COUNCIL OF THE CITY OF PHILADELPHIA

SPECIAL COMMITTEE ON KENSINGTON

Rock Ministries
2755 Kensington Avenue
Philadelphia, Pennsylvania 19134
Thursday, July 18, 2024
10:05 a.m.

PRESENT:

COUNCILWOMAN QUETCY M. LOZADA, CHAIR
COUNCILMAN CURTIS JONES, JR., VICE-CHAIR
COUNCILWOMAN NINA AHMAD
COUNCILMAN MICHAEL DRISCOLL
COUNCILMAN JIM HARRITY
COUNCILMAN MARK SQUILLA

RESOLUTION: 240510

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COUNCILWOMAN LOZADA: Good morning, everyone. Welcome to the Philadelphia City Council and the Special Committee on Kensington and the -- is this better?

(Yes.)

COUNCILWOMAN LOZADA: Yes, better. Okay. Good morning, everyone.

(Good morning.)

COUNCILWOMAN LOZADA: Let me hear you. Good morning, everyone.

(Good morning.)

COUNCILWOMAN LOZADA: Welcome to the Philadelphia City Council and the Special Committee on Kensington. I now note that the hour has come.

Will the Clerk please call the roll to take attendance. Members who are present and in attendance, will you please indicate that you're present when

your name is called.

THE CLERK: Chairperson Lozada.

COUNCILWOMAN LOZADA: Present.

THE CLERK: Vice-Chair Jones.

COUNCILMAN JONES: Present.

THE CLERK: Councilmember Ahmad.

COUNCILWOMAN AHMAD: Present.

THE CLERK: Councilmember Driscoll.

COUNCILMAN DRISCOLL: Present.

THE CLERK: Councilmember Harrity.

COUNCILMAN HARRITY: Present.

THE CLERK: Councilmember Squilla.

(No response.)

COUNCILWOMAN LOZADA: Thank you. A quorum of this Committee is

present and the hearing is now called to order. This is the public hearing on the Special Committee on Kensington regarding Resolution 240510.

Mr. Clerk, will you please read the title of the resolution.

THE CLERK: A resolution authorizing the Special Committee on Kensington to convene for the purpose of investigating and addressing the barriers to accessing treatment beds in the Kensington area.

COUNCILWOMAN LOZADA: I will start by giving opening remarks followed by Vice-President or Vice-Chairman -- you hear me, I just graduated him -- Vice-Chairman Jones, and then I would like to invite my colleagues to say a few remarks if they would like to do so.

I would like to welcome everyone to the Special Committee

on Kensington's first hearing. This Committee is dedicated to fostering a collaborative effort to analyze and evaluate efficacy of current policies and develop data-driven solutions to restore stability in Kensington. Through open dialogue and an inclusive decision-making process, the Committee strives to create a more cohesive and resilient community for all its residents.

This Committee will focus on narrow and specific subjects such as long-term housing, employment and transportation. Today's topic is a product of feedback that we have heard from meetings, town halls and gatherings where people express how difficult it is getting into treatment. This is unacceptable and something that government has the responsibility to fix.

Today we will explore the

disconnect between providers who say we have plenty of beds and people on the ground who say they cannot get into them. The goal of this hearing is to begin to resolve this disconnect and identify areas that we can target in the short- and long-term.

Vice-Chair.

COUNCILMAN JONES: Thank you, Madam Chair.

I want to applaud my colleagues of the Kensington Caucus. A year or so ago we were in Conwell Middle School and we made a commitment based on those hearings, based on what we heard that we would be consistent in our approach to addressing the issues here in Kensington.

We want to also thank Mayor Parker's Administration for being partners in this regard. We are not -- we're ending the operation of silos, silos of information,

silos of resources through hearings just like this so that we can better provide services to the people here.

We said at that hearing a year ago that until Kensington be safe, the city of Philadelphia, no neighborhood is safe. And if you think that some of the issues that happen here aren't in other parts of the city, sometimes it's their little secret. But if you don't go to the source and address it head-on, it will continue to fester.

And we're here. We came back. I remember some of the comments from the people, the stakeholders in the community that said, yeah, this is one-and-done, it's election time, you're not coming back. But our Chairwoman has been 10 toes down in making sure this Caucus works with the Administration to address it.

It's not going to happen

overnight, but we're going to keep coming back. We're going to keep learning how to build a plane while we fly it too. That's right. We want to thank members of the Administration for working with us to provide the information and the resources to make a difference here in Kensington.

Thank you, Madam Chair.

COUNCILWOMAN LOZADA: Thank you.

The Chair recognizes Councilmember Harrity.

COUNCILMAN HARRITY: Good morning, everyone. I don't think it's afternoon yet. Listen, this is personal for me. I live here. I'm also in recovery. I don't understand. A bed's a bed and that's what we want to get --

UNIDENTIFIED SPEAKER: We can't hear you.

COUNCILMAN HARRITY: A bed is a bed as far as I'm concerned.

I don't care what the rating on that bed is. If somebody is waiting to get into a treatment center and we have a bed available, that bed should be available to them. We'll worry about where we transfer them once they're in there. It's about getting them in there at that point in time. So for me, a bed's a bed and that's what we want to get to the bottom of today. Thank you.

COUNCILWOMAN LOZADA: The Chair recognizes Councilmember Ahmad.

COUNCILWOMAN AHMAD: Well, thank you, Madam Chair. And I want to publicly once again commend you and this Committee. I am one of the newer members for having the courage to do this and to understand that we're not going to let perfect be the enemy of good, right. That's one.

Two, we're going to be

working with the Administration. And one of the things we have discussed is we need a dashboard. We need a dashboard with the information about all these beds that we keep hearing about, this conflicting information about who has what and really streamline for our community what exactly is happening, what is in realtime happening and what is the process. So it's hard to do all of that.

We ask for the patience of everybody as this plane is being built, but we also need to communicate effectively during this process. So as someone who comes from a science background, I am invested in making sure this is an evidence-based process, and I also challenge our medical establishment when they talk about harm reduction to talk about harm reduction for everybody, including the community members who live here and don't

have a disorder.

We need to think about everyone when we talk about harm reduction, and we need to send a message loud and clear that we are here, we are going to make this place inhospitable for those who supply these drugs that are killing us, so they understand that it is not business as usual. So thank you all for being here and thank you to all those who are going to give us testimony because we're listening carefully to make sure we move forward effectively and in an evidence-based manner.

Thank you, Madam Chair.

COUNCILWOMAN LOZADA: Thank you, Councilmember.

The Chair recognizes Councilmember Driscoll.

COUNCILMAN DRISCOLL: Thank you, Chairperson Lozada, for convening this special hearing. It's very important. Thank you to

the testifiers for taking your time. We know it's not easy taking time out of your schedules and we appreciate it. And with that, I'll yield my time to the talented testifiers.

COUNCILWOMAN LOZADA: Thank you, Councilmember Driscoll.

I'd like to recognize that State Representative Danilo Burgos is joining with us today. Thank you so much for being here.

Will the Clerk please call the first panel we have to testify this morning on Resolution No. 240510.

THE CLERK: Yes, Madam Chair.

Dr. Lara Carson, Dr. Chris Martin, Dr. Philip Durney and Dr. Megan Reed.

DR. CARSON WEINSTEIN: Thank you very much.

COUNCILWOMAN LOZADA: Good morning. Please state your name

for the record and proceed with your testimony. Thank you for joining us this morning.

DR. CARSON WEINSTEIN: Thank you. My name is Dr. Lara Carson Weinstein. It's an honor to speak with you here today. I'm a family doctor and an addiction medicine specialist. My career at Jefferson is focused on improving the health and the health care experience of people with substance use disorders and serious mental illness.

Beside me are my colleagues, Dr. Philip Durney from Hospital Medicine and Dr. Christopher Martin from Psychiatry, who both lead the inpatient Jefferson Addiction Multi-disciplinary Consult Service, and Dr. Megan Reed, Assistant Professor of the Department of Emergency Medicine.

We are passionate about our

work and strive to help improve the lives of people who use drugs. There are a few things on which we can all agree. Addiction is a complex and chronic disease of the brain. Addiction in Philadelphia is associated with astonishing threats to physical health such as limb-threatening wombs and severe infections of bone, heart, brain and spinal cord.

And finally, addiction and associated physical illnesses are treatable. The challenge comes not from a lack of knowledge or passion, but from a mismatch of available resources and an outdated system design, making it very difficult to provide comprehensive treatment within a system of disjointed pieces of medical, mental health and substance use care.

We will focus our remarks on the consequences of this

mismatch and conclude with examples of innovative solutions that will require programmatic and policy changes within organizations, hospitals, the City, the state, the federal government to bring these programs to scale. Together we can then finally improve quality of life of the entire community.

I'd like to briefly review some background information about fentanyl and xylazine. Fentanyl is a highly potent synthetic manufactured opioid with a short half-life leading to severe withdrawal. People who have developed a dependence on fentanyl are at extremely high dose of overdose risk if they receive so-called detox without ongoing treatment and access to the full range of medications where opioid use disorder, including methadone, buprenorphine products and injectables and naltrexone along

with ongoing supports.

Xylazine is intentionally added to prolong the sedating effects of fentanyl and has become almost ubiquitous in the local drug supply. Xylazine withdrawal causes severe increases in blood pressure, anxiety, irritability and frequently complicates the treatment of opioid withdrawal.

DR. DURNEY: In Philadelphia emergency departments and acute hos --

COUNCILWOMAN LOZADA: State your name for the record please.

DR. DURNEY: Oh, Philip Durney. In Philadelphia emergency departments and acute hospital settings are often the most frequent contact point for people with severe substance use disorders who are seeking inpatient treatment. We are skilled at treating both acute withdrawal syndromes and severe medical

complications of drug use, but the severity of both diagnoses has grown more complex and increasingly harder to manage.

Due to the dynamic drug supply, our patients are suffering from severe complications of drug use that often require prolonged treatment interventions, like weeks of intravenous antibiotics for infection control, aggressive wound care management and rehabilitation from amputations and spinal cord injuries that have rendered them unable to move or function.

Most inpatient substance use treatment facilities that offer rehab beds are unable to support these patients' ongoing medical needs. This has created a large mismatch between supply and demand. Each rehab have specific criteria or levels of care that determine who can be accepted to receive both medical management as well as

treatment for substance use disorder.

There is a large group of patients who are well enough to be discharged from the hospital but are too sick to enter substance use treatment and thus, are not accepted by most facilities.

DR. MARTIN:

Dr. Christopher Martin, Department of Psychiatry at Jefferson Health. Besides medical complexity, there's an additional large group of patients who have complex and undertreated psychiatric conditions. While treatment can begin in the acute care setting, even once stabilized sometimes patients with serious mental illnesses are frequently not accepted by substance use treatment facilities.

Opportunities for intensive inpatient substance use treatment are lost because addiction

facilities are not equipped to support people with medical or psychiatric comorbidities, including suicidality and are locked patient psychiatric facilities, which are increasingly freestanding outside of medical surgical settings, often do not have the capability or expertise to manage more complicated detoxification or withdrawal complaints.

This leaves our most at-need patients either effectively held hostage in general medical surgical beds with the limited addiction care that small consultation services can provide or discharged to the community and highly vulnerable to the ongoing vicious cycle of recurrent substance use disorders worsening medical, surgical and psychiatric conditions and social chaos.

All of this is to say that

while more rehabilitation beds may be helpful for patients who have severe medical or psychiatric comorbidities, which frankly describes the vast majority of the patients we care for on our addiction consultation service, we have a dire need for rehabilitation beds in the model of the DBHIDS Level 4.0 post-acute program with the expertise and motivation to treat the increasingly complex population we treat here in Philadelphia. Expanding the capabilities of such programs as well as making them accessible to our many patients not currently eligible for City-funded programming due to legal residence established outside our city or state or due to lack of compatible insurance coverage.

What we have repeatedly found clinically is that our patients who require but cannot

access this sort of multi-disciplinary care inevitably return to our care sicker and more complicated than before. This is simply not sustainable for our patients or for our health care systems which continue to be strained by increasing demands.

DR. REED: And I'm Megan Reed, the Department of Emergency Medicine at Thomas Jefferson University. And I'm going to be speaking today about a report Jefferson recently released about the opioid use disorder treatment system in Philadelphia.

The funding for this report came from Pew Charitable Trust. And for this study, I led a series of focus groups with certified recovery specialists, people with lived and living experiences of substance use as well as the consumers of the services here in Philadelphia.

The most powerful finding from the study was that many people aren't reaching inpatient beds in the first place because of their experiences of withdrawal during the assessment process. There are six City-run assessment centers where someone has to physically go to answer a series of questions before they can enter treatment. Some people said that once they arrive the process could last up to 16 hours.

This would be arduous for anyone but for someone going through withdrawal, it is typically intolerable. Dr. Weinstein referenced the fact that xylazine is in 99 percent of the opioid supply in Philadelphia now. Xylazine is associated with the unique and agonizing withdrawal syndrome. People come to an assessment center highly motivated to engage in treatment and some

leave discouraged and unlikely to return again due to that wait.

I think there are real opportunities here for creative innovation. Can we find ways to make people more comfortable while they wait while working to shorten the waiting time period? We should roll out the red carpet when someone is ready for treatment, not put up obstacles for them to get in it.

The next massive barrier to treatment entry that people in our study spoke about was access to housing. After inpatient treatment, people are often discharged back onto the street which is extremely destabilizing for somebody trying to stop using drugs. There are programs like Journey of Hope that work with patients on a long-term housing plan upon completion of the program. This can be a great

incentive for people to go into treatment if they know that they have a place to go once they get out.

The location and the neighborhood of treatment was very important to people we spoke to. Some people simply don't want to receive treatment in the same neighborhoods where they were using drugs. One of the certified recovery specialists told us -- this is a quote from him -- the guy who's been using dope and fentanyl for the last 10 years and is trying to get it together doesn't want to go back on the El to the spot where he was getting high. There's a lot of studies that show that muscle memory. He had every intention on going to the clinic, but he wound up in the shooting gallery. There should be no wrong during the treatment, so we need to explore all options for locations of care.

We also need a variety of types of inpatient treatment. For example, many people seeking treatment are part of a couple and they aren't willing to be split up. These people need options to stay together while receiving care or they won't complete treatment even if they enter at all.

We need resources for monolingual Philadelphians that speak Spanish. People in our study talked about many times where people enter treatment and cannot communicate with staff or their peers in group. We need more facilities for people who speak other languages and more programming specifically for subpopulations of people accessing treatment like LGBTQIA+ people, people who are actively parenting and more.

I'd like to close with a quote from the community-based

certified recovery specialist who summed up a lot of what my colleagues have been talking about when he said, there's just not enough, there's not enough detox beds, there's not enough rehab beds, especially with the opioids that are out here now. We're seeing flesh wounds where there's tendons, there's bone, there's major muscle damage, right. There's only 70 beds that will take patients like these, so a lot of these people wind up discharging to stay at skilled nursing facility, if they're even willing to accept them, because if you have substance use disorder stamped on your chart, nobody wants to deal with you. And a lot of these patients wind up being discharged back to shelters, back to the flop house, back to the streets.

These are really difficult and complicated issues to tackle.

I'm going to pass this back over to Dr. Weinstein who will talk about some innovative approaches that we've taken at Jefferson and some things we think can help solve the problems we've outlined today.

DR. CARSON WEINSTEIN: Thank you, Dr. Reed.

Silo busting multi-specialty collaboration is remarkably effective in improving access to and retention in treatment. Innovations at Jefferson include reconceptualizing the addiction consult service into an ecosystem of care for people who use drugs.

This means that care starts even before people reach the hospital through communication with our tremendous community partners such as Project HOME and Pathways to Housing. It means starting withdrawal treatment while people are still in the emergency

department and supporting them through our certified recovery specialist program in partnership with the Council of Southeastern, Pennsylvania and PRO-ACT.

It means that one addiction consult can open the door to many services tailored to the person's needs, ranging from dedicated infectious disease specialty teams or inhospital recovery groups led by our addiction consult social worker.

Importantly, care for people with substance use disorders at Jefferson does not end when people leave the hospital. They have walk-in access to our comprehensive Bridge program five days a week where they can receive treatment with buprenorphine, coordination with methadone, counseling, primary care, social determinant of health support, and importantly, seamless ongoing

access to specialists like hepatology, cardiology, orthopedics and neurosurgery who have treated them in the hospital.

So how can we make further improvements to this system design? We have a critical need to eliminate the mismatch between the capabilities of our rehabilitation beds and the involving and complex medical, surgical, psychiatric and addiction needs of the patients we are caring for in Philadelphia. This care must be accessible to all people in Philadelphia, whether insured publicly, privately not at all or within the carceral system.

We need clearly delineated paths of care for ongoing needs such as wound care, injectable antibiotics, acute physical rehabilitation and further psychiatric stabilization. Let me conclude by saying that our team is here to help. We have the

privilege of working with people who use drugs every day in the hospital, at the clinics and on the streets.

At Jefferson we're committed to a whatever-it-takes approach to care for people with substance use disorders and complex medical problems. What we need is a fully integrated system and payment system to allow people to continue their healing journeys and return to their communities, not just to recover from substance use but to reclaim their lives. Thank you.

