

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

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

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

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

24 I particularly want to thank
25 the stakeholders and the community folks

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

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

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

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

18 Andre, if you can put that up.

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

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

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

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

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2 are trapped in their apartment complex
3 over on Somerset Villas.

4 This is not a creation of one
5 thing, and there's definitely enough
6 blame to go around. This is a public
7 discussion about what we're doing, what
8 we're not doing, what we need to do and,
9 more importantly, how we are going to
10 make sure that we are addressing this in
11 a way that is balanced and fair. And
12 sometimes you got to look back to be able
13 to look forward, and we got to look at
14 what we did, because insanity is -- the
15 definition of insanity is doing the same
16 thing and expecting a different response.
17 And I think we have made strides, but I
18 still think we could do more and I still
19 think we need to do more, and this public
20 discussion is about the solutions and not
21 the blaming of why we are what I consider
22 to be a perfect storm of a lot of bad
23 things happening in one geographic
24 location.

25 So I want to thank all of you

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

15 Thank you very much, Madam
16 Chairwoman.

17 COUNCILWOMAN BASS: Thank you,
18 Councilwoman.

19 I want to acknowledge
20 Councilwoman Helen Gym has joined us.

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

24 THE CLERK: Resolution No.
25 180037, authorizing the Committee on

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

9 COUNCILWOMAN BASS: Thank you
10 very much.

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

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

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

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

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

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

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

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

6 (Witnesses approached witness
7 table.)

8 COUNCILWOMAN BASS: Good
9 morning.

10 MS. GLADSTEIN: Good morning.

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

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

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

25 Our cabinet of health and human

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2 services consists of five agencies that
3 collectively work to ensure that our
4 City's most vulnerable citizens are
5 healthy, safe, and supported. They are
6 the Department of Behavioral Health and
7 Intellectual disAbility Services, the
8 Office of Community Empowerment and
9 Opportunity, the Office of Homeless
10 Services, the Department of Public
11 Health, and the Department of Human
12 Services. I'm joined today by three of
13 those agencies, Behavioral Health and
14 Intellectual disAbility Services,
15 Homeless Services, and Public Health.
16 I'll mention the other agencies are
17 present in the room today, but it's just
18 myself and those three agencies that are
19 planning to testify at this point in
20 time.

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

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2 impact on our communities.

3 We anticipate when the numbers
4 are finalized, four times as many people
5 will have died of drug overdoses in 2017
6 as compared to the number who were
7 victims of homicide. Roughly 1,200
8 people will have died of overdoses during
9 2017. This is as compared to 907 people
10 in 2016 and 701 people in 2015. We know
11 that about 80 percent of these deaths
12 involved opioids.

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

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

8 It completed its work in April,
9 and we presented the final report to
10 Mayor Kenney on May 19th. The report --
11 and I just have one copy here, but we'll
12 be happy to make available if members of
13 Council have not yet seen it -- includes
14 18 recommendations. They're in the areas
15 of prevention and education, treatment,
16 overdose prevention, and the involvement
17 of the criminal justice system. We've
18 been working diligently to implement
19 those recommendations. Our progress is
20 reported in quarterly public meetings
21 hosted by the Mayor's Executive
22 Commission on Drugs and Alcohol. Again,
23 those reports are posted publicly.
24 They're available, and those meetings are
25 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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2 a Medicaid managed care organization for
3 behavioral health services. It operates
4 much the same way as managed care plans
5 through which we all get our health
6 coverage. The City receives an annual
7 capitation from the state, which is an
8 amount of money that we can pay for
9 service for each member covered by the
10 plan. These are state and federal
11 Medicaid dollars and are highly regulated
12 by both federal and state rules. CBH is
13 responsible for paying providers for care
14 its members need, according to those
15 rules.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 COUNCILWOMAN BASS: Thank you
15 for your testimony.

16 I want to acknowledge
17 Councilman Bobby Henon has joined us.

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

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

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2 Health.

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

14 Those overdose deaths have hit
15 every demographic group in every corner
16 of Philadelphia. For example, in the
17 first nine months of 2017 alone, we saw
18 569 overdose deaths in Caucasians, 248
19 overdose deaths in African Americans, and
20 126 overdose deaths in Hispanics. In
21 every race and ethnic group, the number
22 of deaths from drug overdose was far
23 higher than the number of deaths from
24 homicide.

