House and Senate Policy Committees

Rep. Kerry Benninghoff, House Majority Chair
Rep. Mike Sturla, House Minority Chair
Senator Lisa Boscola, Senate Minority Chair

JOINT POLICY HEARING AGENDA
Pennsylvania's Drug Epidemic
August 2, 2016 – Pittsburgh, PA

2 p.m.	Welcome by Chair Benninghoff, Chair Sturla, and Chair Boscola
2:05 p.m.	Opening Comments by Representative Ed Gainey and Senator Jay Costa
2:10 p.m.	Panel One: • Marc Cherna, Director, Allegheny County Department of Human Services • Dr. Latika Davis-Jones, Administrator, Allegheny County's Bureau of Drug and Alcohol Services • Abby Wilson, Deputy Director for Public Policy and Community Relations, Allegheny County Health Department
2:50 p.m.	Panel Two: • Amy Shanahan, Clinical Administrator of Addiction Medicine Services, Western Psychiatric Institute and Clinic of UPMC • Dr. Michael Madden, Chief Medical Officer, Gateway Health • Adrienne Smith, Person in Long-Term Recovery
3:30 p.m.	Panel from Pennsylvania Office of Attorney General: • Renee Martin, Director of Education and Outreach • Becky Berkebile, Director of Drug Control Programs • Stephanie Chupka, Special Agent, Intelligence Unit
4 p.m.	Adjournment

MORE INFORMATION

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Senate Minority Policy Committee: www.senatorboscola.com/policy

COUNTY OF ALLEGHENY
RICH FITZGERALD
COUNTY EXECUTIVE

TESTIMONY BEFORE THE HOUSE AND SENATE POLICY COMMITTEE ON THE OPIOID CRISIS

August 2, 2016

Good afternoon. I'm Marc Cherna, Director of the Allegheny County Department of Human Services (DHS). I'd like to thank Representative Gainey and Senator Costa for the invitation to speak, as well as the other elected officials for your commitment to addressing this epidemic.

The disease of addiction affects everyone. No one is exempt, including me. I have a close family member who has struggled with heroin addiction for many years, so I know first-hand just how devastating it is. It's a disease that doesn't just impact the individual. Family, friends, co-workers are all affected. This disease doesn't discriminate. People from all walks of life, all races, all religions and all ages are affected.

I have been in this business for over 40 years and have led Allegheny County's DHS since its creation in 1997. DHS is an integrated department that serves about 225,000 residents every year. Most have multiple needs, and a large portion have the disease of addiction.

Right now: the opioid crisis is escalating. And its impact is increasing the demand in all of our service areas, from child welfare, to homelessness, to criminal justice, to mental health, and even to the services offered to our seniors.

We know that the primary reason a majority of children are being placed into foster care is due to the parent's inability to care for them due to their addiction. We know that the majority of our homeless have a substance use disorder. We know that the majority of our county jail population find themselves incarcerated due to drug-related offenses.

Dr. Latika Davis-Jones, the Administrator of our Bureau of Drug and Alcohol Services, will address this committee shortly with specific comments on treatment.

I would like to offer a few recommendations for the Committee to consider that I believe would improve our effectiveness.

I am a strong advocate for harm reduction. Many people eventually get into recovery if we can keep them alive and healthy until they are ready to make the commitment. Syringe exchange keeps people from contracting HIV or Hepatitis through dirty needles. When the addict comes to a needle exchange site, it's an opportunity to engage them and encourage them to get into treatment. Widely distributing Narcan, which can reverse an overdose, has saved thousands of lives. Many of those people eventually get into recovery.

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Evidence based guidelines concerning effective treatment released by the National Institute on Drug Abuse indicates that a minimum of 90 days for treatment is optimal, and for many individuals, even more time is needed. Recovery can take years and, often, it is a lifetime struggle. Service systems need to be designed to recognize this fact, and treat this disorder as a chronic disease, not merely an acute illness.

Medication assisted treatment, or MAT, must be among the evidence based treatment options funded to promote recovery. Addiction is a disease of the brain, and treatment by medications such as methadone, Suboxone, or Vivitrol - when combined with patient-centered counseling - has proven to be effective in certain contexts and should be among the options in a continuum of care. Medication assisted treatment allows people to get on with their lives instead of constantly trying to figure out where their next fix is coming from. Individuals can go to work or school and start to become productive members of society.

We need to see more concerted efforts to engage and involve families in the process of patient treatment. Whether an individual needs long-term residential treatment, detox, or outpatient drug and alcohol treatment, family should be involved and incorporated in each step, as a natural support. Allowing supportive families to be a part of a patient's recovery goes a long way in destigmatizing the disease of addiction. And it engages the individual's social support at the very start of the long road of recovery.