COUNCILWOMAN LOZADA: Thank you so much for your testimony. This is just the first panel and I'm already frustrated. But thank you so much to Jefferson. Thank you for the time that you all have taken to meet with my staff to talk about some of the research that you all have done, and thank you for

your commitment to this crisis.

I have a few questions and then I'll open it up to questions from my colleagues. In the OUD report that was released in February there's a section that identified barriers to beds, and you mentioned some in your testimony today.

Can you take a few minutes and give us some more details and also how to implement these recommendations in communities like this one where it's ground zero as well as across the city where we are seeing some of this activity move to?

DR. CARSON WEINSTEIN: Yes. Dr. Reed, can you take that please?

DR. REED: Sure, a few things come to mind. One was already mentioned, having a dashboard. It was very difficult to figure out how many beds are available, what the capacity of the

system is. That was kind of one of the things we are tasked with to find out, what is the current state of the system. It was really hard to figure that out.

I think there's needs to be a dedicated position at DBHIDS because I don't think it's feasible for them to do it with the existing resources they have to keep that information up-to-date in realtime so that I can look it up as somebody with opioid use disorder who's accessing treatment, somebody on our addiction consult service or certified recovery specialist can look it up to find out what's there. People can figure out what the current availability is of the system and match people as a way of kind of breaking down that silo and getting information directly to people.

And then I spoke about location a bit. One other thing

I'll say about location is that sometimes people have been removed from a program for having a conflict with a staff member or another patient or they've left on their own accord because it's just not a match for them at that program.

So having more locations, again rolling out that red carpet, you know. If I live in South Philly and I don't want to get treatment in South Philadelphia because I don't want people to know my business, I should be able to go to another neighborhood to get care.

If I lived in Kensington, it would be triggering for me to go get treatment here. I need to have another place to be able to go. Same thing if I live in North Philadelphia and I just don't like Program X, again being able to go to South Philadelphia. We need a

citywide system.

COUNCILWOMAN LOZADA: I always find it interesting how -- and I mentioned this earlier. I mentioned it multiple times. I find it interesting how we can get a flight anywhere, we can get an Uber, we can get DoorDash, we can get all of these services brought to the area where it's nearest where we are at the moment that we need it, but when we're experiencing a crisis and we can't figure out how collectively we add all of our information into one place to be able to allow for a police officer, outreach worker, a resident, a family member, just anybody to be able to figure out where are these beds.

So I'm hoping -- I appreciate it. I appreciate the recommendation of a dashboard, right, because if we can do all of these other things to socially feed

ourselves and make us happy, we should be able to find a way where people can go online at any time of the day to figure out where we can get someone who is in a crisis situation and connected to the needs that they have.

So, yes, I completely agree we need to figure out how that happens. And I mention that in many of the meetings that I've been in. And one of the pushbacks that I've gotten is that there are these laws, right. There's laws that prevent us from being able to, for instance, reserve a bed for someone who said I'm ready to come into treatment. There's a payment structure that people might won't want to share information about. There are categories apparently that go into these beds.

I want to follow up on what Councilmember Harrity said, right. If someone comes to me and says,

Councilmember, I'm ready for treatment right now and it's 5 o'clock in the morning, I want to be able to go into a location, reserve that bed and have an outreach worker come and pick that person up immediately and take them into the bed.

I don't care what the category of the bed is. We can get them into that bed, stabilize them and then move them into a more appropriate space, right. But everybody that we talk to in this field says we have a window and we need to respond within this time frame.

And so, for me I'm hopeful that at the end of the conversation we figure out how do we create that dashboard where those barriers of what kind of insurance they have, what kind of bed is this is ID'd or submitted, where the loc -- I don't care where it is. I'm hopeful that

we can get to there.

But can you tell us how often do your patients experience I want to come in or they've shown up at Jefferson and you have for some reason or another not been able to continue to provide services or provide the service that they need and get them into a more long-term care after you've been able to stabilize or address their critical need when they come to your door?

DR. CARSON WEINSTEIN: Dr. Durney.

COUNCILWOMAN LOZADA: If you can just speak into the mic because these mics are a little special.

COUNCILMAN JONES: And state your name again for the recorder.

DR. DURNEY: My name's Phil Durney, Department of Hospital Medicine. I run the Addiction Consult Service with Dr. Martin.

So we talked a lot in our testimony about this concept of mismatch, specifically when patients are presenting. If they're coming in -- some patients present to the ED as a contact point that aren't even in withdrawal. They're coming in seeking treatment or bed availability, and we've been trying to come up with innovative ways to reroute those patients so that immediately they can meet with a community health worker or social worker and not be admitted to the hospital.

The issue arises when patients have these really severe medical complications. The Level 4 program has opened a lot of doors us. But when patients are coming in with really severe infections, life-threatening infections or severe debility like they can't walk, they can't move, that's when this mismatch occurs and we

stabilize them in the hospital. We treat their medical complications and we start addiction services that are very comprehensive in the inpatient setting.

The delay happens when patients are looking for rehab, and the rehab cannot accommodate the medical complexity of the patient. The Level 4 has been great for that, but what's happening is there's other levels that are different criteria through ASAM 3.7, 3.5 which have their own criteria and specifications.

We have a lot of patients that have wounds and we're trying to work with these programs to expand their ability to care for some of these medical complications. The patient will wait and kind of digest the inpatient setting just waiting to find a bed just because they happen to have a wound and they can't meet

criteria because of something as simple as a wound. And most of our patients, the majority of our patients have wounds now, as just one example, not to mention other infections.

COUNCILWOMAN LOZADA: Thank you.

The Chair recognizes Councilmember Harrity.

COUNCILMAN HARRITY: Well, first I'd like to thank all for -- I thought my voice was pretty loud. I'd like to thank you all for coming out today --

UNIDENTIFIED SPEAKER: Can't hear you.

COUNCILMAN HARRITY: I don't know if my mic is on. Can you hear me now?

COUNCILMAN JONES: Test, test.

COUNCILMAN HARRITY: Hello -- no? All right. We're getting it. I want to first thank

you all for testifying. Thank you all for testifying and also commend you on your efforts. The Bridge program is one of the most comprehensive plans I've seen in a long time being somebody from recovery.

You know, Lara and Sandy Stein are great people. And I met with them when they were thinking about this many, many times and talked open with them about recovery and what it was about. And I'm glad to hear that you guys hit on some of the most important sticking points.

I'm also telling my colleagues that after actually getting them into the rehabilitation to get sober, the two important things after that point is housing and mental health. Most of us out there are just self-medicating for some form of trauma that we faced either as a young

adult or a child, you know.

Also, Dr. Reed, what you said struck me. When somebody's using in South Philadelphia and they go to get into a recovery program, they might not necessarily want to be in a program in South Philadelphia. It's funny, we have a lot of clichés in recovery. One of them is people, places and things. The same people in the same places lead you to do the same things. So I'm glad to know that you guys are thinking about all that in one.

My question is I guess as a doctor how would you guys figure out this labeling of beds? Again, as far as I'm concerned a bed's a bed, and I get that some people have other medical issues that they have to do. But I believe we need to be working all hands on deck like our Mayor has said, break down the silos and have not only the

medical doctors treating the wounds but the mental health people there with them, and just get these people situated until we can find a bed that's more compatible to them. How can we implement something like that?

DR. MARTIN: Thank you. It's a really great question. I think as the psychiatrist with the team I feel pretty passionately about this. A bed is a bed, but the bed has to be safe and if there's suicidality, if there's acute psychosis, they have to be safe with themselves and the other patients who are there trying to get well.

If they need intravenous medications, you need the means by which to safely deliver those medicines. So the bed needs to be upscaled to the complexity of patients that we're treating right now. That will reduce the backlog

in the hospitals and give everyone an opportunity to get care.

I think there are a couple of different routes into addiction training. I think one of the really interesting things about addiction medicine and addiction psychiatry training if you can come in through the psychiatric residency, you can come in through a variety of medical or surgical specialties as well as through addiction medicine that are funding for opportunities for that training that involves giving up a year as an attending. You have to motivate people to seek that sort of treatment -- or seek that sort of education rather medication.

I think the more physicians we have from different medical backgrounds, the better we'll be able to handle the medical complexity and then increasing the level 3.5, 3.7, 4.0 beds including

the pilot program I think is the answer to the problem.

COUNCILMAN HARRITY: The way this problem is now and is progressing, as your testimony has shown, most of these people are going to come in with underlying medical issues, most likely wounds. So I mean, the simplest thing I can think of was just mark them all 4.0 or whatever and let's make those beds available. How do we get more of those beds, because the bottom line is the longer this goes on the more of these people are going to be coming to us. Most of them have wounds. It's part of the addiction. It's part of them using. They do not take care of themselves.

With the tranq it gets infected. The body's actually rejecting the drugs and that's what's happening, am I correct, and it's pushing it out of the body

through these wounds. And this is a common problem. I don't know. What would you think would be the percentage of people that are coming to these programs with wounds and trauma nowadays to be put into that criteria of a 4 or whatever?

DR. CARSON WEINSTEIN: Great. Thank you very much for that question and for all the questions. I want to make a really important point, that I cared for folks, as we all have, these wounds go down to the tendon or bone. And it has gotten to that point because they are leaving unsheltered and exposed to the elements.

Some of those folks are not ready to come in for intensive care but they come to see us in an outpatient clinic. And with the incredible wound care from the Project HOME nurses and nurse-practitioners training the rest of

us, those wounds can heal completely with standard dressing and soap and water, basic human rights. So we need Level 4 beds, but we need a society which I believe we can create where people's wounds don't get to this point.

Now, we are in a crisis right now so what are we going to do. I hear you. I think there is truly a role for triage and we have talked about this as a group. If there was an influx of folks coming into our system, they would all require medical triage because some would get very, very sick in the jail, in the recovery center. But I think with creativity and allocations for a period of time to work out this triage system, get those that need the hospital to the hospital, those that need Level 4 to Level 4 and so on. I absolutely think we can do that. We're from

Philadelphia. We can do anything.

COUNCILWOMAN LOZADA: I agree. I agree. We're a city of the first class, right.

(Applause.)

COUNCILWOMAN LOZADA: Before I recognize my colleagues, I think it was Dr. Reed who said there are individuals that don't want to receive treatment where they were using, in the communities they were using. Can you say that louder? Can you say how often that happens because it's part of what we have said, right? It's part of what the community of Kensington has said.

Not only do they not want folks to continue to live in addiction in their community, they recognize that these individuals need services but they don't believe that providing them with services in the same community where they are using is going to be

successful for that individual, right, nor is it going to improve the quality of life in this community.

Can you speak to that a little bit and tell us in your research what you have found and how often do you hear that?

DR. REED: Sure, I'd be happy to.

COUNCILMAN JONES: State your name again.

DR. REED: Megan Reed. So a couple of things come to mind when you ask that question. One is the feeling of different types of treatment. So getting away from location of care. Different programs are going to have different approaches, right. Hopefully, they're all evidence-based, provide medication, et cetera, at just minimum. But some are going to have a more spiritual focus, some are going to have less

of a spiritual focus. There are different things that are going to work for different people. And for that reason alone, we need different types of treatment in different locations around the city.

People have really different motivations for why they want to go to a certain place. Some are very emotional. Some are very pragmatic. One reason for a clinic to be located in Kensington as if somebody lives in Kensington and they're parenting and they need to stay close to home or their job is in Kensington, it might be more convenient for them to access treatment in Kensington.

If they live in Kensington and it's triggering for them to receive treatment here, they need to be able to go outside of Kensington. So I think you can make an argument that there is a

need for treatment both inside as well as for every location outside of Kensington. That's what I would say.

And again, with getting into treatment I keep thinking while my colleagues are testifying about this woman that I've been working closely with who's actively using substances, she's been doing research in partnership with me and she keeps showing up with wounds and she keeps showing up into treatment centers and they say, come back when your wound is healed. So she gets her wound treated, she comes back and she has another wound. And these are not severe wounds. These are not advanced wounds that she has. I think providing basic wound care treatment education to people at those centers can help them get treatment the less complex wound where it's really an excuse to not

take a patient.

COUNCILWOMAN LOZADA: Thank you. The Chair recognizes Councilmember Jones and then Councilmember Ahmad.

COUNCILMAN JONES: Thank you, Madam Chair.

My question is how many and how much does it cost? So when we start talking about Tier 4 and this, those are pricing structures where you can get reimbursed probably by some source of medical assistance, I get that. It's okay to do good, but you have to know how much doing cost.

So what I need a little bit of clarity on is what is the universe of need, what is the universe of availability of beds, what is the optimal time in your professional opinion where someone needs to stay in recovery to be successful?

In another life I was on a

board of a recovery entity and one of the statistics that scared me was that there was a 95 percent relapse rate that was in the course of doing business. If we were trying to make McDonald's burgers and 95 percent of the time we failed at making a burger, we would be out of business. So help me understand optimally how long if you could just have a magic money want how long does on average -- I know everybody's an individual -- how long on average does it take for someone that has a fighting chance of success?

And what I'd like about what you said, Doctor, was that triage, one size does not fill all. The folk that come to our prisons, they have a whole different trajectory and reason for being in recovery than the folk that come in willingly.

How do we triage and then

send them on the appropriate course for people that are dual diagnosed because if I don't fix one, the other one is not going to be fixed too? I know that's a lot. But how many and how much?

DR. CARSON WEINSTEIN: I'm going to ask Dr. Martin to answer that. However, before he responds to that you mentioned a 95 percent relapse rate. I want to just make sure that we're clear that evidence-based treatment with methadone, buprenorphine and naltrexone is associated with a 50 percent decrease in all cause mortality for people with substance use disorders. Even the statins, atorvastatin do not have that high level of decrease in mortality.

So we've been doing a lot of things outside of science for a long time when back in the day addiction was a moral failing. Now that we know it is a chronic

treatable disease, there's no reason to have a 95 percent relapse rate with what we have and what we know.

DR. MARTIN: Thank you. A very complex question. To try to peel all some pieces of it, it depends very much on the amount of support that a patient may have outside of the hospital, do they have housing, do they have families who can provide support or other natural support that are available.

I agree with everything Dr. Weinstein said. We need to think of this, all substance use disorders as relapsing, remitting conditions and there may be returns to use that need not be as severe as the initial incident that brought them into medical attention in the first place.

I think this is why the ASAM criteria exist. It would be one thing to make everybody Level

3.5 or 4 but there are patients who can do very well at lower levels of care because they have some of the supports. So it helps guide exactly what you're speaking to, the resources to the people who need it most and if patients are maybe agreeable to a lower level of care, outpatient, intensive outpatient with the supports to manage that, we get them to that level of care as well. But many of these patients need --

COUNCILMAN JONES: How long do you, say, treat? How long do you suggest?

DR. MARTIN: Dr. Gurney and I treat patients in the medical surgical setting. That's the setting that I practice in. I treat patients while they're in the hospital, but these are relapsing, remitting conditions. Very often that's some degree of treatment for life.

That treatment may be stepdown to medication management and therapy or therapy alone, but that's kind of going down through the ASAM criteria for the level of care that's being suggested.

COUNCILMAN JONES: So a person right outside this facility on average, if you had the perfect program that you could design, how long would they need to be there and how much would that cost?

DR. MARTIN: Unhoused patients who have no natural supports and are currently not in treatment, there is evidence that says that longer term treatments, residential treatments, 90-plus days for the initial, that that can be beneficial. But it really does vary entirely on the severity and what supports are available.

I think we face unique conditions in Kensington given the degree of homelessness, nutritional

issues, care of basic medical needs, hypertension, diabetes, they've gone untreated very often for very long periods of time.

COUNCILMAN JONES: So 90 days helps. But how much does 90 days cost?

DR. MARTIN: That's also going to be quite variable between the insurance that's paying for it and the beds. I don't have answers for those questions. That would be better directed at people who run the rehab programs and the insurance companies that are paying for them. I wish I had clear answers for that.

COUNCILWOMAN LOZADA: Thank you. I'm looking forward to a day when we can say that there's some type of universal insurance that will allow people to come in and get the medical services they need whenever and wherever they need it, and we have to -- all of us have to

work towards talking to our counterparts at the federal and state level to figure out how do we create that, right.

If you're suffering from addiction and you're in Philadelphia County but you're from Montgomery County and you have Montgomery County insurance, I need to be able to treat you here. I need to respond to your crisis situation here, right. I can't turn people away because they don't have the appropriate card in their pocket. We need to figure that out. We need to do better at that.

Councilmember Ahmad.

COUNCILWOMAN AHMAD: Thank you, Madam Chair.

Is it on -- okay. Yes, universal health care, that's really universal. That's another goal for another hearing. I have so many questions, but I want to start with commending all of you to

be here. You're taking time out of your schedules, busy schedules of treating people right now.

And I'm particularly interested to understand what is the data that we have that shows everything that has been done up until now, and maybe you can answer that question, what has been the best practice that has evolved out of everything that we've been doing over the last, I don't know, 20, 30 years?

What is -- it's sort of similar to Councilmember Jones' question. What is the optimal fact that we have seen regardless of -- there's going to be variations of the patient of course with comorbidities, that's a different kind of scenario, but overall what has evolved for us to be the best standard of care, which is similar to I guess the Bridge program? So I would love to hear what is that.