25 Every neighborhood in the City

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

10 Even this number of overdose
11 deaths represents just the tip of a huge
12 iceberg of opioid use and addiction. We
13 estimate that between 50,000 and 70,000
14 persons in Philadelphia are currently
15 using heroin; 168,000 people, or one in
16 seven adults, are currently taking
17 prescription opioids; and nearly 500,000,
18 or one in three adults, received a
19 prescription for opioids in the previous
20 12 months.

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

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2 get addicted who otherwise would not.

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

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

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

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

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

15 To prevent people from becoming
16 addicted, we are working to get medical
17 professionals to reduce their prescribing
18 of opioids. Our work includes mailing
19 treatment guidelines to 16,000 physicians
20 in the greater Philadelphia area; mailing
21 dashboards to more than 2,600 prescribers
22 that show how their prescribing compares
23 to their peers; having staff visit over
24 1,300 prescribers in their offices to
25 deliver clear recommendations on

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

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

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

22 My department is also working
23 with the Department of Behavioral Health
24 and Intellectual disAbility Services on
25 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

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

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

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

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

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

5 Our work touches many lives.
6 Both national and Philadelphia data
7 indicates that one in five people
8 experience some form of mental illness
9 and/or substance use disorder. In
10 Calendar Year 2016, Community Behavioral
11 Health had nearly 700,000 members
12 enrolled in Medicaid, nearly half of all
13 Philadelphians. Of those who were
14 enrolled in Medicaid or uninsured,
15 170,000 were directly served by DBHIDS,
16 which is 24 percent of those enrolled.
17 This is consistent with national rates of
18 behavioral health services utilization.

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

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

9 To give you a sense of the size
10 of our network, CBH contracts with over
11 175 separate clinical programs and
12 service locations, and if you look at our
13 department more widely, it's over 200
14 providers. These contracted entities
15 comprise over 2,000 beds, including
16 inpatient hospitalization programs,
17 residential programs for rehabilitation
18 and detoxification, and halfway houses.

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

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

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

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

25 Some of our work to increase

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

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

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2 for other health needs can be connected
3 to treatment. The program, which uses
4 certified recovery specialists, served
5 125 individuals in the month of January,
6 resulting in 78 coordinated referrals to
7 treatment.

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

14 We are also increasing access
15 by scaling up treatment providers'
16 capacity. For example, we've added a
17 partial hospitalization program and we
18 began medication assisted treatment at
19 Kensington from 160 to 300 slots to serve
20 individuals with substance use or
21 significant co-occurring challenges.
22 This year we've also increased
23 availability of buprenorphine by about
24 tenfold, from approximately 100 slots to
25 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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2 p.m. and during the weekends.

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

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

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

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

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

24 Finally, the Consumer
25 Satisfaction Team, which was created in

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2 1990, was the first organization of its
3 kind in the country staffed entirely by
4 recipients of behavioral health services
5 and family members. CST's goal is to
6 ascertain whether members and/or family
7 members are satisfied with the services.

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

17 COUNCILWOMAN BASS: Thank you
18 very much for your testimony.

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

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

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2 opportunity to testify today.

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

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

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

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

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

24 The homeless encampments in the
25 Kensington area, specifically under the

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2 tunnels north of Lehigh Avenue on Tulip,
3 Kensington, Frankford, and Emerald
4 Streets, have an estimated population of
5 200 people.

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

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

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

25 Under the leadership of the

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

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

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

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

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

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2 40-bed, small, low-barrier place in the
3 community for people experiencing
4 homelessness, and in this case
5 specifically opioid use disorder, to come
6 in and be cared for. They can enter
7 without ID, and drug testing is not
8 required, although they are not allowed
9 to bring in their works or to bring in
10 weapons. This model is based loosely on
11 the Safe Haven pioneered in the 1990s by
12 Project HOME and supported by DBHIDS.

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

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

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

14 Today we are pleased to report
15 that Impact Services is in the final
16 stages of negotiating a lease to provide
17 40 more respite beds operated by
18 Prevention Point. And, again, as I
19 mentioned, our goal is to add 60 more
20 Housing First units next year.

