntarily tell the state through the Department of Health how many infants are being born and diagnosed with neonatal abstinence syndrome. The gap continues to be, what do we know beyond that? What do we know about what happens for those infants in the first year of life, the

second year of life? What does it look like when they get ready to go to preschool or go to kindergarten?

So the declaration itself is an insufficient tool. It was and would remain an insufficient tool even if it was in existence.

There's actions happening between the Department of Health and other state agencies to try to get to that information, but that's really demand prioritization and an understanding by each of you.

The other thing that happened since we asked for the task force creation in 2016, there are so many tables, there are significant funding streams, but they are in so many ways, like so many pieces of a puzzle. It is really hard to know whether the puzzle pieces are fitting together, whether they're disconnected, and whether the dots are being connected. We hope that the task force created recently by all of you with Act 2 will be part of that.

And we would urge you, as it relates to having a child's lens on this crisis, to coordinate across state agencies and funding streams, the data and research needed to reliably inform and track the scope of the epidemic and outcomes for children and youth. We are doing so much with too little data that we can trust or understand what it means.

We should explore the rural health access and racial disparities across the continuum of prevention, intervention, and treatment. And we should prioritize family-based treatment services. This is a family disease, including that we need more residential services that permit a child and a parent to remain together. We have to be sure that we are ensuring parents in a potentially fragile state of recovery can access treatment but also not be disconnected from the parent-child bond that they need.

So we need more holistic, family-based prevention services. The Commonwealth should leverage federal funding strategies like the Family First Prevention Services Act. We need a child-focused, trauma-informed response.

You've heard this morning about warm handoffs. So many times a child is present. We did a survey several years ago for the Opiate Command Center, that we sent to them, showing how often EMS or law enforcement responded to an overdose that involved an adult and a child was present. That is a traumatic event, we should then immediately respond to a child in a way that we wrap services and supports around them. And we also need to think through how the handoff looks differently for the mom who might not know what to do with

her children if she goes into treatment. She might desperately want to go to treatment, but what does that mean for my children? And does that mean that the only door open is child welfare. That shouldn't be the case.

We need to listen to individuals with lived experience. I parent with someone who has a substance use disorder. These are folks who are very intentional, working their tails off, really committed to their kids, but they also have a medical condition like heart disease and others that complicate life sometimes, and we should be attentive to that, listen to them, and learn from that.

And then, you've got some great stuff happening in local communities. In Lancaster County, in Allegheny County, in Tioga County, in Philadelphia. There are really good smart regional folks who are coming together, on the ground, across disciplines, and they should be understood for what they're doing, quite frankly, picking up the baton where the state hasn't always been able to carry the baton.

And so I just really appreciate your time this morning. I kind of glossed over my written testimony a little bit in the nature of time. I know you have a busy day.

But if I can just leave you with one thing, it's just really -- it is absolutely every single day, we

see the effect of this crisis on children. And to be responsive to that does not mean that we are punitive or we are harsh against parents or caregivers, but for right now, we'd pretty much proceeded in this epidemic with blinders on and with kind of an absolutely kind of head in the sand as to what the impact is for children. And we haven't even talked about toddlers and through the age of child development and suicides and other risks for children because that would take another whole hearing.

But I just really encourage you to tune in, pay attention, and prioritize children.

Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Cathleen.

Will you be staying on? We're going to have the next presenter provide --

MS. PALM: Absolutely.

MAJORITY CHAIRWOMAN RAPP: -- their testimony, and then we'll have questions.

Thank you very much. That was very, very informative, and we thank you for the written testimony as well.

Our next presenter is Dr. Jeanmarie Perrone, who is the director of Penn Medicine, Center for Addiction Policy and Medicine.

Doctor, could you please raise your right hand? We have to swear testifiers in.

Do you swear or affirm that the testimony you are about to give is true to the best of your knowledge, information, and belief.

If so, please indicate by saying "I do."

DR. PERRONE: I do.

JEANMARIE PERRONE, M.D., called as a witness, being duly sworn, testified as follows:

MAJORITY CHAIRWOMAN RAPP: Thank you. And you may proceed.

DR. PERRONE: Good morning. Thank you for inviting me to participate in this very important hearing.

My name is Jeanmarie Perrone, and I'm an emergency physician, a medical toxicologist, and addiction medicine specialist. I started our emergency department addiction treatment program in 2017 because we saw the ravages every day of the opioid crisis on patients and their families, seeing fatal and nonfatal overdoses increase during the pandemic.

From the front lines of the ED, we found that providing low-barrier, 24/7 treatment, offering same-day buprenorphine, or MAT, starts coupled with

harm-reduction initiatives, such as dispensing NARCAN and fentanyl test strips can begin to address the challenges in treatment access. As has been mentioned, stigma prevents people from accessing treatment in traditional settings.

One particular problem that we're seeing in the Philadelphia area is the increase in overdose deaths in the black community by 35 percent, particularly around the areas of our hospital. These disparities are widening, in particular, in the way people access treatment. We need our programs to benchmark medication initiation as we see overdose deaths increasing faster in communities of color. We need to expand treatment access that's culturally appropriate and commensurate with the rapid escalation in substance use deaths in these communities.

One way to do this is via telehealth. Due to limitations in treatment access during the early part of the COVID-19 pandemic, we rapidly developed innovative strategies to leverage changes in telehealth to provide same-day buprenorphine treatment.

Even though we have the 1-800 Get Help Now program in the state, that program results in up to a two- or three-week delay between a phone call and initiation of medication treatment. We can narrow that gap to the same

day. Patients can call and ask for treatment, and we can connect them with our Urgent Care Penn Medicine OnDemand program and provide same-day starts or medication which allows patients to begin that recovery journey on the same day that they have a motivating moment.

In partnership, the University of Pittsburgh Medical Center and Dr. Mike Lynch has started a similar program that has served over 1,000 people across rural and urban Pennsylvania in the western part of the state.

We believe it's feasible to develop a statewide network of telehealth addiction bridge treatments to expand care from emergency departments and other low-barrier treatment programs and to be able to fill the gaps when somebody is leaving a carceral community, transitioning from discharge of a recovery house, or a discharge from an inpatient treatment program, or from an acute hospitalization. We find that patients have gaps in their medications in all of these transitions, and we can fill that gap and prevent the dangerous reoccurrence of use in a fentanyl-contaminated drug supply.

Additionally, programs that have been led by the state include the Medicaid HQIPs program, or Health Quality Improvement Program, many emergency departments in

Pennsylvania develop treatment linkages to engage patients into treatment in the emergency department by prescribing buprenorphine and making a warm handoff to a local treatment center. This program has been in existence for approximately three and a half years, but can be expanded to some of the emergency departments that hadn't started a program because they were worried about who to hand off to.