There is no "wrong door" when it comes to treatment, and a bolstered peer and recovery-oriented support network will also play an essential role in bringing this crisis to an end. We must expand the availability of peer and recovery-oriented supports for those struggling with addiction. Re-entry work, and support from peers who have gone through or are currently going through treatment, is crucial for patients to be successful in avoiding a substance abuse relapse.

And the value of peer perspectives is not limited to the personal level. Persons in recovery should have a seat at the table in public discourse as well in order to insure this unique perspective has a voice in any crafted legislation or policy addressing the crisis.

Reforming the way we think about confidentiality will open faster and more efficacious treatment coordination for human service and public health providers. State regulations concerning the sharing of information are stricter than Federal standards. Pennsylvania should return to the Federal HIPPA standards of data privacy. Effective coordination of care relies on the ability to share information between departments and with those who are supporting and caring for individuals. Families should know about treatment for those for whom they are caring, and this information is not always available to them under current Pennsylvania privacy restrictions. Many confidentiality issues are wrapped up in a culture of stigma surrounding substance abuse and opioid abuse. Creating freer movement for information among those working with individuals involved in addiction treatment will go a long way to minimizing external stigma by maximizing care for the disorder as a disease like any other disease.

Finally, I need to advocate for additional funding to meet these increasing demands on the treatment system. DHS has seen no increase in funding for the past 5 years, and no restoration of the 10% cuts applied across the board to human services under the previous administration. Treatment eventually does work for many addicts.

I am really pleased that our community leaders are stepping up to address this crisis. Our US Attorney, David Hickton, has mobilized a multi-disciplinary effort to comprehensively address the problem on a

regional basis. The University of Pittsburgh's Institute of Politics has also prioritized this issue under the leaderships of Chancellor Emeritus, Mark Nordenberg, and former U.S. Attorney and current President of the Buhl Foundation, Fred Thieman.

This is an insidious disease, but we can make an impact through a collective effort. If we all join forces we can reduce the incidence of addiction and assist those in currently affected to get into recovery.

Thank you.

COUNTY OF ALLEGHENY
RICH FITZGERALD
COUNTY EXECUTIVE

TESTIMONY BEFORE THE HOUSE AND SENATE POLICY COMMITTEE ON THE OPIOID CRISIS

August 2, 2016

Good afternoon. I'm Dr. Latika Davis-Jones, Administrator of the Allegheny County Department of Human Services (DHS) Office of Behavioral Health (OBH), Bureau of Drug and Alcohol Services (Allegheny County Single County Authority). I am responsible for administering the planning, organization, coordination and evaluation of the bureau which includes the provision of technical assistance and ensuring drug and alcohol providers are in compliance with federal, state and local drug and alcohol regulations and mandates.

Thank you, Representative Gainey, for inviting me to provide comments on the opioid epidemic. Much of my work over the past two years has primarily been focused on addressing this issue. We are currently facing a challenging time in our region, and since 2008, Allegheny County has had more than 1,900 fatal overdose deaths with over 1,300 of those deaths having opioids indicated as a contributing factor. We know that the current opioid epidemic is non-discriminating. We have rich, poor, black, white, old, and young people dying every day. One life lost to this epidemic is one life too many.

As Director Cherna mentioned, I plan to offer a few recommendations on treatment and prevention for the House Policy Committee to consider when it comes to designing and supporting a comprehensive behavioral health response to address this epidemic.

First, it is imperative that we listen to the science. The science tells us that addiction is a chronic disease and we should no longer support the idea of providing episodic care to a disease that should be managed from a chronic care and disease-based approach (NIDA, 2012). We must develop better ways to deliver quality care across the lifespan which includes: pre-treatment, adequate lengths of stay/follow-up/aftercare, and recovery/peer supports. It must also include assistance to providers who seek to deliver evidence-based programming, offer medication assisted treatment, ensure effective clinical relationships, and adopt practices that support overall recovery management (Achara, 2010 & William White, 2006).

The science tells us that treatment works and recovery is possible (NIDA, 2012)! However, currently we do not have enough capacity to treat everyone in a timely fashion should they want help. Therefore, we need to have increased funding to expand access to high quality substance use disorder (SUD) treatment. This means increasing access and capacity across the existing continuum of care which includes out-patient, partial, detox, and short/long-term rehab which ranges from abstinence based programs to full blown harm reduction models (multiple pathways).

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There is a great need for innovative and high quality substance use disorder treatment programs for high risk and vulnerable populations. For example, our overdose death data from 2008-2014 showed that many of the individuals who died of overdoses had a prior history of receiving publicly funded mental health and /or substance use disorder treatment or had been recently released from the county jail. Many of these individuals died within 30-days of their most recent service or within 30 days of being released from jail. The jail and our behavioral health system are uniquely poised to intervene earlier in the progression of this chronic disease. These systems can assess for overdose risk and can provide increased opportunities for overdose prevention education and provide naloxone to all individuals who have been identified as using opiates.

