COUNCIL OF THE CITY OF PHILADELPHIA

COMMITTEE ON PUBLIC HEALTH AND

HUMAN SERVICES

Room 400, City Hall
Philadelphia, Pennsylvania
Monday, March 12, 2018
10:05 a.m.

PRESENT:
COUNCILWOMAN CINDY BASS, CHAIR
COUNCILWOMAN JANNIE L. BLACKWELL
COUNCILMAN WILLIAM K. GREENLEE
COUNCILWOMAN HELEN GYM
COUNCILMAN BOBBY HENON
COUNCILMAN CURTIS JONES, JR.
COUNCILWOMAN MARIA D. QUINONES-SANCHEZ
COUNCILMAN MARK SQUILLA
COUNCILMAN AL TAUBENBERGER

RESOLUTION 180037 - Resolution authorizing the Committee on Public Health and Human Services to hold hearings to assess the City of Philadelphia's efforts, as coordinated by the Managing Director's office and our Human services departments, to prevent and treat abuse, addiction, and disease related to the use of opioids.

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COUNCILWOMAN BASS: Good morning. This hearing is called to order. This is the public hearing of the City Council Committee on Public Health and Human Services. The purpose of this meeting is to hear testimony on Resolution No. 180037.

Members of the Committee in attendance are Councilman Bill Greenlee and Councilwoman Maria Quinones-Sanchez.

And I wanted to ask Councilwoman Sanchez for opening remarks as the sponsor of the resolution.

COUNCILWOMAN SANCHEZ: Thank you, Madam Chair. I will be brief, as I expect most of our speakers to be quite eloquent in their presentations around what has been in many cases tremendous work and strive by folks to grapple with what everybody, both the President and the Governor, has identified as America's crisis.

I particularly want to thank the stakeholders and the community folks

who have been on the ground and have done everything they can to be as supportive as they possibly can.

Why the resolution and why this time? I think it's hugely important that those of us in policy positions and the community understand what in fact the City is doing. There's millions, if not billions, of dollars invested in the opioid situation in the City. We've seen additional resources added and commitments by the Governor and the President. I think it's only fitting that at this particular time, we have a public discussion -- let me emphasize that -- a public discussion about where your money is going, what policies do we have in place, what regulations we have in place, and what are the barriers, those created by the bureaucracy, those managed by the bureaucracy, so that we can meet people where they are and help them through this lifetime situation and at the same time manage the quality of

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life and its impact and minimizing the impact it has on residents and neighbors.

I think that in all of my years in community development work, and I've been at this for a minute, 30-plus years, never have I seen such a complicated, layered situation as I see in the community. I will be unapologetic in my defense for everyone in my district, but in particular the young people who now have -- we have almost normalized what is not normal. Those of us as we sit back and we theorize about what we should be doing really need to pay more attention. And I have a graphic that I will be putting up. It's a photo.

Andre, if you can put that up.

This was sent to me recently through Instagram by one of the Shutterbug. Shutterbug is a small group of photographers out of Stetson. It's a group that we sponsor. And it's an Instagram that he has, and Xavier explains it the best. He takes a picture

of trash and he talks about what happens underneath those tracks every day, the people that he wants to be sympathetic to but at the same time feels extremely distraught at the fact that he can't walk through there and that at night unseemly things happen there.

It is because of Xavier and others that we have to be focused, intentional, and much quicker at addressing this situation. The residents of Kensington and the area that both Councilman Squilla and I represent have been patient. They rolled up their sleeves. They've cleaned streets with us. They've done everything that they can, and yet they're still at basta ya. Basta ya. This is only but so much you can take.

It is sad when I sit and talk to the seniors who live at Somerset Villas who tell me, Maria, I can't even walk over to Kensington to do my daily shopping. There's 100-plus seniors who

are trapped in their apartment complex over on Somerset Villas.

This is not a creation of one thing, and there's definitely enough blame to go around. This is a public discussion about what we're doing, what we're not doing, what we need to do and, more importantly, how we are going to make sure that we are addressing this in a way that is balanced and fair. And sometimes you got to look back to be able to look forward, and we got to look at what we did, because insanity is -- the definition of insanity is doing the same thing and expecting a different response. And I think we have made strides, but I still think we could do more and I still think we need to do more, and this public discussion is about the solutions and not the blaming of why we are what I consider to be a perfect storm of a lot of bad things happening in one geographic location.

So I want to thank all of you

from the beginning. I want us to be respectful in our disagreements, respectful in our passion. There's no one more passionate than this fierce Latina in front of you, but let me tell you that never have I felt more committed and more optimistic, because I do know that the stakeholders on the ground who have been doing this are just as committed to do this. And what I want to do here is figure out how government helps and how government stays out of the way.

Thank you very much, Madam Chairwoman.

COUNCILWOMAN BASS: Thank you, Councilwoman.

I want to acknowledge Councilwoman Helen Gym has joined us.

And I'm going to ask the Clerk to now read the title of the resolution and then I'd like to give remarks.

THE CLERK: Resolution No. 180037, authorizing the Committee on

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Public Health and Human Services to hold hearings to assess the City of Philadelphia's efforts, as coordinated by the Managing Director's office and our Human services departments, to prevent and treat abuse, addiction, and disease related to the use of opioids.

COUNCILWOMAN BASS: Thank you very much.

And I just wanted to echo Councilwoman Sanchez's comments and just to add to those comments, that this is a very difficult topic obviously, but I really wanted to state that there are no throwaway people, and I think that sometimes that gets lost in the conversation.

From the recording of your birth certificate to your death certificate, as a municipality we have an obligation to ensure the best care and treatment for all, regardless of how they live, who they associated with, their struggles and their challenges, and how

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they die, all without judgment. We all need to stand with those who are dealing with substance abuse and their army of supporters.

I'm so proud of Philadelphia's advocacy community, and although sometimes we may agree to disagree, it is as clear as they are loud and clear that we are all in the fight to save people's lives.

There must be a degree of unity among us all, and the purpose of today's hearing is to find that point, find that spot where we can begin to address the crisis that is in front of us and address it in a way that's going to save lives.

And so that being said, I'd like to ask the Clerk to call the first panel to testify.

THE CLERK: Eva Gladstein, Deputy Managing Director of Health and Human Services; Tom Farley, Health Commissioner, City of Philadelphia; David Jones, Commissioner, Department of

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Behavioral Health and Intellectual disAbility Services; Rebecca Rhynhart, City Controller; Liz Hersh, Director, Office of Homeless Services.

(Witnesses approached witness table.)

COUNCILWOMAN BASS: Good morning.

MS. GLADSTEIN: Good morning.

COUNCILWOMAN BASS: Please state your name for the record and begin your testimony.

MS. GLADSTEIN: My name is Eva Gladstein. I'm Deputy Managing Director for Health and Human Services for the City of Philadelphia.

Good morning, Councilwoman Bass and other members of the Committee. Thank you for the opportunity to testify today regarding Resolution No. 180037 to assess the City's efforts to prevent and treat abuse, addiction, and disease related to the use of opioids.

Our cabinet of health and human

services consists of five agencies that collectively work to ensure that our City's most vulnerable citizens are healthy, safe, and supported. They are the Department of Behavioral Health and Intellectual disAbility Services, the Office of Community Empowerment and Opportunity, the Office of Homeless Services, the Department of Public Health, and the Department of Human Services. I'm joined today by three of those agencies, Behavioral Health and Intellectual disAbility Services, Homeless Services, and Public Health. I'll mention the other agencies are present in the room today, but it's just myself and those three agencies that are planning to testify at this point in time.

Today, we are going to review the scope of the opioid epidemic, how we have organized ourselves to effectively tackle the biggest public health crisis in the last century, and addressing the

impact on our communities.

We anticipate when the numbers are finalized, four times as many people will have died of drug overdoses in 2017 as compared to the number who were victims of homicide. Roughly 1,200 people will have died of overdoses during 2017. This is as compared to 907 people in 2016 and 701 people in 2015. We know that about 80 percent of these deaths involved opioids.

Recognizing the scope of this public health crisis, the Mayor created the Mayor's Task Force to Combat the Opioid Crisis in early 2017, a little bit over a year ago. Its charge was to develop a comprehensive and coordinated plan to reduce opioid abuse, dependence, and overdose. It had a very robust civic engagement process. It hosted listening sessions across the City to gather input from residents. In addition, over 200 people actually participated either as a member of the Task Force or one of its

four working committees. All of the meetings were open to the public, and they were very well attended. We were pleased that Councilman Oh was able to participate as a representative of City Council in that Task Force.

It completed its work in April, and we presented the final report to Mayor Kenney on May 19th. The report -- and I just have one copy here, but we'll be happy to make available if members of Council have not yet seen it -- includes 18 recommendations. They're in the areas of prevention and education, treatment, overdose prevention, and the involvement of the criminal justice system. We've been working diligently to implement those recommendations. Our progress is reported in quarterly public meetings hosted by the Mayor's Executive Commission on Drugs and Alcohol. Again, those reports are posted publicly. They're available, and those meetings are welcome and open to the public.

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We work as a cabinet, meeting regularly and integrating our services to increase our effectiveness. The Department of Public Health has taken the lead on prevention and education, working with insurers, health systems, and doctors to slow down the momentum of the epidemic. They have also focused on harm reduction, specifically the distribution of naloxone, or as it's known Narcan, which is the overdose antidote.

Behavioral Health has been working diligently on expanding its treatment continuum, engaging people and helping them get into treatment.

I want to spend a minute here talking about our unique opportunity that we have as the City of Philadelphia regarding behavioral health services for people who are eligible for Medicaid. One of DBH's components is Community Behavioral Health, which we call CBH. It's a non-profit organization that was established over 20 years ago, and it is

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a Medicaid managed care organization for behavioral health services. It operates much the same way as managed care plans through which we all get our health coverage. The City receives an annual capitation from the state, which is an amount of money that we can pay for service for each member covered by the plan. These are state and federal Medicaid dollars and are highly regulated by both federal and state rules. CBH is responsible for paying providers for care its members need, according to those rules.

Like other managed care plans, CBH credentials the providers who participate in the network, negotiates rates with those providers, and manages the care of eligible members. Because CBH is a non-profit organization, it does not take a profit. Its administrative costs are 7 percent, and they are among the lowest of Medicaid behavioral health MCOs in the state. As a result, CBH has

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one of the most well-developed continuums of treatment services available to Medicaid members.

We're proud of this publicly governed non-profit managed care entity, which is an alternative to the standalone for-profit managed care companies that manage behavioral healthcare for Medicaid beneficiaries in other parts of the state. Our plan is especially an asset in times like this when the epidemic requires close integration with other aspects of the City's social services and health.

Under the Kenney Administration, we have continued to build on the strong history and to strengthen integration with other cabinet agencies and key partners in the City. For example, last year we expanded CBH's Board of Directors to include Commissioner Farley and Director Liz Hersh of the Office of Homeless Services, as well adding the Superintendent of the

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School District, Dr. William Hite, and Keir Bradford-Grey, who is the Chief Defender of the Defenders Association of Philadelphia.

In our testimony today, Commissioner Farley will provide more detail on the prevention, education, and harm reduction measures we are taking to address the opioid epidemic.

Commissioner Jones will describe the continuum of available treatment options, innovative programs to encourage people with substance use disorder to enter treatment, and provide more detail on how CBH ensures the quality of providers and consumer satisfaction as well.

Finally, Liz Hersh, Director of the Office of Homeless Services, will provide information on how we are addressing some of the community impacts of the opioid crisis. She will share information on low-barrier housing options and new models that are working

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to provide housing stability and enabling people to choose to enter treatment.

I want to follow on Councilwoman Sanchez's remarks and talk a little bit about the impact the opioid epidemic has had on communities, especially in Kensington.

We have convened a working group for the last several months consisting of about four or five City agencies and several external partners to develop what we're calling an Encampment Resolution plan. We will be sharing the preliminary plan actually this evening with four of the civic associations in that neighborhood, and we'll then be sharing with several other organizations in the community. We want to receive their input and make adjustments to the plan based upon their feedback. Once we have finished that process, which should be completed within the next week or two, we will share it more broadly with the general public and certainly with Council

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offices. We'll brief Council offices on the preliminary plan, but we don't want to put it out there publicly until we've been able to work with the local civic associations.

I wanted to close by sharing that the Mayor's budget proposal includes additional resources to address the opioid crisis. It includes funding for an additional 140 units of low-barrier housing focused on the Kensington community -- Liz Hersh will be speaking more about that -- a police-assisted diversion program for low-level crimes in the East Division that will enable us to move people to services; resources to continue to train doctors on the evidence-based medication assisted treatment; additional supplies of Narcan; and an alternative EMS response unit that the Fire Department will operate that will help connect people to treatment; and, finally, resources to develop a litter clean-up program in Kensington.

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These additional efforts will help us continue to work towards turning the tide on this epidemic, improving the lives of Philadelphians who have been impacted by the crisis.

My written testimony fails to mention that the amount that's in the Five Year Plan is about $20 million for these new services, new resources.

Thank you again for the opportunity to testify, and I'll be available to answer questions.

COUNCILWOMAN BASS: Thank you for your testimony.

I want to acknowledge Councilman Bobby Henon has joined us.

And if we could have the next panel state your name for the record and begin your testimony, and we'll have questions at the end of the panel.

COMMISSIONER FARLEY: Good morning, Councilwoman Bass and members of the Committee. I'm Dr. Thomas Farley, Commissioner for the Department of Public

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Health.

The opioid problem is perhaps the greatest public health crisis this city has faced in the last century. As Deputy Managing Director Gladstein said, when we have finished compiling our data for 2017, we expect to have counted more than 1,200 people in Philadelphia dying of drug overdose, with more than 80 percent of those overdoses involving opioids, including prescription opioids, heroin, and fentanyl.

Those overdose deaths have hit every demographic group in every corner of Philadelphia. For example, in the first nine months of 2017 alone, we saw 569 overdose deaths in Caucasians, 248 overdose deaths in African Americans, and 126 overdose deaths in Hispanics. In every race and ethnic group, the number of deaths from drug overdose was far higher than the number of deaths from homicide.

Every neighborhood in the City

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is hit hard. Of the overdose deaths that we have mapped so far in 2017, Council District 8 has seen 66 overdose deaths, District 5 has seen 95 deaths, District 6 has seen 122 deaths, and District 7 has seen 287 deaths. No Council district will have had fewer than 40 people who died of drug overdose in 2017.

Even this number of overdose deaths represents just the tip of a huge iceberg of opioid use and addiction. We estimate that between 50,000 and 70,000 persons in Philadelphia are currently using heroin; 168,000 people, or one in seven adults, are currently taking prescription opioids; and nearly 500,000, or one in three adults, received a prescription for opioids in the previous 12 months.

This crisis is fed by three problems. First, doctors and other healthcare providers, strongly encouraged by drug companies, are prescribing far too many opioids, causing many people to

get addicted who otherwise would not.

Second, according to the DEA data, Philadelphia has the purest and cheapest heroin of all big cities in the nation.

Third, street corner drug dealers are now distributing fentanyl, a highly potent synthetic opioid that is particularly addictive and deadly.

The crisis has many manifestations and touches nearly everyone directly or indirectly. It has greatly increased the number of people who are addicted and need substance use treatment. It has increased the number of workers who have difficulty functioning because they're under the influence of drugs. It has increased the spread of hepatitis C from people sharing syringes. It has put strains on hospital emergency departments and EMS crews dealing with non-fatal overdoses. It has led to large increases in babies born addicted to opioids, which will further

stress the child welfare system. It has led to increases in people who are living on the streets of Philadelphia and fed the homicide problem from drug dealers fighting over turf.

There is no single solution to this crisis. Addressing the problem requires many actions by many organizations. The Philadelphia Department of Public Health is one of the City agencies implementing the 18 recommendations of the Mayor's Task Force on Opioids.