The telehealth program in the state could actually fill that gap and allow more emergency departments to provide life-saving treatment while we allow telehealth to provide interim bridge prescriptions until someone can be connected to a local treatment provider in more rural areas where the shortages of MAT providers continue to prevent patients in parts of our state from getting treatment that they need.

We also have developed programs utilizing the wisdom of peer recovery specialists which are people in the recovery from opioid use who build alliances with patients and help them navigate the early treatment journey. Peers provide a pathway to sustainable employment for people with substance use experiences. We can expand this workforce and pathway by developing billing and reimbursement strategies for these services that can be initiated in ED visits, primary care, and

obstetric practices, and expand this element of the treatment paradigm.

I also have comments that echo Dr. Johnson's about expanding syringe service programs. These are vitally needed to fill the gaps in expanding the service statewide, but I will refer to her statistics and efforts for a call to action on that.

Overall, we're at a time of great impact, as fentanyl has ripped through the state and country. We need a combination of low-barrier treatment access at any point that a patient accesses health care -- the emergency department, telehealth, low-barrier community centers, and other places, and 100 percent treatment access in the incarceration system with warm handoffs to local treatment providers to sustain that treatable moment that patients may have during that experience.

Today, I thank you for allowing me to speak on this important topic, and I hope that I can provide any subsequent questions and answers for supporting this testimony. Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

We are now at the point where we will be taking questions from you, as well as Cathleen Palm.

I'll look to the members for questions,

comments?

Representative Owlett.

REPRESENTATIVE OWLETT: Thank you, Madam Chair.

And thank you, folks, for being here and the great work that you're doing to protect our youth. And really the testimony around this is so important.

Cathleen, thank you for your comment and your shout-out about the task force. This is something that we've worked on for a long time. I'm happy to see it finally coming to fruition. It got a little bit of a late start, but we're happy that it's happening.

I guess one of my questions, maybe, is -- and maybe it's more of a comment. But we heard about the four times increase you were talking about, the number there. Could you expand on that just a little bit?

And also, maybe a little bit about the importance of the data and not really -- nobody is looking to be punitive. We really want to look at the data so that we can make good decisions moving forward.

I mean, a part of the goal of this was to be able to look at policies. If we can't get the data and don't have the data, isn't that what -- I guess that's my question -- isn't that what really gives us the tool that we need to be able to develop the policies that we're

looking to change or bring about so that we can really help these kids?

MS. PALM: Absolutely, Representative Owlett. And thanks again.

I mean, I want to just say, look, I've done public policy work on children's issues for 30 years. We oftentimes look at things from an adult lens, not from a child's lens.

So one of the things with ingestions is -- there's twofold. You've heard about it this morning. So as part of a response to the pandemic, smartly for adults, there was an opportunity for greater take-home privileges. So there might have been more methadone or Subutex that was available, but something like Subutex is a dissolvable. So if a child picks it up by accident, even if the most cautious parent or caregiver drops something, it's quickly potentially dissolving in the child's mouth. So that's why we need to be talking about harm reduction strategies where there are children in the home as well.

Ingestions in terms of, you know -- the other thing is, do I think I purchased a Percocet pill and really what I purchased was a Percocet pill that's laced with fentanyl. So now I potentially have a -- kind of a double situation if a child has access to it.

And I would really encourage -- I mean,

DDAP has done a great thing by hiring Dr. Lynch as their medical director. There's nobody smarter about understanding child ingestions and access than the Poison Control Centers. So it may be that you want to have a whole conversation with people who are way smarter on this than I would ever suggest I am.

But I know we have been deeply concerned about this, that some of the things that make total sense for adults -- evidence-based medication-assisted treatment, greater access to take-home privileges are all things that potentially, then, if not handled in the right way, have an unintended consequence for children.

So in raising that, we want people to be aware of it, but not aware of it to say, "Shame on that parent for being involved in medication-assisted treatment," or "bad parent." We just want us to start to say, "Has anyone thought about what the lens of this looks like if children get access to this?" How do you cut down on children's access to it?

And I could go on all day, but the data is horrible, absolutely, positively horrible. It really has no lens for children.

Overdoses may not include things like homicide or criminal charges. Rightfully, again, made sense for adults because you don't want to prosecute

someone who calls 911 to report a person's overdose. But oftentimes, if a child gets into something and there's an overdose, there may be criminal charges.

So I would really -- across Medicaid, across all of our funding streams, you are purchasing, through Medicaid, you know, services through the managed care contracts. To what degree are they doing things that really are preventative, intervention, and treatment strategies, not just for parents and caregivers, but also for children. That's really key to ask some tougher questions than we've been asking to date.

REPRESENTATIVE OWLETT: Well, thank you so much for that, and really, looking at it through the lens of the kids that are involved. Oftentimes we don't talk about that and we don't even -- I hate to say it, but oftentimes we don't even think about it, about what's really happening in the home. And helping to protect these kids is so, so important.

And I look at the members of the task force, and I have high hopes, I really do, for the work. I mean, there's some great professionals on this that can really bring us some policy changes, some ideas, that we can really look at here in the House and make some changes to really help to continue to protect these children who often are forgotten in the midst of this conversation.

So thank you so much for your work.

And thank you, Madam Chair.

MS. PALM: And if it's okay, Madam Chair, I'd just like to say something on safe sleep.

I want to be sure that it's not understood that we're penalizing or being punitive about anyone who potentially is overwhelmed, exhausted, and takes and has their baby with them. But one of the things that we know is that the ABCs work, so alone, on the back, in an uncluttered space.

But one of the things Kentucky has done is they've added D to it, to talk about the dangers, because even someone who's taking a medication, a prescription for opiate use disorder, may be more sleepy, more drowsy. So how do we engage them in a thoughtful conversation to say, "So what are you thinking about, what are you going to do with your baby as potentially some of your medication takes hold and you become drowsier?" So really making sure people have really frank and hard conversations about how to care for a child even in the moment that you potentially are also using substances.

MAJORITY CHAIRWOMAN RAPP: Thank you, Cathleen.

Do we have any other questions, comments from the members?

(No response.)

MAJORITY CHAIRWOMAN RAPP: Certainly you've given us a lot to think about. And we really appreciate your testimony and being with us this morning. And if we have further questions, certainly you would be available.

I think Representative Owlett is in touch with you, Cathleen.

But we really do appreciate your testimony today and what you've brought to the table for us, so thank you.

MS. PALM: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

DR. PERRONE: Thank you.

MAJORITY CHAIRWOMAN RAPP: Our last testifiers are Amy Tolliver, who is the executive director of West Virginia Perinatal Partnership --

Mike, are they testifying together or separately?

(Inaudible.)

MAJORITY CHAIRWOMAN RAPP: Okay.

Amy, would you turn on your video, please?

MS. TOLLIVER: Can you see me now?

MAJORITY CHAIRWOMAN RAPP: No, we cannot. It's not on our end. You need to turn on your video.