DR. REED: Sure. Megan Reed. I'm going to be a little repetitive of Dr. Weinstein and say that medications 100 percent absolutely, the shift in how we conceptualize and think about drug use into a more compassionate and also recognizing the agency of people who use drugs to be able to make rational decisions for themselves.

And I think also the recognition that people need their social determinants of health addressed again with housing, wraparound services. You can't just plunk people into treatment and take them out of the lives that they were living for 30 days and then have them go out and be discharged into homelessness or go back to where they were using before without giving people additional support.

Like Dr. Martin was talking

about, it's highly dependent upon what sort of familiar supports they have, economic resources, whether they have a safety net.

COUNCILWOMAN AHMAD: So what I've heard was medically assisted treatment being critical and wraparound social services. This is nothing new. Even though it's data-driven and we know this is the answer, my question is how do we build in flexibility in these processes to adjust to different outcomes for people and also to work with, say, the intake services who like you said 16 hours while they're detoxing (inaudible), those kinds of devil in the detail things is what we really need to start feeding if we're going to build this system that is going to have medical-assistive treatment, chronic care, long-term care, especially around mental health services for people to sustain

their recovery. So you have to deal with it as a chronic disease.

It's a chronic disease where we can manage it where we can look to people to have actual recovery and sustain recovery but a very fragile one because you can get knocked off very easily. So I would love for all of you to try a system where you can say this is what we have, this is what we need, this is where the flexibility has to be built into the intake services, whatever that might be. This is where we have to have flexibility with our service providers who we are giving a warm handoff to.

We need like a checklist of things we need to make to go along with our dashboard and have this checklist to say, two weeks is how long it takes for this one patient to go from this (inaudible) position to (inaudible).

DR. DURNEY: I have a lot to say on this topic, but I'll keep it brief. Again, my name is Phil Durney, the Department of Hospital Medicine. I worked at Jefferson as part of a committee and a design group that created a dashboard for our hospital system.

We have a role of air traffic control in the hospital. We used the EMR and we created a very dynamic dashboard to track outside hospital transfers, emergency room admissions, patients coming from the office and we were able to create this dashboard that has a brain of how to follow these patients through the inpatient setting. And I think that this dashboard has a lot of potential to a lot of the points that you've already made.

If we just fix one piece of this process, this is a continuum. So if we sent someone into the

hospital and then they go to get placed to a Level 4, what happens after they leave the Level 4? If they don't have access to housing or they don't have access to a residential program to transition them, then the wheels can come off again.

So I think this dashboard has a lot of promise, not just of tracking the patients of where the acute beds are available but actually tracking and rectifying this fragmented care that's happening in our community so that we can track patients throughout the entire community as they traverse this landscape of seeking treatment.

COUNCILWOMAN AHMAD: So you already have a dashboard, Jefferson. So it was a conversation with our other support systems that need to come into it to be (inaudible) for our city to

the Department of Health potentially to be the house where we put all of this, which would still have connections to the providers, to Jefferson and small providers so it would be like a brain, as you said, that would have all these nerves in the system, going out all the nerves and the entire system so we can then see where every (inaudible) so we would love to get it.

DR. CARSON WEINSTEIN: So I do want to also -- the Jefferson program is well-advanced. There is a smaller pilot program that Jefferson, my colleagues at Penn, my colleagues at Temple, under the leadership of Project HOME and the Estadt-Lubert, collaborative are actually piloting a dashboard going all the way from acute hospitalization to respite beds to permanent supportive housing. It's a huge undertaking and we're

starting on a very small scale. But with the support to evaluate this and scale it up, there's a lot we can build on and learn. And we have already put a tremendous amount of blood, sweat and tears into the process.

COUNCILWOMAN AHMAD: And this is to Councilmember Lozada's point of getting our federal partners in this process. The reason why we have these drugs coming into our city is a federal issue. We can only do so much. This is a law enforcement issue that has not been handled which is why we are left with the side effect of all of this, right.

So I think having us make the advocacy pitch to state level and federal to really roll out comprehensive dashboard with our realtime interventions can be where we want to go and clearly you guys have already different models for

it. I guess my question is what do we need to do -- what is going to hold us back for actually making it a citywide, city-driven or be afraid to be city-driven with the partners in a private sector?

DR. CARSON WEINSTEIN: That is one of the most straightforward questions. Money.

COUNCILWOMAN AHMAD: That is why I mentioned the federal government, right, which is why we have a state with $15 billion dollars out there (inaudible). This should be a driving force if we want our economy to survive, right. This should be moving us from the poorest big city to a status that we need to be. This is all things that make us in that status.

So we need all advocates, but we all need a comprehensive plan to move forward. We can't move forward without a plan in

place. And this is partly why we're having this hearing to see what emerges as a solid plan with everybody, all stakeholders involved and we can push to say we have evidence-based, we've seen it work at a smaller level. We can scale this up and we can all be partners in doing that and we would love to see everyone working on that. So I thank you all.

DR. CARSON WEINSTEIN: Thank you.

COUNCILWOMAN AHMAD: Thank you, Madam Chair.

COUNCILWOMAN LOZADA: Thank you. I think we find money for everything else, right. We just came out of a national pandemic, right, and we found money. We quickly shifted gears and readjusted and we found money to be able to respond to the crisis that we were in.

And I think that it's

convenient for people to talk about this being a health crisis, but we don't seem to be able to figure out how do we shift gears to be able to respond to the health crisis that is taking place right here in this community, right. And so, I have a problem with it being about money. We have to be able to find it wherever it is because I think it's actually necessary to change how it is that we're responding to the crisis that is happening here.

The Chair recognizes Councilmember Driscoll.

COUNCILMAN DRISCOLL: Thank you. Madam Chair, I'll be brief. I know this panel has to get back to work.

Two quick questions, Dr. Durney. You had mentioned that some folks are too sick to be sent to treatment. What happens to them then?

DR. DURNEY: So depending

on the severity of the medical diagnosis, like for instance if someone has a heart valve infection or a severe infection of their brain or their spinal cord, we have to keep them in the hospital while we proceed with medical or surgical intervention. But what our team has done and I think across the board in the City at a lot of acute care hospitals, we tried to bring addiction management and long-term management into an inpatient setting, into a system that is not designed or optimized for these resources for patients.

So when Dr. Martin and I see patients in the hospital, a lot of the majority of our interactions with them are talking about their acute medical complications, but we actually focus on -- and I say this to patients all the time, what is your life going to look like and what is your journey going to look

like when you leave this test tube, these four walls. We have access to medications here but when you leave the hospital and you have interactions with different people or places or things as we mentioned, that's really where the rubber meets the road and I think that that's usually the issue of when things kind of fall off the tracks, and housing and support are so crucial to that.

COUNCILMAN DRISCOLL: Right, but you're not long-term now and you're not a full long-term treatment center. What's the trigger when you need that bed and that person is not quite ready for treatment? If you're uncomfortable to answer it, that's okay.

MR. DURNEY: I think the trigger is we're trying to decompress the hospital because we have such a high volume of these patients coming in, but it's where

the patient is with accepting and coping with some of their illnesses, right. That's a large part of this too.

We have patients that we have to perform amputations for. They have life-changing -- we make life-changing medical decisions. We encourage them throughout the process during their inpatient hospitalization to proceed to these beds if available and if you feel like they meet criteria for them.

Sometimes patients give a little bit of resistance because they feel like they're not going to receive the same kind of level or caliber of care or support. But in a lot of these instances with the Level 4 program, it's actually better for some of the patients to leave the inpatient setting because it's more targeted therapy and they can continue to get the medications and support that they need at these

programs. So we are trying to mobilize them out of the hospital as quickly as possible when they're deemed medically stable.

DR. MARTIN: And if I could add briefly to that.

COUNCILMAN DRISCOLL: Sure.

DR. MARTIN: Councilman Jones' question earlier, while I don't have the money figures for each level of care, I can guarantee you that Level 4 and Level 3.5 is significantly less expensive than another day in the medical surgical hospital.

COUNCILMAN DRISCOLL: And real quick, Dr. Weinstein, and I thank you for highlighting, there's a lot of people that I still don't think understand it's not a moral failing but it's a chronic disease. We deal with folks all the time that will say, no, they're just weak, they're just this, they're just that. Actually Patrick

Kennedy actually convinced me many years ago that it was a brain disorder just like liver cancer, any kind of disorder like that.

And I know it's more complex than this, but fentanyl I believe was designed to get people out of real severe pain, right? I think that was its original intent. Does your hospital still use fentanyl? And if so, do you buy it from -- your purchasing department just buys it from a drug manufacturing company?

DR. CARSON WEINSTEIN: Thanks. That's a super interesting question. And, yes, fentanyl is a very important drug in folks with anesthesia and severe acute pain and pharmaceutical grade fentanyl is really life-saving in these situations. But the issue is that illegally manufactured fentanyl can be made in a lab relative to growing a field of poppy seeds and

processing that to make heroin versus opening a lab and making fentanyl. There's no comparison as to the speed and the efficiency and it's such a smaller amount to distribute internationally. So there's a lot of very smart people getting the fentanyl out and we need to match that with our field.

COUNCILMAN DRISCOLL: Thank you. Madam Chair.

COUNCILWOMAN LOZADA: Thank you. The Chair recognizes Councilmember Harrity.

But before that, I want to go back to the money situation. As a city, we've received millions in opioid settlement costs. We need to figure out how we use the funds that we received to be able to use it to address the needs that we have, right. And so, at some point later on in this conversation I'd like to figure out why and how can we consider that, right, how do we

consider using some of those dollars that we currently have and redirect them to creating opportunities that would help really address the crisis that we have.

And before Councilmember Harrity, I'd like to recognize Council President Kenyatta Johnson has joined us. Thank you so much, Council President.

(Applause.)

COUNCILWOMAN LOZADA: When I went to Council President and said, Council President, we have a Public Safety Committee that responds to the public safety issues in our city but we need a special committee that will just speak to the crisis that we're experiencing in the Kensington community and it needs to be separate from the Public Safety Committee.

I didn't have to advocate a

whole lot. He recognized the need to be able to create a committee where we can specifically have conversations about what is happening here. So I just want to express my gratitude to Council President Kenyatta Johnson for also understanding that this community needed to be prioritized. So thank you very much, Council President.

The Chair recognizes Councilmember Harrity.

COUNCILMAN HARRITY: Just real quick -- I'm sorry. Just real quick. Those of us who are in recovery, the guidelines for recovery changed. As an example when I first got sober the first time in '88, '89, we were taking our psychological medication.

Before that time when my father first got sober in early '80s, he was a Vietnam vet suffering from post-traumatic stress, and the rule was no mind-

altering substances, so taking his actual psychological medication wasn't allowed for his recovery at that time. And because of the Vietnam vets and their struggles with post-traumatic stress, we figured out that wasn't necessarily the better case. They couldn't get any real time if they weren't on their psych meds.

And I'm glad to see that we're going that way with the maintenance medications, some of which are better than others. Methadone and Suboxone is one type of maintenance med, but there's another one that actually only has to be taken like once a month or something like that. What is that medication and how much now is that being used compared to some of the other medications that are taken daily?

DR. MARTIN:

Dr. Christopher Martin. There are

a couple of injectable options. There are multiple brand names for buprenorphine which is the active ingredient Suboxone that you mentioned, so that can be given monthly. And also, naltrexone. Naltrexone, Vivitrol branded, has a long-acted injectable form as well --

COUNCILMAN HARRITY: That's the one that (inaudible) --

DR. MARTIN: It blocks the effect of it. There's an alcohol treatment medication that will make you physically ill.

COUNCILMAN HARRITY: Because that's kind of a matter of catch 22, right. Some of these maintenance medicines actually make people ill (inaudible) and I guess it's just the -- I'm sorry. So it's just the preference of the client of which works better. So in your opinion which medication would be a better fit?

DR. MARTIN: And that's a very personal question with individual patients and their providers. I will take a bit of exception to the euphoric effects of methadone and buprenorphine products when prescribed appropriately.

When prescribed appropriately, they are preventing withdrawal. They may be managing pain, especially under patients who have chronic wounds, neuropathic pain after some of their medical and comorbidities as well. But I would not say that when they're prescribed appropriately that they're causing euphoric effects.

COUNCILMAN HARRITY: Okay. Thank you.

COUNCILWOMAN LOZADA: I'd like to thank you for being with us today.

Are there any other questions from the Committee

members?

COUNCILWOMAN AHMAD:

(Inaudible).

COUNCILWOMAN LOZADA: There being none and before the Clerk calls the next panel, I'd like to call Council President Kenyatta Johnson for remarks.

(Applause.)

COUNCIL PRESIDENT JOHNSON: Well, first I just want to say good morning. I just wanted to take time out of my schedule today to come support the work that the Special Committee of Kensington has been doing and most importantly just inspired and powered by your leadership, so anything that I can do to continue to be supportive of your efforts.

I think when we talk about breaking down barriers to treatment we should be doing everything we can to do possibly, especially around the Kensington issue, but

overall when it comes to dealing with those who suffer addiction, we should make that process easy for anyone who is seeking treatment.

So whatever I can do to be supportive, don't hesitate to let me know. But I am inspired by your leadership and how y'all are working together. This is a very comprehensive group of individuals. It takes a very, very comprehensive approach to deal with an issue that is very, very significant here in the city of Philadelphia.

And so, I'm going to get back to the work at hand, but I just want to thank everyone who came. But most importantly, I see the Administration is here so it's going to have to be a partnership to get things done, but I'm also inspired by the leadership of the members of City Council.

You started from day 1 to make this a priority and we won't

be one-and-done. We will be back until we make sure we eliminate this issue. And so, I'm just thanking you for having this and I wanted to come and show some support.

(Applause.)

COUNCILWOMAN LOZADA: Thank you, Council President.

Will the Clerk please call the next panel to testify.

THE CLERK: Yes.

Dr. Maggie Lowenstein.

(Applause.)

COUNCILWOMAN LOZADA: Thank you for being with us this morning. Please state your name for the record and proceed with your testimony. I'm going to ask that you speak into the microphone and try to project your voice so that folks behind you can hear.

DR. LOWENSTEIN: Sure. So I'm Dr. Maggie Lowenstein. Is that good?

COUNCILWOMAN LOZADA:
(Nodded affirmatively).
DR. LOWENSTEIN: Great. Okay. Good morning, Councilmember Lozada and members of the Committee. And thanks for the opportunity to testify on this critical topic. I am a Philadelphian and a resident in Councilmember Squilla's District and I'm also a addiction medicine physician at Penn where I focus on providing care for patients with substance use disorders both in the hospital as well as in outpatient settings and focus on progress to improve access to substance use treatment.
Today I'm testifying on my own behalf based on my experience as an addiction treatment provider and researcher for the past 10 years. Over this time I've witnessed the severity of the crisis in our city but also the

fact that substance use disorders are treatable. And has been noted by City Council, we are facing many challenges in promoting treatment access.

Some of my comments will likely amplify the remarks made by my colleagues at Jefferson, but I'd like to sort of highlight three obstacles to care that we are seeing for people experiencing addiction in Philadelphia as well as some of the strategies we've taken at Penn and across the City.

So the first is really insufficient services across the continuum of care. We talk a lot about rehab beds as a solution rather than thinking more broadly about the wider continuum of care for patients with substance use disorders.

I do want to be clear that rehab is a really important and helpful treatment setting for

patients, especially for those with complex medical conditions or without a safe place to live, and often a first step for the patients that we're talking about right here in Kensington. But we also need to remember that addiction is a chronic condition that persists long after an individual completes their stay in a rehab facility and we need to be prepared to offer high-quality longitudinal care to promote recovery.

We absolutely need more high-quality rehab beds in Philadelphia and we need beds, as has been mentioned, that can manage both complex withdrawal symptoms and medical complexity that's associated with our current drug supply. We also need high quality and comprehensive outpatient care.

In the context of opioid addiction, this means rapid and consistent access to medication

treatment like buprenorphine, Suboxone and methadone. We're setting patients up to fail if we're not providing this care as these are the gold standard of medications that when prescribed over the long-term promote health and recovery.

Along with outpatient care, we need to recognize that a lot of treatment is happening in general medical settings, including primary care clinics, emergency departments and hospitals. In Philadelphia and in Kensington, just specifically as was mentioned, we're seeing patients with increasingly complex medical conditions such as severe infections and wounds, and the presence of xylazine in our drug supply is only exacerbating this trend.

It's also worth noting that access to sterile needles is a critical factor in combating

complications and reducing the spread of diseases like HIV and Hepatitis and we anticipate the complications like wounds and infections will become more prevalent and severe in the absence of sustainable funding for needle exchange programs.

At Penn, we've built an interdisciplinary addiction medicine consult service, much like you heard about the one at Jefferson. And I know that hospitals across the City are working hard to build up our inpatient services. But we need to recognize that patients need additional support services following an inpatient environment.

Upon discharge, patients experiencing addiction often need nursing home care, medical follow-up, substance use care and a host of other services to get their lives back on track. It's

difficult for anyone to navigate this complicated need of services and it's especially hard for patients without reliable transportation, phone access or housing.