To prevent people from becoming addicted, we are working to get medical professionals to reduce their prescribing of opioids. Our work includes mailing treatment guidelines to 16,000 physicians in the greater Philadelphia area; mailing dashboards to more than 2,600 prescribers that show how their describing compares to their peers; having staff visit over 1,300 prescribers in their offices to deliver clear recommendations on

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prescribing less; and working with every healthcare system in Philadelphia and every health insurer in Pennsylvania to discourage opioid prescribing by their healthcare providers.

Paired with this work, we have run mass media campaigns directed to consumers called Don't Take the Risk, warning about the risks of opioids, even if a doctor prescribes these drugs.

For people who are dependent on opioids, we are working with the Department of Behavioral Health and Intellectual disAbility Services to expand medication assisted treatment by physicians. The specialized substance use treatment system will need to be supplemented by MAT offered in medical practices if we are to reach everyone who needs treatment.

My department is also working with the Department of Behavioral Health and Intellectual disAbility Services on overdose prevention and harm reduction.

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We provide funding to Prevention Point for their work to prevent HIV and prevent overdoses. We distribute the opioid antidote naloxone to many different organizations that either use it to revive people or give it to drug users and people in contact with them. This fiscal year we have already distributed over 28,000 doses of naloxone. And this week we're launching a media campaign encouraging everyone to carry naloxone.

I'm available to answer any of your questions.

COUNCILWOMAN BASS: Thank you very much, Commissioner.

And if you would state your name for the record and begin your testimony.

COMMISSIONER JONES: David T. Jones.

Again, good morning, Chairwoman Cindy Bass, Vice Chairwoman Maria Quinones-Sanchez, members of the Committee on Public Health and Human

Services. Again, I am David T. Jones, Commissioner of the Department of Behavioral Health and Intellectual disAbility Services. Thank you for the opportunity to testify in response to Resolution No. 180037.

DBHIDS is responsible for oversight of our provider network that serves children, youth, adults, and families in Philadelphia with behavioral health challenges and/or intellectual disabilities.

Today's testimony will focus on the following three areas: DBHIDS response's to the opioid epidemic, the treatment continuum with a focus on substance use disorder and access points, quality oversight of the DBHIDS provider network.

Much of this work is centered at Community Behavioral Health, which, as Eva described, is a City-governed non-profit managed care entity that delivers behavioral health for

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Medicaid-eligible individuals. DBH also manages services for individuals who are uninsured.

Our work touches many lives. Both national and Philadelphia data indicates that one in five people experience some form of mental illness and/or substance use disorder. In Calendar Year 2016, Community Behavioral Health had nearly 700,000 members enrolled in Medicaid, nearly half of all Philadelphians. Of those who were enrolled in Medicaid or uninsured, 170,000 were directly served by DBHIDS, which is 24 percent of those enrolled. This is consistent with national rates of behavioral health services utilization.

Regarding the opioid epidemic, you've heard already from others about the unprecedented magnitude of the crisis. I will just underscore that and say that ensuring that individuals who have opioid use disorder having access to treatment is among my highest priority as

Commissioner as well as for the Department as a whole. We are making progress. In Calendar Year 2016, more than 26,000 individuals participated in substance use disorder treatment services and about 14,000 of whom were treated for opioid use disorder.

To give you a sense of the size of our network, CBH contracts with over 175 separate clinical programs and service locations, and if you look at our department more widely, it's over 200 providers. These contracted entities comprise over 2,000 beds, including inpatient hospitalization programs, residential programs for rehabilitation and detoxification, and halfway houses.

In addition to the bed-based services, CBH also offers its member services of varying levels of intensity within ambulatory and community-based settings. These services include outpatient and intensive outpatient programs, partial hospitalization, and

services designed to keep recipients in community settings such as case management and peer specialist services.

Our efforts to address the epidemic are centered around making sure treatment is accessible and removing any barriers that keep it from being so and making sure treatment is of high quality and effective.

I will talk in a moment about our general quality efforts, but in the area of opioid use disorder, as you've heard, the most effective treatment is medication assisted treatment. MAT is the use of medications such as methadone, buprenorphine or Vivitrol in combination with counseling and behavioral therapies. Research has demonstrated that MAT is twice as effective as other types of treatment for opioid use disorder, so much of our work is focused on increasing the availability and use of MAT in Philadelphia at all levels of care.

Some of our work to increase

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access involves bringing resources to where folks are. For example, through our coordinated response by facilitating addiction treatment, we've increased the number of days a week we are offering on-site assessment at Prevention Point Philadelphia, as well providing a mobile medical vehicle that takes services to individuals in need of treatment. We also have added funds to a program that helps individuals to obtain identification cards for treatment services.

In coordination with our community partners that include again Prevention Point, Project HOME, and One Day At A Time, we've expanded outreach efforts to engage individuals and connect them to services, supports, and treatments in the Kensington/Fairhill area. We've begun a warm handoff program at Temple Episcopal Emergency Room and the Crisis Response Center so that individuals who present after overdose or

for other health needs can be connected to treatment. The program, which uses certified recovery specialists, served 125 individuals in the month of January, resulting in 78 coordinated referrals to treatment.

While thanks to Medicaid expansion many more individuals are eligible for CBH services, there are some individuals who are not insured, and we've streamlined our access to same-day services for those who are uninsured.

We are also increasing access by scaling up treatment providers' capacity. For example, we've added a partial hospitalization program and we began medication assisted treatment at Kensington from 160 to 300 slots to serve individuals with substance use or significant co-occurring challenges. This year we've also increased availability of buprenorphine by about tenfold, from approximately 100 slots to more than 1,000 slots.

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To be consistent with national best practices and to move away from stand-alone detox, which has been shown to be less effective, we are working to embed withdrawal management, including medication assisted treatment to help manage withdrawal management symptoms across all levels of care, working towards the goal of having all providers offer the service. Withdrawal management is currently being offered in the community through several providers, including PHMC Pathways to Recovery, Northwest Human Services, and Wedge Recovery Centers.

Recognizing the importance of stable housing to recovery, we've expanded the use of 17 DBH-funded recovery houses from 300 to 333 beds and added a seventh site to our Journey of Hope housing program, which increased capacity to 128 beds. We've also extended hours of some residential programs to take individuals after 5:00

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p.m. and during the weekends.

We are also supporting eight newly funded substance use disorder early intervention programs to provide individual, group, and family therapy.

At the same time, we are working in concert with the Health Department and other City and community partners to reduce fatal overdoses and save lives. Last year, DBHIDS Narcan Training Series trained more than 700 individuals to administer Narcan and distributed 265 Narcan kits to individuals trained. This year, we hope to train an additional 700 individuals. Our trainings are open to all City department employees, peers, family members, provider agencies, stakeholders, and the public. We also plan to distribute more than 16,000 doses of naloxone to partners this year.

Now I will talk about how we ensure that individuals -- that our services are high quality and providers

are following the state and federal rules that apply to Medicaid. Like any managed care plan, CBH has an extensive structure in place to monitor providers' adherence to programmatic and contractual obligations. The Network Improvement and Accountability Collaborative Division at DBH is responsible for monitoring and reviewing all providers. The Quality Management Division serves as a hub for assessing significant incidents, quality of care concerns, and complaints and grievances for the purposes of problem-solving, trending, and case analysis and to develop safeguards to prevent future occurrences.

Additionally, there is a Compliance Division, which assists in facilitating adherence to applicable federal and state regulations governing the Medicaid program as well as CBH policies and procedures.

Finally, the Consumer Satisfaction Team, which was created in

1990, was the first organization of its kind in the country staffed entirely by recipients of behavioral health services and family members. CST's goal is to ascertain whether members and/or family members are satisfied with the services.

We have provided an overview of the Department's response to the opioid epidemic, provided information about accessing treatment, in particular for substance use disorder, and shared components of our oversight process. I am appreciative for the opportunity to testify today. If you have questions, I will answer them now.

COUNCILWOMAN BASS: Thank you very much for your testimony.

And would you state your name for the record and begin your testimony.

MS. HERSH: Good morning, Councilwoman Bass and other members of the Committee. My name is Liz Hersh and I'm the Director of the City's Office of Homeless Services. Thank you for the

opportunity to testify today.

Using the Kensington Count plans as the basis, the Office of Homeless Services established a 23-bed respite with Prevention Point last winter. Based on its high utilization, we then expanded it to 40 beds this winter. In its first year of operation, Prevention Point's respite served 160 people, of whom 40 percent entered treatment or got permanent housing. This is a tremendous success. Our method has been to listen to the people on the ground closest to the problem and support their efforts and addressing it to the best of our ability.

Similarly, we added 15 dedicated beds to the 60 already being provided by Pathways to Housing, the first in the nation street-to-home program for people with opioid use disorder. To date, they have a 100 percent housing retention rate, and half have entered treatment or are practicing

abstinence. Again, a remarkable success rate and an approach we plan to expand on in the next fiscal year if the dollars proposed by the Mayor are made available.

Despite this expansion of investments, the growth of homeless encampments by the opioid -- driven by the opioid crisis is plaguing Kensington. It is a humanitarian crisis that presents a health and safety threat not only to the people living there but to the neighbors who live nearby. We must acknowledge this reality.

On January in our Point in Time Count, we found that the number of people experiencing street homelessness in Kensington -- and that's defined as zip codes 19133, 25, and 34 -- had actually gone down from 227 to 210. Yet Kensington has the second highest concentration of homeless people in the City after Center City.

The homeless encampments in the Kensington area, specifically under the

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tunnels north of Lehigh Avenue on Tulip, Kensington, Frankford, and Emerald Streets, have an estimated population of 200 people.

Encampments are a national and growing problem. The National Center on Homelessness and Poverty found a 1,342 percent increase, 1,342 percent increase, in the number of homeless encampments, from 19 in 2007 to a high of 274 in 2016, the last full year of data. It's a national crisis.

And yet the new budget proposed by the White House slashes all forms of evidence-based housing assistance, leaving communities like Philadelphia on our own.

Working in a coordinated effort with partners throughout the City, we have taken a number of steps to manage this dire situation so far. And I want to acknowledge again that we are also frustrated and know that it's not enough.

Under the leadership of the

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Eastern Division Police Inspector Ray Convery, he established a Homeless Detail, a small group of officers dedicated entirely to the homeless encampment. This is based on the model in Center City, replicates that successful model. They do a nightly count of people sleeping, weekly clean-ups, and have a constant presence in the community. Deploying the combined push and pull of the police officers and the homeless outreach teams, the people in the encampments were asked to move to one side of each street to allow the neighbors' safe passage. This arrangement was the suggestion of the Somerset neighbors for Better Living to enable neighbors to walk through the tunnels without going into the street. While it is progress, it is far from the resolution needed.

The Streets Department has increased to twice weekly trash pickups, and encampment residents have been

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provided with trash containment supplies. At the neighbors' request, L&I has also inspected all the local scrap metal collectors, and one has closed down. Scrap metal is a source of income often used for drug purchase that leads to petty theft in the neighborhood and has been a cause of considerable concern.

The Office of Community Engagement under the direction of Joanna Otero-Cruz, in coordination with the police, has distributed kits to neighbors that include sharps containers, grabbers, no trespassing signs, and blue light bulbs to empower residents to take back their streets by containing and minimizing the harm of needles on the street and discouraging intravenous drug use in front of houses. This also enables the police to enforce no trespassing laws.

In addition, our office is aggressively pursuing an additional 80 respite beds. A respite is about a

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40-bed, small, low-barrier place in the community for people experiencing homelessness, and in this case specifically opioid use disorder, to come in and be cared for. They can enter without ID, and drug testing is not required, although they are not allowed to bring in their works or to bring in weapons. This model is based loosely on the Safe Haven pioneered in the 1990s by Project HOME and supported by DBHIDS.

The respite uses a Housing First model. While many of us wish that those in the encampments would seek treatment first, experience is showing us that sometimes providing housing first is a better option. We have found that when people have a place to come in to get warm or cool, fed, medical care, feel safe and comfortable, then they can start to make plans and think about their future.

Based on the success of this model, we have aggressively pursued a

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second respite in the neighborhood. It's taken several months to identify a site, as the community is divided. Some believe that Kensington is already a magnet and that any new respite should be sited elsewhere, while others are clamoring for more beds. We analyzed the number of homeless facilities in the neighborhood and found that it is actually quite underserved. There is one shelter, and that's the one we established last year.

Today we are pleased to report that Impact Services is in the final stages of negotiating a lease to provide 40 more respite beds operated by Prevention Point. And, again, as I mentioned, our goal is to add 60 more Housing First units next year.

I'd like to talk a little bit specifically about encampments, because this is a new problem and encampments need a new strategy. The Office of Homeless Services has researched other

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cities to try to better understand how better to address the problem. San Francisco is the model that looks most promising. They have over 1,000 tents on the streets of San Francisco. They have deployed what they call an Encampment Resolution Team. It's a multi-disciplinary team that engages and then helps resolve the homelessness of the residents.

They use what I will simplistically refer to as a carrot and stick approach. They first develop a by-name list of people in the encampment and assess what they need, and they do this systematically. They begin the resolution process of helping people who can go home, and if they can, if they want treatment, to help them get access, to get ID or entry into a respite, which they call a Navigation Center. They go so far as in some cases as to begin medication assisted treatment on the street and have found that with

medications like Suboxone that some people are able to think more clearly about their lives and make better choices. And as David Jones already said, there's mobile services that would be able to deploy a range of these -- mobile teams that would be able to deploy a range of these services.

The Navigation Center offers a range of services with easy access. It also offers beds for people finding, as we have, that a good night's sleep, meals, safety, stability, and care enables better problem-solving. And in the final stages of the encampment resolution team, what they do is the police come in and notify people that the encampment will be permanently closed down, and they have found that this has been successful. And, again, bear in mind that this only works if the services have been available and made available to meet those individual needs through that process.

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As a result, in San Francisco they're seeing about a 65 percent success rate in people accepting safety off the streets. Twenty-five percent of those have exited homelessness, and they've seen an 85 percent reduction in tents. Today in San Francisco they've resolved 23 encampments comprised of 944 people. Obviously additional resources have been deployed to achieve this success.

And as Eva mentioned, we are working with our partners at DBH, the Police, and the Managing Director's Office to establish an encampment resolution and deploy the new Prevention Point site as our Navigation Center. And as Eva said, we can't move forward and make this plan -- we can't fully develop this plan or make it public until we have shared it with the civic associations, and we are beginning that process tonight. We tried to do it last Wednesday, but everybody knows about the snow.

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We're also going to need everyone's help in the community throughout the broader community to redirect their generous contributions away from the encampments and provide the meals, move-in kits, furniture, clothing to help people transition to more stable housing situations. We are developing a list of what our providers can use in the hopes that everyone can help. It is abundantly clear that we can't solve this problem alone.

That concludes my testimony. Thank you again for this opportunity, and I will remain available to answer questions.

COUNCILWOMAN BASS: Thank you very much for your testimony.

Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

And, again, as I said from the beginning, I know that particularly over this Administration's term, we've seen a

very aggressive approach to resolving this issue, but I want to go back a little bit before we move forward. And I think one of the most critical points of this is understanding how we got here around some of the, what Dr. Evans used to call, a saturation of services, particularly in the Kensington area.

Over the last four years, the federal government has closed several mental health organizations in this immediate area because of medical fraud and non-compliance issues.

I'd like to talk a little bit about what DBH has done, is doing, has changed to address the issue of quality providers in light of this subtle intervention that was necessary.

COMMISSIONER JONES: Thank you, Councilwoman Sanchez. Just to start, I think a couple points I think are important to make. One is that while what we try to do is make sure that we right-size the service array for a

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particular community, and so while I think the perception was that there was really kind of maybe a saturation, in fact what we have known is that for the ten districts -- in fact, you guys, your district is right in the middle. And so we actually have always felt that we needed to make sure that we were being as responsive to the members' needs as possible.