There we go. Now we can see you.

And are you unmuted? Yes, there you go.

MS. TOLLIVER: I am unmuted. Can you hear me?

MAJORITY CHAIRWOMAN RAPP: Yes, we can.

MS. TOLLIVER: All right. I did --

MAJORITY CHAIRWOMAN RAPP: Hold on just a second.

I need you to raise your right and -- it is a new rule for House hearings that you take an oath.

So if you would raise your right hand, please. Do you swear or affirm that the testimony you're about to give is true to the best of your knowledge, information, and belief?

If so, please indicate by saying "I do."

MS. TOLLIVER: I do.

AMY TOLLIVER, called as a witness, being duly sworn, testified as follows:

MAJORITY CHAIRWOMAN RAPP: And thank you very much, Amy, for being with us today. We had -- way back when we were planning in the fall for this hearing, you were on the list. And we're glad that we're finally able to conduct this hearing. And you may proceed.

MS. TOLLIVER: Okay. Thank you.

And I'm very happy to be here, and I appreciate the invitation. I did prepare a PowerPoint presentation that we did share with the committee staff. Is it all right that I show the PowerPoint now?

MAJORITY CHAIRWOMAN RAPP: Yes, you may.

MS. TOLLIVER: Okay. Can you see the PowerPoint?

MAJORITY CHAIRWOMAN RAPP: Yes, we can.

MS. TOLLIVER: Okay.

Well, I just wanted to again say thank you for inviting me to talk about the work that we're doing in West Virginia. I've been listening to all the testimony thus far, and we are, of course, experiencing the same issues, the same concerns, and the same struggles that you are in Pennsylvania. So we are all in this together in regard to the opioid epidemic and substance use concerns.

So I want to tell you just briefly about who we are. I'm the executive director of the West Virginia Perinatal Partnership. We are a nonprofit organization with a mission to engage and unite health care providers and stakeholders in improving maternal and infant health outcomes.

We are the perinatal quality collaborative for the state of West Virginia, not dissimilar to the

Pennsylvania perinatal quality collaborative that was formed in Pennsylvania in 2019. We are all doing similar work across the country and focusing on improving outcomes for pregnancy and infants in the first year of life.

Some of the work that we're doing in West Virginia really does center around infant and maternal mortality and morbidity, focusing on all of the various issues that impact pregnancy.

You can see here on this slide, we do a lot of outreach with our hospitals, we work on breastfeeding, we work on pregnancy health education, transportation concerns, and access to care generally.

And one of the most significant issues that we have been focusing on, of course, substance use during pregnancy. It does really consume almost half of the work that we do. We are, of course, recognizing that if you don't have a healthy pregnancy, you're not going to have healthy outcomes for the infants. So substances in pregnancy was recognized very early on in the work that we have done as really critical and essential to the ability to impact outcomes.

So we have statewide efforts that we're focusing on. One, identifying the concerns and then training medical and nursing professionals across the state to be able to engage and care with the patients

appropriately. We do a lot of work around research and policy.

We -- early on in our work with the partnership, we were established in 2006. And at that time, all of our neonatal intensive care units in the state were at capacity. We were diverting babies out of the state of West Virginia to Pennsylvania, Ohio, and Virginia, and some to Kentucky because our NICUs were unable to care for our sickest babies. We did some looking into that concern and we understood from our neonatologists at the time that our NICUs were at capacity because we had so many infants who were withdrawing from opioid exposure. We tried to take a look at claims data in regard to medical discharge claims to see, well, how many babies do we have in West Virginia that are experiencing opioid exposure and withdrawal. We quickly found that that data was lacking.

I heard a lot about lacking data earlier from the other testimony. We have had the same concerns and hurdles in West Virginia. So we were trying to get a handle on the data and understand what is causing the problems here.

So I'm going to just quickly go through our sequential efforts here. So first, we did a study to ascertain the extent of substance exposure in pregnancy in

West Virginia. That was in 2009. From there, we moved on to recognition that we needed a standardized definition of neonatal abstinence syndrome within our birthing centers of the state so that we would be consistently diagnosing infants who are experiencing withdrawal from opioids and other substances with NAS. And then, we started looking at how do we collect that data well. And we -- I'm going to talk a little bit further about our birth score tool that we implemented, some additional questions regarding substance exposure and NAS, and then, tracking that we have done through that work.

We -- the umbilical cord study that I just mentioned that was performed in 2009, at that time, it was eight hospitals that participated in a blind study. They took the umbilical cords from every baby born in those hospitals during one month, the month of August, I believe, in 2009. And what we found was 19 percent of the babies born in those hospitals were exposed to substances in utero. The substances, by and large, were marijuana, alcohol, opiates, benzodiazepines, and methadone.

You can see here that THC, marijuana, was the biggest, most widely used substance; coming in second was opioids, opiates. And I wanted to note that, by and large, it was polysubstance use. If somebody was using a drug or alcohol, they weren't just using one. They were

using multiple drugs or alcohol.

At that time, we then moved on to the concern that we weren't identifying our infants well in our hospitals. And so we pulled together the neonatologists and pediatricians from around the state to focus on coming up with a unified definition of neonatal abstinence syndrome. We realized there was different definitions being utilized in different facilities. And in order to get a good sense of really how many babies were being treated and diagnosed with NAS, we really had to have a consistent definition employed throughout the state.

So the pediatric leaders and neonatal leaders in the state agreed upon this definition: That NAS is diagnosed when a baby has prenatal exposure to a neuroactive substance and exhibits clinical signs or symptoms of withdrawal regardless of whether or not pharmacological treatment is required.

So once we had a uniform definition, we at the perinatal partnership worked with our neonatologists from three different NICUs throughout the state, and we took a team of those neonatologists and nurses to every delivery hospital in the state of West Virginia to train their teams on the definition that we were to use in West Virginia and how to accurately document that in the

medical record, so that we could have clear and consistent data as we're moving forward with the focus on the concern.

One of the ways to have that clear and consistent data was to utilize a data collection tool that we have in West Virginia that is unique to our state. Other states may have something similar. I am not familiar with whether Pennsylvania has something similar to our tool. We call it Project WATCH. And it consists of a birth score assessment on infants, a newborn hearing screening, a newborn congenital heart disease screening, and then the intrauterine substance exposure and NAS documentation.

We had in existence the birth score tool since 1998, I believe. And that tool was designed to ascertain whether an infant had a greater risk of dying within the first 12 months of life. Various screening instruments were employed and documented. And every baby in the state of West Virginia has the birth score tool performed on them and documented in their chart. That was already in existence when we started looking at adding questions around substance exposure.

Over the years, we added the newborn hearing screenings and the CCHD, the critical congenital heart disease screenings. In 2016, we had added a

question to say, "Did the baby have intrauterine substance exposure? And if so, were they diagnosed with NAS?"