However, we must also expand access of naloxone to family members, youth serving organizations, child welfare, homeless outreach teams, and other key stakeholders who often engage, through the course of their daily work, individuals who use opiates. Please note, not only should these stakeholders have access to naloxone but they should also be prepared to distribute naloxone to individual that use opioids.

Increasing treatment capacity and expanding the use of naloxone are extremely important endeavors but it's also equally as important that we help individuals learn how to access our behavioral health system. My department receives hundreds of calls per month from individuals not knowing how to get help for themselves or for loved ones. We recently launched a short-term (2 months) public awareness campaign that focused on decreasing stigma about addiction and telling individuals where to call to get help. We need public awareness campaigns like this to continue but on a much larger scale if we want to increase the likelihood of individuals seeking help and learning how to access our system of care.

Traditional mental health providers, primary care physicians, and hospitals need to be equipped to include the assessment of opiates and/or other drugs whether prescribed, or illicitly obtained, in order that the over-all needs and related history of the individual are considered and addressed.

Back to discussing the importance of science and doing what we know works. The literature is quite solid on indicating that medication assisted treatment (MAT) is a viable option for those addicted to opioids. For example, methadone maintenance treatment (MMT) is designed to reduce illegal and harmful opioid use along with the many problems (e.g. crime, death, disease) associated with its addiction. The primary goals of MMT are to decrease and/or eliminate opioid use, to reduce criminal behavior, and to prevent individuals from contracting Hepatitis C and/or HIV. For those that use opioids, methadone maintenance treatment can be an important point of contact with service providers, because it provides an opportunity to educate drug users about harm reduction approaches (i.e., condom usage, needle exchange, effective needle/crack pipe cleaning methods) while addressing their opiate use and potentially their mental health needs (SAMHSA, 2005). Drug treatment is HIV and Hepatitis C prevention. It is therefore imperative that we increase the capacity for medicated assisted treatment, and include consideration of not only Methadone, but also Suboxone and Vivitrol. The decision to use a medication as an assist should be a clinical and medical one, made by the attending physician, clinical team, and the person receiving treatment.

In order combat this epidemic we must continue to develop cross system partnerships and align regulatory and administrative structures to enhance our behavioral health system that builds on the strengths and resilience of individuals/persons in recovery, families, and communities. However, our system must be adequately and flexibly financed to provide an array of services that are accessible, integrated, person-

centered, and culturally competent. We must remember that no one system or agency has the resources to meet all of the needs of persons addicted to opioids and/or other substances. An effective cross-system partnership, and integrated approach will require the ability to collaborate across service delivery systems (physical health, mental health, drug and alcohol) and share pertinent medical information in the best interests, and in full transparency, of those being served.

The good news is recovery emerges from hope and recovery is a reality. It can, will, and does happen!

Thank you.

COUNTY OF ALLEGHENY
RICH FITZGERALD
COUNTY EXECUTIVE

Statement of Dr. Karen Hacker for Public Hearing on Opioids, Tuesday August 2nd

The opioid crisis hit Allegheny County in the early 2000's, and since then we have seen a startling rise in opioid-related overdoses impacting our County. Last year, there were 422 overdoses; of which the majority were related to an opioid. In most cases that opioid was heroin, which has now replaced oral pain killers as the number one opioid contributing to overdoses. More recently we are also seeing the rise of fentanyl as a further contributor to overdoses. This opioid is significantly stronger than heroin and when laced with heroin contributes to further risk of overdoses.

Western PA is not alone in facing this crisis. However, we only recently implemented a prescription monitoring program. As we begin to diminish the supply of oral opioids we are concerned that there are numerous additional addicted individuals who will transition to heroin and face overdose risk.

Today I am here to share the Health Department's perspective on the situation as it exists and to ask for support to help quell this epidemic. From a public health perspective, we are currently trying to address the issue along a continuum; from prevention to treatment, but as yet, with little or no new resources. I applaud the work of many of my colleagues and fellow departments who are trying to impact change. Unfortunately, the epidemic continues to expand. Support is needed to fully implement evidence-based practices on the ground that involve prevention as well as treatment options.

We are pleased with the policy decisions that have been made by the Governor and his Departments and by the Legislature. The passage of Act 139 provided the Good Samaritan protection necessary to make naloxone readily available to those who need it. However, there is still work to do. We know that less than a third of our police departments here in Allegheny County are currently carrying the drug and despite a standing order here in the County and the PA Physician General's own standing order for naloxone, many pharmacies are not carrying the drug and/or not utilizing the order. We also know that overdose-related calls to 911 do not appear to have increased significantly after the passage of Act 139. I am concerned that individuals may still fear criminal consequences of making a lifesaving call to 911 if they witness an overdose from illegal consumption of opioids.