Second, just another point of clarity is that when we actually have worked with providers who have had challenges, although there may have been federal intervention, it was really our decision ultimately to ask them to leave the network, and so that has been the process that continues.

The other thing is that we continue, first and foremost --

COUNCILWOMAN SANCHEZ: Before you move forward, can we talk a little bit around that decision-making process, right? So Eva mentioned that the Board

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has been kind of reconstituted and members have been added. Who selects the Board of CBH?

COMMISSIONER JONES: So the Board -- the process is really one that is delineated in the bylaws of Community Behavioral Health, and essentially the Mayor through those bylaws appoints a number of ex-officios, and those ex-officios were defined as you heard Eva speak of. So they have included, for example, as the Commissioner, I am the Chair of the Board for Community Behavioral Health. You actually also have the Deputy Managing Director, Eva Gladstein. You have the Commissioner for DHS. You have both Commissioners to my left and to my right, Commissioner Farley and Commissioner from Office of Homeless Services, Liz. And so -- and then there are -- we've expanded again to include the Superintendent. So there's a process where based upon, again, bylaws and then based upon, as we see the health plan

evolving, making sure that we have the proper expertise on it to make -- again, to inform and provide the oversight for the committee.

COUNCILWOMAN SANCHEZ: Doesn't the bylaws require there be community participation also on the Board?

COMMISSIONER JONES: And included are actually family members, as well as there's a person with lived experience. So the bylaws do require that, and we've accommodated that.

COUNCILWOMAN SANCHEZ: So those folks are available?

COMMISSIONER JONES: Those folks are active on the committee.

COUNCILWOMAN SANCHEZ: Is this on a website that people could readily see?

COMMISSIONER JONES: So that information is included within, if you go on the website, within CBH's -- the bylaws. Although I will tell you we have been amending those, updating those.

That information certainly can be available.

COUNCILWOMAN SANCHEZ: Are those Board meetings public?

COMMISSIONER JONES: Those Board meetings -- the information that comes out of that Board meeting is public information. So if there is a request and we certainly have shared minutes as that information has been requested, and we will certainly continue to do so.

COUNCILWOMAN SANCHEZ: So you're not required by law as all the other Boards or quasi organizations have public Board meetings?

COMMISSIONER JONES: So the bylaws don't necessarily dictate that it is public, but it does, again, dictate that the minutes coming out of the meetings be shared.

COUNCILWOMAN SANCHEZ: So were the minutes posted also on the website?

COMMISSIONER JONES: The minutes, again, are made available.

They're not consistently posted on the website.

COUNCILWOMAN SANCHEZ: Okay. So let's talk a little bit around the quality of the providers and ratings. I know that particularly over the last couple years, we've talked about, similar to what has been done at DHS, creating some sort of matrix so people know who is in the system, and you worked and I think in April of 2017 you submitted to my office a list of the providers.

Is there an easy way for folks to see who are the providers, how much money they get, and what they're contracted to do?

COMMISSIONER JONES: So I think that we go through, as I mentioned, in terms of kind of quality oversight through the Network Improvement and Accountability Collaborative a process where the providers in our network are credentialed. And so that credentialing typically takes the form of either a

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six-month, a year, two or three-year. That information is certainly available in terms of who the agencies are that are in our network, so we have that information in terms of the broad network. It also indicates typically the type of services that they provide.

We actually at this point don't necessarily have, though, a rating scale for each of those providers. We actually have gone through the credentialing process, and that has been the way that members have been informed.

COUNCILWOMAN SANCHEZ: So what is the reluctance to put this up and make it available publicly? I think if I'm a resident of any city, as a Councilperson -- this is a question I've been asking for ten years -- why are we so reluctant to share this information publicly about who is being funded to do what, how they're credentialed, if they're under review, if they're not meeting their credential status? Why

can't we make that public?

COMMISSIONER JONES: So, again, I think the information around credentialing has been made public. I think that we have a sense as to where people's status --

COUNCILWOMAN SANCHEZ: Where is it made public if it's not easily available? If I am a potential patient, one of the qualifying Medicaid folks, where do I go that I see who the provider that specializes in what I may feel is what's wrong with me and what kind of provider they are?

COMMISSIONER JONES: So I have two responses. One is that so for any of the members whom are looking for information, so we actually have a 188-545-2600 number that you can contact as a member at any point in time and both request services and ask for information about a provider. So that information is available and has been out.

Again, in terms of a

credentialing process, that information through our Network Development is also available. And so we -- you can contact through that 188 number Member Services and ask for Network Development and again get information specifically about a provider.

We have really focused much more on making sure that members have an understanding around choice and that that choice includes the requisite kind of cultural and linguistic needs and array to then be able to accommodate their needs. So that has really been mostly our focus.

COUNCILWOMAN SANCHEZ: So you're not opposed to making this more readily available; you just are not there yet?

COMMISSIONER JONES: So I think that we continue to explore ways that we can make the network of providers more transparent to our members, and certainly we explore and look for strategies to

accommodate that.

COUNCILWOMAN SANCHEZ: Is that a yes or a no?

COMMISSIONER JONES: So I think -- again, I think we continue to be open to exploring what makes it easier for providers to be able to access the network. So it's a yes, we're open to the idea.

COUNCILWOMAN SANCHEZ: I think it's important that people know who are non-profits, who are for-profits, what the Board leadership looks like, who is making the decision.

Is there a reluctance by the Administration to allow your Board meetings and your decision-making process to be public?

COMMISSIONER JONES: So I think that as it pertains to non-profit and for-profits, that information actually -- we typically share that through our minority, women, and disabled-owned business enterprise information that is

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updated annually. And so certainly I think that information is available. And then I think that the Board is likely certainly receptive to the idea of making Board meetings more public.

COUNCILWOMAN SANCHEZ: I think it's important. Again, when you look, I think one of the challenges we have with all of these service providers -- and I can go back, I think it was, five years ago when I made a request during the budget time to request that we look at where these places are sited, because I think people should know who needs the service, right, and where the service is being provided.

I'm a strong proponent. I mean, I've been called a methadone queen because I have supported the expansion and the placement. I'm not the NIMBY person. But I think one of the problems is that people don't make a distinction between one type of service and another, and when we assure residents that 75, 65

percent of the folks receiving those services can walk there, I think people are more accepting to what's going on versus some of the things that we see with 8th and Girard and others where people feel those types of services when you have 3,000 people coming to one service provider as disruptive.

And so to the extent that people are aware of who are the providers in the community, I think it's just better for all of us, right? People need to know. And I'll give you an example. There are about ten providers in the data that you provided me, there are about ten providers with budgets of over $100 million within walking distance of these encampments. If I'm a resident of this community, I want to know why is my quality of life being disrupted when I have $100 million in service providers in this area. And part of the reason is, providers do different things, right? But people don't know how to make that

distinction.

So how do we get people to support us if we're not being public, if we're not being transparent, if we're not telling people how people get credentialed, if we're not telling people who are the service providers that are problematic, may have issues with their credentialing? I think this is important.

I think there's a stigma attached to Kensington and in particular the barrio around these service providers, because they close up and then another sign goes up. Multicultural Services closed three years ago. There's a new sign up there that says Suboxone. I have no idea who they are, right? So I have to answer to residents, and I don't know how to navigate your website to figure all of that out.

I think there's -- I think we need to improve how we inform people who is providing what service.

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How much -- and I wanted to ask you one more thing. You mentioned -- I think the other thing that I want to make clear is -- and, again, I think your testimony, Mr. Jones, you talked a lot about a lot of things that are going on, but the fact of the matter is, a lot of this recently just started. I want to be clear that it's mostly been under your leadership. This is not something that's been going on forever, some of the service providers, but I wanted to draw in particular to this. We are also supporting eight newly funded substance abuse disorder early intervention programs. Who? Was that service RFP'd? What's the criteria? Where are these places to be going sited?

COMMISSIONER JONES: So I want to talk -- I want to speak to a number of things you raise, Councilwoman Sanchez. First of all, I did want to go back and also say that on our website actually within the Network of Care, it does

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actually also list our providers and the type of services. And then as it pertains to quality, also on our website we actually have information around evidence-based practices. So what we've tried to do is to not only make sure that members have access to treatment, but they actually have access to high-quality treatment. And so it actually lists the providers on our network who are implementing various types of evidence-based practices so that family members who may, for example, want to participate in cognitive behavioral therapy, as an example, can go on the website, find out that X provider provides, has clinicians trained in cognitive behavioral therapy and, as more, making an informed choice, have that be where they decide to go and seek treatment. So I wanted to be real clear about that.

The other issue is that as we are talking about stigma, which I think

you're absolutely right about it, it's always an ongoing concern, I think where we also have to be careful about is -- and candidly, I will be candid. I think that there is -- Council is very committed to addressing this issue, but sometimes even the way these hearings are conducted is a bit stigmatizing in that -- so we'll have a hearing about mental illness, we'll have a hearing about addictions, but we won't necessarily talk about diabetes, asthma, heart diseases, which also are health conditions and have an impact on the community. So the fact that we have these hearings -- and, again, we should certainly make sure that David Jones as the Commissioner for the Department of Behavioral Health and Intellectual disAbility Services is doing everything I can to make sure that folks have access to these services, but not in a way that makes it look like something is wrong with folks or that -- just the illnesses

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in themselves is stigmatizing.

COUNCILWOMAN SANCHEZ: That's why the issue of the epicenter being in Kensington is so problematic, because if you want to de-stigmatize it, you can't continue to concentrate all of this stuff in one area, because that doesn't help.

COMMISSIONER JONES: And I think it's the point you made too, though, which is it's the balance of putting it in a place where if individuals want to seek treatment, that it's accessible, but without it being so overwhelming that you have so many centers. We try to be very conscientious about, again, making sure that members have choice and that they also can access services. And so clearly it's a fine balance, and that's what we try to achieve, and we try to achieve that in working with you all as well as obviously working with family members.

I also wanted to just underscore the point around us being as a

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department really receptive to figuring out what the needs are, and some of this -- and I appreciate you indicating that some of this has started recently, and then some of it actually has been ongoing.

I will say that I think that the Department of Behavioral Health and Intellectual disAbility Services has a pretty comprehensive network of services. I think that the way we are structured in terms of Community Behavioral Health being a part of our department, I think you heard Eva mention the idea that there was only about a 7 percent administrative kind of expenditure, but the other thing that we do is, there is actually -- there is no other health plan or very few health plans in the country that does not retain profit. Community Behavioral Health retains no profit, and in fact when they manage well, within 3 percent, that goes back into Philadelphia. So it's a reinvestment of services and

support, so then we're able to figure out then what are those additional services that are needed and make a reinvestment in the community and then --

COUNCILWOMAN SANCHEZ: Let's talk --

COMMISSIONER JONES: If I can make this final point. The other only thing I would say is that 93 cents out of every dollar is spent on medical expenses. And, again, that doesn't happen any place else in the country.

And so I just want to emphasize that. I mean, that's the commitment that the Department has to serving Philadelphia.

COUNCILWOMAN SANCHEZ: So let's -- and I don't want to monopolize the time, although I could. Real quickly, because I think it's important, going back to decision-making, the fact is that we have in particular in those budgets, you have program money, you have fee for service money, and you have this

reinvestment. And, again, when I look at the data and how it's presented to us, different providers get different money, and there doesn't seem to be a matrix for that. And you talked about evidence-based programming. Are you funding stuff that's not evidence-based programming, and what is the correlation between -- again, I want to learn lessons learned. We've closed four centers there, right? I mean, one of them that is closing down March 31st is at the foot of Gurney Street. There's a correlation there between the pipeline of new addiction and what we're doing, and that's what I want to learn. What did we miss? What are we missing in the connectivity between the service providers that we're shutting down who are losing their license and some of the challenges that we face in the community?

COMMISSIONER JONES: So just, again, you continue to ask very good questions, and I'm trying to respond to

all of them as much as possible.

So there really is a pretty -- I think a fairly predictable algorithm to our funding around -- so we actually have, as we've indicated, Medicaid dollars that come in, Medicaid dollars. That's the largest percentage of our spend, and so it ends up being somewhere around 80 percent of our dollars are Medicaid dollars. And then we probably have -- just in terms of how we spend. So we spend on folks who are eligible for Medicaid and then there's probably another 10 or so percent for uninsured and then obviously we have the folks who have intellectual disability services and EI, and that accounts for some of our other spending. So that's actually fairly predictable.

And then you asked -- so we certainly try, to the extent possible, to ensure that most of our funding is supporting where there's evidence-based.

Now, certainly there are

services that are being developed that are more evidence in form. They haven't necessarily gone through the scientific scrutiny to become evidence-based, but they're evidence in form, and we try to support those as well. So I think that is our process.

And then as it pertains to where agencies are coming up, again, we've tried to look at Philadelphia broadly, recognize where there are services -- where the service need is most consistent and then look across our service array and bring up the services that are needed.

So, for example, I mentioned that we have -- we brought up partial hospitalization program for people with substance use disorder. That had been a service that had not been in our array and it had been sorely needed. We also brought up partial hospitalization for children, because we recognized that there was a need there.

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And so I think we are constantly both listening to what the community is saying. We are looking at our array in terms of service array, and then we are looking at trying to kind of match those against where services need to be developed and brought up, and that's kind of how we go through. And it typically all goes through, as you all requested some six years back or so, a procurement process. So most of -- the vast majority of the services that are coming up we bring in via a procurement process.

COUNCILWOMAN SANCHEZ: This is my last question. I'm going to -- I'm even looking at even lower hanging fruit than that. How does anybody have 15,000 patients in an extended house-front? Real basic, right? Multicultural was one house and then they bought the other house and then it's two houses and there's 15,000 patients. I'm even looking at lower hanging fruit than that.

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How is it that these places that we've closed down -- what are the points where you start saying, wait a minute, where's the quality, when you have thousands of people being -- I call them the storefronts, right, and this little storefront office, 6,000 patients, 10,000 patients, even -- at what point does that not ring a bell that there's a problem?

COMMISSIONER JONES: Sure. So, again, I think that part of the process is that we have, through even compliance now, that we are probably taking a closer look and really benefiting from lessons learned is, we've actually developed what I think we refer to as our Special Investigation Unit. So what we know is that best information as it pertains to a provider that may have a large member enrollment is that hearing from a community around that provider and those concerns or even wait times or challenges like that. So I think what we're doing

and what we're doing more recently is certainly taking a look at those situations where there is, again, high member enrollment.

I am not necessarily aware of like the numbers that you just mentioned, but certainly once it reaches a certain threshold, I think we certainly are trying to use tips from the community to take a deeper look at those providers.

COUNCILWOMAN SANCHEZ: Madam Chair, I don't want to manipulate. I want to get into the homeless stuff, but I will defer to my colleagues for right now.

COUNCILWOMAN BASS: Okay. We'll come back around.

I do have a question, though, to follow up on the Councilwoman's questions. And as you were talking, you mentioned that the Network of Care was on your website that lists who the providers were, because I think that that's really critical. I was on my phone. I can't

find it anywhere. And so I think that if you can find that information and make it available to the Committee and to the public, I think that that will be really helpful.

One of the big problems that we have is that there's a lot of tax money that's being spent and people want to know where it's going. I want to know where it's going. And so we can't get the programs that we want, the quality programs, and expand those programs if we have providers who are really bad actors, really perpetrating a fraud, acting like they're out here to help folks, but they're really interested in the dollars. That's what they're really interested in. And so we need to distinguish who those folks are and call them out and pay particular attention, as the Councilwoman was saying earlier, because we need to also know what kind of work they're doing, what the patient size, what the caseload is, and also what kind of work

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is done in terms of a coordination of efforts among them in the same neighborhood. And so these are all things that we'd like to have more information about.