This is a little bit more detail about the questions that were added to that tool: If they had substance exposure, was it documented in the prenatal record, was there a positive drug test at birth, was it self-reported, et cetera, by the women, or other? And then, later in 2020, we added the questions around what substances the infant was exposed to in utero.

So now we are collecting on every baby born in West Virginia hospitals these specific questions about their substance exposure. So we will know what substances they were exposed to.

And then this, again, is just showing you how we have a "yes" or "no," and then we have the definition with the birth score tool.

There was a lot of training done for nurses across the state who complete that tool in the hospital to make sure that it is completed consistently and accurately as well.

Here's a little bit of data from our birth score tools so far in regard to the intrauterine substance exposure and NAS.

Now, in West Virginia, our population is a lot smaller than that of Pennsylvania. So you can see,

the first column has all the births. And we have had a declining birth rate over the past 15 to 20 years, and you can see that is still declining. But you can see consistently we've had just under 14 percent of our babies born in West Virginia are exposed to substances in utero. And I'll refer back, in 2009, it was around 19 percent.

We have been doing a lot of work in West Virginia in regard to education and training of health care providers, as well as trying to really hit hard the access to opioids. So we've had a little bit of a bump down, but not significantly enough. We seem to have plateaued around that thirteen and a half to fourteen percent exposure rate.

And then, you can see, of those babies exposed, this is about the percentage, about five and a half percent of our babies are then diagnosed with neonatal abstinence syndrome. And that rate is around 54 in 1,000. And if you look at the national rate, it's around seven or eight babies per one thousand are diagnosed with NAS.

So clearly, in West Virginia, we have a significant problem. But we do believe that possibly our numbers are higher and better reflected because we are counting the babies very, very precisely now and not using the hospital discharge data that I do know is utilized

across the state to look at this number. So we do believe our numbers are slightly higher because we have a better way to collect that data through our birth score tool utilizing the Project WATCH.

So as I mentioned, yes, our problem is very big. And what can we do about this?

Initially, as we were getting to the point where we had really good data, we were recognizing that our maternity care providers were ill-equipped to deal with the concern. They are trained in how to work with the ladies to have a healthy pregnancy. They are not necessarily our behavioral health, mental health experts. So that was a concern within our maternity clinics and our hospitals as well.

Our experts dealing with behavioral health were not -- they were ill-equipped to deal with the pregnant population that is using substances. So we kind of had, you know, pointing the finger in one direction -- "Well, they're the ones that can do a better job in working with this population; oh, no, the others are the better equipped." No one was picking up the slack, really, and directly providing that care to our pregnant patients.

So as I've heard so many other presenters talk today, healthy moms make healthy babies. If we're

trying to improve our outcomes for our population, we have to start with the care during the pregnancy. So we developed a program in West Virginia and implemented it around 2011. And we called it the Drug-Free Moms and Babies Project.

Our goal was to develop and evaluate and document and then replicate programs that support those healthy baby outcomes by providing care to women during pregnancy who are identified as substance use exposure. We wanted to implement what we call an integrated service. So we are integrating the behavioral health services into the maternity care environment. Tying in the screening, the early screening and intervention and referral for care and follow-up.

This is the model that we developed, and we have been expanding throughout the state. It focuses on outreach and doing that expert analysis, or assessment, the screening for brief intervention, referral for treatment. Our model includes a care coordinator and a recovery coach within each clinic. They provide that prenatal care. They provide the referrals for treatment. There is a big focus on proper use of medication-assisted treatment and group and individual counseling.

Again, of course, there are all those social services that are critical to helping families move

forward in their recovery and getting -- doing home visitation and providing WIC, nutrition services, housing, childcare, or transportation, all of those barriers that these families have in accessing quality care.

So this is a model, as I mentioned, where we are integrating all of these services into the maternity care environment and that may be an obstetrician's office or that may be a hospital that serves all of those patients that deliver at their facility where we are integrating all of this care together, centrally operated by an individual called a care coordinator that really coordinates the services for any needs the women may have.

These are all of the sites that we have now implemented throughout the state of West Virginia. There are 17 sites. They are either at an obstetrician office, clinic, or hospital. And we have a direct integration of all of this care into our federally qualified health centers and behavioral health centers.

Here's a little bit of data regarding the women who are enrolled in our program. We have a strong focus on data collection. So every woman who receives care, we do collect a lot of data on her outcomes and her baby. So you can see just by enrolling and getting the care, we are decreasing the substance exposure by the time

they are delivered through each trimester.

Some other outcomes we have are, that we are looking at, are -- one of the biggest issues, of course, is preterm birth. So what we've shown, on the left side of this chart, are the births to those ladies who are enrolled in the care in one of those 17 sites throughout the state. The green section is the general population of women who have been identified with intrauterine substance exposure.

So you can see that right off the bat, we are reducing our preterm birth rate in West Virginia by providing that care, that integrated care throughout the pregnancy. Neonatal abstinence syndrome is dramatically reduced from the 40 percent on average of those exposed to 28 percent of those in our programs.

I do want to note, of that 28 percent in our programs, 100 percent of those infants were born to women with medical-assisted treatment. They are on Subutex, Suboxone. So that is not necessarily that they are still using illicit substances; they are in a treatment program. We know treatment does still cause NAS, and we know we have better outcomes for women who are on MAT. So that is not necessarily a bad percentage.

We are increasing the breastfeeding rates of women who are in the programs as well. And we are

improving the retention of that family, the mothers being discharged with their infants rather than going into the foster care system.

We have new and continuing challenges that I have heard the other speakers discuss as well. Of course, other drugs and how do we address things such as the increased use of methamphetamine across the state of West Virginia, but we also have, of course, social needs, and those social needs are a big impact in access to care. So that's transportation or the ability to have childcare or the ability to just access care in their community.

And then I've heard a lot about stigma, and we have concerns there as well. People being concerned to access treatment because they're afraid of having their child taken away or afraid of incarceration. And then, of course, we have provider shortages in some of our more rural areas of the state.

So we have a lot of continuing challenges that, I think, are not dissimilar to those in Pennsylvania.

That concludes my slide presentation and I'm more than happy to --

MAJORITY CHAIRWOMAN RAPP: Thank you, Amy. Can you stay with us until our last presenter and then we'll have questions for both.

So thank you very much. Thank you very much for the slides as well. Those are very, very informative. So if you can stay with us.

At this time, Sonja Bingham, who is a community activist, is with us this morning.

And, Sonja, please have a seat up front here.

If you would remain standing, ma'am, or stand, raise your right hand. Do you swear or affirm that the testimony you're about to give is true to the best of your knowledge, information, and belief?

If so, please indicate by saying "I do."

MS. BINGHAM: I do.

SONJA BINGHAM, called as a witness, being duly sworn, testified as follows:

MAJORITY CHAIRWOMAN RAPP: Okay. And you may proceed.