Accordingly, as a city we need to additionally focus -- in addition to some of the things already mentioned, focus on improving transitional support. Too often I encounter patients who leave rehab, hospital or jail without adequate medication, follow-up or help for their addiction, medical or social needs. We need to invest in support services to ensure that patients can navigate our incredibly challenging system.

I can share that at Penn we've implemented telehealth and some increasingly inperson transitional services through our Care Connect program, which

provides care navigation. And I'm happy to speak more in detail about this as part of our questions, but we need to think about how to broaden the services sort of long-term for patients so that they can access any care that they need ongoing, more rapidly and without barriers.

The second area I'd like to highlight, which has been mentioned before, is the mismatch between the treatment options that are available in our city and the patient needs. As has been described, the complicated needs for medical care, addiction treatment and social services are a real challenge. And the models that account for these multiple complexities are lacking.

For example, as you've heard patients seeking substance use treatment who also have infections or wounds struggle to

get into rehab that has the capacity to care for these issues. Patients who need nursing care after hospitalization can't always continue to receive substance use treatment in those nursing facilities. For example, many nursing homes will not accept patients on methadone.

It's also very difficult to attend outpatient appointments if you're disabled by chronic wounds or you lack adequate housing or transportation. In light of these challenges, we need to think about investing in programs that can concurrently address the medical substance use and social needs of those experiencing addiction.

The last area I'd like to highlight is the persistence of policies and practices that create barriers to ongoing treatment. We know that treatment, particularly again as has been mentioned,

medication for opioid use disorder improves outcomes for those living with addiction. And what we really need to think about is prioritizing in our city same-day access to these effective medications and making it easier for people to stay in treatment by adopting approaches that prioritize medication support as soon as possibly and deliver care to people when and where they need it. This includes same-day initiation or re-initiation of medications like methadone or buprenorphine and use of adequate and up-to-date doses of these medications without restriction as well as removing other outdated policies that prevent people from staying in treatments like discharge for one episode of use, like zero tolerance-type rules.

Programs with punitive policies often exclude who they are ultimately trying to help. On the

other hand, programs that are willing to meet patients where they are and employ harm-reduction principles foster a more effective treatment environment. You may have heard that a harm reduction organization -- people who interact with syringe service programs and other harm-reduction organizations are five times more likely to enter treatment than those who don't, and I think that's because these types of programs are often the only places where people feel welcome, safe and cared for. If we want people to remain in care and ultimately improve outcomes, we need programs that meet their needs and treat people with dignity.

So to conclude, we all of course want to help people suffering from substance use. We can do that by investing in proven treatments for addiction, shoring up the continuum of our substance

use disorder care and improving social supports like housing.

We need to focus on high quality evidence-based treatment and low barrier access to medications like buprenorphine and methadone. We need to continue to invest in comprehensive inpatient and outpatient treatment service for those with medical complexity. Thank you again for the opportunity to testify and I look forward to your questions.

COUNCILWOMAN LOZADA: Thank you for your testimony.

(Applause.)

COUNCILWOMAN LOZADA: Thank you for your testimony. I think that one of the things we're going to recognize today is that all of us are saying the same thing, right. All of us want the same thing. The question is how do we get there, right.

A year ago we met with a

lot of providers and we met with community residents. We talked about what the issues were. We're still talking about the same issues. We need to figure out how do we move forward, how do we change how we're responding to this crisis and connect people without all of those barriers.

Every person that has come up here today has talked about very similar barriers. And so, can you tell me how do we begin to minimize or eliminate completely some of those barriers that we know well prevent people from getting into these beds? And can you also talk to me a little bit about the more warm-line program that Penn Medicine has that connects patients to beds?

Tell me about that program. Is it much easier for folks to get into beds when they're coming to your program? Can someone from off

the street, can an outreach worker refer someone into this program? How does that program work and how do we start to peel off some of the barriers that we're talking about?

DR. LOWENSTEIN: Sure. Those are great questions. So I think the first question of just sort of how we address some of the barriers to beds, I would just amplify some of the comments made by my colleagues on the prior panel. I think more transparency around sort of how people can get referred, where their space is important.

I think improving or kind of adding staff that can address sort of higher levels of complexity within a rehabilitation setting is critical. So they mentioned sort of the Level 3.7, the Level 4, those are the ASAM levels of care. But in order to implement those, you need staff who can safely do

wound care, administer medications, things like that.

And so, I think outputting more of our beds to that higher level would be very helpful. I think also there's inevitably some waiting period, some shuffling around. It's never going to be snap your fingers and someone's going to get into a bed. So I think we need to have strategies that we can stabilize patients while they're waiting.

Those who are in the hospital we can keep them and continue to medically stabilize them while they're admitted. For those coming from the community seeking treatment, it's difficult to ask for someone to sit for 15, 20, 30 hours waiting for a bed without any sort of treatment. So if there are ways that we could -- they don't necessarily have to be in a bed, but if there are ways we

can sort of expedite that care that I think will go a long way as well. So those are a couple of thoughts about inpatient beds.

I think just to expand further on outpatient I think we need more walk-in kind of low-barrier services, whether it's methadone access on the same day, whether it's buprenorphine access on the same day, those are the primary modalities to treat opioid addiction and we need those to be available as soon as possible for anybody who wants them.

Speaking of Care Connect specifically or the warm line, it's the Care Connect Warm Line is the full name, that's a program that we've developed at Penn at primarily telehealth-based, although we do have some inperson staffing and it's really designed to provide exactly the type of services I'm talking about. It's a

single phone number staffed by a skilled and compassionate substance use navigator, some of whom are people in recovery, some of whom have case management backgrounds, who answer the phone seven days a week, 12 hours a day, and really the goal is to help people to figure out, help sort out what their needs are.

So the patients are triaged, they ask what are you looking for, how can I help you. If it's buprenorphine or Suboxone, we are able to route them to a provider on our telehealth urgent care line at Penn which sees people for a variety of conditions all day and all night, but they can do buprenorphine starts there.

If it's methadone, if it's inpatient treatment, they provide sort of personalized navigation to that patient to figure out how they can get to where they need to be.

A lot of this is done in partnership with our hospital, with our community partners. Some of it is with PAD. Some of it is partnered with Merakey centers.

I think what's really important to highlight is the emphasis on the relationship because there is no single solution for every patient. But what we do need is a knowledgeable -- what we try to provide is really the knowledgeable navigation that can help patients get plugged in quickly into this very difficult-to-navigate system.

So again, we can do same-day buprenorphine starts. We can get patients assessed for inpatient and we can get them quickly plugged into methadone all through that initial phone call.

COUNCILWOMAN LOZADA: And is your program available and accessible to patients 24 hours a

day, 7 days a week?

DR. LOWENSTEIN: Right now it's 12 hours a day, 7 days a week. I think we would like to expand it. And funding is always a limitation, but I will say it is available to anyone in Philadelphia. It does not have to be a patient at Penn and it does not have to be a patient who has insurance. We can cover uninsured patients as well.

COUNCILWOMAN LOZADA: And do the providers that provide services to residents or to those living unsheltered on the streets of Kensington, do they have information about this program, are they aware of this program and do they have access?

DR. LOWENSTEIN: They certainly have access. I know we've made a lot of efforts to do outreach, but we're always excited for more opportunities. I'll just say that I think one of the biggest

challenges is when we're talking about people experiencing unsheltered homelessness and some of the most severe social and medical challenges, people don't always have a phone to call us. So we're working and actively working to expand some of our inperson services so that we can provide these same treatments and care not solely to people who can call us on the phone, but we also accept phones from outreach programs and things like that. So, yes.

COUNCILWOMAN LOZADA: Are there any questions from members of the Committee?

COUNCILWOMAN AHMAD: Yes.

COUNCILWOMAN LOZADA: The Chair recognizes Councilmember Ahmad.

COUNCILWOMAN AHMAD: Thank you for your testimony. I wanted to just go back to the point that this is a chronic treatable

condition. When we have something like another chronic condition like diabetes and have a prescription, Metformin or whatever and they're taking other assisted resources for that person to be successful, but they have to keep going and you the caregiver prescribe this whole scenario of these things that need to happen, I would love to see if you would prescribe the follow-up as medical care, meaning post-hospitalization when they go into actual maybe long-term and they go out on their own where they're still getting medically-assisted treatment to stay opioid-free, can you have like a check-off on the screen that tells you what this patient needs to get and it can be a medical prescription? Can you prescribe the full continuum of care is what I'm saying?

DR. LOWENSTEIN: Not in a traditional way, I guess. I think

that sort of developing a bundle of services that is a checklist is something that I know we do. I think all the hospitals do as part of their addiction consult services. I think rehabs do that as part of their discharge. But a lot of it is the devil's in the details and sort of getting patients where they need to go, navigating various barriers that come up.

As far as the medical treatment, we do recommend sort of long-term prescribed medications for opioid use disorders, buprenorphine and methadone. And those are administered in, you know, buprenorphine can prescribed in many different settings, including primary care where I do it. Methadone can be administered in methadone clinics and both are set up to do longitudinal treatment.

But again, I think there is not always sort of reimbursement or funding for these other wraparound services, the coordination piece and all the things that actually allow patients to get where they need to be to maintain their medication, maintain their counseling, whatever the treatment is.

COUNCILWOMAN AHMAD: The reason I say this is there needs to be one entity that is watching this patient starting from the in-hospital care all the way through, like a primary physician who takes care of a child, you know, a pediatrician takes care of all the things, the shots, the regular checkups.

I just would like our medical community to think like that so that your job doesn't end just doing the Suboxone or -- all those other things that need to

happen because this kind of support will not be useful with a relapse if those other things are not in place. So I'm just asking for a medical home for a patient with all these wraparound services and to make this a priority in order for us to see real progress in this arena.

DR. LOWENSTEIN: I think that's very much something we all are hoping to do. I think Dr. Carson Weinstein mentioned the Project HOME model that we're all a part of. It's in major health systems. And I think many of us provide this care in a primary care setting and are hoping to continue to build those models. So thank you for that.

COUNCILWOMAN AHMAD: Yeah. So it's really building an accountability in this process, that you come in for this care but it doesn't stop here in order for

this treatment to be successful and there's an accountability for everybody in this process to make sure that patients are successful in staying in recovery.

So I don't know how you measure the accountability, how we make it a priority. But that's where I think we need to go once we coordinate all the services.

Thank you, Madam Chair.

COUNCILWOMAN LOZADA: Penn Medicine has a mobile care unit in this footprint, correct?

DR. LOWENSTEIN: Some of our -- there's a research mobile care unit. And some of our providers work on other organizations' mobile units. I'm not sure which one you're referring to.

COUNCILWOMAN LOZADA: Does a mobile care unit from Penn Medicine park somewhere in this community to provide services to

those who are suffering from addiction or those who need it?

DR. LOWENSTEIN: I'm not sure at the current moment if they do. But they have at times, yes.

COUNCILWOMAN LOZADA: Okay. And can you tell me during their time or during your time how many individuals have you all been able to connect to beds through this program?

DR. LOWENSTEIN: I'm not personally involved in that program so I personally can't speak to that, but we can direct you to -- we can help figure that out to be helpful.

COUNCILWOMAN LOZADA: Okay. I'd like to know that. If you can share that information with this Committee, that would be awesome. And then can you also tell me, we have outreach workers out in this community. Who do you have a relationship with that as your

direct context that would help to bridge patients to the beds that you all have available through this program on the ground here in Kensington?

DR. LOWENSTEIN: So to be clear, we don't own any of the beds with Care Connect. We connect patients to the beds that exist already, but we have partnerships with many of the agencies here. I know that we work closely with Merakey. We work closely with Prevention Point. And I think also with DBHIDS. We've partnered with many and met with many of them a number of times. But again, always happy to do more of it.

COUNCILWOMAN LOZADA: The Chair recognizes Councilmember Driscoll.

COUNCILMAN DRISCOLL: Thank you, Doctor, for all you're doing for this important topic. Do you see resistance from the providers

in trying to engage with you to -- if they have available beds, are they afraid to share that information because it's sort of private stuff that they don't want out there to see the success or not success of their individual program? Do you see that?

DR. LOWENSTEIN: Are you referring to program level metrics or patient information, like individual patient information?

COUNCILMAN DRISCOLL: I mean, just trying to assess the bed availability and program availability.

DR. LOWENSTEIN: I know that for example on our consult service when we're trying to discharge a patient who needs a rehab bed, it's typically a process where a social worker will call back, do a number of different communication strategies to a bunch of different rehabs. They will

review the charts and let us know what capacity they have so there's not a huge amount of transparency, but I think that's probably going on across the city in a pretty inefficient way.

And so, some of the discussion around dashboard or greater transparency will be helpful. Yeah, that's probably the best answer I can give.

COUNCILMAN DRISCOLL: Yeah, I sense that reluctance too. I worked for a credit union and we had folks that did the title insurance. So we had a ton on our list and then we had a wheel and we just switched the wheel. Every time a new customer came in, we would refer it out and then you can even do regional, that sort of thing.

I just don't feel today that we have that wheel built yet to spin, and that's where I think

some of the frustration is coming from us and I know you're trying and I know there's a lot of competition in your world in health care right now. We're not trying to create winners and losers in the marketplace. We're just trying to solve a problem. So thank you, Doctor.

COUNCILWOMAN LOZADA: If you could help us identify -- if you can help us be more transparent, right, and identify how successful has Penn been in the Kensington community connecting people to some of those beds, it would also help us, right? And so, I think that's what we're really looking for.

We're really looking for you're in the community, you're providing services. This sounds like a program that can really help people transition into living very healthy lives, right. Because the

way the program was explained to me was Penn can connect people to beds much easier than other programs in this community.

And so, I'm trying to figure out what are those successful numbers, how many beds do you have access to, where are those beds and how long do people stay in those beds, what are the challenges that people have when they first walk in and what are the challenges that they can experience on their way out and how do we provide those wraparound services to help them be successful? That's really what we're looking for.

DR. LOWENSTEIN: I would just say that again we have access to the same beds as everybody else, but I think what we're doing through this program is sort of being able to provide individualized navigation and kind of decongesting EDs or assessment

centers and really sort of assessing patients in our own setting and helping sort of sort out a variety of needs while they wait for a bed or while they get plugged into outpatient treatment.

So I wish -- but unfortunately we don't have any access to any special beds or beds that are not available to other places. But as you've heard, many different institutions and settings are working to get patients into the same set of beds.

COUNCILWOMAN LOZADA: The Chair recognizes Councilmember Harrity.

COUNCILMAN HARRITY: Hello. How are you today. So there's been a lot of talk about the beds but also the outpatient programs. Actually the first place I ever went was Penn's outpatient program on 40th and Market back then in the '80s.

But I would like to know your opinion on the people that we're dealing with right now. I know when I first went to Penn's outpatient program I was 17, I was young. While my addiction was pretty heavy, I hadn't had a lot of time of being out there or I guess my bottom was different, right. So we say hitting bottom, my bottom was different from when I was 17 to when I end up going back in a second time. But in the second time I fully believe there was no way I would have been in an outpatient program. I needed to be somewhere where I was in a facility.

In your opinion -- I mean, I get like sticking maybe in an outpatient program just to get them in some place until we can find them something else, but in your opinion do you think an outpatient program would actually work for

these people?

DR. LOWENSTEIN: I will say I see it works. I mean, I do this care myself. It's not everybody. Like you've heard many times, it's hard to give an across-the-board answer. It depends a lot on the patient and --

COUNCILMAN HARRITY: It's personal.

DR. LOWENSTEIN: Right. And I think it is very difficult to care for your wounds, care for your substance use and do other things if you're unhoused and that I think is a big barrier. But I will also say that I have myself seen patients get better who are unhoused. And again, medication and low-barrier supports play a large role in that. And so, I think both are needed. Even for people who go to rehab or inpatient, we still need those supports afterwards in that same

capacity.

COUNCILMAN HARRITY: Thank you.

COUNCILWOMAN LOZADA: Are there any additional questions for the panelist?

(No response.)

COUNCILWOMAN LOZADA: Thank you so much for your testimony. Thank you for joining us today.

(Applause.)

COUNCILWOMAN LOZADA: Will the Clerk please read the names of the next panel.

THE CLERK: Commissioner Marquita Williams, Deputy Commissioner Amanda David, Andrew Devos, followed by David Holloman, Deputy Commissioner Pedro Rosario, Joelle Anderson and Noelle Foizen.

(Applause.)

COUNCILWOMAN LOZADA: Thank you for joining us this morning to provide testimony. Please state your name for the record and begin

your testimony. And we are going to begin with Marquita Williams, Interim Commissioner for DBHIDS.

DR. WILLIAMS: Good afternoon.

COUNCILWOMAN LOZADA: Make sure you speak into the mic. Thank you.

DR. WILLIAMS: Hello. Can you hear me?

COUNCILWOMAN LOZADA: (Nodded affirmatively).

DR. WILLIAMS: Very good. Good morning, members of the Philadelphia City Council Special Committee on Kensington. I am Dr. Marquita Williams, Interim Commissioner of the Department of Behavioral Health and Intellectual Disability Services. Joining me today are Amanda David, Interim Deputy Commissioner of DBHIDS, and Andrew Devos, Chief Operating Officer at Community Behavior Health. Donna Bailey, CEO of CBH,

was unable to attend today.