And so with that being said, Councilman Henon, followed by Councilwoman Gym, and then Councilman Squilla and Jones.

COUNCILMAN HENON: Thank you, Madam Chair.

And good morning, and I think it's going to be a long hearing, but I do want to speak about your one comment on the stigma of these hearings and the stigma of these conversations. I think it's important that we do have these hearings and I think it's important that we really dig down to the information, who is credible and who is not credible, who has issues as a quality care provider with the Department. I think the public should know and I think we should know as members who represent people, because

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we're out in the front lines just as you are and we are in a crisis mode and we are trying to confront it, not as somebody that is in the industry but somebody who cares about people, who is out there trying -- I've gone to pharmacies in my district. I went to every single pharmacy in my district and asked them if they were made aware -- in conjunction with the Health Department, by the way, so thank you, and Prevention Point -- are they aware that the standing order -- that there's a prescription from the Pennsylvania Surgeon General that anybody can walk into any pharmacy and purchase whether it's insurance or privately naloxone and what are they doing to promote it. What are we doing in our community groups to counter the stigma of somebody who is addicted to drugs or alcohol. We're doing it. I know I'm doing it and I know other members are doing it, and I'm ready to talk about it publicly so we can -- I

mean, this is 2018, not 1918, where you just used to lock up people and co-mix and commingle the populations who had substance abuse, drug abuse, and mental disorders. I don't think that works. I don't think there's evidence-based on that.

But that's not in my purview and I don't claim to know what the best way to treat that. But the commingling of, I think, population is somewhat of an issue.

You were talking about tips from the community, and I'll get into that in a minute. The question is, how do you determine who and who will not provide critical detox and any other level of care of services?

COMMISSIONER JONES: So a couple comments, Councilman Henon. Just wanted to underscore your point around we also think it's critically important that for, in particular individuals who are suffering from the disease of addiction,

that treatment is the course of action certainly as opposed to incarceration or being locked up. So we absolutely share that.

And I think that it's also important to remind everyone that the state certainly does the licensing of agencies. We work very closely, and part of what we're trying to do is, as I mentioned earlier around medication assisted treatment and evidence-based practices, we recognize that there are several pathways to recovery and we want to make sure that people have broad access to those various pathways of recovery.

What we have found is that if medication assisted treatment is one of the pathways and the therapies that are associated, again, in terms of -- the outcomes are much better.

What we've also found at times is that if you're just looking at, for example, detoxification alone, what

happens is an individual would go into detox, but in fact becomes at increased risk for overdose coming out of that. So what we're trying to do is, again as much as possible, work with our broad provider network to make sure that they have the information that they need to then serve Philadelphians and meet their, particularly substance use disorder, needs well.

So we've done a lot of work throughout to make sure that the information around medication assisted treatment is being included, again, within each level of care so that individuals who go through the treatment process don't necessarily have to just enter through a detoxification door. I think that's kind of the evolution of how treatment services are being provided, and that's kind of -- and certainly that's what we're committed to. So we are working with the providers to share that information and to achieve those

outcomes.

COUNCILMAN HENON: And you mentioned MAT after the word "but," so before "but," you had mentioned that there are other providers and there are other methods of treatment that some tips from the communities may have had some positive outcomes with some other wraparound services. And for me, having that choice as you had mentioned I think is kind of important. This way a client who -- somebody would come into a detox -- I would imagine if somebody who was on heroin or opioid addiction would come into a detox. They'd go through a five, seven-day detox and then they either go to an in-care facility, whether it's MAT or -- but there are other methods of trying to rehabilitate yourself from this insidious disease, but they -- let's just say they go drug free for X amount of days, whatever the level of cares are. I think they're step-down levels, like a 3B and a 2B. And then

when they want to have after care after that, they've been drug free, they automatically, if they want to have CBH's involvement, that they'll automatically go with MAT assistance after they've been drug free. Is that somewhere in the process? I mean, this is tips. I'm just going off of tips from the community and some other good quality, evidence-based, I think, outcomes that the combined services have really cut down on a lot of relapse in some of our communities.

COMMISSIONER JONES: So what I'll say is, ultimately an individual has choice in their kind of recovery process. And so it's not an absolute that you come through any level of care and you have to participate in drug free or you have to participate in medication assisted treatment. I think it's really driven largely by that individual and their work with their treatment team.

Again, what we are saying is that overall, again based upon what the

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science is saying, is that individuals with opioid use disorder specifically who participate in medication assisted treatment, the outcomes are much better. Again, we still recognize that there are many roads to recovery and want to give that flexibility. We just are saying percentages-wise, again, participating in MAT has generated better results in terms of longer recovery, and we want to and are, again, sharing that information around kind of the science and the outcomes, and that's how it works. But to just go where I began, which is ultimately each individual has the opportunity to make a decision for their recovery process.

COUNCILMAN HENON: Right. And I'm glad to hear that obviously the individual has the choice, but would they have the choice with the Department of Health, with CBH? Would they have that choice for their care of treatment, substance abuse treatment?

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COMMISSIONER JONES: So within our network -- and I think that, again, they have the choice. What we are saying within our network, because there's a little nuance in the question that you're asking certainly, right?

COUNCILMAN HENON: Evidence-based is also evolving as well, just as -- you said that the types of evidence-based MAT treatments have evolved; is that correct?

COMMISSIONER JONES: So medication assisted treatment has become an evidence-based practice.

COUNCILMAN HENON: Right. But it has evolved as well, just as we are moving towards an MAT -- I'm not going to say mandate, but maybe the percentages are higher. But that's also evolving, same as other choices.

COMMISSIONER JONES: So certainly the idea of how and what we encourage and expect in our network, that continues, yes, to evolve based upon the

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information and the science.

COUNCILMAN HENON: Okay. What is withdrawal management?

COMMISSIONER JONES: I couldn't hear you.

COUNCILMAN HENON: What is withdrawal management?

COMMISSIONER JONES: So withdrawal management essentially is -- so the process by, as you were talking about, detoxification. So as you are going through detoxification or I would say withdrawal management of the chemical that you're on, that that could happen in a different level of care as opposed to it just being that you go through detoxification to kind of detox from the chemical that you're on and then go into treatment. That we're suggesting that, for example, that can happen while you are in an intensive outpatient program and you then are having that treatment and those therapies paired with medication assisted treatment. That can

happen kind of as opposed to it being a three-step process, it becomes much more of a one or two.

COUNCILMAN HENON: All right. And is it automatically paired with a MAT treatment or does the client have the choice of going drug free?

COMMISSIONER JONES: So primarily, again, we are encouraging that MAT be the pathway. Ultimately, again, each individual still has some choice.

COUNCILMAN HENON: So my last question and I'll yield to my colleagues, because I'm sure there's a lot of good questions. And I think for the record, nobody is proclaiming to know how to treat people, just that there are some neighborhood tips in the communities in services that have been part of this system network, and so there are some choices.

The question is, the coverage, Philadelphia residents versus non-Philadelphia residents. I had -- my

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understanding is that there are some facilities that have been offering some of the substance abuse services in the City. They may not receive financial support from the City, but out-of-county patients and clients are welcome to be in their facility and then they get reimbursed for that. Is that in fact a challenge that we have or is there something that we need to address to make sure that anybody who wants to go anywhere for substance abuse or opioid addictions, making sure that the quality provider is reimbursed?

COMMISSIONER JONES: So two responses. One, we actually -- I think in terms of the provider network, we have a fairly robust provider network in Philadelphia, and if you are enrolled in Medicaid in Philadelphia, then actually it would be us as CBH specifically but the Department broadly as the payer for services. If you go -- and so if another individual, let's -- this is an arbitrary

example -- is enrolled with Magellan and they come in to the City, then Magellan would still continue to be their payer. So based upon where your place of residence is as it pertains to Medicaid is who the payer is.

COUNCILMAN HENON: Okay. Well, I'll yield for another time. Thank you.

COUNCILWOMAN BASS: Thank you, Councilman.

Before we go to Councilwoman Gym, I just had a quick question. So one of the things I realized as I was sitting here and after going through your testimonies is that when we talk about what the City is doing to address opioid addiction and heroin addiction, no one mentioned safe injection sites. Is that still on the table?

MS. GLADSTEIN: As we announced at the end of January, that we are at the very beginning of the process, that we did not anticipate that the City would either operate or fund a comprehensive

user engagement site. So it has not been mentioned today for that reason.

COUNCILWOMAN BASS: Okay. So would the City be -- so we're not operating and we're not funding. So what role would the City play in safe injection sites? Because one of the concerns that I have is in terms of liability from the City for pregnant users, for someone who drives up into a site and then uses and then drives off, or underage, minors, all of which can and does happen every single day in the City of Philadelphia. But what is the City's role -- would the City's role be in safe injection sites?

MS. GLADSTEIN: The way we have initially outlined it -- and our thinking is evolving, so I don't have answers to those particular questions -- was that the City would help facilitate in terms of identifying potential other funding sources, perhaps with site selection, and certainly with providing wraparound

services to any such site.

As we think about this, I think your point is very well taken, and we're having conversation about whether or not there are certain standards or criteria that would need to be developed for any such site.

COUNCILWOMAN BASS: Okay. I think that that will be really helpful as we have this discussion, because there's just so many unanswered questions. And I get beat up on Twitter about the fact that I have questions that are unanswered, but I'm still looking for the answers and really just trying to make sure that we cover all of these things. And I do think that before we made such an announcement about safe injection sites and the desire to proceed, that we really probably should have had some of these thoughts wrapped up and been able to have presented them to the community, especially that would be most affected.

MS. GLADSTEIN: I think your

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point is well taken. We are setting up a series of community forums starting in several weeks and we'll be in touch with every member of City Council. We have four for which we have scheduled dates and locations and another four that we're working on. So we appreciate that recommendation.

COUNCILWOMAN BASS: I'll come back, because everybody is teed up.

Did we find that information on the website yet, the Network of Care?

COMMISSIONER JONES: The Network of Care.

COUNCILWOMAN BASS: Did we find that yet?

COMMISSIONER JONES: It's under the Philadelphia Network of Care.

COUNCILWOMAN BASS: What's the web? If you can get us the information, because we'd like to be able to share it with everyone who is here.

Councilwoman Gym.

COUNCILWOMAN GYM: Thank you

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very much, Madam Chair, and thank you very much to you and Councilwoman Quinones-Sanchez for this important hearing.

I think that we have put an enormous amount of money and effort into addressing the consequences of opioid prescription, over-prescription, and I'm curious today to talk a little bit about folks who don't often get stigmatized in this situation, which are actually the doctors and the hospitals who are really doing some aggressive prescribing.

It was interesting for me because my husband recently had knee surgery, and it was not necessarily a minor surgery, but it wasn't a major one either. He was given two weeks worth of OxyContin pills that probably would have knocked him out for two weeks by a major prescriber of one of the largest hospitals in the City, and it wasn't done through somebody like on the street, but it was done with somebody with some of

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the highest degrees and respect in this City. And I'm not suggesting that it was entirely without merit, but he didn't use a single pill and he didn't really need one. And so it does bring me to ask a question about the Health Department's plan to really take a serious look at holding medical providers and doctors accountable.

I know in your testimony, Commissioner Farley, that you said that you have mailed out guidelines, you've mailed out dashboards, staff had visited prescribers, and you're working with health insurers, but you know as well from the report that it sounds like other cities are also taking extremely aggressive approaches. I think Staten Island was a really good example of a city -- or a borough that was three to four times higher, engaged in an aggressive -- what sounded like a pretty aggressive campaign, and I guess I want to give you some time to flesh out how

you are looking at some of these things. But in particular I also want to see an evidence-based approach towards serious education of our medical health professionals. They are the ones who are prescribing these opioids that get people started on the kinds of addictions that then lead them into street addictions and others, and it just feels like -- I'm very curious about how aggressive it is.

So in part, like it sounded like there were aggressive efforts at direct training. The City was particularly clear about addressing directly with providers. I know you have staff visiting, but I'm curious about some of the more specifics and also what measures of -- what ways are we able to measure the efficacy of a serious campaign. And at the end of the result, as you know, when Staten Island did this aggressive campaign, that really held these medical providers accountable and some of our doctors who are very

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prestigious but still need to be in this mix. I mean, they have to be at this table. They saw a 29 percent decline in their overdose rate.

So could you flesh out some more? Because I think that part of your testimony sounded -- I didn't get a clarity about how the Health Department is really holding some of these folks accountable.

COMMISSIONER FARLEY: So, first, I completely agree with you that doctors are prescribing too much, and the example you gave is just one example that's happening all over the City, and I, frankly, find it shocking that it's still happening this far in the epidemic when there's been this much attention drawn to the over-prescribing. Two weeks for minor surgery, 30 days for minor surgery is completely unnecessary.

This has happened over a period of decades when those doctors have been encouraged by the pharmaceutical

companies to prescribe too many of these drugs, and the doctors have been told things which are not true. They've been told that these drugs are safe and effective for treatment of chronic pain when they're neither. And the Health Department is doing what we can to try to change that practice which has occurred, again, over a period of decades.

We are doing this, I have to say, although we have no regulatory authority over doctors. We can't say you cannot. So we're using every lever that we can, including hitting every doctor again with the letters, going into the practices of specific doctors and delivering very clear messages on how they ought to be prescribing less. That, what I'll call, detailing campaign where we went into the doctors' offices was patterned after the Staten Island campaign, and the Staten Island campaign was something that I was in charge of when I was in New York City, and it was

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in fact successful. That detailing just happened in December and January. So we don't know yet the impact on prescribing here in Philadelphia. I'm hopeful that we're going to see a continued and more accelerated decline in prescribing.

We do know that the amount of prescribing that's taking place in Philadelphia is going down. It is not going down fast enough, and the levels of prescribing are still two to three times what they were in the 1990s. So besides this, I'll say, aggressive education of physicians, a stronger step, which is something we are a strong proponent of, is to have health systems or health insurers put rules in place that actually make it a lot harder for physicians to prescribe inappropriately. For example, have an insurance company not reimburse for a prescription for 14 days after minor surgery when that is not indicated. We have strongly encouraged insurers to do that. Blue Cross/Blue Shield has a

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policy in place. The other Medicaid insurance plans in the City are putting in place policies that are not quite as strong, and we are hopeful to have policies in place for every insurer in the state and sometime in the next six months or a year, but that is happening through our encouragement, not that we have any legal authorities to do that.

COUNCILWOMAN GYM: I mean, one of the reasons why I think medical providers perhaps don't feel so much is that there's not as much focus on them. There's like a tremendous amount of stigmatization of communities, of the people who are using, of everything else, but the light of accountability doesn't feel like it's shone on our medical community as well.

I'm curious about -- I mean, I understand the one-on-one kind of engagement. I think that that's highly individualized and also extremely private. It sounded like some of the

work that's been done in other places have tried to bring more accountability in a much more public fashion. So, for example, a public convening of a table of some of these folks is also particularly another way to recognize that this is not just going to be a bunch of mail that you're going to receive or private visit, but the City's actually going to convene these tables, it's actually going to tell people specifically these are the guidelines, so that it echoes not only to that individual doctor and those medical providers, but it also echoes out to other people.

I think that there's been a lot of publicity about the responsibility and onus on individuals, how communities have to handle it, how the City has to pick up millions and millions of dollars to respond to and very, very little on the flip end to say, hey, doctors in the lab coats who are prescribing these things, where are you in this accountability

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scheme.

So is there like some sense about how to make it more public in terms of -- it's not so much like bringing them here, but actually the City convening that public table of accountability and saying these are the guidelines, this is -- we cannot force you, but we are exerting our public leverage to demand that these things change and we're counting the numbers to see whether it is changing.

COMMISSIONER FARLEY: I'm not quite sure what sort of process you're talking about, but, again, we're using every lever that we can find. If you have suggestions and other levers that we can use, I would be happy to hear them, because I agree, this is what is feeding the problem. This is what probably started 20 years ago that is ending up with people homeless in Kensington, and we're going to need to change those practices.