MS. BINGHAM: I want to thank you for having me and being able to come before you to give you some insight and a lens into the opioid crisis from a resident perspective.

(Inaudible.)

(Interruption.)

MS. BINGHAM: Oh, okay. I don't need a microphone. My ex-husband said I had a woofer and a tweeter in vocal cords.

MAJORITY CHAIRWOMAN RAPP: We prefer that you use the microphone, so if you would please speak into the mic. This is being recorded --

MS. BINGHAM: Okay, perfect.

MAJORITY CHAIRWOMAN RAPP: So we would ask you to speak into the mic.

MS. BINGHAM: And so I moved to Harrowgate, Kensington area about three years ago. I sold my house, had an opportunity to become mortgage-free, pay for my kids' college, cash -- something I didn't appreciate until I was much older. My dad is a retired naval aviator, my mom is a retired principal. I've lived pretty much a life of privilege. I've never lived in a black-and-brown community until I had the opportunity to sell my old home in Fishtown and move one mile down the road. I thought, "How different could it be?" How different indeed, I soon came to find out in the last three years.

Over the last three years, I have gained a greater insight into what it means to live in a community of color that has been designated the safe injection site. It has been designated the sanctioned encampment area for Philadelphia. And I say this because tens of millions of

dollars are being poured into our community to ensure that the opioid crisis does not leave our parameter of where we live.

Every morning, we wake up every single day to trash -- I have pictures that I provided for you -- trash, feces, urine, needles, our children are walking through this filth, through crime. They are watching people who are -- we call them zombies. They are zombieing out up and down the street as they're going to and from school. They're walking by people who are sitting on the streets shooting up, with needles sticking out of their necks.

Nowhere else in the city is this allowed to exist. To the point where we can get pulled over for a traffic violation with our eight-year-old children in our car while they step over someone who's dozing out with a needle sticking out of their arm to give us a traffic violation, but they do nothing to the people who are terrorizing our community.

We live in a virtual nightmare. We have been designated the area where it is okay to buy, use, and sell drugs. There is no way you can sanction an encampment in a community of people that have nothing to do with it.

I've sat here and I've listened to all of

the very well-thought-out policies and initiatives that are being brought forward and introduced, and the data that's being considered, but you never consider the people in the communities that live there. We are the unheard voices. We are the people that are being overlooked and traumatized.

I hear a lot about trauma-informed. It's like an oxymoron. Everybody is worried about the trauma or the harm reduction that's happening to those who are suffering with addiction, but they don't worry about our children who can't use their parks or who can't go to the playground, who can't play in their streets. Hell, we can't even sit in our homes because the drug dealers are fighting for the corners that make millions and millions of dollars each and every year without fear of getting shot while you're sitting in your own home. Read the news; that happened last week in my neighborhood, six blocks from my home.

In September of 2021, my house was firebombed. Two months before that, another block captain who was walking to go get medication for his wife from Walgreens was brutally attacked by the sanction encampment that Stephanie Sena was fighting the city of Philadelphia to allow to exist in our community. He was brutally attacked and ended up in the hospital. And they had to

put a plate in his wrist. He's self-employed.

So impoverished, overlooked, trauma-induced, crime-ridden, fearful community that's under -- we're under poverty. The average income is about $17,000 a year. That's the average household income in my community.

We put together a GoFundMe to help him be able to feed his eight- and six-year-old children during the times he was recovering because he was attacked simply walking to the market.

We are targets in our community. We are the targets. If we speak out, we are vilified. We are made to feel like we do not have the right to say, "This is unacceptable." But yet, everyone that does not have to live in these communities can sit in their glass rooms overlooking the city and decide what good initiatives or policies are that we should be introducing and implementing in communities that you don't live.

Come to my neighborhood, see what my children see, see what the seniors who don't even come out of their houses have to deal with.

I have a next door neighbor, they will not sit on their front stoop. They sit out in the backyard and in the garages and set up little lawn chairs because they're afraid to sit out in front of their home. It is

disgraceful.

And we never consider the people that live in the communities. We've asked, "Sanction an encampment somewhere on the outskirts of the city." You know, they're going to use drugs, you're saying "it's okay." Hell, you're ready to go into business with Safehouse after giving Prevention Point millions and millions of dollars. And we soon discovered why we had people going through our trash every day, because Prevention Point will give people access to Medicare, Medicaid, food stamps, all they have to do is give a name, address, and a Social Security number. So they're going through our trash to get our personal information, and we don't find out that we're on welfare because they use Prevention Point's address.

This is what lack of oversight and these bright ideas do for our community.

We literally have no rights. And I often wonder, I say to other officials -- I'm very involved. I say, "I wonder if we had seven to eight hundred black people living in Center City, the campers, would we have this same approach to enforcement? I wonder."

I mean, we had it happen in Center City, and we told our officials, "We're watching what you're doing with the encampment in Center City" -- this was in

June of 2020 -- "we're watching what you're doing. We've been asking you to eliminate and eradicate the encampments in our community for years. We're watching.

"And if you get rid of the encampment in Center City before you address the hundreds of people that are living in our community, you're going to send us a very clear message, that black and brown lives don't matter."

That's the new "it" terminology, right? Black and brown lives don't matter. Blue lives don't matter. It's absolutely insane.

Imagine your children watching you work with city officials and officials telling you "your voice matters and you're valued," and doing block cleanups and going to meetings and sending e-mails and reporting crime and partnering and doing everything that you're supposed to be doing, and at every turn, they implement something that you said is not going to work.

Imagine the message our children are seeing, the ones who are going to school seeing people bring them water and bring them clothes and bring them book bags and bring them tents. Stephanie Sena brought them cell phones, so that they could videotape us when we are going out and telling them to get them out of our community.

We had to form an old lady gang to go around and to walk our dogs so we could take pictures and patrol our park. It's insanity.

And at every turn, all we hear is, "We need to consider more about, you know, the harm reduction and we need to consider" -- but nobody is considering the harm that's happening to people that have no drug addiction problems at all.

Every single day is a nightmare. The city has now given us paint kits to paint over graffiti because the drug dealers take corners and they'll -- I gave you pictures -- of graffiti. And they have arrows to point to where the new drug corner is. So they give us -- instead of arresting drug dealers and putting them in jail and sending them away, violent offenders, repeat offenders -- no, they invest in giving us paint kits so we can go out there and paint over the graffiti. So we clean up the feces, we clean up the urine, we paint over the graffiti, we get attacked. And at what point are we going to say, "What we're doing isn't working?"

And now, our city is honestly and earnestly considering allowing Safehouse to open up a facility that will not be managed and controlled by a health care facility.

And they say at every turn, we want it --

we don't want it to exist in your neighborhood, but at every turn, they keep pouring more and more and more resources into a community that does not want to have anything to do with it. And you're sending a very clear and loud message.