I am pleased to provide testimony today on behalf of the Department of Behavioral Health and Disability Services. I would like to start by acknowledging not only the individuals who are struggling with this disease but also families and entire communities. I know that this topic elicits a great deal of emotions and certainly frustration given the complexity and necessity of the involvement of multiple systems.

DBHIDS' approach is to enhance the continuum of service options in which the level of service matches the behavioral health needs and circumstances of individuals seeking behavior health services. CBH, DBHIDS' contracted Medicaid-managed care organization, has served as a cornerstone of Philadelphia's behavioral health system maintaining a comprehensive

network of approximately 200 behavioral health providers.

Through a contract with DBHIDS, CBH pays for, coordinates and manages access to a wide spectrum of substance use disorder programs and other behavioral health services for Philadelphia Medicaid recipients. In their role CBH does not provide SUD or mental health services. They pay for these services which are delivered by behavior health providers in our network.

CBH does not control the Medicaid member eligibility or enrollment, which is the state county assistance office's responsibility. CBH can only pay for the medically-necessity behavioral health services provided by our members.

Access and availability: Access and treatment beds in Kensington is indeed a significant

concern. The availability of treatment beds directly impacts the ability of individuals struggling with addiction to receive timely health and support. There is no waitlist for treatment beds.

However, there is a waitlist for recovery beds that ranges from 175 to 250 beds individuals daily. CBH takes a bed census three times a day. The treatment bed availability is posted on the DBHIDS website through our treatment availability database and is posted three times per week Mondays, Wednesdays and Fridays by 1:00 p.m. We are currently working on building a bed registry that will help streamline availability and referrals through CBH's network, which includes approximately 1,874 SUD beds.

CBH does not own or manage these beds but contract with behavior health provider agencies

that own these beds and can deliver the SUD treatment. Individuals can access critical treatment services through the provider network, which includes 80 SUD treatment service locations operated by one of our 36 in-network SUD treatment providers.

In 2023 over 23,000 members utilized SUD services, just under a quarter of our nearly 100,000 utilizing members. Over 28 percent of our adult utilizing members had a substance use disorder in 2023. Opioid-related disorders were also the third most common primary behavior health diagnosis amongst adult aged 18-plus who utilized services in 2023. To help locate available beds, the CBH psychiatric emergency services team assist health care staff with identifying available SUD beds, makes care recommendations and shares treatment history to ensure our members access the care that they

need.

All levels of bed base are provided by CBH in-network providers are forms of medical treatment and are not housing or shelter. As the Medicaid payor that receives federal and state funding specifically to pay only for health care services, CBH can only pay for medically-necessary behavior health services.

After an individual decides that they want treatment, among the next initial steps to accessing services involves receiving an assessment from a behavior health provider, a mobile crisis unit, an outpatient clinic or an emergency department and our crisis response center to determine what treatment is best for that individual member.

Emergency departments and crisis response centers both operate 24 hours a day, 7 days a week. Here are actions that we've

taken to remove barriers to SUD treatment and enhance access: Since 2021, DBHIDS has required that all substance use disorder providers in our network deliver care in alignment with the American Society of Addiction Medicine or ASAM, as you've heard here today.

The ASAM criteria include requirements for developing four levels of recovery-oriented, evidence-based SUD treatment services, each designed to meet an individual's specific treatment needs. The ASAM criteria covers SUD screening and assessment diagnosis and a determination of the best level of care for an individual based on their current symptoms.

To reduce barriers to care, we have also removed prior authorizations, a decision-making process where a provider must first request that CBH approve a

treatment as medically necessary before the individual can receive the treatment.

This year, 2024, we removed prior authorization for medically managed withdrawal management formerly referred to as detox. CBH also removed prior authorizations for Level 3.5 ASAM care, which includes medically-managed residential SUD care for individuals with serious psychological or social issues who need 24-hour oversight and who are at risk for imminent danger to themselves or others.

For many individuals who have experienced an overdose or are on the verge of an SUD crisis, this is the initial treatment environment needed to stabilize the individual's SUD symptoms, prevent overdose, deter relapse and begin the recovery process.

DBH has also taken various

steps to ensure access to medication-assisted treatment or MAT through the SUD-covered service continuum. Since 2019, we have required all in-network drug and alcohol outpatient clinics to provide MAT directly in their clinic or have a clear linkage with the clinic that can provide MAT services.

In 2022, CBH also expanded contracts with our in-network provider Temple Health, which is the Episcopal campus, Penn Health Hall-Mercer location and Friends Hospital to allow for the payment of MAT induction in their crisis response centers, which includes a total of three locations.

Additionally, CBH is now conducting an MAT accessibility survey with SUD in-network providers to access the availability of MAT across the network. Additionally, DBHIDS

meets regularly with CRC clinical and medical directors to ensure barriers to reaching SUD treatment beds as a next level of care that there are no barriers.

When an in-county provider is at capacity, CBH will authorize an out-of-county bed-base level of care. The CRC staff then works with the out-of-county provider to arrange transportation typically provided by the provider to transfer the member to the out-of-county bed.

There are service expansions to reduce barriers. Since 2018, CBH has issued several procurements to expand contracts with in-network providers and have taken other steps to make the following SUD service expansion. We made the addition of 200 additional SUD beds for residential substance use disorder services.

These were added to the bed

ability to the network in 2022. We've increased the low-intensity SUD residential treatment service availability in 2022 through expanding contracts with existing providers. There are four new regionalized intensive SUD outpatient service programs. These were also created in 2022 through expanding contracts with in-network providers.

We've increased our outpatient addiction services also in 2022 by expanding contractors with additional in-network providers such as the Wedge Recovery Centers and Kirkbride. These resulted in the Wedge offering Medicaid-reimbursable services at a new location and enabled Kirkbride to expand their outpatient SUD services, allowing Kirkbride to provide a full continuum of SUD services.

We've also increased our

partial hospitalization program offerings, providing MAT in 2022 treatment for occurring treatment and other behavior health diagnosis. This has resulted in 50 additional SUD partial hospitalization slots for CBH members.

These services include 20-plus hours of weekly organized outpatient treatment during the day for people with SUD who need intensive routine care but who do require 24/7 attention in a residential SUD facility. Further, we've entered a contract or contracts with out-of-network providers to provide methadone induction.

Additionally, we've added mobile home care in collaboration between Kensington Hospital and DBHIDS to conduct wound care services and outreach to individuals in the Kensington area

and throughout the city of Philadelphia. The purpose of this program is to assess and treat wounds directly onsite in the mobile medical units.

The mobile wound care vans also provide physical health clearance for admission into substance use disorder programs across the city. The mobile wound care program partners with homeless outreach, Rock Ministries, PDPH, PPD, the Managing Director's Office and community providers throughout Philadelphia. This program has partnerships with providers with health systems throughout the city as well.

Additionally, we are continuously examining network capacity with an intent to issue necessary procurement to ensure continued access and availability of services. The growing presence of xylazine and fentanyl and

opioids used in the street, which causes severe wounds and infections among users, has also increased the need for high-quality SUD bed base care.

In response, in 2023 DBHIDS launched the Level 4 ASAM Post-acute Wound Care program in partnership CBH, Kensington Hospital and Eagleville Hospital. This innovative program provides post-acute hospital-based SUD care to individuals who need intravenous antibiotics. To be eligible for the program, an individual must have been hospitalized in the medical unit, have severe wounds and need a PICC line for intravenous antibiotics.

Since 2023, over 200 people have been admitted to the program with majority completing the program and continuing in their recovery. Most of the substance abuse disorder treatment providers

are accessible via public transportation with the exception of a few out-of-town bed-based providers. Individuals who receive an assessment and require that level of care are transported to the program via ambulance and/or taxi.

The DBHIDS Mobile Outreach and Recovery Services Unit also works to provide linkages to recovery support and substance use treatment. MORS has engaged over 2,000 individuals and facilitated 346 linkages treatment and is able to facilitate more rapid access into treatment by providing assessments from within the community.

Waitlists: DBHIDS has partnered currently with a consulting group to work on strategies to look at effective ways to decrease wait times. The consulting group has collaborated

with DBHIDS staff to assess the barriers reported from both the crisis centers and the treatment providers to better understand the concerns and possible challenges leading towards long waiting times. Based on the responses, a work group including the providers will work together in developing processes to eliminate any gaps that will impact the delivered services.

Couples and families: Treatment programs are for individuals. However, Philadelphia does offer several SUD programs where women can receive treatment with their children. In order to ensure access for individuals across the developmental life span, we are working to advance maternal health equity and access to SUD treatment for mothers struggling with addiction as another top priority at DBHIDS.

In fact, in 2018 CBH launched the Mommy Helping Hand program. CBH Care managed, coordinate care for pregnant and postpartum birthing mothers with SUD and other physical and behavioral health conditions to meet their multiple needs. Our Care managers meet members in their homes and in other community settings, schedule doctors' appointments, educate them on health concerns and connect them to community resources.

Additionally, DBHIDS has approved funding for a Journey of Hope couples program. And once the program is up and running, it will bring online 18 ASAM 3.5 beds serving 8 couples. The program may be a first of its kind offering residential SUD services for couples.

DBHIDS partners with many local health care providers and

other organizations to connect our members with immediate SUD care. We work with surrounding counties and take individuals from these counties into programs that contract with our insurances. If someone from out of county is uninsured, we will work with the county, see what county authority to get the individual placed in the county of origin. DBHIDS works with the court system, PPD, housing and a number of other agencies to support the navigation and needed resources for all individuals in need. We understand that this is a complex challenging concern and it takes a multi-layered solution.

We appreciate the ongoing support of Council and thank you, the Special Committee on Kensington, for giving us an opportunity to highlight the work of both DBH and CBH. DBHIDS remains committed to partnering

with you, the Mayor's Administration and other stakeholders to address the SUD and our behavior health challenges facing Kensington and our great city.

Individuals in need of SUD or other behavior health treatment can call our 24/7 member services line at 1-888-545-2600. And if an individual is in a behavioral health crisis, they may call 988. Thank you very much for the opportunity to testify before you today. My colleagues and I are available for any questions.

COUNCILWOMAN LOZADA: Thank you so much for your testimony. I'm going to move to have questions asked of Dr. Williams by the panel and then we are going to take a 30-minute break, and then we will return to hear the rest of the panel and then move on to public testimony.

Thank you so much for being with us.

DR. WILLIAMS: Thank you.

COUNCILWOMAN LOZADA: You started with there is no waitlist for beds. And I find that really interesting. I also find it frustrating and confusing, right. Because when we are responding to those who are trying to get into beds, there's always challenges, right.

There's always -- we often hear there are no beds. And so, I'd like you to help me understand there not being a waitlist and is that a myth, is there miscommunication, is there lack of transparency? I'd like you to help me and the rest of the panel as well as those who are here with us today, help us understand where does that come from.

DR. WILLIAMS: Thank you, Councilwoman, for that question.

There are many types of beds. And when we say that there is not wait for beds, we're talking about our substance use disorder treatment beds. Earlier in my testimony I did say that there was a wait for some recovery house beds.

But I think when people see, okay, so there is this large number of folks over here and then there's maybe a small amount of beds potentially, that those beds will get up eaten up quickly. And then there's this idea, well, there's no beds, because every day we hear this number of maybe 100 beds are available or 80 beds are available.

I think the thing that's important, and there are a couple of points to be made here, is to remember that everybody who needs treatment doesn't need treatment at the same time. So there's a constant dynamic movement of people

through our system.

Also, everyone who needs treatment is not going to need the same level of care of treatment when they start. And then when you talk about readiness, we know that readiness is going to continue, and contemplation -- I think maybe it's time -- all the way up to action.

And so, there's a lot of conversation about what's available, when people want it and what's not available. But if you look at our website every day, the number is there around how many beds are available. And it seems to be typically somewhere around 100 beds. What that also means is that if we have 1874 beds and only 100 beds available, at any given time you have 1700 people moving through the treatment continuum.

So this idea that there are no beds, I think it may be due to what kind of beds people are

looking for, misinformation. But we're here to give you the correct number, the correct information and to tell you where you can find it every day.

COUNCILWOMAN LOZADA: How many people do you think are living on the streets of Kensington today?

DR. WILLIAMS: You know, that's a hard --

COUNCILWOMAN LOZADA: We're talking about 100 beds that you say are consistently available, right?

DR. WILLIAMS: Yeah.

COUNCILWOMAN LOZADA: Would you say consistently on a daily basis, consistently on a weekly basis, on a monthly basis --

DR. WILLIAMS: It flows. It ebbs and flows.

COUNCILWOMAN LOZADA: What's the flow? Tell me the flow.

DR. WILLIAMS: Just in this last week, today it's 121 beds. Yesterday it was 116 beds in the

evening. In the morning, it was 108 beds. So it moves up and down as people move in and out of the treatment, the level of care that they're in.

COUNCILWOMAN LOZADA: What's the number of people that are living on the street?

DR. WILLIAMS: You know, we don't have that number here for you today.

COUNCILWOMAN LOZADA: How often does DBHIDS count the number of people that are in the street?

MS. DAVID: Quarterly.

DR. WILLIAMS: Quarterly we do --

MS. DAVID: Hi. I'm Amanda David. I'm the Interim Deputy Commissioner at DBHIDS. And we do a quarterly count. OHS manages the winter count. We do a spring count, a summer count and a fall count.

COUNCILWOMAN LOZADA: In

your last count what was the number of people that were living on the street?

MS. DAVID: I'm going to have to get that number for you.

COUNCILWOMAN LOZADA: We'll be back at 1 o'clock. I'd like to have that number. It's a number we need to know, right. If we're talking about the challenges that people are experiencing to get into these beds, we can't figure that out if we don't know what the number of need is, right.

And part of our issue is that we can't ever get a consistent number, right. So as we're trying to identify the barriers to get into these beds, we need to be able to identify the number of beds and where are those beds. How many providers does DBHIDS contract for services here in this community, in the Kensington community?

DR. WILLIAMS: I don't have

the number of providers in the Kensington community, but there are 80 as to the treatment providers.

COUNCILWOMAN LOZADA: Is that a number you guys can get us by 1 o'clock?

DR. WILLIAMS: Yeah, we can get that number.

COUNCILWOMAN LOZADA: I'd like to know what the number of providers are that you all contract and fund in this community. I'd like to know how much you pay them to provide services. I'd also like to know what services are they supposed to be providing here as it relates to connecting people to services, right. And before they can get services, they sometimes have to go into that bed process; is that correct? They have to come in somewhere, right?

DR. WILLIAMS: Right.

COUNCILWOMAN LOZADA: So if you all can help us understand,

right, how many providers are here, who they are and what are the services that they're supposed to be providing, I would appreciate that. And I'd also like to know your last count. What was your last count and how does that compare to the number of other partners, Police, Office of Homeless Services and others who do a count as well. How does that differ, right?

MR. HOLLOMAN: Good morning, Council Chairperson Lozada. Dave Holloman, Interim Executive Director for the Office of Homeless Services. Just want to report on the number, according to our point-in-time count which the Office of Homeless Services continuum of care is mandated to do one count per year, the number of people that were counted this past January that were unsheltered was 976.

However, there's three different methodologies when we talk about count. There's a police count that has an observation count, more of a census count. And then it's the DBH quarterly census count. Those numbers based on what police allocation range anywhere between 400 to 600. Again, those are observational count.

The Office of Homeless Services does a methodology count that is vetted by HUD in which we're required to do. Those seasonal counts are done to look at trends. But for the last several years, the numbers in Kensington always continue to fluctuate depending on the season.

However, this current year here when we have those consultation meetings with law enforcement and other partners, those numbers range anywhere between as low as 400 and upwards

to 600 that's in the Kensington area.

One of the things that we looked at during the last point-in-time count is the highest number of unsheltered individuals in the city of Philadelphia we're seeing in the Kensington area. That used to be the opposite for this area. It used to be Center City. So that's content there. DBH and Police can speak more about their methodology that they use, but I believe it's more of a census count. And again, seasonal to seasonal to look at different trends.

COUNCILWOMAN LOZADA: I appreciate that. Thank you. I'd still like to know what was their number. On the record I'd like to know what is their number for their last count.

DR. WILLIAMS: The last number that we gave in the last hearing had to do with the number

of engagements that were made by DBHIDS, the outreach team in Kensington. And that number was somewhere in the 600. We'll get the exact number again. But our number at that time was about how many people we engaged on the street.

COUNCILWOMAN LOZADA: And I'd like you to explain what's a successful engagement to DBHIDS and your outreach workers.

MS. DAVID: Hi. A successful engagement is any kind of connection we make with an individual to help move them toward a life of recovery. So an engagement could be building a relationship with the individual to eventually accept placement. But the goal is always to get the individual off of the street either into housing or into some level of substance use disorder treatment program.

To date, we have actually done 5,000 engagements. It's not an unduplicated number. The continued engagement could be -- it could be continued engagement with one person or a set of people. We're going to get the unduplicated number, but we've also made 221 placements in the beginning of the year. So that could be into a hospital, it could be into a treatment program or it could be into a recovery house or safe haven, and emergency shelter. We work with OHS to do that as well.