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

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

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

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

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

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2 As a result, in San Francisco
3 they're seeing about a 65 percent success
4 rate in people accepting safety off the
5 streets. Twenty-five percent of those
6 have exited homelessness, and they've
7 seen an 85 percent reduction in tents.
8 Today in San Francisco they've resolved
9 23 encampments comprised of 944 people.
10 Obviously additional resources have been
11 deployed to achieve this success.

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

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

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

18 COUNCILWOMAN BASS: Thank you
19 very much for your testimony.

20 Councilwoman Sanchez.

21 COUNCILWOMAN SANCHEZ: Thank
22 you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 COUNCILWOMAN SANCHEZ: So those
15 folks are available?

16 COMMISSIONER JONES: Those
17 folks are active on the committee.

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

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

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2 That information certainly can be
3 available.

4 COUNCILWOMAN SANCHEZ: Are
5 those Board meetings public?

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

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

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

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

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

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2 They're not consistently posted on the
3 website.

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

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

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

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

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

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

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2 can't we make that public?

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

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

16 COMMISSIONER JONES: So I have
17 two responses. One is that so for any of
18 the members whom are looking for
19 information, so we actually have a
20 188-545-2600 number that you can contact
21 as a member at any point in time and both
22 request services and ask for information
23 about a provider. So that information is
24 available and has been out.

25 Again, in terms of a

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

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

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

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

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2 accommodate that.

3 COUNCILWOMAN SANCHEZ: Is that
4 a yes or a no?

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

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

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

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

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

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

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

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

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

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2 distinction.

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

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

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

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

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

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

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

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

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2 in themselves is stigmatizing.

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

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

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

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

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

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

6 COUNCILWOMAN SANCHEZ: Let's
7 talk --

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

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

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

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

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

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2 all of them as much as possible.

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

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

25 Now, certainly there are

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

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

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

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

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

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2 How is it that these places
3 that we've closed down -- what are the
4 points where you start saying, wait a
5 minute, where's the quality, when you
6 have thousands of people being -- I call
7 them the storefronts, right, and this
8 little storefront office, 6,000 patients,
9 10,000 patients, even -- at what point
10 does that not ring a bell that there's a
11 problem?

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

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

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

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

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

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

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

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

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

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

11 COUNCILMAN HENON: Thank you,
12 Madam Chair.

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

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

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

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

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

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

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

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

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

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

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

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

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2 outcomes.

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

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

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

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

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

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

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

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

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

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

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

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2 information and the science.

3 COUNCILMAN HENON: Okay. What
4 is withdrawal management?

5 COMMISSIONER JONES: I couldn't
6 hear you.

7 COUNCILMAN HENON: What is
8 withdrawal management?

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

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

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

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

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

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

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

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

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

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

10 COUNCILWOMAN BASS: Thank you,
11 Councilman.

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

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

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

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

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

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2 services to any such site.

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

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

25 MS. GLADSTEIN: I think your

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

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

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

14 COMMISSIONER JONES: The
15 Network of Care.

16 COUNCILWOMAN BASS: Did we find
17 that yet?

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

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

24 Councilwoman Gym.

25 COUNCILWOMAN GYM: Thank you

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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2 scheme.

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

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

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

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

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

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

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

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

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

12 COUNCILWOMAN SANCHEZ: But we
13 haven't disqualified anybody?

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

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

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

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

5 COUNCILWOMAN SANCHEZ: I'm
6 sorry.

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

25 I'll have one more quick

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

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

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

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

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

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

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

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

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

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

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

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

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

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2 broadly.

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

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

25 So I don't want to talk about

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

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

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

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

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

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

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

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 better off. And so that's also in part
3 why I talked about kind of the broader
4 strategies that we're using.

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

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

25 So thank you.

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2 COUNCILWOMAN BASS: Thank you,
3 Councilwoman.

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

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

16 (Witness approached witness
17 table.)

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

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

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

5 Good morning, Councilwoman
6 Bass, Chair of the Committee,
7 Councilwoman Maria Quinones-Sanchez, and
8 members of the Public Health and Human
9 Services Committee. My name is Rebecca
10 Rhynhart. I'm the City Controller. I am
11 here today to testify on Resolution
12 180037, which authorizes the Committee on
13 Public Health and Human Services to hold
14 hearings to assess the City of
15 Philadelphia's efforts, as coordinated by
16 the Managing Director's Office and our
17 human services departments, to prevent
18 and treat abuse, addiction, and disease
19 related to the use of opioids.