Kensington Harrowgate is our sanctioned encampment area, and we ask one simple thing: When you're considering your policies, when you're considering your initiatives, think to yourself, "Is this something that I would want in my backyard? Would I want this facility right next to me? Would I want people to be allowed -- with no permits -- be able to leave the food so the rats can come in at night and take the food up and down the block and just leave it there. Would I want this next door to my house? Would I want this in the park where my children want to play?"

Because if the answer is "no," ask yourselves why is it "yes" for us?

Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Sonja. Can you remain for some questioning?

MS. BINGHAM: Sure.

MAJORITY CHAIRWOMAN RAPP: We want to get back to Amy. I think there's a few questions for her.

MS. BINGHAM: Perfect. Yes. Do I move?

MAJORITY CHAIRWOMAN RAPP: You can just stay there.

So let's go back to Amy. I'm going to address some questions to her. We have about 20 minutes left, so we'll give, like, 10 minutes to Amy and then come right back to you, if that's okay?

MS. BINGHAM: Okay.

MAJORITY CHAIRWOMAN RAPP: All right. Thank you.

Amy, so I actually do have one question for you. And thank you for your testimony; it was very revealing.

So with all of your studies and everything that you've done in West Virginia, was that driven through legislation, or was that driven through your Department of Health, your hospitals? What drove all the studies and everything? Like the umbilical cord study, what drove that? Was that --

In Pennsylvania, we've added to newborn screenings. We've had to do it legislatively.

So what drove all of that in West Virginia?

MS. TOLLIVER: Well, there were a number of things. So the umbilical cord study, it was funded by our Bureau for Public Health under our Department of Health and Human Resources.

We then were moving forward with our education. That has been funded by our Bureau for Public Health as well. And we also have a strong collaboration between our Bureau for Public Health and Behavioral Health, and some private foundations in West Virginia, the Benedum Foundation which is also in Pennsylvania. And so between the three of them, they have funded a lot of the work in regard to the Drug Free Moms and Babies sites. That has been funded through those three agencies, as well as federal, state opioid response funds that have come into West Virginia and have gone through our Bureau for Behavioral Health and then been granted to our organization to implement those programs as well.

So it's a combination of that.

MAJORITY CHAIRWOMAN RAPP: But nothing was driven through legislation? It was just done through the organizations and your Department of Health and your agencies?

MS. TOLLIVER: Well, we have had some budgetary, you know, work that has, you know -- our state budget, where they have put funds in to directly support this work.

Our legislature has -- as well as the birth score tool, it was already legislatively established. And so they didn't need to implement any new legislation to

add the collection of data regarding substance exposure in neonatal abstinence syndrome. That was done through rules, of course, in West Virginia. I'm not sure of the similarity in regard to our rulemaking process in Pennsylvania. But our rulemaking process is that it has to go through our legislature. So the rules to add those questions and such, I believe were then filtered through our legislative process to approve.

And then, we have done a lot of work in West Virginia through policy and legislation to implement our maternal and infant mortality review team. So that was done around the same time as we were starting this work so we could better ascertain, you know, the cause of death for our women and our infants.

MAJORITY CHAIRWOMAN RAPP: Okay. Thank you very much. I was -- that answered my question. It was actually legislatively driven, so we can certainly take a look at that and maybe contact some of your legislators or you, yourself, and find out that legislation. That might be something we could mirror here in Pennsylvania.

Any other questions for Amy?

Representative Frankel.

DEMOCRATIC CHAIRMAN FRANKEL: Thank you, Amy.

How can you keep mothers in treatment after

birth? I mean, do you have a program to do that?

MS. TOLLIVER: (Inaudible) we developed -- it is to support the women during pregnancy and postpartum. So if they are in -- if they have become engaged in their recovery process, they are receiving medication-assisted treatment and that counseling and such, and that still remains for them as they enter the postpartum period, our programs are designed to support the women in their care and treatment for two years postpartum.

But what we have found is, of course, it is difficult to have them remain engaged. And so lessons learned over the period of time that we've been doing this, we know that we are much more successful in supporting the women and engaging the long-term recovery if we have an ability to integrate the services into the behavioral health centers and other behavioral health treatment providers.

We've done a lot of work where we are having strong collaborations between our maternal care providers and behavioral health providers. So there's a warm handoff as they are exiting the maternal care arena and they're staying with the behavioral health treatment providers.

Another extremely important piece of the puzzle is residential care for women in recovery. And

residential care then allows the woman to bring her infant or young children with her.

That has been extremely lacking in the state of West Virginia. And our Bureau of Behavioral Health has done a lot of work to fund the establishment and creation of residential treatment facilities throughout the state. So that is a big piece of the puzzle in regard to really maintaining that care for the women.

DEMOCRATIC CHAIRMAN FRANKEL: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Amy. That was very informative, and again, thank you for your PowerPoint presentation. That is very helpful, you know, for us as we look toward maybe some possible legislation to help our mothers and our facilities fighting addiction here in Pennsylvania.

Thank you for taking the time, for being with us today.

So at this point, we're going to turn to questions for Sonja.

Sonja, I really appreciate you coming forward.

You know, I live up in the other corner of the state. I live in Warren, Pennsylvania, which is 60 miles east of Erie, if you know where Erie is.

MS. BINGHAM: Huh-uh.

MAJORITY CHAIRWOMAN RAPP: So I come from a rural community. And basically, I've seen slides, which you have shared with us, from San Francisco and other areas of the United States. We don't get a lot of Philadelphia news unless the major networks, you know, cover something in Philadelphia.

Certainly, we've seen the news about the carjackings and all of that kind of thing going on in Philly. I will say, right now, Philly is not a place that I care to visit right now.

But I really appreciate you bringing to us another side of the issue because we definitely want to be compassionate and caring, because as many people know, drug abuse does affect almost everyone in our society today. And we want to have a compassionate heart, but we need to see the other side too, how it does affect neighborhoods and people living in those communities where this is taking place.

So -- but I thought there were some court cases that said that this was not going to be allowed to happen in Philadelphia. So what has happened as far as since those court cases took place?

And you are still seeing -- I'm looking at the pictures. I don't live in the city of Warren. I live

outside of Warren, but I can't imagine that my community would tolerate that or my law enforcement or our mayor.

MS. BINGHAM: Exactly.

In regards to -- there are a lot of court cases. So are you talking to specifically to the safe injection site?

MAJORITY CHAIRWOMAN RAPP: Yes, yes, the Safehouse, the safe injection site.

MS. BINGHAM: Bill McSwain did go to federal court, we won, and we even won on appeal for Safehouse.

What's happened now is we have had a changing of the guards with our new attorney general, and Mayor [sic] Garland -- they are more -- and the Biden Administration is more -- leaning more towards having safe injection sites. They're now calling them overdose prevention to kind of, you know, change the brand.