COUNCILWOMAN LOZADA: So is it a myth that a successful engagement is someone accepting a bottle of water or is that truth?

MS. DAVID: Sometimes that's the entry into having a conversation with an individual. So a person accepting -- if you're handing out something that the individual needs, working off of

Maslow's hierarchy of needs like giving them water so that they will begin to engage, trust you and create a meaningful relationship with you, sometimes that's the first step into moving toward these other -- moving toward placements, accepting treatment and those types of things.

One of the things that we really like to do is get to know the individuals who are on the street so that we can help make the right placement for the individual to help make whatever placement is going to stick.

COUNCILWOMAN LOZADA:

Dr. Williams, from the beds that you mentioned that you all have access to, what are the cost of those beds?

DR. WILLIAMS:

Councilwoman, we don't have that information with us today, but we can prepare it for you and submit

it to you.

COUNCILWOMAN LOZADA: Do any other members of the Committee have questions? I want to take a break.

COUNCILMAN HARRITY: I do.

COUNCILWOMAN LOZADA: The Chair recognizes Councilmember Harrity.

COUNCILMAN HARRITY: You said in your testimony that today available is 121 beds. What is the breakdown of that because we all have heard that 121 beds is not necessarily 121 beds depending on the classification? Again, going back to what we're saying that a bed is a bed, let's just get them in, how does that break down? What beds are available out of 120? What levels of care, how many of this care can you do, how many of that care can you do a day? What is the actual breakdown?

DR. WILLIAMS: When we say

121 beds, those are substance use disorder treatment beds. And Amanda I think has some additional information.

MS. DAVID: So for the 3.5 beds, we had 77. For 3.7, medically-monitored intensive inpatient services we have 10. For 3.7 WM, we had 30. The ACM 4.0, medically-managed intensive outpatient, this morning we had 1. Now, we have 12 I got a notification on. And then ACM 4.0 withdrawal management is 3.

COUNCILMAN HARRITY: So with that being said, 77 beds that are 3.5, right? What's the difference between 3.5 and 3.7 besides the 2 percentage points or tenth percentage point?

MR. DEVOS: Hi. This is Andrew Devos from Community Behavioral Health. Those are -- so Pennsylvania implemented the American Society of Addiction

Medicine or ASAM level of care system. And part of the reason they had to do that is really to maintain their 1115 wavier that they have to pay for substance abuse treatment through Medicaid. That was really the deal with CMS to do that.

And what that does is lays out -- and we do have some handouts that we can give you and we can talk to you more over time about how those lay out, but they really line up with how they're staffed and what is kind of the focus of the bed. So 3.1 is a halfway house. 3.5 is your typical rehab. When people say they're going to rehab, they don't have major medical problems. They may some wounds. They may have some other things.

And 3.7 is really moving into high psych and/or high medical need. And then the Level 4 that

we've talked about, those are very medically-intensive beds. Those are people that have chronic medical. They're going to need 24/7 staffing. And it really aligns with the staffing. That's part of what some of the medical professionals this morning were talking about, making sure somebody with a PICC line can go into a place where they're going to be able to get that kind of treatment and have doctor care 24/7. So it's a continuum of care, kind of less intensive to more intensive.

COUNCILMAN HARRITY: It kind of baffles me because I see these poor individuals every day and by my layman diagnosis of looking at them and interacting with them, they're all 3.7 to 4.0. So why are we even messing around with the other stuff, you know what I'm saying? Let's make them all 3.7 and be done with it and get

everybody into treatment. I just don't --

MR. DEVOS: I think you've raised some --

COUNCILMAN HARRITY: And you guys are the ones that actually do the intake stuff, so you guys are the ones that put down, all right, they need this care. How does that come about? I'm trying to get a grasp on what beds. I just don't get it. Common sense would dictate that if you have an individual who's ready to go into treatment, let's get them into treatment.

MR. DEVOS: Correct.

COUNCILMAN HARRITY: But I would also say that most of these people out there are on the high end of needing multiple services. So why are we playing around with the other ones. Let's just get into that and start helping people.

MR. DEVOS: I would agree

that we're trying to catch up to that and move to that. I'm very interested, we're very interested. I loved your idea about when somebody's ready we need to get them into a bed. So we are talking about some providers just developing something that would be an engagement and triage center just to get them in --

COUNCILMAN HARRITY: What I'm saying is we're dealing with this. This is an everyday thing of dealing with these people. We know what we're dealing with. We know what their issues are, you know what I'm saying. They all have basically the same issues, homelessness, open wounds, mental health issues.

So my thing is why are we even bothering with the other stuff. Let's just make them all 3.7, 4.0 and send them. If the beds are there, just send them all

in.

MR. DEVOS: Well, I think that's something to talk about with the people who licensed the DEDAP(ph) around how to do that. Part of it is the change in the drug supply has really driven medical wounds -- remember, we were dealing with the pandemic, just trying to get providers through the pandemic.

So 2021 into 2022, we had -- some of our rehabs would have 80 people out at a time with COVID, so really just trying to keep things staffed and up. During that time is really when the drug supply changed over the last five years when we started seeing these wounds. And I would agree we need to accelerate that. We need to look at how to get those beds.

We have been talking to providers. We've had providers like the Behavior Wellness Center

at Girard who's open to wound care. We have the Level 4 post-acute, which really took a lot of work, as the Jefferson people talked about this morning. Engaging with the medical units who didn't know how to kind of get and refer and set people up to go into rehab, engaging the physical health managed care organizations who pay for the medication to say we need to streamline the way it can go from, say, somebody in a Jefferson Medical Unit to be paid for an equal bill for the same medication. So I would say we're catching up to it. We share your passion and concern.

COUNCILWOMAN LOZADA:

There's a crisis in Kensington. There's a crisis in Kensington. We've been talking about the crisis for years. You all have $1.7 billion in a budget, $1.7 billion. There's a crisis in Kensington.

Y'all have the capacity in this department -- and, Dr. Williams, I'm rooting for you. I'm rooting for you.

DR. WILLIAMS: I appreciate that.

COUNCILWOMAN LOZADA: I need us to recognize that there's a crisis in Kensington.

DR. WILLIAMS: We recognize it.

COUNCILWOMAN LOZADA: We can't keep coming to hearings -- we cannot keep coming to hearings and not have any information. Commonsense answers to very commonsense everyday questions that we have asked multiple times. All of these questions, all of these questions I asked during the budget hearings. These are common sense. We need to respond to the crisis that we have. We have talked about the barriers that we have. Why haven't we responded to them

because they don't seem difficult to me. They don't.

We have providers. How many providers are here? Who's getting the money? Who are they responding to? Are we responding to 1,000 people, to the 976 people that we say or are the same five providers responding to the same 200 people? And if they are, then let's shift the money.

I can't understand why are we making it so difficult. This community deserves to restore their quality of life.

(Applause.)

COUNCILWOMAN LOZADA: I don't think that we are asking for anything that is difficult. And I think that it is this department that holds that key. You guys are the people that contract these services out, right. Your workers are the ones that are out in this community every day. And I want to

say to those workers that are out there, we appreciate you. We appreciate your work.

(Applause.)

COUNCILWOMAN LOZADA: We know that it is not easy. We know that there are challenges. We know that the people out there that are suffering from addiction are sometimes not friendly because they are in pain. We get it. But we cannot continue to come to hearings, to meetings, to town halls and keep saying we don't have the information because I call bullshit on that. I call bullshit.

You know why, Dr. Williams? Because I know we have the numbers, because I know that we can respond. Because when we're writing out the contract and we're asking for money at the federal and state level, we have to provide that information. We have to. We have to be able to tell people who's getting the money

and what are they supposed to be doing with it. And we have a responsibility to this community to be able to respond to that.

And we asked this same question at budget hearings. We asked the same question a year ago, right. I expect more. I hold you to a higher level than I held your predecessor. And you know why. I don't have to tell you that. You know why, right?

DR. WILLIAMS: Yeah.

COUNCILWOMAN LOZADA: So I expect us later on this afternoon to be able to have those numbers. Because before we leave today this Committee needs to have some type of a roadmap to be able to say we're going to fight for your department, we're going to fight for those outreach workers that are out there every day and we have to get them more funding.

If we have to shift how

we're giving people money to be able to provide services, then as a Committee we need to be able to do that. We can't do it if you're not being transparent. And so, I want to for the life of me -- I don't want to have a heart attack up here today. But I want to make sure that people that come up here today -- we're recessing, we are going to recess and we're going to come back. We're going to recess for 30 minutes. But I don't expect people to come up here to tell me you don't have the information. You've had a year, a year to respond and find the information.

I know you don't. I know you haven't had a year. And I recognize that there are people in this Administration that have not been in their positions for a long time, but you knew what the issues were coming in. You know what the issues are coming in. And you've

also worked in government long enough to know what the questions were going to be when you were coming here.

There is a crisis in Kensington that we must respond to. We have to change and restore quality of life in this community. And this is not about elections. This is not about votes. This is not about anything other than the people that are trying to raise their families in this community.

(Applause.)

COUNCILWOMAN LOZADA: Council colleagues, I think we're going to call for a recess.

DR. WILLIAMS: So can I say something to that?

COUNCILWOMAN LOZADA: Yes, ma'am.

DR. WILLIAMS: So I can appreciate your passion and your frustration. We had a conversation about this in April. And what we

intended to do was talk about how the department looks at barriers and the things that we do every day, every week, every month for years as you've been saying to reduce those barriers. So that's what we prepared today.

In terms of the financials, the rates, the providers and how much money they get, we hadn't prepared that for you today, but we're not saying we can't prepare that for you. So it's not a matter of being transparent. It's a matter of intending to have another conversation today about the multi-layered problem, the multi-tiered, multi-interagency approach. So we also feel like needs to happen, yes, behavior health holds a part of the key --

COUNCILWOMAN LOZADA: A large part of it.

DR. WILLIAMS: A part of the key, right. But this is a big

problem and it's not just about behavior health and treatment services. It's going to take all of us to really get together and not be siloed in our understanding of how to approach the problem to actually bring a solution to the problem.

COUNCILWOMAN LOZADA: And we talked about that. We talked about that a year ago that there were silos. And the assignment when people left the room at Conwell was, we are no longer working in silos but breaking those down and we need to do something different.

And my ask is what have we done differently, who are the people that you're funding, what is their responsibility, not just to the contract but to the people that they're serving and the people whose community these people are living in. And so, I get it, I get

it. But we need to be better-prepared. We need to be better-prepared. And that is all a part of the conversation.

We can't figure out where the beds are or how many beds we need if we don't even know how many people are out there.

MS. DAVID: I got the number for our last count. Our last count was on May 15, 2024. And there were 828 people in Kensington.

COUNCILWOMAN AHMAD: Total across the city?

MS. DAVID: Total across the city there were 1,303.

DR. WILLIAMS: But I will also go back to what I was saying in the beginning and make the point about the number of people versus the number of people who need treatment and who are ready for treatment and who are going into treatment. So we can get that

number for you, but it doesn't mean tomorrow that we're going to need 800 beds. We have to make sure that we have a number of beds ready for the people who present themselves at a specific moment in time and we have had that.

We not only have these 121 beds, but we have out-of-network beds and we have surge beds. We're waiting for this big surge and making partnerships and contracts with people for that time to come. So I want you to understand that we're thinking about it in the same way that you're thinking about it and holding these spaces for the time that will come. But I think it's faulty to think that if you have this group that they're going to need that number of beds in that same day.

COUNCILWOMAN LOZADA: There's a crisis in Kensington and we need to figure out how we get

828 people from living unsheltered in the streets of Kensington.

DR. WILLIAMS: Yes, I agree.

COUNCILWOMAN LOZADA: We need to figure out how we get 1,303 people into whatever service it is they need --

DR. WILLIAMS: Got it.

COUNCILWOMAN LOZADA: -- and out of our streets. Because if they are hurting the quality of life in this community, then the goal for us is not for them to move to another community to ruin that community. So we need to figure out how are we responding to the crisis in Kensington.

DR. WILLIAMS: Got it.

COUNCILWOMAN LOZADA: On that note, I'm going to break for recess for 30 minutes. We'll be back at 1 o'clock. Thank you.

(Lunch recess.)

COUNCILWOMAN LOZADA: We're

going to get ready to begin and continue our hearing. This public hearing of the Special Committee on Kensington is regarding Resolution 240510.

Before we begin, I'd like to recognize that Commissioner Kevin Bethel has joined us. Thank you so much for the work that you do every day. Thank you.

I'd also just like to note that if there's anyone here that would like to sign up for public testimony or public comment, there's a table back here. Sarah from my office is in the back there to my left and she's happy to sign you up.

We are going to have the Clerk call the folks that are on this panel again just so that we're clear with who we're starting it up with, and then I'll open it directly to my colleagues for questions, follow-up questions for

DBHIDS.

Will the Clerk please share who the members of this panel are.

THE CLERK: Yes, Madam Chair. We have Commissioner Marquita Williams, David Holloman, Deputy Commissioner Pedro Rosario, Noelle Foizen and I'll get the other two names for you shortly.

DR. WILLIAMS: Deputy Commissioner Amanda David and Andrew Devos, COO of Community Behavior Health.

MR. DEVOS: Thank you, Commissioner.

COUNCILWOMAN LOZADA: Thank you. And then we have a representative from the PAD program as well.

MS. ANDERSON: Joelle Anderson.

COUNCILWOMAN LOZADA: Thank you. Right before we recessed we had very specific questions that we needed to find answers on.

Commissioner Williams gave her testimony. My colleagued didn't have an opportunity to ask questions. And so, I'd like to recognize Councilmember Dr. Nina Ahmad to proceed with her questions.

COUNCILWOMAN AHMAD: Thank you, Madam Chair.

Good afternoon. Thank you for being here.

DR. WILLIAMS: Good afternoon.

COUNCILWOMAN AHMAD: This is a very important issue and I thank you all for -- I know you all are working hard. We just have to make it work smart to make sure what work you're doing results in making Philadelphia a safe and healthy city. And so, I thank you for that.

I just had a specific question about first you mentioned an 800 number in the most recent

count in May. What was that number, 800 and --

MS. DAVID: 28.

COUNCILWOMAN AHMAD: 28 in realtime count on that one day in Kensington. Do you have a sense of the 828 people where they fit in the -- so first of all, do they have SUD? I don't know if all 828 have them or not. Are they assessed in any way during that count or after or any way to asses? What is this population of 828? Are they people with addiction disorder? And if they are, where are they on the spectrum?

Meaning, you said there were beds available, treatment beds available but not recovery spaces, if I understood you correctly. And to my colleague Councilmember Harrity's point, most of them and what we see with our own eyes are probably 3.7s. But apparently a lot of 3.7s are really assessed at

3.5, so there's a different level of services that go because of the way that they're identified.

So I wanted all of those interconnected questions to be answered. One, about the population you're serving when you do a count; two, about where they are in the continuum of needing care; and three, is it true that people get their status changed in order for less resources a spot in recovery?

MS. DAVID: Hi. Amanda David, Interim Deputy Commissioner at DBHIDS. So when we do the count, we count any individual who appears to be homeless. That person could be bedded down, sleeping potentially in a tent. If there are tents, we count those individuals and anyone else that we believe to be homeless.

It is actually just a 1, 2, 3, 4, 5 kind of count where we

really get into meeting people and understanding what their challenges are through the engagement that I talked about earlier. We would assume that most of the individuals in Kensington do have a substance use disorder. The homeless count, we assume that they have a substance use disorder, but we couldn't tell you who would assess at a 3.7, at a 3.5 and those types of things.

COUNCILWOMAN AHMAD: And the next piece about 3.7s being reclassified as 3.5, this is anecdotal feedback that people are assessed at lower levels of needing care. I'm not sure of the motive, but I hear that's a practice and I wanted to know if there's any truth to that?

DR. WILLIAMS: Councilwoman, I don't know that there's any truth to that. What I do know is that people are

continually assessed in whatever level of care they are with the goal of moving them down to less acute settings and moving forward with their recovery. The way that you're describing it I haven't heard that.

COUNCILWOMAN AHMAD: Okay. We'll have to get more evidence about that, if it's actually true because this was all about a reimbursement model. That's where that was coming from.

I just want to go back to that realtime count. Is there a follow-up for us to know what is the population we are dealing with to know what the services are needed. If we just leave it at a count and don't know anything beyond that, then how do we know who needs treatment beds, who needs recovery?

And to Jimmy's point, I think mostly they would be probably

treatment beds. And if they're substance use disorder, I can't imagine we're going to send them to a halfway house situation. So I just wanted to know what you're doing to follow up to really assess the population, what their needs are and how we're meeting those needs. If you don't collect that data, how are you going to deliver the care?

MS. DAVID: Yeah. Thank you. The way that we do follow-up to that is through our everyday outreach engagement. So we have the DBHIDS homeless outreach teams with the contracted group of providers that provide those services. We also have the Community Wellness Engagement Unit that does connections with individuals to find out what their needs are. And then we also have the mobil outreach and recovery services that is able to do

assessments with individuals who are seeking treatment on the spot and be able to move them into, get them into the right space for the level of care that they're appearing to assess at.

And then once they get to that treatment program, they would then need to go through an ASAM assessment to determine the actual level of care. We also have connections with the PAD group that Joelle here is representing and the AR-2 team through the Fire Department.