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COUNCILWOMAN SANCHEZ: Point of information. For the doctors that are getting paid fee for services from us through CBH or Behavioral Health, do we know how many times they prescribe and what the rate is in comparison to other doctors? Do we have a way of tracking that within our network?

COMMISSIONER FARLEY: CBH has data on Medicaid prescriptions, so that would not be the entire practice of the physician --

COUNCILWOMAN SANCHEZ: But even in that, are we looking at those patterns and seeing if there's --

COMMISSIONER FARLEY: Yes, and we know that doctors are over-prescribing.

COUNCILWOMAN SANCHEZ: So we continue to pay them even though we know doctors are practicing and over-prescribing within our network?

COMMISSIONER JONES: I think what we're also doing is following up

with those physicians to make them aware of what their prescribing patterns are against other docs. So we're giving them information. So we actually have begun to inform them in terms of kind of where they are, again, in comparison to various different types of disciplines, different types of docs. So we're giving them information now to then help them correct their behaviors.

COUNCILWOMAN SANCHEZ: But we haven't disqualified anybody?

COMMISSIONER FARLEY: It's not that CBH is paying them. These doctors are prescribing opioids for pain and they're being reimbursed by the other -- the physical MCOs, not us.

COUNCILWOMAN SANCHEZ: Which is why we don't have a bigger sense of who it is, because that's not our oversight purview, the state?

COMMISSIONER FARLEY: Right. And the state has a database of all prescriptions and we have access to

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de-identify data there, so we can give you numbers, but we don't have names from that.

COUNCILWOMAN SANCHEZ: I'm sorry.

COUNCILWOMAN GYM: No. I appreciate that. I mean, I think that there are questions here that we should be talking about that include questions about disclosure, questions about tracking and analysis. But in the way that the light of responsibility and onus and to some extent a lot of personal blame and shame sometimes has shone on our people and our communities, I need that to shine on all different parts of the spectrum with the same kind of rigor and accountability and measures of efficacy that it is shining on everybody else. And I'd like to follow up with you a little bit more on how you're measuring the efficacy of this campaign in particular in terms of its reducing.

I'll have one more quick

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question, although I don't know if we have somebody here who can analyze this a little bit, but I don't know if this is -- if this works for Commissioner Gladstein, but could you -- I am extraordinarily pained by not so much folks who are struggling personally with addiction but also their families and especially children and youth who are watching neighbors and family members and others go through the horrors of addiction. And what supports are we actually giving them in these neighborhoods, in the schools, in the after-school programs to help them address what's happening? I mean, this is a public health, public safety, but very much a situation where we can't have young people growing up believing that this is normalized behavior, that they don't have themselves residual trauma that they're dealing with witnessing overdose deaths that are happening in the streets, communities that are being

racked apart, encampments that they have to walk through, needles on the street, users. All of this is incredibly painful when you think about it from a young child's perspective.

So I'd love to hear what efforts the City is doing to try and invest more in helping address some of the needs of our young people in after-school programs and in schools as well.

MS. GLADSTEIN: I'll begin, although I think David may also be able to add to this, and we've announced some of these interventions certainly with piloting a new program in the schools where we'll be putting eventually teams of four people in each school, but it's still very much at the pilot phase right now to provide support for the school environment.

We've also increased out-of-school-time resources across the City. DHS is one of the major funders of

that. I will not say that there's a curriculum that's particularly focused on this issue, but certainly trauma-informed and certainly creating a safe space for young children after school is very important to do.

And then in general, DBH has been looking very hard at its services to children at both DBH and CBH and trying to really advance and enhance the resources that are available to young people in the City in a way that I think wasn't done in the decades before. It was primarily an adult-focused system.

So there are more services beyond what has been kind of a traditional crisis approach to providing what will be called urgent care centers. So there's a way to -- a place to go and which doesn't require the kind of emergency, taking somebody out of their community, but the ability to work with the young child and their family in their community.

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I think David might want to add more to that. I'm not sure.

COMMISSIONER JONES: So we certainly agree with the idea that we want to make sure that services are going to the entire family. And so to that end, there are a couple things that are happening and, Councilwoman Gym, you're aware of these. So part of the -- just in terms of our health promotion, we certainly have tried to get out front and done more of the work with Mental Health First Aid. So there is actually a curriculum that actually is more youth focused. We've actually also provided prevention services to about 30,000 youth within about 90 schools, and those are charter and parochial as well, with the idea again trying to shore up and help with resilience. Some of that -- it's been broader than trauma-informed, but that's been a part of some of the curriculums that we've been using. Some of it is around certainly bullying

prevention, but we feel like kind of it's a combination of that array that actually is helping.

And then what we also have available for -- and this is for kind of children, families more broadly, is that there is an online screening that anyone can go on and take that then -- when they are having any kind of challenges, that they can answer the question. It's obviously very much an anonymous screen that then will give them some insight as to whether it's a situation where given the circumstances it's kind of a typical response or if it's kind of across that threshold and it is really starting to approach there being some kind of a mental health concerns or conditions.

So I think that is that array, but I think that certainly we have, I think, a pretty good partnership and are continuing to explore even with Superintendent Hite around what kind of prevention strategies we can use more

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broadly.

As you all know, the vast majority of our funding certainly is on treatment, but we are taking much more population health and trying to get upstream even more.

COUNCILWOMAN GYM: So I am more interested in the City's departments being much more strategic and directional about its investments for kids. So we know generally like the field of trauma is highly needed. I'm talking specifically related to this crisis. We know that there are children and families who are struggling in specific neighborhoods with schools right there in them dealing with those crises. I have gone into a number of the schools. I have talked to those teachers, who will tell you directly about the trauma they're experiencing with the children that are happening. We know where those schools are.

So I don't want to talk about

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like a generic kind of approach or let Superintendent Hite and you work out a bunch of programs. I'm asking more specifically about investments directed to specific schools in the areas that are directly hit.

So one great example -- I will give this -- is the partnership that we have with CBH to identify 22 schools that would receive a social worker in them, for example, that would be servicing more towards a whole school community, who could help work with the school community as opposed to like being targeted around individualized students. And I'm wondering whether your department is looking specifically at making sure that public schools that are specifically hit by the opioid crisis -- and we know where they are based on -- they're in the epicenter of it. Those teachers are in the epicenter of it. Those children are experiencing it on a day-to-day basis when they walk to school, when they're

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going back home to their families, when they're walking back and forth. What specific investments are you making?

I could list the schools if you want, because I want to know, that these kids need help and so do those teachers. They need it. I hear it all the time.

COMMISSIONER JONES: So it's the intervention that Eva referenced and you just mentioned specifically. So the Support Team for Educational Partnership, that STEP program. We certainly -- as CBH is a part of it, we've been very much at the table around the planning for that.

I think the other piece that I just mentioned in my testimony are the eight newly funded -- those providers. I can't specifically delineate whether they are going to be in schools. We can certainly look at that and get back to you about if in fact that's happening, but certainly the idea and that approach is to work with families to provide kind

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of individual group and family therapy for folks who are experiencing kind of any challenges as they pertain specifically around a substance use disorder.

So we are going to build on the idea of STEP -- I mean, STEP, the whole approach is also to be able to look more broadly at within those 22 schools, look at school climate in addition to being able to provide some consultation support for individuals who may be experiencing kind of the various types of psychiatric stress.

So we are, again, committed to that. As I responded, I wanted to give kind of both kind of a bridge and then some more specific things, because I think that while we're dealing with this crisis right now, there's yet to be one that we haven't necessarily anticipated. And so to the extent that we can get in front of that and help folks to be more resilient, I think obviously families are

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better off. And so that's also in part why I talked about kind of the broader strategies that we're using.

COUNCILWOMAN GYM: Madam Chair, I don't think that we're going to be able to figure all of this out, but I definitely do want to follow up. We've had a good relationship trying to figure it out with CBH. I am much more specific about seeing a strategy directed towards children and youth in schools and outside of schools that are specifically related to this opioid crisis. That's what this hearing today is about. I think it's extremely important.

Those young people -- you want to talk about crisis. It's the young people who are growing up watching it right now who are then going to become teenagers and young adults trying to figure out where the City was for them when they needed it the most, when they were five and six years old.

So thank you.

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COUNCILWOMAN BASS: Thank you, Councilwoman.

I just want to do a couple things. Number one, I want to recognize Councilman Al Taubenberger. Also we have our City Controller, Rebecca Rhynhart, who has joined us. So if we could have her come and give her testimony and then we'll go to Councilman Squilla and then Councilman Jones and then back to the panel.

It doesn't have to be everybody. Just so the Controller can have a mic.

(Witness approached witness table.)

COUNCILWOMAN BASS: And if we could ask the last panel to sit in the front chairs there, because we don't want you to go too far. We'll be right back at you.

Thank you for being here. Please state your name for the record and proceed with your testimony.

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CONTROLLER RHYNHART: Rebecca Rhynhart, City Controller. Thanks for having me here today.

Good morning, Councilwoman Bass, Chair of the Committee, Councilwoman Maria Quinones-Sanchez, and members of the Public Health and Human Services Committee. My name is Rebecca Rhynhart. I'm the City Controller. I am here today to testify on Resolution 180037, which authorizes the Committee on Public Health and Human Services to hold hearings to assess the City of Philadelphia's efforts, as coordinated by the Managing Director's Office and our human services departments, to prevent and treat abuse, addiction, and disease related to the use of opioids.

In 2017, more than 5,000 Pennsylvanians died from drug overdoses. About 1,200 of those lives lost were here in Philadelphia. The opioid epidemic is a serious problem facing our city.

In January of this year, I

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announced that my office would conduct a performance audit of the Department of Behavioral Health and Intellectual disAbility Services. This audit of DBHIDS, which has an annual budget of about 1.6 billion, will assess the validity and effectiveness of their spending.

DBH largely contracts out the services it provides to individuals through non-profit agencies. The audit will specifically probe the provider selection process, the effectiveness of the services provided, and the process for determining how much funding a provider receives, among other factors.

The opioid crisis is a complicated issue, with no easy solutions. The goal of our audit is to understand how the Department is spending money on addiction services and to ensure that the money is being spent wisely, responsibly, and efficiently.

I applaud the Committee on

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Public Health and Human Services for wanting to hold these hearings to shine a light on the City's overall approach to combatting opioid abuse and addiction.

Thank you, and this concludes my testimony.

COUNCILWOMAN BASS: Thank you very much for your testimony.

If we could have the former panel come back. And, Ms. Rhynhart, if you could stay close by as well.

CONTROLLER RHYNHART: Sure.

COUNCILWOMAN BASS: If we could have the former panel come back.

And, Councilman Squilla, you're up next.

COUNCILMAN SQUILLA: Thank you.

Commissioner Farley, my question --

COUNCILWOMAN BASS: They're going to go get him.

COUNCILMAN SQUILLA: Okay. He had said in his statement -- I guess I could ask him when he comes back -- that

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the epidemic is growing and that it is actually getting worse than it was the previous year. Do we have statistics? I know he said it was -- was it 70,000? Does anybody know?

MS. GLADSTEIN: I'd rather wait for the Commissioner.

COUNCILMAN SQUILLA: Seventy thousand people addicted to --

MS. GLADSTEIN: I'd rather wait for the Commissioner to come back.

COUNCILMAN SQUILLA: I'll ask it when he comes back and we'll ask that question. I was just getting to the point that it seems like it's still not at its peak, the heroin epidemic. Would you agree, the panel agree to that?

MS. GLADSTEIN: I think, yes, we would agree to that, because we continue to see opioid prescribing to points made by Council already and obviously we see the number of deaths increasing.

COUNCILMAN SQUILLA: Do we know

the actual number of opioid users or heroin users in the City, an estimate?

MS. GLADSTEIN: Again, that's an estimate that the Health Commissioner has, but it is simply an estimate. We don't know the actual number.

COUNCILMAN SQUILLA: And the state has called this an emergency, correct? We had some concerns. We know the budget is $1.6 billion, which is a good sum of money, and thank you for the Controller looking at those dollars to see how it's spent and we appreciate your help on that, but the state that has considered it an emergency, are they now offering additional dollars to the City to help fight this?

MS. GLADSTEIN: No, they are not. We were grateful to have them declare the emergency because what they did was primarily make a set of regulatory changes that removed some of the barriers that people experience in accessing treatment. And so we felt it

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was beneficial, but it did not add any new resources.

COMMISSIONER JONES: And I think to the point that you also are raising around the potential growth, I mean, so what we anticipate and what we would like to see included even in the Health Choices rate is to make sure that we have a rate that would address the additional capacity that we would need to deal with kind of the new services that we would need to bring up to address the issue.

COUNCILMAN SQUILLA: Now, there's a reimbursement from the state, correct? Could you explain how that works?

COMMISSIONER JONES: There's a capitation arrangement that comes -- so the dollars essentially come from federal to state and from state to the city via Department of Behavioral Health and Intellectual disAbility Services. The City actually manages the capitation

risk, and so what happens is -- and we then contract with CBH, which gets so much per member per month, and that per member per month rate includes the cost of providing medical services to -- medical behavioral health services to those individuals. So we are expected to manage within that rate and so whatever services that are needed to be provided. And so what we found is that the rate that the state has proposed in terms of that Health Choices rate is not adequate to cover all of our needs, particularly as we may have some expansion needs based upon the growing array of folks with substance use disorder.

COUNCILMAN SQUILLA: So, in your knowledge, do you think that would prevent adding the additional providers in any way if you have a shortfall of dollars?

COMMISSIONER JONES: So I think what happens is that we go through -- certainly as we expand the provider

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network, that would be a procurement process, and certainly if we needed to have additional services brought up, if the rate isn't adequate to cover additional services, then certainly it would have an impact on both the services and potentially providers coming in to the network.

MS. GLADSTEIN: If I could just add, we've discussed this a little bit with Councilman Squilla. I want to make sure the other members of Council are aware that the capitation that we were originally provided by the state several months ago was, we thought, really significantly deficient. It was less resources than we spent in '16, in Calendar Year '16, and in what we're finalizing for Calendar Year '17. We've had a number of conversations with the state. They've added more resources, but we still anticipate a significant gap.

The latest information from the state, which is the Pennsylvania

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Department of Human Services that manages these resources, is that they will look again at what our utilization is; in other words, what the number of members who have used which services, and they will do that in the middle of the year, I assume June or July, and may be able to -- in addition to their seeking a waiver from the federal government, may be able to add resources after that point. But that's problematic for us because we're on a calendar year and would have to wait six months into the year to know whether or not we have new resources. And also our practice in the past has indicated that we do not get mid-year bumps, although it's been offered before. So this is a significant issue for us.

COUNCILMAN SQUILLA: Is that part of the $1.6 billion for the budget?

COMMISSIONER JONES: So that actually is an appropriation, and so we -- again, it would be part of the

appropriation if we got all of it.

COUNCILMAN SQUILLA: So are you saying then would it be a shortfall in your budget if you didn't get it all?

COMMISSIONER JONES: Well, so we certainly are saying that we wouldn't have the adequate resources to be able to meet any expansion needs. And so from that perspective, we clearly wouldn't be able to cover all services.

COUNCILMAN SQUILLA: Because we had reached out to Secretary Miller to come down to the meeting, and unfortunately she wasn't able to come, but she did say that we have -- her statement was in an e-mail that, We have had numerous calls and meetings with correspondence regarding the 2018 rates for DBH/CBH. We have also asked for some additional information on their proposed initiatives. We have also assured both Mr. Jones and Erney -- Joan, I'm sorry, that we will review the rates again at mid year to ensure adequacy.

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Do they have to review what we're doing before they would decide to increase the rates?

COMMISSIONER JONES: So we feel like the additional information that the state has requested that we've provided, my guess is that they are currently reviewing that additional information and think, as Eva has indicated, then we are hopeful that they would do a significant mid-year adjustment.