MAJORITY CHAIRWOMAN RAPP: Let me just interrupt you a minute. Have there been any overdoses at all at these sites or there's enough personnel there that prevents that?

MS. BINGHAM: Well, they -- let me just be clear: The sites will not be 24/7, right? So you're going to open up a site. Let's just say you open up for 10 hours, let's say we opened it up for 12 hours a day, right? So people will be allowed to go in, shoot up, and then come

back into the neighborhoods in which they are allowed to operate. That's it. That's the only thing.

All of the trash, all of the quality of life issues, people breaking into our homes, those will still continue to exist because they will walk right out of those doors and right into our communities. That is what we don't want.

Our position has been that if this is what, you know -- and I'm not a medical professional. This is not my wheelhouse, right? I've been forced to kind of be involved in this simply because I moved one mile down the road.

Our position has been, if that is the way we are moving, then they should be in medical facilities, right? Treatment -- if that's what we're going to do, we're not going to allow an organization to come in and to open up a facility that's supposed to be a life-saving facility and not have the oversight that governs medical facilities. It's like -- I can't even imagine that this is what we are proposing.

And the DOJ reached out to us in the middle of these conversations and said, "We want them to be in medical facilities too, but your elected leaders are supporting Safehouse's desire to open their own brick and mortar.

MAJORITY CHAIRWOMAN RAPP: So by elected leaders, do they mean officials with --

MS. BINGHAM: Mayor Kenney, Krasner, yeah.

MAJORITY CHAIRWOMAN RAPP: Not the legislature at this point in time?

MS. BINGHAM: No.

MAJORITY CHAIRWOMAN RAPP: Thank you. I do have a question from Representative Paul Schemel.

REPRESENTATIVE SCHEMEL: Yes.

Thank you, Mrs. Bingham, for coming.

So what you're describing, I'm trying to get a picture of, is injection sites, which has been referred to here as, like, a syringe program, I guess, where people can come. Does that -- has that drawn in the people who have lived in your community before these sites were there? Does that draw in not just users, but also drug dealers? Basically, does it become a center for all of the drug activity, in our observation?

MS. BINGHAM: Absolutely.

So what's happening is -- to think that you can buy, use, and recover in the same place is completely unrealistic. It's not going to happen. To have a recovery center and you walk out the door and the dealer -- dealers walk into Prevention Point. I know; I have someone that works there. They tell us what's going

on in these places.

Dealers not only send runners in -- and they use drugs on-site for some of these recovery centers. But as soon as they walk out the doors, it's an opioid haven. There are dealers on every corner. Like on every -- as soon as you walk out your door, literally.

Sunday mornings, I can wake up and I'll see 50 to 100 users coming up my block, and I know there's a free sample on the block, literally. And I'm, you know, texting the inspector just because I work -- you know, I do a lot of advocating so I have, I can directly dial the inspector for the east division, like, "We got samples on this corner and that corner." And they will send the police and you know.

But that is a daily -- and that's our life, that's our life. And so to say, knowing that the problem exists in Kensington, let's just say it wasn't by design that Kensington became the place to use drugs, what would make you think that you could buy and use drugs to your heart's content, because they do not arrest them, they do not force them to go to treatment.

They allow them to come in by droves, and the majority of them come from outside of Philadelphia. I know personally because I have personally given them my SEPTA TransPass and put money on the card, talked to their

family members, like, "Get your son home."

"Oh, but he's from such a wonderful neighborhood."

"Keep him in your neighborhood, like, keep him in your -- don't send him here. You're lucky I found him and not a dealer that would sell him."

They have fight nights where the users fight for the next hit of drugs. Like, it is absolute insanity.

And you're thinking that you're going to put a recovery center in the middle of all this chaos. They are going to go into this treatment program and get healthy and walk out the door and be strong enough to withstand what's literally outside the door -- because they're waiting outside the doors.

We have a diversion program that takes people and -- all we say is that it takes them closer to their dealer, because they'll get caught in one part of our neighborhood and the dealers literally are, like, surround where the police assisted division program. So as soon as they walk out from saying, "Okay, I'll go into a program. Yes, I'll do all the things you're telling me to do. Please don't arrest me and take me to jail. Okay, yes, I'm going to go into treatment. I'm going to do everything. Yes, yes, yes." And they count it as they

engaged someone. Now they're claiming this as a victory. They walk out the door and their dealers are right there.

You cannot buy, use, and recover in the same area. So we're saying, please, start to find sites that are outside. Start to -- I always say, "Two heads are better than one; four heads are better than two." It's not really difficult to understand. Like, why would you put all of the issues that are opioid related on a community of 60,000 people. We have millions -- three million in Philadelphia. Why wouldn't we do something to kind of disperse it and kind of, you know, kind of address it in all of the communities.

If we're so concerned for the plight of the person suffering with addiction, why would we allow them to live in squalor and feces and walk around with open wounds and tell them they can't go to treatment because they've got sores up and down their body. But they're allowed to live in our community and people bring them bandages and wound care stuff, and that's what we're cleaning up three or four times a week. They're bringing them clothes. If they're bringing them socks, we're cleaning up socks that weekend. If they're bringing them bottles, we're cleaning up bottles. If they're bringing them book bags, we're cleaning up book bags. And this is every week.

MAJORITY CHAIRWOMAN RAPP: Thank you.

Sonja, Representative Tim Bonner has a question, ma'am.

REPRESENTATIVE BONNER: Thank you, Madam Chair.

Mrs. Bingham, I appreciate you being here today and presenting your testimony.

I'm trying to understand the full scope of your problem. Are the people that are coming to your neighborhood, they don't reside in your neighborhood?

MS. BINGHAM: No, they do not.

REPRESENTATIVE BONNER: These are people from outside of your neighborhood?

MS. BINGHAM: Absolutely.

REPRESENTATIVE BONNER: And do you have any support groups that are in any way assisting you with this battle, or are you a lone voice in this neighborhood?

MS. BINGHAM: We're pretty much alone. We meet with the mayor every other month. We go to all of the Kensington meals program and the Opioid Response Unit, and I'm on the PDAC, the advisory council for the police district, like, I go -- I'm in El Barrio es Nuestro meetings with the mayor's NDO office. We partner, but every time they get ready to -- they say they listen to what we're saying -- this is not going to work. Now we

have a 100-day challenge program they're rolling out. This is not going to work, right?

There's a reason why they're not camping all over the city. We're asking you to do that here, right? If you're not allowed to live in public spaces, if you're not allowed to use drugs, right -- if I go out and I'm drunk, I can get a ticket for public intoxication, right? Not someone who's using heroin.

So I'm just -- we just ask. Can you please do the same things that you do for the rest of the city for our community? And we are alone.

We have officials that say they work with us and listen to us, but they're the minority. And so what's happening is the rest of, like, the city council and all the different agencies recognize that if they say, "We support you," they know it's got to go to the rest of the city. You know, having it contained in Kensington keeps them clear with their constituency in East Mount Airy and Roxborough and Rittenhouse and Center City and South Philly, right?