COUNCILWOMAN AHMAD: And my last question before I yield is do you have in the teams that do the assessment, is there medical personnel there who are doing the assessments in this team?

MS. DAVID: For the teams that DBHIDS oversees, the outreach teams do not have a medical person. Some of the teams have clinical

behavioral health staff who can see what the needs are for the individual and then move them to -- either they can transfer them to the MORS team who can do an assessment on the street or they would take them to a crisis response center depending on what the individual's need is.

COUNCILWOMAN AHMAD: The reason why I think having some medical personnel in that team, early team, would be because all of our medical professionals here said MAT is needed, medically-assisted treatment is needed, right. And I think to reduce the time involved of one person doing this, the next person doing another assessment, by the time we lose the person who is ready to go into treatment, we've had three layers of doing things.

So if we can reduce the time and condense what we have to do and have an assessment, then is

where I think we could have our hospitals and all of those who get reimbursed by Medicaid, have a capitation program there, could look to see how they partner with you -- so we need to rethink what I'm saying -- to partner with you on the ground so they know who's a real 3.7 and who needs to go where right away instead of putting three, four layers. And by that time, the patient was looking for the next time they're not in detox, they're going to go off somewhere. So we need to get people the minute they are ready without increasing that time to get into actual treatment.

So one of the things I want to look at is how do we make our hospital or whoever is doing that in-bed-with-treatment, at that point of engagement so we can have a much faster, better way of giving our folks the treatment that they

need.

Thank you, Madam Chair.

DR. WILLIAMS: Thank you, Councilwoman.

COUNCILWOMAN LOZADA: Thank you. Before I recognize Councilmember Harrity, before we went to break, there were a series of questions that we needed to get responses to. And the questions were questions that we've also asked during budget hearings. We've asked them and been asking them over a course of a year.

And the reason why I feel it's appropriate to ask those questions because many of you on this panel that represent DBHIDS have been in those conversations, right. And so, can you please provide us the responses to who's in Kensington that is a partner provider, what is their responsibility, how much are they getting? If you don't have that

information, where can we find that information? When can we have that information?

I think it's important that those very basic questions are answered because like all of you, we on this Committee have a responsibility to respond to community residents, right. And if we're going to town halls, if we're going to community meetings and people are consistently telling us this is a good provider, that's a bad provider, this is a provider that's not really doing what they say that they're doing and they're continuing to receive contracts, it becomes a problem, right.

It becomes -- there's a sense of distrust that we as electeds who are put in these positions to be able to respond to people, they feel like they can't trust us. And I think that part of we have been doing over the course

of the last few months, right, with this new Administration is change how community residents feel about their government, right.

This community for the last eight years lived under an Administration -- and I'll say it here, I'll say it tomorrow, next year, next month in front of whomever -- they've lived under an Administration that was not responsive to them, right, and for a lot of different reasons.

And I'm not going to even try to make reasons up as to why the past Administration wasn't able to respond the way this community deserves to be responded to, right. I'm not going to make that up. I'm not going to go there. But we all know, we've all been here long enough to recognize that the Administration was not and did not do their due diligence when providing basic quality-of-life

services to this community, right. Can we all agree on that?

DR. WILLIAMS: Yes.

COUNCILWOMAN LOZADA: And so, these are questions that this community has had for a long time. And I need to know that you know who your providers are who are here, that you recognize that they are your providers, that you recognize how much money you're paying them, that you know the services that we expect them to be delivering to the people of this community. And that if you realize that they are not providing these services, that we create mechanisms that will allow us to redirect those dollars. And it shouldn't matter to us who the hell that person is connected to, who they know, how long they've been in the system, right. It shouldn't matter to us.

What should matter to us is

that we are using tax dollars, people's money, to be able to receive a basic quality of life, right. We should know that this is not acceptable in anybody else's neighborhood, in Society Hill, Drexel Hill, Chestnut Hill. None of the Hills of this City would this BS be permitted, right.

And so, we have people who are saying to us we're paying attention and you guys are killing us. You're destroying our community. Our children see this every day. Our children cannot be expected to be successful contributing citizens to our great city if we continue to traumatize them every day, right.

(Applause.)

COUNCILWOMAN LOZADA: So together, we're going to do this together. We are going to figure out who these clowns are, right, that are saying they are supposed

to be doing some type of service but are not. And we are going to figure out together who are those really amazing providers, even if they're the small ones that are really doing some impactful work in our community. And we're going to figure out how do we provide them with additional resources. It's that simple.

(Applause.)

COUNCILWOMAN LOZADA: It's common sense.

DR. WILLIAMS: Right.

COUNCILWOMAN LOZADA: I want us to be a government that is doing business and we're using some basic common sense because we would not allow this in other neighborhood. So, Dr. Williams, I'm going to allow you to respond to all of those questions that we had before because I don't want -- I want to stop. I want people to not see me walk into a room and say

holy shit. I don't want that. That's not who I am. As an individual, that's not who I am.

I want you to understand that I'm going to hold you accountable. And I want to be held accountable too. I do, right. I don't want people to be freaked out when I walk into a room because I'm going to ask them a question that they don't know an answer to. Yes, you do. You know I'm going to ask. You know because I've asked before, right. And you know because we have a responsibility to the people.

We have a responsibility to change what has been happening here for a really long time. And so, I want to do this together. I never want people to feel like I got them because I don't want to have you. That's not the kind of business that I want to be in. But I do want you to know that I'm going to

hold you accountable, that this Committee up here is going to always hold you accountable.

And that if we ask you a question today and you didn't have the answer, that's okay. But we're going to expect the answer because you got to come back in front of us, right.

DR. WILLIAMS: Yes.

COUNCILWOMAN LOZADA: You got to come back. You're not going to be able to hide. You work for us. We work for the City. We work for you. We're supposed to work together. We need to figure this out. So the goal is to become partners and recognize that what has been happening here is not what should be happening here because it wouldn't happen anywhere else, and that we are not going to be here 12 months from now having this same conversation.

So I'm going to allow you

the floor. Thank you very much.

DR. WILLIAMS: Thank you, Councilwoman. We appreciate that. And I appreciate your passion every time I see you, right. We want the same things. We wanted the same things yesterday. We want the same things today.

In our plight to make sure that we're doing things better, we're doing many of the things that you're talking about, looking at our providers, making sure the ones that are bad actors are out of our system, looking at the small providers that maybe don't have the capacity and infrastructure of some of the larger ones but they're doing great work, they have great outcomes. And we've been looking at ways to bring them into our system. There are a number of things that CBH has been doing to make it a lot easier to become a provider as well as that DBH has

been doing with BIPOC providers. And so, I wanted to let you know that we hear you and we're right there with you.

In terms of some of the things that you asked for around providers in this area, we have that. And Andrew Devos is going to give you that information and talk to a little bit who they are and what is happening. But I do want to say all of the information that you asked for in terms of the financing, we were not able to pull together in the last 30 minutes. But we will pull it together for you.

We're happy to have a meeting with our finance team and look at what we're doing with CBH and with your office to look at how we can answer these questions in a fuller way but also create a different solution we have had up to this time. So I'm willing to do

that with my team and your team.

COUNCILWOMAN LOZADA: Thank you.

DR. WILLIAMS: Yes.

MR. DEVOS: Hi again, Councilmembers. Andy Devos from Community Behavior Health. We've broken it out by the two zip codes that we think of usually as Kensington, 19134, 19125. We also have 19124, which is kind of adjacent, if you would like that as well.

But here in 19134, we have APM which as both a substance use outpatient program and a mental health outpatient program. We have Beacon Point Recovery, which has 120 SUD beds and broken out by 90 of them are 3.5 and 30 of those are 3.7 WM, withdrawal management which used to be known as detox.

COMHAR, which is really kind of centralized here, has a number of services. They have

mental health case management, mental health outpatient. Within that mental health outpatient, they do have the ability to do suboxone treatment. And then they have a day program for people with serious mental illness called a Community Integrated Recovery Center.

We have Esperanza, which is a federally qualified health center. They also do medication-assistive treatment there. Very small mental health outpatient program called Get Well, which is really just one psychiatrist. Hispanic Community Counseling which has three mental outpatient locations here. And finally in 19134, PHMC has Pathways to Recovery which is the substance use disorder partial hospital program that has 60 slots. That's where people can go up to 20 hours or more per week.

In 19125, COMHAR has

another mental health outpatient program. We have a mental health outpatient provider called Emilio Medical Group. And then one of our largest providers in our network which is Temple Episcopal which has as well as -- they have the Temple faculty practice plan, which is kind of the doctor group like we said with Jefferson this morning. They also have a mental health outpatient clinic. They have the crisis response center, a large acute inpatient psychiatric program. Then they also have something called an Extended Acute, which is a psychiatric program for people who need longer term --

COUNCILWOMAN LOZADA: What is that one again? I'm sorry.

MR. DEVOS: Extended Acute. And then finally, they just recently opened a substance use disorder outpatient program on the grounds of Episcopal as well. So

those are those two. Would you like 19124? It's kind of towards -- going up toward the Boulevard?

COUNCILWOMAN LOZADA: (Nodded affirmatively).

MR. DEVOS: Best Behavioral Health, which is a mental health outpatient provider. COMHAR, which has something called a long-term structured residence, which is really for people with serious mental illness where they can get treatment and also with longer term.

Friends Hospital, which is a large hospital in our system, nearly 200 beds and they also have a crisis response center. That's all acute inpatient psychiatric care. GPHA, which is the federally-qualified health center. Northeast Community Center for Behavioral Health, they have mental health outpatient. They have

mental health case management, and they have three of the day programs for people with serious mental illness that are called Community Integrated Recovery Centers.

Northeast Treatment, which has two substance use disorder outpatient clinics in 19124. They also have some services for children called Intensive Behavioral Health Services. That includes ABA, which is specifically for kids with autism as well as their regular IBHS. And they have family-based services, which is also a mobile service for children and families.

Also in 24 is Resources for Human Development that has New Start II, which is one of the Journey of Hope rehab programs that we talked about for people who qualify under the chronic homeless federal definition. And finally, we have Wedge Medical Center which

has one mental health outpatient program and three substance use disorder outpatient programs in the 19124. We can get those to you as well.

COUNCILWOMAN LOZADA: So we have about 20-plus providers that provide services within a very specific area or walking distance. And so, I'd like follow-up from you around how much do they get, what's their commitment, who are they providing services to, right?

Are they providing services to 200 individual clients? Are they providing services to the same 200 clients, right? How often are these clients frequent flyers? And do you even do an assessment of these individual providers? And if so, give us a report back on how is that assessment, what do you assess, how do you make decisions to shift dollars. I want to know everything you know about these

individual people, right.

If they provide beds, if they're responsible for beds, how many beds are they responsible for? What are the challenges that they're experiencing when people are reaching out to them to get people into these beds, what are the challenges?

And, hey, I'm even excited about give me some success stories. Tell me, tell me how great they are, right. And why we should continue to trust in them as a community, right. Because this is not about us. This is about the people who live here trusting that provider and making sure that that provider is really providing the services that they're getting paid to provide.

The Chair recognizes -- thank you so much for getting the information to those follow-up questions. Yes?

MR. DEVOS: And just to let you know, those are all the Medicaid-funded CBH providers.

COUNCILWOMAN LOZADA: Okay. Thank you. Thank you for that.

The Chair recognizes Councilmember Harrity.

COUNCILMAN HARRITY: Thank you for being here again today. So my colleague Dr. Nina Ahmad was hinting toward some things. So you know we're being told from the providers that we talk to that they'll assess somebody at a 3.7 and then when they call to get them placed into something, the person on the other line or whoever they're dealing with tells them, oh, no, they're a 3.5.

Who is in charge of that? Where does the buck stop when it comes to who's making the decision of what bed a person actually needs, you understand what I'm saying? We're getting feedback

that they'll call and they'll say, oh, I reassessed this person and he's a 3.7 and meets the other comprehensive thing and the person on the other end of the line or whatever says, no, we believe they're a 3.5. What can you tell us about that and who makes that decision? Who is the ultimate person that says, no, this person is 3.5 or this person is 3.7, this person is 4.0 or whatever?

MS. DAVID: So at the place where the individual is assessed those folks are trained in how to administer an ASAM and what goes into the ASAM level of care assessment. Through a set of dimensions they determine what level of care a person is assessed at. They then make the referral to a treatment provider that is that level of care to move them into that space to find a bed and get them into that space. We do not

condone dropping or changing the level of care. If the individual is assessed at a 3.7, they should be referred to a 3.7.

COUNCILMAN HARRITY: Well, apparently that's not the case. That's not the -- sorry. Apparently that's not the case. Apparently what is happening is they're assessing about one thing and then somebody along the line is changing that assessment to say, oh, no, we believe that this person is 3.5.

Whose decision is that? You're telling me that they're doing it in the assessment on the street is what you're saying or in the intake center or wherever they're at, wherever they go to get the services?

MS. DAVID: Yes, wherever the person gets the assessment. So it could be at the Crisis Response Center --

COUNCILMAN HARRITY: So the person that does it then, right?

MS. DAVID: Yes.

COUNCILMAN HARRITY: Who do they report to? Who is the one that ultimately makes a decision on what bed is what and what a person is able to go into? So if they assess it at 3.7, why and who is the person saying, oh, no, they're only a 3.5? How is that decision made?

If somebody else has already looked at them and he's right there in front of them and they can see what they need physically, but somebody else along the line is actually making the decision on whether that person gets the 3.7 care or are demoted to a 3.5, that's what I'm trying to figure out?

MR. DEVOS: We had talked earlier about certain levels of care, that CBH has no prior

authorization. That's the 3.5, that's the 3.7 WM, which will be detox. For the 3.7 and the Level 4, the clinical information is called into CBH. It's reviewed by a clinical care manager. That's the first person who would make the determination. Most often they do agree and authorize it, but if there's a clinical opinion that doesn't meet the medical necessity --

COUNCILMAN HARRITY: No, this is done --

MR. DEVOS: Then they review it with a --

COUNCILMAN HARRITY: Are they sitting in front of the person when --

MR. DEVOS: No.

COUNCILMAN HARRITY: Then how can they make that decision?

MR. DEVOS: I understand your concern.

COUNCILMAN HARRITY: Then

there's no way to make that decision.

MR. DEVOS: They review it with a physician, but I understand your concern.

COUNCILMAN HARRITY: You understand what I'm saying?

MR. DEVOS: Yep, absolutely.

COUNCILMAN HARRITY: Absolutely ludicrous and this is quite frankly bullshit, you know what I mean. We're talking about families here. I don't care what it is. If the person on the ground says this should be a 3.7 and somebody else is changing it to a 3.5, that is not right. The person who is physically in front of the person should be the person making that decision.

And I'm not saying that this is you --

MR. DEVOS: No, understood.

COUNCILMAN HARRITY: -- I'm

saying who is it that I have to go after in order to get this situation rectified? Now, is it the insurance companies because they don't want to pay that extra money for care? But most of these people are on Medicaid, so who actually is making this decision?

MR. DEVOS: Just to finish what the process is, the care manager would then review that with a physician at CBH. They would make the final determination, but again they are not --

COUNCILMAN HARRITY: They're not looking at the person.

MR. DEVOS: Correct.

COUNCILMAN HARRITY: They don't know what the immediate physical needs are.

MR. DEVOS: Correct.

COUNCILWOMAN AHMAD: Which is why we need them on the team.

COUNCILMAN HARRITY: It's a little frustrating. I apologize

for that.

MR. DEVOS: No, I completely understand your frustration.

COUNCILMAN HARRITY: It's so much bull, you know, to navigate the system. What people aren't getting is that these people don't have that (inaudible) --

UNIDENTIFIED SPEAKER: Can't hear.

COUNCILMAN HARRITY: I said this is a decision that's going to affect their whole lives from that point on. The fact of the matter is do they get the care that they deserve and need or do they get the care that some bureaucrat said they need. I just want to figure out who I have to go after to hold responsible for this and how we change it, because the bottom line is this has to changed. It can't be done like that.

There's no way somebody can

make an assessment over the phone not even looking at a person, seeing what the physical condition that they're in is and then make an informed judgment of their treatment should be cut down from 3.7, 3.5 when they haven't had a chance to observe the person in person. That's not acceptable.

COUNCILWOMAN LOZADA: Thank you, Councilmember.

The Chair recognizes for the record that Councilmember Mark Squilla has joined us. And I'd like to recognize you for a comment or for a question.

COUNCILMAN SQUILLA: I want to ask a question real quick because I know -- I missed the part where you said you have plenty of beds. I'm sure you said that. The question is too on the assessment process, is there data that shows all the people who are being assessed and then what assess level

of care they're assessed to? So you have data that says all of the people who were assessed and then what level of care were they sent to?

MR. DEVOS: We do as far as if they're going to a bed-based level of care.

COUNCILMAN SQUILLA: Well, how about even IOP, MAT?

MR. DEVOS: Ultimately, aggregate we have that. On an individual basis, like a Crisis Response Center is able to do an assessment. If they see a person needs like an IOP level of care, they'll just make that referral directly.

COUNCILMAN SQUILLA: But you have those numbers like how many people came in?