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

25 In January of this year, I

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

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

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

25 I applaud the Committee on

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 Public Health and Human Services for
3 wanting to hold these hearings to shine a
4 light on the City's overall approach to
5 combatting opioid abuse and addiction.

6 Thank you, and this concludes
7 my testimony.

8 COUNCILWOMAN BASS: Thank you
9 very much for your testimony.

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

13 CONTROLLER RHYNHART: Sure.

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

16 And, Councilman Squilla, you're
17 up next.

18 COUNCILMAN SQUILLA: Thank you.

19 Commissioner Farley, my
20 question --

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 the epidemic is growing and that it is
3 actually getting worse than it was the
4 previous year. Do we have statistics? I
5 know he said it was -- was it 70,000?
6 Does anybody know?

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

9 COUNCILMAN SQUILLA: Seventy
10 thousand people addicted to --

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

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

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

25 COUNCILMAN SQUILLA: Do we know

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

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

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

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

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

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

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

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

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

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

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

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

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

24 The latest information from the
25 state, which is the Pennsylvania

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 Department of Human Services that manages
3 these resources, is that they will look
4 again at what our utilization is; in
5 other words, what the number of members
6 who have used which services, and they
7 will do that in the middle of the year, I
8 assume June or July, and may be able
9 to -- in addition to their seeking a
10 waiver from the federal government, may
11 be able to add resources after that
12 point. But that's problematic for us
13 because we're on a calendar year and
14 would have to wait six months into the
15 year to know whether or not we have new
16 resources. And also our practice in the
17 past has indicated that we do not get
18 mid-year bumps, although it's been
19 offered before. So this is a significant
20 issue for us.

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 appropriation if we got all of it.

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

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

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

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

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

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

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

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

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

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

13 COMMISSIONER FARLEY: Yes.

14 COUNCILMAN HENON: Without any
15 real accurate pinpointing the numbers.

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

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

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

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

17 COMMISSIONER FARLEY: Well, we
18 know --

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

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

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

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

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

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

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2 that we're about -- I think it's about 86
3 percent in terms of have a co-occurring
4 disorder. So we're seeing people about
5 86 percent have both a substance use and
6 mental health disorder. We still are --
7 our spend still broadly is higher on,
8 candidly, mental health disorders solely,
9 but we actually are seeing an increase in
10 the number of folks who are coming
11 through with opioid uses. In fact, I
12 think over the last seven years have seen
13 a 34 percent increase. And so from that
14 perspective, our spend is increasing.

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

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

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

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

23 COMMISSIONER JONES: Correct.

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

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2 getting better or being productive?

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

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

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

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

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

25 COUNCILMAN SQUILLA: Reduces

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2 that by 37 percent?

3 COMMISSIONER JONES: Correct.

4 COUNCILMAN SQUILLA: But they
5 stay on methadone?

6 COMMISSIONER JONES: Or
7 buprenorphine or Vivitrol, depending upon
8 which medication is working better for
9 them, yeah. And then it looks like it
10 also -- it looks like that members --
11 they have a 42 to 47 percent, again,
12 lower risk of the condition reoccurring,
13 42 to 47 percent lower risk if they are
14 participating on medication assisted
15 treatment.

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

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

22 (Witness approached witness
23 table.)

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 Deputy Commissioner for the Department of
3 Behavioral Health and Intellectual
4 disAbility Services, Planning and
5 Innovation.

6 Your question, Councilman,
7 again was?

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

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

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

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

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

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

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

25 COMMISSIONER JONES: And I

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

4 COUNCILMAN SQUILLA: They
5 maintain their sobriety.

6 COMMISSIONER JONES: They
7 maintain their sobriety.

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

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

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

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

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

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

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

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2 very low percentage, between 15, 20
3 percent.

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

6 DEPUTY COMMISSIONER LAMB: In
7 many cases they do.

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

14 DEPUTY COMMISSIONER LAMB:
15 Right.

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 another source.

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

8 (Witness approached witness
9 table.)