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To make policy reality on the ground, we need resources to orchestrate an effective response; in public health, community health centers, treatment facilities and non-profits who interface with the highest risk clientele in the highest risk communities. Similar to another epidemic, the AIDS epidemic, we need strategies that connect with addicts and engage them in treatment.

If we are successful in engaging addicted individuals in treatment, the question remains: Do we have enough treatment of the right type, and can we help individuals find those options? Currently there is no treatment on demand and any obstacles that are in the way will inhibit our abilities to address addiction. There need to be a variety of treatment options available including abstinence only programs as well as medication assisted treatment. Making the right treatment available at the right time and for the right length of time is critical, as is making sure all citizens know how to access treatment when they or a loved one are ready.

Medication assisted treatment using suboxone, methadone and vivitrol are evidence-based practices, but we see far too few of these options being offered and far too few programs that are comprehensive in nature. We need to more effectively connect mental health and substance abuse treatment such that providers in both realms understand the needs and progress of their patients. Recognizing that confidentiality is paramount, we must still find ways to coordinate treatment between providers for the benefit of the patient. We must recognize that after periods of abstinence including jail terms and completion of or dropout from treatment, individuals are at high risk for overdose. These critical periods represent times where innovative treatment options and support should be available. We were pleased to learn of the passage of Act 76 last month, which will improve Medicaid access for individuals post incarceration and potentially mitigate overdose risk via increased access to covered treatment.

Lastly, we need to understand the epidemic in all of its proportions using data to help us identify "hotspots" and bring targeted interventions to bear.

The opioid epidemic has changed significantly in the last decade, but it has been with us for years. We applaud the efforts of the Legislature to provide the tools we need from a policy perspective, but we need to do more to address implementation of those policies. Help our on the ground organizations coordinate, analyze and monitor our efforts in real time. The epidemic will require that all involved sectors work collectively to address the issue. Thank you.

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UPMC LIFE CHANGING MEDICINE

Western Psychiatric Institute and Clinic of UPMC

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My name is Amy Shanahan. I am the Clinical Administrator for Addiction Medicine Services (AMS) at Western Psychiatric Institute and Clinic of UPMC. I have worked in the addiction treatment field for more than 20 years and have been overseeing Addiction Medicine Services at UPMC for seven years.

Over the years, we have learned so much, and UPMC has worked hard in its commitment to helping people with substance use problems. Addiction Medicine Services was one of the first programs in the country to offer integrated treatment for substance use and mental health problems. Today, we are committed to providing comprehensive, co-occurring treatment, prevention, education and research programs that are person-centered, research-based, and recovery-focused.

UPMC is making a significant contribution to the opioid epidemic – the stark reality is evident in our focused efforts to meet the emergent needs of our patients.

In our experience, we have heard countless times how tired people are of going to rehab, spending months and years in treatment programs and how some people who want treatment cannot or will not participate in treatment. People do not want to be addicted to substances. People want to be well, and to get well. And people do get well, in their communities, with family and friends, and in treatment programs.

However, it takes more than the treatment programs. In a system oriented for healing and recovery, it takes all of us - our hospitals, treatment centers, schools, criminal justice services, employers, and families.

There is no panacea for treating this chronic condition. We need all forms of treatment, and every form of kindness and care for individuals and families who are suffering.
We know so much more now than we did 20 years ago. We definitely know there is no quick fix, and that it will take adequately funded, well-coordinated systems of care:

- We know, because of access to data, the magnitude of the problem. In the United States, for example: 40 million Americans age 12 and over meet the clinical criteria for addiction involving nicotine, alcohol or other drugs. That is more than the number of people with heart conditions, diabetes or cancer.

- Of those who do receive treatment, few receive anything that approximates evidence-based care. This compares with 70% to 80% of people with such diseases as high blood pressure and diabetes who do receive treatment.

- Meanwhile, another 80 million Americans fall into the category of risky substance users, defined as those who are not addicted, but use tobacco, alcohol and other drugs in ways that threaten public health and safety.

- Addiction and risky substance use constitute the largest preventable and most costly public health problem in the U.S., totaling over $467 billion a year.

- The total costs to federal, state and local governments of substance use, which usually has its roots in adolescence, are at least $468 billion per year—that's about $1,500 for every person in America.

- We also know, from scientific research, that addiction is a disease that affects both the brain and behavior.

- We have identified many of the biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease.

- In fact, because substances change the brain in ways that foster compulsive use, quitting is difficult, even for those who are ready to do so.

- The initial and early decisions to use substances reflect a person's free or conscious choice. However, once the brain has been changed by addiction, that choice or willpower becomes impaired.

- Through scientific advances, we know more about how drugs work in the brain than ever, and we also know that substance use disorders can be successfully treated to help people stop risky and chronic substance use and lead healthier lives.