So they say they are with us in solidarity, but they're not. They do not do anything to help eradicate this.

REPRESENTATIVE BONNER: I'm assuming the mayor has come and seen this firsthand?

MS. BINGHAM: Yeah.

REPRESENTATIVE BONNER: If there's one thing that you could ask us to do today to support you, what would that be?

MS. BINGHAM: Stop investing in the opioid crisis in Kensington.

REPRESENTATIVE BONNER: Okay.

I have not had a chance to read your testimony today, but I will. And hopefully, there will be some contact with you.

Thank you, ma'am.

MS. BINGHAM: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you.

Representative Frankel.

DEMOCRATIC CHAIRMAN FRANKEL: Yes, thank you.

Thank you.

It's a harrowing story. I really feel for you and your community. But I also want to suggest that, you know, this harm reduction strategy, obviously, has, you know, unintended consequences that are significant, and we need to recognize that. But I also wanted to note that there are other harm reduction strategies. And I want to -- my colleague, Representative Schemel -- I just want to say this is not a needle exchange program, it's

a -- or syringe exchange program.

MS. BINGHAM: Prevention Point is a needle exchange program.

DEMOCRATIC CHAIRMAN FRANKEL: Okay, but --

MS. BINGHAM: And they don't exchange. People will go in there with one and they will walk out with a roll of fifty. And the dealers send them in there and that's what they use to sell to the out-of-towners who come to buy the drugs.

DEMOCRATIC CHAIRMAN FRANKEL: But there are ways to do --

MS. BINGHAM: So in essence, the city is in the business of dealing drugs --

DEMOCRATIC CHAIRMAN FRANKEL: Right.

MS. BINGHAM: -- because they financially support it.

DEMOCRATIC CHAIRMAN FRANKEL: But I think you can separate a safe injection site issue from a syringe exchange --

MS. BINGHAM: No, it's all the same. It's all the same. It's really all the same.

You know, these institutions need to be run and held to standards that other medical facilities are held to. They do not have the oversight.

When we let the mayor know in our meeting

in August of 2020 that Prevention Point was giving out, distributing five million needles in Kensington a year --

DEMOCRATIC CHAIRMAN FRANKEL: Oh, okay.

MS. BINGHAM: He had no idea. They had no idea. They had no idea. He was like, "This cannot be true." We were like, yes, we got the data from Prevention Point.

Like, we are in this now, more than we ever wanted to be, right?

People feel and they understand where we're coming from. We're not saying "don't help people with addiction," we don't have that. We're not saying "don't save lives." That's not -- we're saying "save us."

DEMOCRATIC CHAIRMAN FRANKEL: Right.

MS. BINGHAM: Like, look at us in the middle of this. Like, when you're thinking about doing all these things. Putting a needle exchange program where you can come and give one for fifty. And then they take the 20 and give them to the dealer so they can get a bag of heroin, like, what are we really doing here? What are we promoting? Because we're not promoting sanity.

And our children are watching this. Kids who do not have anything to do with the drug game or have any part in this are watching this. And we're planting seeds that are going to grow roots and produce fruit. And

what are we showing them? That you can be someone that deals drugs, does drugs, and we'll bring you three squares -- I've had several people who use tell me, "Yeah, I love coming here during the summertime. I get three squares, they -- like, why would I leave?"

They bring them -- we had a Hepatitis A outbreak. So all the residents who live there, we now have to go get Hepatitis A shots because we're cleaning up their underwear and their socks. And our president of our civic association got Hepatitis A, by just living -- we don't have any -- none of us use drugs, none of us. And this is literally like our life.

I do not leave my house after two o'clock in the afternoon, absolutely not. Every time my child leaves the house, I'm like, "Oh, dear God, please let him come home," because the violence is off the charts.

We don't have prosecutors that will prosecute. We don't have systems in place that support our police adequately. We don't have it. They're like, "what can we do?"

I mean, the policies and the initiatives that are happening right now are definitely hurting a community of color. And I just think it's a real travesty because you think about some of these kids, grandkids, and great-grandkids are the same ones from the crack epidemic,

where their parents, grandparents, great-grandparents, when they were addicts, they were thrown in jail. But now 30 years later, the color of the attic is changed and now we need resources.

What are we saying? What are we saying -- what are we teaching our children?

I'm not here about black or white, I'm here about what is right? And no one looks at us when they think about it. If you don't want it in your neighborhood, you don't want it next door to your house, don't think about putting it in ours, or any of the communities where opioid is ravaging a community of people that don't have anything to do with drug addiction. It's not right.

DEMOCRATIC CHAIRMAN FRANKEL: Well, thank you for your testimony.

MS. BINGHAM: Thank you.

MAJORITY CHAIRWOMAN RAPP: Sonja, thank you so very much.

As I said, I live in a much more conservative area than where you live. I would hope that we -- we do have many issues in rural Pennsylvania with opioids and drugs, but we also, where I live, we support our law enforcement.

MS. BINGHAM: Absolutely.

MAJORITY CHAIRWOMAN RAPP: But I really appreciate your bravery, you know, in coming forth and telling another side of the story. And as I said, we all want to be compassionate to someone who has a drug addiction, but at the same time, we can't allow those same people to destroy our communities.

I mentioned, you know, San Francisco and what I've seen out there, just on the news network, how they are cleaning up feces in the street and going out and, you know, everything. I mean, you know, I can't believe that our society would allow this to happen. But I'm one of those people who can't believe that we're allowing all of this to come across the border.

And it's very disturbing to me. One of the previous testifiers called the whole opioid crisis, chemical warfare. And after listening to his testimony, I guess that's my conclusion as to what is happening to our society. We are allowing a chemical warfare. And you see it in your neighborhood.

So I want to thank everyone for being here today, the members -- your input, your questions, all of the testifiers.

We have a big problem in Pennsylvania. And I appreciate everybody who's on the front line, you know, working hard to -- trying to avert this, but it is a huge

issue.

And I'm a firm believer that as long as our border and our mail system -- whether that be the mail system, FedEx, UPS, whomever, and our law enforcement and our DAs and our mayors allow this type of behavior that you're seeing to continue and continue at our southern border, we're not going to be able to combat this until we put a stop to the root cause and where it's coming from.

So I thank you to all of the presenters and members for you taking your time to be here, and those who joined us virtually. Thank you.

Thank you so much, ma'am.

MS. BINGHAM: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, members. This hearing is adjourned.

(The hearing concluded at 11:02 a.m.)

C E R T I F I C A T I O N

I hereby certify that the proceedings are contained fully and accurately in the notes taken by me on the within proceedings, and that this copy is a correct transcript of the same.

Summer A. Miller

Summer A. Miller, Court Reporter
Notary Public

My commission expires:
November 13, 2022