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

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

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

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

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

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 Vivitrol as it retains to opioid use
3 disorder. If we were to change the
4 conversation around the disease and say
5 so now we are then talking about cancer
6 and we want to prevent the spread of
7 breast cancer, and so we have somebody
8 that's on Tamoxifen, right? And then you
9 would say, so how long do you keep that
10 person on Tamoxifen? And if Tamoxifen
11 then continues to keep that person alive
12 and is part of the treatment process, we
13 would say, okay, that makes sense. And
14 then you would then use the other
15 treatment strategies you could to then
16 help that person to thrive.

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

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

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

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

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

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

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

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

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

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

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

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

24 COMMISSIONER JONES: Okay.

25 COUNCILMAN SQUILLA: Thank you.

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 know if anyone had any specific questions
3 for her.

4 COUNCILMAN JONES: Yes.

5 COUNCILWOMAN BASS: You do?
6 Okay.

7 Can you hang for just a few
8 more minutes?

9 CONTROLLER RHYNHART: Yes.

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

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

25 COUNCILWOMAN BASS: And one

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 other thing. I just want to announce
3 just so everyone knows that this is not
4 the end of the conversation. Our next
5 hearing on this matter will be on April
6 4th from 5:30 to 7:30 at the Cardinal
7 Bevilacqua Center at 2646 Kensington
8 Avenue. So we certainly hope folks will
9 be able to attend that hearing as well.
10 So this is not the end of the
11 conversation.

12 So Councilman.

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

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

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

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

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

5 COMMISSIONER JONES: That's
6 correct, Councilman.

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

14 COMMISSIONER JONES: I think
15 that's correct also.

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

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

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

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

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

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

18 COMMISSIONER JONES: Mm-hmm.

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 percent of the folks are Philadelphians.

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

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

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

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

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

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

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

13 Thank you, Madam Chair.

14 COUNCILWOMAN BASS: Thank you.

15 COMMISSIONER JONES: Thank you,
16 Councilman Jones.

17 COUNCILWOMAN BASS: Thank you,
18 Councilman.

19 Councilman Taubenberger.

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

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2 an understanding, a better understanding,
3 than this.

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

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

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

25 COUNCILMAN TAUBENBERGER: So

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

4 COMMISSIONER FARLEY: Right.

5 And that's a survey that's self-reported.
6 It's less than perfect, but it's the best
7 we have.

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

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

21 COMMISSIONER FARLEY: It may be
22 85 percent, but it's in that range. The
23 large majority of people are from
24 Philadelphia.

25 COUNCILMAN TAUBENBERGER: Okay.

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

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

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

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

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

15 COUNCILMAN TAUBENBERGER: Thank
16 you very much.

17 Madam Chair, thank you.

18 COUNCILWOMAN BASS: Thank you.

19 Councilwoman Quinones-Sanchez.

20 COUNCILWOMAN SANCHEZ: Thank
21 you.

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

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

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

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

25 CONTROLLER RHYNHART: Of CBH?

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

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

16 CONTROLLER RHYNHART:
17 Absolutely.

18 COUNCILWOMAN SANCHEZ: -- how
19 decisions are made and governance
20 decisions.

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

25 COUNCILWOMAN SANCHEZ: And then

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

12 CONTROLLER RHYNHART: Yes.

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

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

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

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

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

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

6 COUNCILWOMAN SANCHEZ: Thank
7 you.

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

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

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

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2 for David, some clarity, because I think
3 there's misinterpretation. When you say
4 25 percent of our services are available
5 at any given time, there's an assumption
6 that there are 25 percent of our beds
7 available. Let's talk about who are the
8 beds in the system, who pays for them,
9 and if in fact we know that Pathways to
10 Housing is working, if in fact even the
11 proposal that has been presented in -- I
12 think it's \$2.2 million in this budget
13 year and Eva mentioned \$20 million over
14 the next five years. Is that enough? I
15 mean, are we really just setting
16 ourselves -- we talked about
17 performance-based budgeting. If we know
18 there's a need, how much are these beds
19 costing us and what is it going to take
20 so that we can get the 200 people who
21 have a homeless issue, in addition to an
22 addiction issue, in these encampments
23 into some of these beds?

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

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

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

15 MS. HERSH: No. It's horrible.
16 It's really a function of resources. We
17 spend on average, our system, \$40 per day
18 per person who is in a shelter. We added
19 54 or 56 beds this year.