- Scientists use this knowledge to develop effective prevention and treatment approaches that reduce the toll substance use takes on individuals, families, and communities.

Despite what we know, there is so much work to be done. We need to change our systems in order to improve treatment access and reduce the stigma that creates barriers for people asking for help. We need to change our thinking and our beliefs. People who struggle with substance use shouldn't be punished, put in jail, or pushed in the corner of our schools, hospitals or communities Although we've been saying it for years, everyone now understands that addiction and substance use problems affect everyone.

- We need to educate the public. Substance use is a public health problem and addiction is a complex brain disease that, in most cases, originates in adolescence.

- Our health systems must work to prevent or delay the onset of substance use through effective public health measures.

- Our health care providers need to make screenings for substance use problems routine. They must intervene to reduce risky use and provide appropriate treatment if needed.

- We need to continue to build upon what we know and develop comprehensive strategies based on research and what is known about addiction. Providing Narcan to address the opioid crisis is a step in the right direction. In fact Pennsylvania has saved nearly 1000 lives after making Narcan available to police officers in the community. And yet, this is not enough.

We also need to reverse the opioid epidemic (so Narcan ISN'T needed). We need to decrease substance misuse and addiction through supporting and funding prevention, intervention, and treatment programs.

Prevention and Early Intervention

There are proven strategies for preventing and treating substance abuse. Prevention and early intervention strategies that not only prevent but also intervene in risky substance use through research-based public education and awareness, proven school- and community-based programming, and effective regulations that reduce the availability, accessibility and appeal of addictive substances.

The Allegheny County Drug and Alcohol Programs support a system of providers who provide evidenced-based prevention programs to area schools and organizations. At UPMC, the WPIC Addiction Medicine Services is the Commonwealth's approved Student Assistance Trainer for Allegheny County and provides state approved training and technical support to schools to develop Student Assistance Teams to identify students who are experiencing barriers to learning that may be associated with mental health and/or substance use problems and to get those students and parents connected to the appropriate level of care.

The Children's Community Pediatrics (CCP), a subsidiary of Children's Hospital of Pittsburgh of UPMC, launched the **SMART (Screening, Motivational Interviewing and Referral to Treatment) Choices program.** A key component of this center is the development of the *Substance Use Prevention* model, which trains pediatricians to evaluate their patients for risk of addiction and allows them to refer their patients and families to on-site, specially trained behavioral health specialists for necessary intervention and treatment.

These programs must continue to have funding in order to be able to address the known risk factors for substance use and those factors that contribute to prescription drug and opioid misuse.

Treatment and Disease Management

We need to provide and fund effective treatment, disease management and support for those with addiction. UPMC offers a comprehensive approach that begins with childhood preventive services, as mentioned above, and extends to intervention and treatment serves. At UPMC, we understand that opioid addiction is a chronic

illness and thus offer a wide-range of support for those with substance use problems, many of whom also have co-occurring psychiatric disorders. AMS provides ambulatory detoxification; intensive outpatient and medication-assisted (Buprenorphine & Vivitrol) treatment at the **Center for Psychiatric and Chemical Dependency Services**; as well as providing medication-assisted (Methadone & Buprenorphine) treatment at the **Narcotic Addiction Treatment Program**.

Fully Integrated Addiction Medicine

The time has come for addiction medicine to be fully integrated into health care systems and medical practices. Health care providers, especially physicians, are our front line in disease prevention and treatment. They must understand the risk factors for addiction, screen for risky substance use and intervene when needed, to diagnose, treat and manage addiction just as they do all other diseases. The UPMC School of Medicine is preparing medical students in addressing substance use problems by training them in evidenced-based practices to identify, screen and engage individuals in need of services.

The Magee Women's Hospital of UPMC developed the Pregnancy Recovery Center that ensures pregnant women who are using substances are receiving the care, treatment, and support needed in order for them to engage in recovery and deliver healthy babies.

- The AMS program employs Peer Navigators – people who have lived experience in recovery from substance use and mental health problems – to assist patients in navigating the health and behavioral health systems.

These programs must receive adequate funding and reimbursement rates that help.

Policies and Regulations

We need to ensure all of our providers have *updated information* – policies and regulations - and tools needed to prevent, intervene and treat people who are at risk or have substance use problems. We need to support AND fund the **Comprehensive Addiction and Recovery Act (CARA)** which promotes a wide *range of evidence-based best practices* including public education and awareness campaigns, screening and early intervention (SBIRT), opioid overdose prevention programs, expanded access to medication-assisted treatment (MAT) and prescription drug monitoring programs and provide recovery services to address and reduce the collateral consequences from drug convictions.