COUNCILMAN SQUILLA: Okay. I want to go back and I know, Dr. Farley, we had just asked about earlier the epidemic and it seems to be still on the rise. Is that something that the City sees happening here, the increase in heroin use and opioid addiction?

COMMISSIONER FARLEY: We're certainly seeing an increase in overdose deaths obviously. We don't have a way of counting how many people out there are using heroin or injecting heroin. We have survey data that can give us an

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estimate of how many there are. And so our impression is based on the number of people overdosing that probably that number is increasing, but we don't have a hard count to track that.

COUNCILMAN HENON: Point of information, if I may, Councilman.

A question to the doctor. So estimated like -- I think the estimated number of heroin users in the City of Philadelphia is 70,000; is that correct?

COMMISSIONER FARLEY: Yes.

COUNCILMAN HENON: Without any real accurate pinpointing the numbers.

In your estimation, beyond the heroin users in the City of Philadelphia, what is your estimate of people who are addicted and are being prescribed opioids, which seems to be, in my opinion, a much, much larger and greater number.

COMMISSIONER FARLEY: The survey that we did last summer suggested that 168,000 people in the City, 168,000

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adults, were currently taking prescription opioid pills. Not all of those people were addicted, but probably a lot of them were, and so that's a lot. It's a huge number. That represents one in seven adults in the City.

COUNCILMAN HENON: So when you look at future growth, you're looking -- I mean, you can start with that, right, and then go from there to see what kind of reimbursements we need, what kind of treatments we would need, and how to estimate some sort of financial budget for trying to deal with opioid addiction. Would that be correct?

COMMISSIONER FARLEY: Well, we know --

COUNCILMAN HENON: Because people would be surprised how many people get addicted to opioids by going to the dentist.

COMMISSIONER FARLEY: Yes. The number is huge. Now, a number of those people will end up not going through a

formal treatment program. That's one of the things we do know. Some people just do stop on their own. So it's hard to predict how many of those will ultimately need treatment, but certainly the need for treatment is very large, and so any limitations on funding for the City is going to be a real problem.

COUNCILMAN HENON: And last point of information, Councilman. I apologize for taking your time.

The rate of reimbursement that the feds pass through from the state down to the municipality, which is the City of Philadelphia, to your department, what are the difference in percentage of rates on how you treat somebody with addiction, substance abuse and addiction? So is there a higher rate in treating with MAT than there is dealing with other supportive services that are drug free?

COMMISSIONER JONES: So that what we actually are seeing is probably just in terms of people coming through,

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that we're about -- I think it's about 86 percent in terms of have a co-occurring disorder. So we're seeing people about 86 percent have both a substance use and mental health disorder. We still are -- our spend still broadly is higher on, candidly, mental health disorders solely, but we actually are seeing an increase in the number of folks who are coming through with opioid uses. In fact, I think over the last seven years have seen a 34 percent increase. And so from that perspective, our spend is increasing.

COUNCILMAN SQUILLA: Thank you. So we had seen, just to piggyback on some of the other questions, that MAT is twice as effective as other options for the opioid addiction. What are the statistics? So it's twice as effective. So you know people are on MAT, they are able to become working and productive citizens in society a lot more than some of the other uses. So what are the statistics on this?

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COMMISSIONER JONES: So, again, what we're able to -- what we know is that, again, probably if an individual has chosen medication assisted treatment, that they, again, are twice as likely to then come through kind of the treatment and recovery process and then -- and not necessarily relapse. And so -- and although we recognize that certainly relapse is a part of kind of the recovery process, we are finding that individuals, again, who choose medication assisted treatment along with the additional therapies, again, progress more through their recovery.

I would have to get back to you to give you more drill-down data, and I certainly can do that.

COUNCILMAN SQUILLA: I mean, you made the statement twice as effective. So it's two to one, correct?

COMMISSIONER JONES: Correct.

COUNCILMAN SQUILLA: So for every person that uses MAT, they end up

getting better or being productive?

COMMISSIONER JONES: So, again, what we're saying is that just in terms of the recovery process, that these individuals -- so we're finding that they don't necessarily -- they don't overdose and certainly obviously if you're not overdosing, then we don't necessarily -- we're not experiencing seeing individuals who then choose MAT experience the death of someone who may have just selected detox alone.

COUNCILMAN SQUILLA: So do we have the statistics on the number of MAT people that have not overdosed?

COMMISSIONER JONES: So here's what we have. So if you use MAT, it looks like it reduces your risk for readmission by 37 percent.

COUNCILMAN SQUILLA: Readmission if you're on MAT --

COMMISSIONER JONES: So being readmitted into a higher level of care.

COUNCILMAN SQUILLA: Reduces

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that by 37 percent?

COMMISSIONER JONES: Correct.

COUNCILMAN SQUILLA: But they stay on methadone?

COMMISSIONER JONES: Or buprenorphine or Vivitrol, depending upon which medication is working better for them, yeah. And then it looks like it also -- it looks like that members -- they have a 42 to 47 percent, again, lower risk of the condition reoccurring, 42 to 47 percent lower risk if they are participating on medication assisted treatment.

COUNCILMAN SQUILLA: The condition reoccurring. So, I mean, none of this makes any sense.

COMMISSIONER JONES: I'm actually going to have Roland come up and speak a little bit to this.

(Witness approached witness table.)

DEPUTY COMMISSIONER LAMB: Good morning. My name is Roland Lamb. I'm

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Deputy Commissioner for the Department of Behavioral Health and Intellectual disAbility Services, Planning and Innovation.

Your question, Councilman, again was?

COUNCILMAN SQUILLA: It was the statistics on MAT. We're saying that MAT is twice as effective than any other means of support for the opioid addiction. So we were trying to -- what are the statistics? Like is it -- you're saying 50 percent of the people who are on MAT either get off opioids and are able to have a functional life if they do MAT compared to other avenues?

DEPUTY COMMISSIONER LAMB: The overall success rate of MAT --

COUNCILMAN SQUILLA: What's success? What the definition of success?

DEPUTY COMMISSIONER LAMB: The success rate is not a renewal of the use of illegal drugs. So to begin there, that's the baseline, if you want to talk

about success. So if I'm no longer using illicit drugs and if I am now beginning to recapture my life and that's a part of the long-term recovery -- and I think that we need to be clear. That's the business that we're in. We're in the business of not just treating someone but long-term recovery. I would tell you that MAT has approximately about an 80 percent success rate.

COUNCILMAN SQUILLA: Eighty percent of the people who use MAT never go back into heroin or opioid addiction?

DEPUTY COMMISSIONER LAMB: I'll put it this way: have a higher probability of long-term success in terms of recovery. So that means that it's possible that you may have an episode here or there or somebody who goes back to using an illegal drug, but it's not a sustainable episode. Usually what happens is for many people, that relapse is a part of their long-term recovery.

COMMISSIONER JONES: And I

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think another way of thinking about it too is they maintain their sobriety.

COUNCILMAN SQUILLA: They maintain their sobriety.

COMMISSIONER JONES: They maintain their sobriety.

COUNCILMAN SQUILLA: Or they maintain the medical treatment, the medicine.

DEPUTY COMMISSIONER LAMB: Right. Some people who actually go into treatment, they relapse and you don't see them anymore until they are in a crisis, but you have other people who may go into treatment, who are getting good responsible treatment and they may have an episode where they do pick up again, but the issue is they stay in treatment and they resolve the issue and they eventually are able to sustain their recovery process.

COUNCILMAN SQUILLA: And you put them back onto the MAT to get them and try to keep them sustainable.

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So if we were going to do true statistics, how many people who are on MAT ever went back and be able to do an opioid or a --

DEPUTY COMMISSIONER LAMB: I'm not sure I understand your question.

COUNCILMAN SQUILLA: If I was on MAT, right, say there was 100 people or 1,000 people on MAT, which we know we have a lot more than that, what percentage of them actually either ever got off of methadone or ever went back and tried heroin or some other opioid?

DEPUTY COMMISSIONER LAMB: Well, getting off of methadone is a small number by comparison. Let's say for the sake of argument you have about 6,000 people in the City of Philadelphia and between 5,000 and 6,000 people who are on methadone. So the question would be is whether or not those folks -- what percentage of those folks ever come off of methadone, and I would tell you at this point in time you're talking about a

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very low percentage, between 15, 20 percent.

COUNCILMAN SQUILLA: They stay on methadone the rest of their life?

DEPUTY COMMISSIONER LAMB: In many cases they do.

COUNCILMAN SQUILLA: Because it seems like -- I know last year we had talked about MAT seemed to be the evidence-based treatment. You went in and we decided to push more for providers of MAT, correct?

DEPUTY COMMISSIONER LAMB: Right.

COUNCILMAN SQUILLA: And we still -- I guess we still don't see a decrease in ODs or people becoming, I guess, productive in society on that. So we're keeping people -- the reason why I'm saying that is, we had a couple mothers come to my office and individuals who wanted to try to get off of MAT, and it was then brought to them that they did not want to try to advise them to go to

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another source.

COMMISSIONER JONES: So what I'm going to ask real quick is actually have one of my medical directors to come up to be able to respond to some of the questions, Dr. Neimark.

(Witness approached witness table.)

DR. NEIMARK: Good morning, Councilman Squilla. Good morning to the Council. I'm Dr. Geoffrey Neimark. I'm the Chief Medical Officer at CBH. Thank you for this opportunity and for the question.

I just wanted to respond in the following way: There are various outcomes around medication assisted treatment. The two times -- one that's being talked about here is really about achieving abstinence over a set interval. If you were to compile all the outcomes on MAT, which have been really robustly shown across a wide range, and that's everything from fatal overdoses, lowering

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HIV and hepatitis rates, community safety and a range of others, we'd be happy to provide you with that information. I think one of the dangers in terms of this discussion is getting into a rehashing of the debate around whether MAT is effective or not. That's been proven. We actually are moving now to --

COUNCILMAN SQUILLA: Could I say one thing real quick? Because this is the same arguments that's being used for the safe injection sites. If we had everybody freely go in and shoot heroin, right, they wouldn't die because they would be in there, they'd be monitored, and we would keep them alive. So it's a harm-reduction strategy, correct? So, I mean, the same thing is if we just had everybody and just say, all right, everybody just go shoot heroin and nobody would ever die, that would be better than methadone. That would be better than Vivitrol. That would be better than everything.

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DR. NEIMARK: Look, I think if you're looking at a harm-reduction model, you can look at other municipalities and countries who have adopted the practice you are talking about. I think we're talking about a medicalized model around methadone, around Suboxone, around Vivitrol that's highly effective and it works and at the end saves lives, and that the more we argue around whether it works or not, the less likely we're going to get to a point where the outcomes we want we achieve.

COUNCILMAN SQUILLA: I don't think we're arguing whether it works or not. We know it works, right? If we keep the people on heroin, it works to keep them alive, correct?

COMMISSIONER JONES: But I think just to add, I think that, again, the risk here is that -- so we are raising the conversation around medication assisted treatment and we're talking about methadone, buprenorphine,

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Vivitrol as it retains to opioid use disorder. If we were to change the conversation around the disease and say so now we are then talking about cancer and we want to prevent the spread of breast cancer, and so we have somebody that's on Tamoxifen, right? And then you would say, so how long do you keep that person on Tamoxifen? And if Tamoxifen then continues to keep that person alive and is part of the treatment process, we would say, okay, that makes sense. And then you would then use the other treatment strategies you could to then help that person to thrive.

I think that the principle, irrespective of the disease, is what we're trying to do. So here we're saying medication assisted treatment is effective in helping a person to, again, achieve long-term recovery. Do we keep them on it forever? I think it depends upon kind of what's working. But, again, at the end of the day, we want to make

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sure that they are able to then have a sustained life that's of quality.

COUNCILMAN SQUILLA: I mean, nobody is opposed to medical assisted treatment I think as a means, but there should be some other ways to maybe try to wean people eventually off that who want to get off it and who want to go out to a more maybe sober living or drug-free living, and it seems like we are pushing more the other way.

When you get some of the answers that we get, it's like how do they get off of methadone? You say, well, why do they have to get off, you know? And that to me -- some of these people do want to. I mean, the kids we talk to, the parents we talk to. And they seem like they're being pushed more into that level even though they want to get off it, and that's my concern. It's not that whether we use MAT or not. It just seems like we're going to an avenue where it's going to be constant

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medication and medication forever, and that's the part that scares me.

DR. NEIMARK: And I think I agree with that. As a physician, at the end of the day, I know if you cannot be on a medication, that's always better than being on one. However, if you need one for your well-being, for your functioning, and for everything else, that's an individualized decision that we would encourage our treatment providers to make with our members. What we are advocating for is for our providers to offer informed consent to a treatment that works. We're trying to break down stigmas. When we use terms here like drug-free treatment, we should actually call it medication-free treatment. Even little things like that really impact how we think about things, and I think we need to be mindful of that.

COUNCILMAN SQUILLA: And I agree, and I think that should be an option. I think we could still -- I

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mean, because we talked about it. We have doctors out there -- and Councilwoman Sanchez and myself both have doctors out there that weren't participating in the insurance, but Dr. Summers and Dr. Verdell, who have been actively supposedly helping our addicted population, have been taking advantage of them, and it took us five years to get them to go to jail.

But, I mean, these are things that we've been working on, and it's frustrating, because the big push toward medicine and, yes, medicine -- we're big proponents of medicine. We want to help people, but there are a big group of people who after taking medicine want to try to get off of it, and I think that if we want to do medicine free, I think that should be an option. And I think even medicine initially and then wean its way off to be medicine free, that should be an option, but just not -- right now it just seems like we're just pushing MAT

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wholeheartedly when we should have other options out there for folks. And I appreciate your input.

COMMISSIONER JONES: And, Councilman Squilla, the only thing I would say is that, again, we also continue to make sure that individual choice is first and foremost, and so if folks -- making sure that folks are informed about what the options are is also what we continue to --

COUNCILMAN SQUILLA: I hear you say that, but some of the kids that tell you when they go in there, they don't have a choice. They put them right into MAT, and that's something we -- and maybe the Controller could be able to find this out by doing interviews, by seeing that why are our people doing that. I mean, that reflects back up on you, and if that's the case, what are we doing as a city?

COMMISSIONER JONES: Okay.

COUNCILMAN SQUILLA: Thank you.

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COUNCILWOMAN BASS: Thank you, Councilman. I think those are excellent points, and if there's an opportunity to have someone removed off of any substance, I think that that's a goal that we should be working towards. I certainly understand and recognize it's an individual decision and everything doesn't work for everybody, but we also know that there are programs out there for folks who aren't doing the medication assisted treatment, and you have a lot of programs that are already out there that are doing recovery work, and one of the things that we suggested in our Five-Point Plan is let's invest more in those programs that are really operating on a shoestring budget and doing incredible work without resources. So I just wanted to put that out there as well.

Just a couple of quick things. We're getting ready to lose our City Controller, so for the members, I don't

know if anyone had any specific questions for her.

COUNCILMAN JONES: Yes.

COUNCILWOMAN BASS: You do? Okay.

Can you hang for just a few more minutes?

CONTROLLER RHYNHART: Yes.

COUNCILWOMAN BASS: Okay. So Councilman Jones is next and then Councilman Taubenberger and Councilwoman Maria Quinones-Sanchez. And we're going to ask -- I hate to do this to you, Councilman Jones. We're going to ask you to be as brief as possible. We're running out of time. So at 1 o'clock there's another hearing in these Chambers and we still want to try to get through as many of our speakers as we possibly can.

COUNCILMAN JONES: So, Madam Chair, I will follow your orders and be as brief as possible.