20 COUNCILWOMAN SANCHEZ: Excuse
21 me. How many?

22 MS. HERSH: It's either 54 or
23 56.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MS. HERSH: That costs us
22 \$10,500 per unit on average.

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

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

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

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

24 COUNCILWOMAN SANCHEZ: You said
25 30 landlords. Are you saying --

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2 MS. HERSH: Thirty individuals.

3 COUNCILWOMAN SANCHEZ: Thirty
4 individuals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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2 this costing us?

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

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

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

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2 we see right now?

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

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

12 MS. HERSH: Rent. It's rent.

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

15 MS. HERSH: It depends. It
16 usually averages between \$1,000 and
17 \$1,100 and it's guided by the HUD fair
18 market rent. So it depends -- some of
19 them are less. We certainly try to do
20 less, and generally we exceed those
21 goals, but we try to be conservative in
22 our estimates and then exceed those
23 goals.

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

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

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

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

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

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

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

23 COUNCILWOMAN SANCHEZ: Per day?

24 COMMISSIONER JONES: Correct.

25 COUNCILWOMAN SANCHEZ: Why the

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2 difference?

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

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

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

14 COUNCILWOMAN SANCHEZ: And the
15 Medicaid reimburses for the housing?

16 COMMISSIONER JONES: For the
17 services.

18 COUNCILWOMAN SANCHEZ: For the
19 services.

20 COMMISSIONER JONES: Right.

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

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037

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

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

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 that into this conversation. There had
3 been a fairly long-term agreement in
4 which up to 500 units and vouchers would
5 be available each year, and they just
6 have not been due to reduction in
7 resources there.

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

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

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

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 want to expand the shelter system.
3 People say we need way more shelter beds,
4 but what we're trying to do is balance it
5 out to put the money into housing. The
6 difference is that a shelter bed may turn
7 over three or four times in a year,
8 whereas once somebody is permanently
9 housed then or even temporarily housed,
10 that subsidy has to go for the whole
11 year. So it's not a one-for-one
12 replacement. So that's the balancing act
13 that we're trying to find.

14 COUNCILWOMAN SANCHEZ: Okay.

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

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2 COUNCILWOMAN SANCHEZ: I guess
3 I'm very frustrated in that we have 120
4 people approximately in need of some
5 low-barrier housing to get them off the
6 street. And, again, I hate to sound like
7 a broken record, but I will sing and
8 dance by myself if I have to, because
9 nobody seems to be listening. If it's
10 \$40 per day for us to create this
11 low-barrier situation and we're only
12 planning 140 beds, how are we ever going
13 to catch up? I mean, I just -- and I
14 want to get to this. This encampment
15 situation, if we don't tackle it now, it
16 will become spring and summer. It will
17 get normalized, and it's going to be
18 harder. People are more willing to come
19 in in the cold than they will be in the
20 summer.

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 it that we are not getting the money to
3 at least take care of these 120
4 immediately? Is it a crisis or is it not
5 a crisis?

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

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

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

25 MS. HERSH: What did you say?

1 3/12/18 - PUBLIC HEALTH - RES. 180037

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

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

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

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

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

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

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

18 And they said, How about 43rd
19 and Market?

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

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

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

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 send a horrible message that this is okay
3 in that particular neighborhood.

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

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

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

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

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

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

23 COUNCILWOMAN BLACKWELL: You
24 all really have that much information?

25 MS. GLADSTEIN: Council, if you

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 will, we had asked several people to not
3 be here today and to testify April 4th.
4 So there are several names on the list of
5 people who will not be here today and do
6 not expect to testify, and I can either
7 give you those names or let you know as
8 you call them out.

9 COUNCILWOMAN BASS: You have
10 written testimony?

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

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

1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 are testifying on education issues, which
3 is another issue that's critically
4 important here in the City of
5 Philadelphia.

6 So what we're going to do is,
7 unfortunately, we are going to have to
8 adjourn for the time being until the next
9 hearing, which is going to be on April
10 4th, 2018 from 5:30 p.m. at Cardinal
11 Bevilacqua Center, 2646 Kensington
12 Avenue.

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

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1 3/12/18 - PUBLIC HEALTH - RES. 180037
2 hearing on April 4th.

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

6 (Committee on Public Health and
7 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
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