CARA designates funding for evidence-based programs and communities experiencing a high rate or sudden increase in opioid use. We are one of those communities. In 2015, 3383 drug-related overdose deaths were reported in Pennsylvania which is an increase of 23.4% from the total reported in 2014.

Allegheny County experienced a rate of 34.30 overdose deaths per 100,000 people which is a 37% increase from 2014. http://www.overdosefreepa.pitt.edu/wp-content/uploads/2016/07/Analysis-of-Drug-Related-Overdose-Deaths-in-Pennsylvania-2015.

We need to continue to provide **specialized programs** to improve the health and wellness of our children and to reduce multi-generational addiction. We need to support improved treatment opportunities for pregnant and post-partum women. We need to provide funding for residential treatment programs for pregnant and post-partum women and support pediatric and family-based services and develop new types of treatment for this population (**Improved treatment for pregnant and postpartum women act of 2015).**

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Gateway Health
A better way.℠

Public Hearing Testimony Provided by Gateway Health℠
Confronting the Heroin/Opioid Epidemic in Pennsylvania
Tuesday, August 2nd, 2016

Good afternoon Representative Gainey and the HOPE Caucus members.
Thank you very much for your commitment to confronting the significant Heroin/Opioid epidemic here in the Commonwealth and providing this forum to share information on tangible strategies to assist in this effort.

I am Dr. Michael Madden, Chief Medical Officer of Gateway Health℠ where I have played an active role in assisting our members with behavioral health and substance use disorders. Gateway Health℠ is a mission driven managed care organization, based in Pittsburgh and has proudly served the Commonwealth's Medicaid and Medicare Advantage Special Needs communities for over 23 and 10 years respectively. In Pennsylvania, we serve over 312,000 Medicaid beneficiaries in 40 counties and in excess of 50,000 Medicare Advantage Special Needs beneficiaries in 39 counties. In total, Gateway Health serves over 533,000 low income individuals in six states.

Gateway Health℠ and Neonatal Abstinence Syndrome (NAS)

Gateway has had a deep commitment to optimizing the care of pregnant women with substance use disorders (SUDs) as well as their infants. Beginning in 2004, an advisory group of highly invested stakeholders from across Pennsylvania was convened to study best practices in managing the care of infants whose mothers used AODs, particularly opioid-type drugs. This group was comprised of physicians and other clinicians from the Thomas Jefferson Medical College, Allegheny Health Network, Magee-Women's Hospital and Children's Hospital of UPMC, Lancaster General Women and Babies Hospital, St. Christopher's Hospital for Children, and the Pittsburgh Mercy Health System.

Within this group, Gateway embraced a leadership role to pool together experienced clinicians as well as state and agency administrators, and researchers to develop and implement best practices that have become the foundation of care provided to opiate exposed women and their infants. Outcomes of this collaboration now lasting over a decade, has produced several products to assist clinicians in improving their treatment of women who use SUDs during pregnancy and their children including:

- An instructional DVD on Neonatal Abstinence Syndrome (NAS): Assessing the Infant, produced with WQED Multimedia in Pittsburgh to teach and validate the scoring of infants for NAS;
- An NAS Clinical Management Document developed as a guide for the management of NAS by clinicians to maintain consistency and best practices implemented to optimize the health outcomes of these infants;
- 3 Major Conferences in Pennsylvania:
  - Pregnant Women with Opiate Dependence: Identification and Treatment and Neonatal Abstinence Syndrome: Assessing the Infant, both held in Pittsburgh in 2006;
  - Identification and Treatment of Pregnant, Opioid Dependent Women and Their Newborns, held in Hershey in 2008; and
  - The Impact of Substance Use on Pregnant Women and Their Newborns, held at Geisinger Health System in 2010.

The NAS DVD has been available to clinicians and distributed across the nation as a training tool to support the competency of Neonatal Intensive Care Unit personnel scoring and treating infants exposed to opiates in utero. The companion document was updated in 2010 to reflect the best practices at that time to optimize the health outcomes of the infants. Since that time, trials using buprenorphine to detoxify infants has brought new information to the management of those infants of women using opiates during pregnancy.

Today, Gateway still embraces a leading role within the Commonwealth's Medicaid managed care organization (MCO) community in developing best practices to effectively treat pregnant, opiate using women and their children. This is done through collaboration with the PA Department of Human Services (DHS) in establishing a medical home model, where Suboxone is offered and prescribed as part of the prenatal treatment in an obstetrical setting for women in southwestern Pennsylvania. We also lead the collaboration between the Commonwealth's Medicaid physical and behavioral health MCOs as well as clinical and SUD treatment professionals in this area.