COUNCILWOMAN BASS: And one

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other thing. I just want to announce just so everyone knows that this is not the end of the conversation. Our next hearing on this matter will be on April 4th from 5:30 to 7:30 at the Cardinal Bevilacqua Center at 2646 Kensington Avenue. So we certainly hope folks will be able to attend that hearing as well. So this is not the end of the conversation.

So Councilman.

COUNCILMAN JONES: Thank you, Madam Chair, and thank you for bringing this difficult, complicated discussion to Chambers. No matter what you think you are when you get elected, you're not an expert on everything. So you have to rely on experts to kind of get up to speed on not only what is happening but what should be done. So I thank you for bringing that, you and the Committee.

I had the unenviable displeasure of burying Nasser Fattah last week who died of an opioid addiction. He

was found in Sister Falaka's other part of the block, having been in his room for two days and no one knew he was in there. We just put him to rest. And the shame of it is, I didn't know he was addicted to opioids and he seemed just fine to me. And so it is a problem that has different faces. Some people are able to mask it better, but it is one of those problems where it has reached tidal wave proportions, tidal wave. And I found out and I want to thank Dr. Lamb, Commissioner Jones for being a part of that education. My good colleague Kenyatta Johnson and I are always talking about gun violence, but when you gave me the statistics of 1,200 deaths last year, it put it in perspective that this is a tidal wave that we need to address.

A couple of things. And thank you for the other things you do. If I have it correctly, your department is more of a gatekeeper of funds and insurances that you subcontract out to

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other entities to deal with specific services that are required. Is that true?

COMMISSIONER JONES: That's correct, Councilman.

COUNCILMAN JONES: Second thing is that the concern is, are we getting the best return on our investment when we invest in some of those services? And that is a constant question that we should receive constant data and information about. Is that true?

COMMISSIONER JONES: I think that's correct also.

COUNCILMAN JONES: And I think that the City Controller on the stage of her swearing in made that one of her priorities, to kind of take a look at that, because it represents such a large portion of our expenditures as a city, and I thank her for that, because the point is -- and that shouldn't be met with fear, but it should be replaced with fact. The reason I say that is because

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everybody in this Chamber wants to do good. I believe that. But everybody in this Chamber doesn't know how much good costs, and we have to figure that out with limited resources that we have, how to get a higher rate of return, more people -- I heard should we sedate people through their addiction or should we push towards recovery. That is an elephant in the room for me. At the end of the day, there should be an end of the day hopefully with a happy ending that people successfully get out of their addiction, and I know -- I hate to use the term "some of my best friends are," but some of my best friends were in that situation and actually did find their way through it, through God, through spirituality, through programs that exist out there, but managed their way through it.

So I never, ever want to live a world where we don't push for people to recover and just maintain the even plain. It's not good enough to me.

And so a couple of things. And I don't need to know the answer to this now. I would like to know the answer to this by the time budget gets around.

You gave me some statistics about demographics of the addiction process and those people that lost their lives to it. I want to dig down into that.

The other question that a lot of people bring to me is, where are they from? Are they from Bucks County, Montgomery County, New Jersey? And I found out from you that they may well still be mostly Philadelphians; is that correct?

COMMISSIONER JONES: Mm-hmm.

COUNCILMAN JONES: That's a myth that's out there.

COMMISSIONER JONES: And so certainly we will get you some of the data on the individuals who pass as a result of the overdose and that, again, we recognize that probably about 90

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percent of the folks are Philadelphians.

COUNCILMAN JONES: So I have a recovery center in my district. It's not just Councilwoman Sanchez. And I want to do good. I need -- and I want to thank you for helping me with one of them, which I won't name, but there are some unintended consequences that happen with those centers and that I need you to pay keen attention to.

I funded more McDonald franchises in the City of Philadelphia than Ronald McDonald himself. That was a part of when I was at PCDC we put money into them. The one at -- several of them have told me they are about to close because they have been taken over by people from those various centers. One is on Frankford Avenue. He came into my office and told me he's getting ready to turn the lights out. And one is on Jefferson Street.

As much as I want to be a part of the recovery process, you know I stood

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up in the community when they wanted to close it. I said, no, you will not do that, because they're our brothers and our sisters and they need our help. But also what I want to encourage in other parts of other communities is that you do like you did for Parkside where you intervene and let people know that we have to be good neighbors, and wherever you're talking about putting those injection centers, they have to have good neighbors. The people who pay private investment into residential properties need that from you.

So a leg on the stool of a recovery and treatment has to be how those centers fit into surrounding communities. And if you do that by the budget time and come up with that brilliant plan, I will consider you genius. Okay? But anything I vote on has to include that. Other places I know do that kind of service and they do it, quite frankly, for a lot less, and

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they're a part of that community, whether it's snow removal, whether it's clean-ups, whether it's barbecues and donating the hamburgers and the hot dogs. I know this to be true. But that has to be a key component in any recovery center, needle exchange in Philadelphia.

And I'm going to stop with that because she said be brief, but I'll give you enough time to answer it during budget.

Thank you, Madam Chair.

COUNCILWOMAN BASS: Thank you.

COMMISSIONER JONES: Thank you, Councilman Jones.

COUNCILWOMAN BASS: Thank you, Councilman.

Councilman Taubenberger.

COUNCILMAN TAUBENBERGER: Thank you, Madam Chair Lady. And I want to thank you and Councilwoman Quinones-Sanchez and Councilman Squilla and Councilman Domb for bringing this issue to our attention so we could have

an understanding, a better understanding, than this.

I'd like to just talk about a couple things on statistics. It was testified there are about 70,000 heroin users in Philadelphia. I just want to -- and if I'm wrong, please correct me.

Out of the deaths, it was just testified a moment or two ago 90 percent are from Philadelphia County. It was also testified that the statistics aren't all that accurate, which I can understand. What can we do to make the statistics a little more accurate, or can it even be done?

COMMISSIONER FARLEY: I'll take part of that. The number of current heroin users in the City you can only get by doing some kind of survey, and those surveys are less than perfect, because heroin users may tell you that they're not using heroin on the survey or they may be --

COUNCILMAN TAUBENBERGER: So

you're actually asking the user themselves, which I can understand.

COMMISSIONER FARLEY: Right. And that's a survey that's self-reported. It's less than perfect, but it's the best we have.

We do have good data on the people who die from overdose because we get statistics from the Medical Examiner. We can get you a very specific number on what proportion of those people are from Philadelphia and what proportion are not, but I think 90 percent is a pretty good estimate.

COUNCILMAN TAUBENBERGER: If that statistic is pretty firm at 90 percent, there would be no reason. I mean, unless you really wanted to give it to me.

COMMISSIONER FARLEY: It may be 85 percent, but it's in that range. The large majority of people are from Philadelphia.

COUNCILMAN TAUBENBERGER: Okay.

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That still means that there are some people coming from outside the area -- or outside the county. I wouldn't say outside the area.

What do you think we could do to better coordinate with our suburban counties? Because obviously this is a major problem everywhere and we can't deal with everything, but we can deal with a lot, but the more we know, the better off we can deal with it.

COMMISSIONER JONES: So two responses. One is certainly that what we do know is that for anyone who is funded via Medicaid, their county of origin actually pays their expenses. So even if we had someone coming from a surrounding county but they are enrolled in that county's Medicaid program, that would actually be the fund. That would be the payer for their services. So that's one.

I think as it pertains to the other piece is that we actually also have within our department a single county

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authority, and they meet regularly or at least monthly with the other single county authorities in the surrounding counties, and this is part of an ongoing agenda item where they talk about how we can help an individual who may have come -- and, again, this is obviously not necessarily from the other states, but who have come from one of the surrounding counties get reconnected and get supported. And so that is a process that's in place that we, again, try to address that issue.

COUNCILMAN TAUBENBERGER: Thank you very much.

Madam Chair, thank you.

COUNCILWOMAN BASS: Thank you.

Councilwoman Quinones-Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

If I could have the Controller real quick, because I know she's pressed for time and I want to -- so before you came in and testified -- and we want to

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thank you for your willingness to share some of what you're doing internally. Some of the discussion that came up in the early part of our hearings was around DBH and CBH around what regulatory and statutory confinements they had around some of the issues that we brought up -- and I don't know if they're going to be included in what you're looking at -- was their bylaws, their Board membership, contracting decisions. Is there anything in particular within that framework that -- we're interested around the issue of disclosure of minutes and public meetings. Is there anything that you've seen so far that statutorily limits them from having to be public?

CONTROLLER RHYNHART: You're talking about the non-profits that we contract with?

COUNCILWOMAN SANCHEZ: No. I'm talking about the governance, the Board of CBH.

CONTROLLER RHYNHART: Of CBH?

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At this point, I think our audit is at the beginning stages, so we haven't hit any material roadblocks to date on getting the information that we need to start that process.

COUNCILWOMAN SANCHEZ: So we would be interested in anything that limits their ability to be more public in their meetings, providing minutes in a public setting, all of those types of things, if there's any issues, maybe confidentiality issues that we should be aware of as we try to get a more open discussion about --

CONTROLLER RHYNHART: Absolutely.

COUNCILWOMAN SANCHEZ: -- how decisions are made and governance decisions.

CONTROLLER RHYNHART: I mean, definitely transparency is a big issue and something that's very important. So absolutely. Happy to do that.

COUNCILWOMAN SANCHEZ: And then

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the other question we talked about when you were in your previous role was the issue of really looking at the conformance of contracts and compliance as it relates to it. One of the areas is, as you and I were working on procurement reform, there was a concern about the lag time between the beginning of the fiscal year and when actually organizations had conformed contracts.

CONTROLLER RHYNHART: Yes.

COUNCILWOMAN SANCHEZ: And whether that ultimately ends up costing the City more money. So is that an area that you'll be looking at?

CONTROLLER RHYNHART: The audit of Behavioral Health is focused on the providers' performance in terms of outcomes, positive outcomes, and making sure that the money is going to the right places. The issue of the providers not getting paid in a timely manner is a serious issue. I don't know where the Kenney Administration is on that now, but

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a year or so ago it was definitely a big issue and one that involves more than just the Department of Behavioral Health but across Law Department and other departments as well. But that is something that I could refresh. It's something that the City needs to get better at. I mean, providers waiting 120 days after service is provided to get paid, those types of instances are just not okay. So that is something that I would be happy to dust off and look into.

COUNCILWOMAN SANCHEZ: Okay. Well, thank you. We are definitely interested again is there -- not only it's bad practice, right, but are we losing money because we're contracting people on a letter of commitment, and then as we reconcile budgets, are we paying more for stuff than we should be had we been clear and transparent about provider services from day one. And to me is -- are we losing money in that as a transaction when we don't conform a

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contract until January for someone who is providing services in July.

CONTROLLER RHYNHART: We'll look into it definitely. Thank you.

COUNCILWOMAN SANCHEZ: Thank you.

And I want to kind of regroup and have Liz and David answer a little bit of this, because I think it's important and one of the reasons why we did this hearing, and then I'll let Madam Chairwoman go through however we're going to run through the rest of the hearing.

I want to talk specifically -- and we're going to hear a little bit from some of the stakeholders the model that has been working that Liz referred to earlier, and so I want to get to that, because ultimately the issue of the encampments is about people's homelessness. So let's talk about beds.

What are the beds that we currently have in the system? How are they being utilized? And particularly

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for David, some clarity, because I think there's misinterpretation. When you say 25 percent of our services are available at any given time, there's an assumption that there are 25 percent of our beds available. Let's talk about who are the beds in the system, who pays for them, and if in fact we know that Pathways to Housing is working, if in fact even the proposal that has been presented in -- I think it's $2.2 million in this budget year and Eva mentioned $20 million over the next five years. Is that enough? I mean, are we really just setting ourselves -- we talked about performance-based budgeting. If we know there's a need, how much are these beds costing us and what is it going to take so that we can get the 200 people who have a homeless issue, in addition to an addiction issue, in these encampments into some of these beds?

MS. HERSH: We have in the homeless system about 3,500 emergency

housing beds. The system runs at about from somewhere between 90 and 120 percent of occupancy at any given time. And what that means is that when all of the beds are filled, then there's a certain number of people who on any given night may be sitting up in chairs. We have --

COUNCILWOMAN SANCHEZ: How frequently does that happen? I think people really need to understand that this is a practice that apparently we're okay with, because we have people sitting up.

MS. HERSH: No. It's horrible. It's really a function of resources. We spend on average, our system, $40 per day per person who is in a shelter. We added 54 or 56 beds this year.

COUNCILWOMAN SANCHEZ: Excuse me. How many?

MS. HERSH: It's either 54 or 56.

COUNCILWOMAN SANCHEZ: And I think this is an important number,

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because we say we are in a crisis, but we added 54 beds.

MS. HERSH: This is the resources that we have.

What we did -- and we would readily agree that it's not enough. What we've also been trying to do is not end up with a massive shelter system, because a shelter is -- it can become a dead end for people. Really the solution to homelessness is a house or an apartment or a place where people can live.

With the opioid crisis, some people who come through recovery actually don't need a subsidy. They may need a helping hand to get back on their feet again, but they may, once they're fully in recovery, they may be able to work and they don't need our system, except on a short-term basis. And then there are other people who if, as David said, have a serious mental illness and addiction, they may always need some support. So the Pathways units cost the system --

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housing -- permanent supportive housing costs about $15,000 a unit. That's a rent subsidy. And then Medicaid pays another chunk of change, and it varies depending on the suite of services.

COUNCILWOMAN SANCHEZ: So that's 15,000 because we're paying a full rent to someone?

MS. HERSH: That's the rent. That's whatever it costs to administer, sign up a lease, inspect the unit, if there's repairs that are needed. It varies. Some of those subsidies may be lower, but the regulations that guide that are based on the HUD regulations where we pay a landlord a fair market rent, and that's regionally determined. We don't expect that a private market housing provider actually takes a loss because they house one of their people. So it's a fairly expensive service, and one of the things that's happened is, for example, Pathways, they have 60 units that are funded by the federal

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government, but with all the budget cuts over the years, the federal partnership has shrunk. So last year we -- or this current year we've added about 100 units by adding through the budget and by reallocating resources.

COUNCILWOMAN SANCHEZ: So we went from 60 to 100 of the --

MS. HERSH: 60 to 75. But then we added -- it's called -- the generic area is called permanent supportive housing, and it's a rent subsidy for people who don't have enough money to pay a market rent, together with a suite of social services that follow them. And that's largely funded by Medicaid, assuming they're Medicaid-eligible and the services are medically necessary.

So permanent supportive housing is the evidence-based practice. It has about a 90 percent success rate in preventing a return to homelessness. Within our system as a whole over the past two years, 93 percent of the people

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who have entered our system, wherever they've entered it, as they've exited to permanent housing, 93 percent of them don't return to homelessness. So that's what we want to do, but given the cost, we're trying other things as well.

We've tripled our dollars for prevention this year. So we're trying to help more people if they're coming from -- if they're coming from a house already, to help them stay where they are rather than coming in, or rapid rehousing, which is a short-term subsidy, just for as much as a year, sometimes just to help people get back on their feet and get employment and stabilized housing.

COUNCILWOMAN SANCHEZ: And how much do those beds cost us?

MS. HERSH: That costs us $10,500 per unit on average.

And then this year we've been piloting what we call shallow rent, and this has been a partnership with DBHIDS

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and us where we're working with 30 landlords and we're paying them -- we pay them $600 a month and the individual pays 200. So many of the people who are on the street actually have an income. They're getting money from SSI or SSDI. They're permanently disabled. And that gives them about $700 or $800 a month, plus food stamps. So the most they can afford in rent is $200, and that's one reason that they're either in a shelter or on the street, because they can't pay their rent. So we've been doing this. We've been piloting this shallow rent, which is about half the price of a regular rent subsidy. So we have landlords who would like to do more, so our hope --

COUNCILWOMAN SANCHEZ: How many people do we have in that system?

MS. HERSH: Thirty. So this is brand new.

COUNCILWOMAN SANCHEZ: You said 30 landlords. Are you saying --

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MS. HERSH: Thirty individuals.

COUNCILWOMAN SANCHEZ: Thirty individuals.

MS. HERSH: Right. And they're individuals who have come out of DBH programs or shelters who have -- they have a source of income, but they can't afford a market rent. So we're piloting that to see if there are other ways that we can expand that would be less costly.

So the goal is that -- everybody is a little bit different, and our system is trying to provide the lightest touch possible. We don't want to over-serve people, but we try not to under-serve them within the resources.

I'll just say one more thing since you asked about the demand. We did hire a national consultant through a competitive process to assess the number of units that are needed, and the system assessment reveals that we would need about 2,000 permanent supportive housing units in order to really address the need

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in the City. So that doesn't mean that every person living in poverty --

COUNCILWOMAN SANCHEZ: This would be for folks in addiction or this is just across the spectrum?

MS. HERSH: Addiction, serious mental illness or physical -- some sort of disability that will for their lifetime likely prevent them from paying a market rent.

COUNCILWOMAN SANCHEZ: So there was a report that was issued? Can you share that?

MS. HERSH: No. We're still in the process. It will be issued in late spring, early summer, with a set of strategies.

COUNCILWOMAN SANCHEZ: So the low-barrier housing is not your pilot one?

MS. HERSH: So low barrier is kind of a way of doing business, if you will. So low barrier means we try to make it as easy as possible for people to

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come in. So in the old days, you had to prove that you were deserving of assistance. That was the way we worked, right? So those -- 30 years ago we didn't know better. What can you say? We made mistakes. But nowadays the idea is you just come in. You don't have to show ID. Like I said, you have to leave your works outside and you have to leave weapons and you have to behave well, right?

COUNCILWOMAN SANCHEZ: And how many of these slots do we have?

MS. HERSH: So all of our -- we're moving to make all of our programs low barrier. So low barrier might be a safe haven, and I think we have a couple hundred beds, and they're largely funded through DBH and HUD.

COUNCILWOMAN SANCHEZ: So we're funding 128 at what cost?

MS. HERSH: Two hundred and twenty-five Safe Haven beds and then we have 120 Journey of Hope, which is

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residential treatment, and then we have about 3,500 shelter beds, 3,400.

COUNCILWOMAN SANCHEZ: You said Journey of Hope is how many?

MS. HERSH: One-twenty. That's residential drug treatment for people who are chronic.

COUNCILWOMAN SANCHEZ: And how much is that costing us a day?

MS. HERSH: I don't have those dollars. We'll get back to you. That program is extremely effective with chronically homeless people, people who have been on the street for a very, very long time. And as a matter of fact, I think we have someone here who may have been through one of those programs.

COUNCILWOMAN SANCHEZ: And I want to get to the cost, because if we're going to go back to the core of why we're here around the coordination of how do we break down these encampments and deal with the homelessness of folks, let alone the treatment services, how much are

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those beds costing us and how many are we going to expand to to be able to get ultimately -- to do away with the encampments, whether you use the San Francisco model or another model?

MS. HERSH: So the budget proposal on the table is to add 140 beds over the course of the next year. Eighty of those would be respite beds. That's street into a low-barrier respite based on the model that we currently have with Prevention Point. So two additional sites, 40 beds each. And then add approximately 60 supportive housing units, some of which would be Housing First, others of which would be permanent supportive housing that people move into afterwards.

COUNCILWOMAN SANCHEZ: Now, the estimate is that there's 120 people right now in those encampments. So we're looking at 140 over the course of the next year. So you know it's not enough. So we still don't know -- how much is

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this costing us?

David, I know you were trying to get a number for us.

MS. HERSH: Journey of Hope -- the total dollar amount for what we've proposed is $2.3 million just within the Office of Homeless Services, putting aside the DBH piece.

COUNCILWOMAN SANCHEZ: But I think what we're trying to get is an idea -- and this is part of the challenge, right? Because even those of us who try to be in the weeds of this, not because we want to but because we need to be, what is the most effective low barrier, low costing, and what are we doing to support that that's working, right? That's working. Because I think one of the things is, we all agree the shelter situation for this unique population is not the best place for them to be. So how much are those costing us, the low-barrier ones, so that we can quickly address some of the issues that

we see right now?

MS. HERSH: So the respite beds are about $40 per person per day. That doesn't include daytime services. That has a different -- and then the supportive housing units are $15,000 a year in general.

COUNCILWOMAN SANCHEZ: Why so much? That wraps up to $1,200 per person for 12 months.

MS. HERSH: Rent. It's rent.

COUNCILWOMAN SANCHEZ: So we're paying $1,250 rent for one person?

MS. HERSH: It depends. It usually averages between $1,000 and $1,100 and it's guided by the HUD fair market rent. So it depends -- some of them are less. We certainly try to do less, and generally we exceed those goals, but we try to be conservative in our estimates and then exceed those goals.

COUNCILWOMAN SANCHEZ: Can you provide for the Chair where these beds

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are currently located as it relates to the system citywide? Because one of the things we've also heard at community meetings that has been a little bit concerning is the beds are not where people are and people -- that whole discussion. So do you feel the beds are equally distributed around where the need is?

MS. HERSH: We think -- I did that analysis based on your suggestion, and within Kensington the emergency housing beds, Kensington is underserved. So the only respite that exists there right now is the Prevention Point respite. Our goal is to open that second respite as soon as we can and then the third in the general area, which would then give us 120 emergency beds.

The longer term beds are based on where the apartments are available. It's really up to the individual, where they can find a place, where we find a landlord, where it meets housing quality

standards. The only exception would be if it's an affordable housing development, Francis House of Peace or one of Project HOME or Bethesda or Catholic Social Services developments.

COUNCILWOMAN SANCHEZ: So, David, how is this different, less expensive, more expensive than the recovery houses that you currently fund?

COMMISSIONER JONES: So a couple responses. One is that the issue, generally speaking, with the low-barrier housing is that that's all, for the most part, kind of temporary housing. So it's only going to get you, I think it's, maybe about six months or so average length of stay. JOH is a little bit longer. Safe Haven, the per diem for Safe Haven is about $85. The per diem for Journey of Hope is about $300. And so --

COUNCILWOMAN SANCHEZ: Per day?

COMMISSIONER JONES: Correct.

COUNCILWOMAN SANCHEZ: Why the

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difference?

COMMISSIONER JONES: Because you're getting treatment also. It's a treatment program is the difference. And the --

COUNCILWOMAN SANCHEZ: Now, are they eligible for fee for services through your traditional services? How are you marrying these?

COMMISSIONER JONES: So think about Journey of Hope being paid via Medicaid. So that's how that's --

COUNCILWOMAN SANCHEZ: And the Medicaid reimburses for the housing?

COMMISSIONER JONES: For the services.

COUNCILWOMAN SANCHEZ: For the services.

COMMISSIONER JONES: Right.

COUNCILWOMAN SANCHEZ: This is a debate we've been having for a long time. Isn't housing stability part of a treatment plan, and why is it that we separate it from the service provided?

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COMMISSIONER JONES: So what we -- if you think about it in terms of to the extent that having someone housed and stabilized is part of the treatment, right, but if -- so, again, this is the argument that we make around physical health. So that if you went in and you had diabetes or you had asthma, you may get a longer hospital stay to treat that, but you wouldn't necessarily then get permanent supportive housing as a component of that ongoing. That's why I was saying that the issue here is that so once treatment is completed, the ongoing housing issue in terms of a social determinant of health continues to be in play, right?

So that's why I think part of what we have to try to do is figure out, again, in terms of those housing vouchers and when they're available, that that becomes something that folks then are able to be connected onto on an ongoing basis.

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COUNCILWOMAN SANCHEZ: So you're saying the Journey is 300 because it includes treatment, $85 for Safe Haven, $40 for respite, right?

MS. HERSH: Correct. And treatment would be -- if people are in treatment, that's separate. That would be a separate service that they would be referred to.

COUNCILWOMAN SANCHEZ: So we're talking low barriers. We all acknowledge we're in this crisis mode. When are we doing this waiver for this identification? How are we figuring out how to do that?

MS. GLADSTEIN: Can I just add one piece before we address that question, which is we've also had a significant change in terms of the number of units and vouchers that are available from the Housing Authority in the last several years. That's due to several factors, and we've been working with PHA, but I think it would be remiss not to add

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that into this conversation. There had been a fairly long-term agreement in which up to 500 units and vouchers would be available each year, and they just have not been due to reduction in resources there.

So that was our pathway for permanent supportive housing for quite a number of years, and now we're developing new ways to provide permanent supportive housing without those resources, and it's been a significant challenge and it's one that we're adjusting by evolving some of these services. So I think that's important to say here.

COUNCILWOMAN SANCHEZ: So, again, how much do we pay for a shelter bed?

MS. HERSH: Forty dollars on average. It's a range.

COUNCILWOMAN SANCHEZ: If you multiply $40 per day by 30 days, it's still $1,200.

MS. HERSH: That's why we don't

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want to expand the shelter system. People say we need way more shelter beds, but what we're trying to do is balance it out to put the money into housing. The difference is that a shelter bed may turn over three or four times in a year, whereas once somebody is permanently housed then or even temporarily housed, that subsidy has to go for the whole year. So it's not a one-for-one replacement. So that's the balancing act that we're trying to find.

COUNCILWOMAN SANCHEZ: Okay.

MS. HERSH: And I agree with you, and I think one of the frustrations that we're facing is I think we all agree that housing -- having a place to live is a social determinant of your ability to be healthy, to work, to do well in school, to sustain a recovery, and it's really impossible to do that from the street, but we don't -- we're having to largely provide those resources ourselves at this point in time.

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COUNCILWOMAN SANCHEZ: I guess I'm very frustrated in that we have 120 people approximately in need of some low-barrier housing to get them off the street. And, again, I hate to sound like a broken record, but I will sing and dance by myself if I have to, because nobody seems to be listening. If it's $40 per day for us to create this low-barrier situation and we're only planning 140 beds, how are we ever going to catch up? I mean, I just -- and I want to get to this. This encampment situation, if we don't tackle it now, it will become spring and summer. It will get normalized, and it's going to be harder. People are more willing to come in in the cold than they will be in the summer.

So I just -- I feel like if we know all of this, I think we have enough stakeholders, many who are here online to testify to tell us about some of the great things that they're doing, why is

it that we are not getting the money to at least take care of these 120 immediately? Is it a crisis or is it not a crisis?

MS. GLADSTEIN: I would say, Councilwoman -- and we'll discuss this -- we don't believe that all will need to go into respite immediately. We're hoping some may go back home. We're planning that some may be able to go into a unit if they have not been on the street a long time or addicted for a long time.

Having said that, we agree with your urgency, and we also expect that not everybody will be in respite for a full year. So we're expecting to be able to serve people very intensively and help them move out to create room for more beds, which has been the experience with the first respite.

COUNCILWOMAN SANCHEZ: So why is it okay for us to have these encampments in Kensington?

MS. HERSH: What did you say?

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COUNCILWOMAN SANCHEZ: Why is it okay for us to have these encampments in Kensington?

MS. GLADSTEIN: We have not said that it's okay. What we have said is we want to make sure that we have the resources to offer people several options before we end the encampments, and that is the preliminary plan that we shared with you and we'll be sharing with the civic associations.

MS. HERSH: It's absolutely not okay. You know, in my view, the fact that we have 950 people who are essentially sleeping and living on the streets of Philadelphia day in, day out, nothing about that situation is okay. I think that's why we're here trying to figure out what to do.

Nothing -- it's outrageous that there's almost a million people across this country who are sleeping outside when we have these vast resources. There's nothing about it that's okay.

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COUNCILWOMAN SANCHEZ: So do you feel you're working fast enough?

MS. HERSH: No, absolutely not. At the same time, you know, we're doing what we can, and it's frustrating. Finding a site -- you know this as well as I do, Councilwoman. As many people as would line up and say we need more beds, there are going to be that many who line up and say put them out at 48th and Market, which is what they told me when I went to one community. They said, What are you going to do about the encampments?

I said, I have the money to open a respite. I need a site.

And they said, How about 43rd and Market?

So, I mean, it's one of those things that's complicated that we're trying to resolve. We have one site that every day I think we're closer to signing the lease. Impact is here today. We have another site that we're working on.

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If somebody can give me a "just add water" site, we can get another 40 beds up. We can get another 80 beds up.

MS. GLADSTEIN: And we did discuss that with you last week, one additional site that we're looking at right now.

COUNCILWOMAN SANCHEZ: Now -- okay. And, again, I don't want to take up, because I know we have a bunch of folks who are going to talk a little bit around some of the stuff that is working. I just think that we knew when we were going to clean up Gurney Street, that we were going to bring to the light something that everybody knew was there, which was at any given time anywhere between 75 and 150 people needing housing, let alone the treatment for addiction.

And I just feel like we have enough partners in the room, in this room alone, that we should not have anybody in an encampment. And I think that we just

send a horrible message that this is okay in that particular neighborhood.

And while we sit here and look through all this bureaucracy, a site, I just think we're not moving quick enough around this stuff. And even in our budget proposal, putting $2.2 million is not going to be enough. It's not going to be enough. And I think as we get closer to this budget discussion, that's why it's important to really understand this whole service model that we have and looking at what are the other ways that we can better treat folks in a more efficient way.

And it's hard for me to tell folks we don't have money when I see all this money. This is my CBH binder for the last year. I have a bookshelf for the last ten years, trying to understand why this City thinks it's okay for us to have people living in the streets.

A soapbox. I'm sorry. I'm just very frustrated.

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COUNCILWOMAN BASS: It's all right. It's all right.

COUNCILWOMAN SANCHEZ: I know we have another hearing, and I'm going to apologize, because it's mainly my fault for asking all the questions, but if the Chairwoman would indulge us.

For folks who are here to testify, if some of the folks would voluntarily allow us to hear your testimony in the community session, that would be extremely helpful so that we can at least get through Panel 2. I know some folks have written testimony. As the Chairwoman said, this is just the beginning of the conversation, but I know some of you, because I've read all of the testimony already, have some really good points to make. So we want to balance this out, because the Chairwoman of the next committee is here.

COUNCILWOMAN BLACKWELL: You all really have that much information?

MS. GLADSTEIN: Council, if you

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will, we had asked several people to not be here today and to testify April 4th. So there are several names on the list of people who will not be here today and do not expect to testify, and I can either give you those names or let you know as you call them out.

COUNCILWOMAN BASS: You have written testimony?

MS. GLADSTEIN: From them? No, we do not, because we expect that they would testify on April 4th.

COUNCILWOMAN BASS: Okay. So this is the deal. We're right up against the next hearing, which was scheduled to begin at 1:00. And we started pretty much on time this morning. So this has been obviously a conversation that's long overdue, that we need to have more of, and unfortunately we're not going to be able to get through the rest of our panels because the next hearing has to start and they have some limitations with their panels as well and their folks who

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are testifying on education issues, which is another issue that's critically important here in the City of Philadelphia.

So what we're going to do is, unfortunately, we are going to have to adjourn for the time being until the next hearing, which is going to be on April 4th, 2018 from 5:30 p.m. at Cardinal Bevilacqua Center, 2646 Kensington Avenue.

We are going to keep going, though. I don't want folks to feel discouraged. I really do apologize that we're not able to hear from everyone today, but clearly this is something that needs to be thoroughly discussed and vetted, and we're going to continue the conversation until there's no more conversation to be had. And so for the next hearing, we are going to have everyone in the order in which you were scheduled to testify. You will be testifying in that order at the next

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hearing on April 4th.

So I just really want to thank everyone for being here, and this Committee is adjourned.

(Committee on Public Health and Human Services adjourned at 1:05 p.m.)

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CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the foregoing matter, and that this is a true and correct transcript of same.

MICHELE L. MURPHY
RPR-Notary Public

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