As a result, we have seen the creation of the Pregnancy Recovery Center (PRC) at Magee Women's Hospital of UPMC in Pittsburgh which began operation in July 2014. Opiate using women receive therapy being converted from street drugs to Subutex (very similar to Suboxone) in an outpatient setting while continuing to get their Pregnancy and Medication Assisted Therapy (MAT) in one location. The approach at the PRC is closely tied to social work services and 100% focused on appropriately addressing the medical-social needs of these women. The PRC is delivering superior care at lower costs and only 1/3 of the infants of opiate using women require treatment for NAS once they are born. The results of the 1st year of this program include:

- 60% of the women enrolled completing their pregnancy are free of other drugs
- Of 108 patients, 39 have graduated to Community Recovery
- Of 49 babies delivered, 30 did not require medication for NAS. 32 mothers are breastfeeding

Magee Women's Hospital is looking to expand this program to other locations. Gateway is now assisting Allegheny Health Network in developing a similar program at several of its hospitals. DHS is hopeful that 20 centers around the Commonwealth will be developed and has included funding for this initiative in the physical health (PH) Medicaid MCO rates for this year and made it a contract expectation to continue this effort in 2017.

Gateway Health℠ and "Cash Clinics"

Pennsylvania has a significant issue finding sufficient physicians to provide legitimate MAT to Medicaid enrollees. In recent years, we have seen a proliferation of "cash clinics" in which providers are charging Medicaid recipient's cash for this care. Gateway has aggressively attacked this issue by identifying such clinics, auditing them, offering them opportunity to become legitimate, quality providers for our plan members, or shutting off their ability to prescribe for our plan members as long as we can assure a legitimate alternate location for their care.

We have developed audit tools and processes, MAT-only provider contracts, MAT provider directories, and educated the Commonwealth's Medicaid PH and behavioral health (BH) MCOs in such processes at a Summit convened by DHS for this purpose. Our activities have resulted in reducing the proportion of our members receiving their MAT from non-participating providers. DHS has responded to the "cash

clinic" issue in 2016 by creating the Opioid Use Disorder Center of Excellence program, providing grants for participating providers to add a minimum of 300 slots for treatment purposes and meet high quality standards. 20 grantees have been announced and we look forward to referring our members to these sites of quality care. But, many more are needed.

Gateway Health℠ and SBIRT

SBIRT (Screening, Brief Intervention, and Referral to Treatment) is an evidence based practice used to identify, reduce, and prevent problematic use, abuse and dependence on alcohol and other drugs. Primary care providers (PCPs) and emergency departments (EDs) using SBIRT is a strategy recognized nationally to improve recognition of substance abuse and improve the rate of patients getting into necessary treatment. Gateway has supported projects to employ this method in local ED's and PCP offices. We have also developed contract addenda to pay PCP's for providing this care. We previously participated in a collaboration with the University of Pittsburgh, Allegheny General Hospital (AGH) and UPMC to provide SBIRT to patients in the Emergency Department at AGH. This study demonstrated substantial cost savings compared to patients who were not screened in prior years and a control group at the Mercy Hospital ED. We are currently participants in a grant program with DHS, AGH and UPMC designed to 1) train peer navigators at three hospitals to be "consultants" for nursing units to provide this service, and 2) train social work staff at an additional hospital to screen and get medical patients into treatment.

Recipient Restriction

In collaboration with DHS, we actively use the Medical Assistance Recipient Restriction Program, commonly referred to as the Lock-In Program, to stem opioid abuse. It creates the ability for us to restrict members to one Primary Care Physician and/or one pharmacy of the member's choice for a period of 5 years for opioid prescriptions. This is a program to detect and deter member over utilization, fraud and/or abuse. We look at members seeing 3 or more physicians for the same problem within a 30 day period, or filling medications at 3 or more different pharmacies. In 2015, Gateway Health reviewed over 2300 members and succeeded in adding 476 newly restricted members to the Recipient Restriction Program. As of the end of May 2016, we have a total of 688 restricted members. Gateway leads the MCOs in the state of PA for total restricted members. Of the newly restricted members in 2015-2016, 64 members appealed, and Gateway Health has never lost an appeal hearing. The data has always supported the restriction. The lock-in membership totals have been estimated to save Gateway Health and the state of Pennsylvania $1.5 million in 2015, and it's been very gratifying that a significant number of those members locked-in have started treatment for their opioid dependence with Suboxone. We have had members tell us that we have saved their lives by getting them into this program.

Naloxone – a rescue medication

In an overdose setting, Naloxone (brand name Narcan) can be lifesaving. Historically, very few addicts or others on high doses of narcotics had it in their homes. In the last year, Dr. Karen Hacker, Director of the Allegheny County Health Department and Dr. Rachel Levine of the Department of Health, issued standing orders so the residents (or their family members) of Allegheny County and now the whole state, can get this medication without the need of admitting their addiction to anyone. This will save lives and Gateway has paid for 200 doses, just in the last 6 months.

Privacy Laws that Complicate Care

I would also like to comment on a major barrier that we face. The Behavioral and Physical Health MCO's face a real challenge in coordinating care for shared members with AOD's, since the Pennsylvania D&A Abuse Control Act (71 P. S. § 1690.108(c)), prohibits the sharing of this information without individual member consent. The MCO's receive a Service history File from DHS, but all information regarding AOD treatment is scrubbed from this file. I strongly urge you to reconsider this privacy policy which I believes serves to further stigmatized persons with SUD's and further complicates our ability to provide them comprehensive care.

In summary, we are proud to be associated with this body of work thus far and highly encouraged to know that particularly in the treatment of NAS, it has served as a practical guide to professionals nationally seeking to achieve the best outcomes relative to treating this scourge of narcotic addiction, particularly in pregnant women who use opiates and their exposed infants.

We welcome, and look forward to continue working with the Commonwealth and other committed partners to reign in the devastating impact of opiate addiction and dramatically improve the health outcomes and overall quality of life for those addicted and their loved ones.

Thank you for your time and attention.

Michael Madden MD

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Adrienne Smith, Person in Long-Term Recovery

My name is Adrienne Smith and I am a woman in long-term recovery. What that means to me is that I have not used any mood or mind altering substances in over 5 ½ years. I am a registered voter, an employee, a wife, a positive role model to my nephew, a volunteer, and an upstanding member of my community.

I started using alcohol and marijuana at age 13. From that time, I used at least one substance every day for the next 26 years except for the few days that I was unable to get something or was in treatment.

At the age of 18, I added powdered cocaine to the mix.

All the while, maintaining excellent grades in school with little effort.

I was always looking for the maximum outcome with the least amount of effort.

I felt that if I was maintaining good grades and had a job then there wasn't a problem.

Opiates, in the form of other people's prescription pain medication, entered the picture when I was about 25.

They gave me energy and the ability to work long hours and continue my education.

By then I had earned my BSBA and had a good job.

Along with my husband, we also owned our own business, our own home, three rental properties, and 5 vehicles.

Keeping up with all the work we had created started becoming more difficult.

Crack cocaine and heroin entered the picture, and then I quickly lost the ability to maintain my lifestyle.

Work, morals, and possessions became secondary.

Within the next year, I became homeless, penniless, jobless, helpless, hopeless, and unattached to reality.

I began committing more serious crimes and taking part in demoralizing activities.

My perception became distorted.

Drugs became the only thing that mattered.

I didn't see a way out.

The disease of addiction altered my ability to problem solve,

I actually thought that the problem was that I didn't have enough drugs.

Getting robbed at gunpoint during drug deals on the street and home invasions became an acceptable way to live.

I didn't see a problem with not having utilities.

This is how much my addiction distorted my perception.

[MORE ON BACK]

I knew that 28 days in rehab wasn't going to repair all of the damage and chaos in my life.

Thank God I finally got arrested.

I was facing a mandatory minimum of 2-4 years.

I convinced myself that 2-4 years wouldn't seem long and that I could get out and continue my drug use where I had left off.

Recovery didn't seem like a realistic option.

My husband, who had been in recovery for a year, and my attorney talked me into entering Allegheny County Drug Court.

Drug court told me to get into a long term treatment facility or I would go to jail on my trial date.

I chose jail.

I could not stop using.

I wasn't a bad person that needed to get better, I was a sick person that needed to get well.

After 21 days in jail, I was placed in a 6 month, 3C level of care. Then I was fortunate enough to live in supportive housing while attending Intensive outpatient 3 days per week. The supportive housing program mandated and provided transportation to 12 step, mutual aid support meetings.

None of these levels of care told me about the MATP, showed me how to make and follow a budget, or taught me about time management. I had to learn from another client how to utilize and navigate public transportation. I thought my credit was beyond repair. I was fortunate enough to have had many these skills prior to my treatment. Even after a year of recovery, I still struggled with communication skills, feelings of inferiority and self esteem issues. Many individuals suffering from substance use disorder do not have these skills. This is why Peer Based Recovery Support Services are so important.

I got a referral to a paid Recovery Support provider while in inpatient treatment.
I did not hear from the agency until six months later.

I was fortunate enough to have met volunteers of Message Carriers and Lost Dreams Awakening who provided me with Recovery Support Services. The recourses that I continue to acquire from volunteering myself at these organizations are immeasurable.

Even if one has these skills, how useful are they if the individual's basic needs are not satisfied? I would not have been able to stay clean without a home, clothing, or food. How would I have gotten to treatment without transportation? How would I even have been accepted into treatment without insurance? How would I have gotten to mutual aid support meetings had I not owned a car or already known someone that would take me?

Timeliness is critical for recovery. Waiting for these services can be the difference between life and death. I believe that if more paid Peer Based Recovery Support Services were available then more people could and would find and sustain recovery.

I am one of the lucky ones.