MR. DEVOS: Yes. So we can link together between the Crisis Response Center evaluation that we get billed for and then what's

their next level of care.

COUNCILMAN SQUILLA: The reason why I'm asking that question is we have people who are unhoused and people who have told us that they have nowhere to go, yet they will be assessed as IOP, MAT. And we don't see how that is possible for that person to get the successful care that they need in order to get the help that they need. So we want to understand why they're being assessed at that level knowing what their situation is and then how we could help to change that. And I know we have available beds so it's not because we don't have enough beds available, right. So what is the reason why it seems like these folks that really have nowhere to go are still being assessed at that level?

MR. DEVOS: I think that's where we should engage with our

provider partners to talk through, especially the Crisis Response Centers, about what they're seeing in that moment that would make them think about that assessment.

COUNCILMAN SQUILLA: All right. I'd like to see if we can get that data to the Chair too on those individuals --

MR. DEVOS: Sure.

COUNCILMAN SQUILLA: -- so that we can then look at those numbers also to help with the providers and you and all of us because we're not the experts. We're only hearing from the people who are on the street that are telling us this. So I think if the providers are doing that to them, then maybe we need to change what their assessment process is.

MR. DEVOS: And I don't want to speak for the providers, but I do think sometimes when they see that somebody has completed a

rehab treatment recently and then come within days back, that's probably the most often -- it could be that they do need to go back into rehab.

There are people -- we're going to get the unique number of people served by provider for the Councilperson. I think it would also be good for us to look at how many people -- because we have over 8,000 people who were in bed-based substance use services. But that just represents the unique people that have that service. Some of them might have been in three times in the year. So I think that's compelling information.

COUNCILMAN SQUILLA: Well, how many unique individuals? You said 8,000?

MR. DEVOS: Last year it was over 8,000.

COUNCILMAN SQUILLA: Unique not --

MR. DEVOS: Correct, yep. But some of them may have been in more than one time.

COUNCILMAN SQUILLA: If it's more than one time, they're not unique.

MR. DEVOS: We're not counting them -- in that 8,000, those are unique individual people, right. Some of those unique individual people though may have been in -- it doesn't then change the total. So it could be 12,000 treatment episodes with 8,000.

COUNCILMAN SQUILLA: 8,000 unique individuals?

MR. DEVOS: Yeah.

COUNCILMAN SQUILLA: And you have both those numbers?

MR. DEVOS: Correct, yeah. And I think that's worth looking at too because that's a question to find out too. What is it that the people -- we've talked a lot about housing. We've talked a lot about

things on the backend. We --

COUNCILMAN SQUILLA: What is working, what is not working, right.

MR. DEVOS: Correct.

COUNCILMAN SQUILLA: And we can probably decipher some of that information from some of those numbers.

MR. DEVOS: And one of the things as a managed care organization we're measured on that we really pay close attention to try to do what we call warm handoffs is linkage to the next level of care, because really the long-term recovery and some of the Councilpeople even talked about, the rehab really sets the stage, but the rubber meets the road when the person walks out the door.

COUNCILMAN SQUILLA: And when you do that warm handoff, there's a process of following that person through the next phase,

right?

MR. DEVOS: Right.

COUNCILMAN SQUILLA: So do we have those numbers, like when you do the warm handoff?

MR. DEVOS: To see how many people do follow up through the next level, yes.

COUNCILMAN SQUILLA: And so, you have those numbers too?

MR. DEVOS: (Nodded affirmatively).

COUNCILMAN SQUILLA: And that's something that we need to see, right?

MR. DEVOS: Correct.

COUNCILMAN SQUILLA: Because if they're successful through the first phase and then they go to the next level of care, are they successful in that next phase, right. And then we can determine what other resources we need, do we need additional resources in that second phase if

it's not working or how we can do it because it helps us help you help our providers make the best decisions.

COUNCILWOMAN LOZADA: And I think that speaks to the why we need to know who the providers are, who they're serving, what level of services and have the capacity to be able to be redivert if we find that we're not getting what we need, right. It's because of reasons as basic and as simple as those that the Councilmember has just finished describing, right. And so, getting us that information is extremely important for us to continue to be able to do the work that we know to need to do in order to improve quality of life for those who are suffering in addiction and the people of this community. So thank you so much. We look forward to receiving that information.

COUNCILMAN SQUILLA:

(Inaudible).

COUNCILWOMAN LOZADA: And we talked about that, right, providing resources for them to continue on their road to successful healthy living.

I'd like us to, Mr. Clerk -- are there any other questions for DBHIDS?

COUNCILWOMAN AHMAD: I don't know if this is the right place to ask this question, but you all obviously will be involved in this case. I wanted to ask about the issue of (inaudible) and what's your role in that and what is the outcome for patients who are (inaudible). So I don't know if this is the right panel to ask this. So through your disaggregating of data, do you have this type of patient who involuntarily is taken in and subjected to (inaudible)?

MR. DEVOS: So we were talking -- Councilmember Harrity and I were talking briefly about drug and alcohol inpatient treatment which is just in the process of being kind of framed out and potentially enacted. So right now involuntary commitment is really on the mental health or psychiatric side. In fact, drug and alcohol issues can kind of preclude people from being --

COUNCILWOMAN AHMAD: Being treated.

MR. DEVOS: Yes, depending on the situation. There are people with serious mental illness who also use substances and may need to be involuntarily committed. On the CBH side, that's an automatic for us. We also don't prior authorize acute psychiatrics. So just to try to help, it's seen as an emergency admission. They just flow right in.

As far as the process itself, that's on the county side. There's a group called the Philadelphia Crisis Line. They are certified as mental health delegates, which is really a state title. They're the ones who look at the criteria of an involuntary commitment.

It has to be witnessed by the person who's called the petitioner of the involuntary commitment and it has to be within the last 30 days. It has to be eyewitnessed. There's some that are automatic which are a two-physician 302 or a police officer 302. So we're just going to set those aside for now.

COUNCILWOMAN AHMAD: And that's what I was getting at, the police officer 302. Is that something that they encounter or is that something they will encounter?

MR. DEVOS: For

psychiatric, oh, absolutely. Both police and SEPTA police are often involved.

COUNCILWOMAN AHMAD: So does that intersect with SUD at all or will there be a future for SUD?

MS. DAVID: The Mental Health Procedures Act doesn't allow involuntary commitment for substance use disorder at this point, those are the rules that we follow. It just doesn't allow it, unless there's psychiatric.

COUNCILWOMAN AHMAD: So there's been some concern around that and that's why I'm asking. Is that on the horizon?

MS. DAVID: That's not something we can speak to. State laws will have to be changed.

COUNCILWOMAN AHMAD: Because there is a state bill about that. That's why all the questions are outlined. And I don't know the status of the bill, but there has

been a bill already.

MR. DEVOS: That's what I was talking about with the Councilmember. We're watching that. We're thinking about how the implementation of that could look, see if it will mirror. There are other ways that aren't involuntary commitments historically and it just depends on kind of the City's Administration and really the District Attorney's Office. In the past there was a lot more court-ordered treatment, which isn't involuntary commitment but it was court-ordered.

COUNCILWOMAN AHMAD: That's going through a court process.

MR. DEVOS: Correct.

COUNCILWOMAN AHMAD: And so, just -- it's very clear we need this aggregated data and we need follow-up to see what exactly is happening for all the different treatment modalities we have out

there, and we need to know to put this much money in this individuals who are treated, this is they are being tracked one year out, six months out, whatever the case. We need that data. We just need to know what is happening with patients that you're treating because that should determine how you're awarded contracts to these providers. But you must have that data, am I correct, that you are tracking their progress and who they're treating and what the outcome for those patients are. You have that data?

MR. DEVOS: We have data on the recovery process, long-term recovery process.

COUNCILWOMAN AHMAD: So how do you decide who you're going to give a contract to, based on what? How do you renew people's contracts? Is there an outcome-based approach to this?

MR. DEVOS: We have something called value-based contracting and we have pay-for-performance, which kind of ranks out our provider network. And then we have a quality review process that --

COUNCILWOMAN AHMAD: There's not result-based review that determines whether this organization will get another contract?

MR. DEVOS: They typically stay in the network unless there are -- I mean, there are providers who have had to leave the network because they are not performing.

COUNCILWOMAN AHMAD: How do you know that? What tells you unless there's an incident? So you don't have a normal tracking. So if I were going to do a contract, multi-year contract which is renewed every year, I would like to know at the end of that year how is

your performance, how many people you treated, what is their outcome and then I'll decide, yes, I'll renew my contract with you or not.

I'm amazed that you don't have that process already in place that will tell us before we had to remove them what were the things that would alarm us or make us happy. It should be a report.

MR. DEVOS: We absolutely have that process in place.

COUNCILWOMAN AHMAD: And that's how you renew your contracts?

MR. DEVOS: A profile of the provider of their number of critical incidents, the number of complaints.

MS. DAVID: There's also a review that happens based on the provider's performance the last time they were monitored. So it's called -- our NAIC team goes out and it's the Network Improvement

and Accountability Collaborative. They do a multi-level review for all of our levels of care, and it assesses the provider where they do a clinical tour, they do a clinical record review, staff file reviews, conversations with individuals receiving services. They do a living review with talks to the indiv -- they review the record, they talk to the individual, they talk to the individual's counselor, they talk to the individual's counselor's supervisor to make sure all the information matches. And then a credentialing status is determined by that along with whatever's happened with them related to quality and compliance, so there's a --

COUNCILWOMAN AHMAD: That happens on an annual basis? How does it happen?

MS. DAVID: So providers can receive a status of six months

if they're not doing well, one year, two years and three years.

COUNCILWOMAN AHMAD: So you keep giving them money to do the work if they don't have a clean bill of health?

MS. DAVID: They get corrective action plans in order to improve, and then they work with the provider to help them improve. And then the provider also has to show that they're improving. And we continually go back and monitor those providers.

COUNCILWOMAN AHMAD: I would like to see a status report on every third-party provider that you contracted, what is their status, like do you give them a number, this is a high-performing one, this is a medium-performing one. This is on probation, whatever it is. I want to see that report and how we are rewarding them and what is the outcome,

because that 8,000 number should be all going down if these are all high-performing spaces, right. So there has to be some kind of assessment and equation has to be balanced in some way. I would like that data.

Thank you, Madam Chair.

COUNCILWOMAN LOZADA: For the record, we're going to ask DBHIDS to please provide a provider assessment report to us for the providers that receive funding for the very specific services in this community.

Just as a follow-up to Councilmember Ahmad's question, what would cause a provider not to receive a contract renewal, right? You've given them a corrective action plan, how many stripes do they receive before they have been kicked off of the contract list? Andrew Devos mentioned that they typically stay, they typically

remain providers. So tell me what would cause DBHIDS or CBH to say, you know what, this is not a good provider, we've given them 20 different action plans and they've not responded or we gave them three or we gave them one. What's that process?

And then I want us to wrap up with DBHIDS because I want to move on to the opposite side of those that actually do the work on the ground and I want to hear from them what are some of their challenges. I'm going to start with Police, then OHS, MDO and the PAD program. I want to hear from them and I want to be respectful of people's time as well. But if you can --

MR. DEVOS: And there are incidents that put providers out of the network more or less immediately if there are critical incidents that happen with a

provider. But each provider's unique as far as their size, ability to engage.

So we really try to put them on corrective action and move the needle towards quality. We have a group that can do technical assistance with them to help support them in that. But after you've applied technical assistance, often times it's through either the documentation that you see of the provider or through the NAIC process where we have people going out and reviewing with providers.

COUNCILWOMAN LOZADA: I want you to be really honest because I think that what I am hearing, right, Councilmember Lozada, Chairperson is hearing they really never get kicked off of becoming a provider, right --

MR. DEVOS: We can go back and review some of the ones that

have.

COUNCILWOMAN LOZADA: -- unless there's something extremely serious. And what I want people to understand is that this is a new Administration, this is a new day and I don't care who you know and who you don't know and how long you've been a provider. If you're not handling your business in this community, then you shouldn't get a contract, right. It's that simple.

(Applause.)

COUNCILWOMAN LOZADA: I think we need to understand that we have to do things differently and we have to recognize as government -- and it's not just your department, right. As government we've never been able to hold people accountable and assess and adjust or remove those who don't provide the services that they commit to giving us, right.

We're really great at, oh,

this is a problem, everybody is an expert at identifying the problem, but we never can figure out how do we remove this individual from our system and from our process if they're not doing what they say they're going to do and the problem persists or get worse.

And so, this Committee as I've mentioned before is committed to doing things differently. And we want to work with you to figure out, you know, I hope that that report that you're going to share with us will show us who are those providers that you've had to put on corrective action, what is their response to that corrective action plan, have you done a re-assessment of that plan and how have they progressed, right. I think that's the expectation --

MR. DEVOS: And we can get you that.

COUNCILWOMAN LOZADA: --

because we want to be able to say you're no longer going to be a part of our system and you're no longer going to line your pockets on the backs of poor people. Not going to happen anymore.

MR. DEVOS: Oh, absolutely. And we only want quality care for the citizens of Philadelphia. We can get you information on what that process looks like. It starts with a corrective action plan and it escalates. It goes, you know. And there's a review that happens. That review can go to the CBH Board.

Anybody at CBH who sees a concern with a provider can call a provider teaming. And then there are things that automatically happen with providers that cause a teaming, certain critical incidents. A teaming is when a cross-departmental group from CBH comes together. There's

immediately -- there's a list of actions. We can get you that too when we have a teaming.

There's a list of actions that you can take that are kind of like 0 to 60. Sometimes somebody hits in the middle and then it progresses. You're on our watchlist at that point. There's a lot of work that starts being done with the provider. We try to invest in the providers to try to make them better.

Many of our providers are grassroots providers that are from the community, we really want them, but there are absolutely deal breakers right out of the game. And we want the same thing that you want. We really do want the quality of care. We don't want it to be less than.

COUNCILWOMAN LOZADA: Thank you.

Are there any additional

questions for this particular part of the panel?

There being none --

COUNCILMAN SQUILLA: One last question I guess. How many people from our PAD program enter the treatment services, do we know?

COUNCILWOMAN LOZADA: We're going to probably be able to respond to that on this part of the panel, but DBHIDS -- are there any additional questions for DBHIDS?

COUNCILMAN SQUILLA: No.

COUNCILWOMAN LOZADA: Thank you so much today for your testimony.

DR. WILLIAMS: Thank you, Councilwoman. I look forward to following up.

COUNCILWOMAN LOZADA: We look forward to the follow-up information. Thank you.

If we can start with the Police Department and follow the rest of the panel. I know and I

want to apologize to our officers. I know that the 25th Police District is having an extremely important event today where they are hosting a community block party and many of our officers are here and can't attend. And that's an extremely important event because they recognize that community residents are sometimes living in communities or in neighborhoods on blocks that are occupied by individuals that don't allow them to come freely out of their homes or kids can't play out in the street. And the 25th Police District has year after year ensured that the community has a day for them to feel like they can run and jump and play and be in the community together, and that is happening today and many of them are here with us and can't participate.

So I want to make sure that

I give Deputy Commissioner Rosario an opportunity to respond to some of the questions that this panel has so that they can get to the community that is really excited about having them be with them.

THE CLERK: Madam Chair, I'd like to recognize a representative from Merakey who will be joining this panel. Natasha Lundy.

COUNCILWOMAN LOZADA: If Ms. Natasha can join us at the front, that will be awesome. Let's start off with Deputy Commissioner Rosario. Thank you so much for being with us today and for being patient through this long process.

I think that again many of the questions that we have are basic commonsense questions, right. Your offices are out every day. They're out 24 hours a day. Can you please share with us some of the experiences that your officers

have shared around the challenges that they have when they've encountered individuals who are involved in consumption, the illegal activity of consumption, on our streets?

What are some of the challenges that some of your officers experience when that individual says to them, officer, I know that I'm wrong, I know that I am in bad shape, because I've had the opportunity to speak with many of them and they recognize what their situation is.

What are the challenges that some of your officers experience getting people into beds, getting people into some of those services that they desperately need?

DEPUTY COMMISSIONER ROSARIO: Good afternoon, Councilwoman and body. It's a privilege to be here before you

today to be able to speak before you in our community and provide you with a significant update. To answer your question, first of all, I want to acknowledge that I have Inspector Bullick -- Inspector Luca -- sorry, I promoted him -- Inspector Luca, Captain Bullick, Lieutenant Pittaoulis, Sergeant Hannesson, Lieutenant Casale. I really want you guys to understand what we are trying to create here, the type of atmosphere understanding that the community of Kensington has been an afterthought for such a long time, right. And under the leadership of Mayor Parker and Commissioner Bethel has been made a priority again to re-establish a certain quality of life, a certain expectation of public service from its police.

So one of the mandates that Commissioner Bethel has had for us is to make sure that we staff our

area appropriately. And I just really want the community and you as a body to understand from the Inspector to the Captain, to the new Inspector we have here, Inspector Vann who's running the mini station, Sergeant Hannesson, these are all people that have had the opportunity to lead, and they've done their time and they could go anywhere else in the department, and they asked to stay here to be part of this process.

There was a core group of footbeats assigned to the Kensington mini station prior to the class that just graduated. They were all volunteers who want to be here and work. So that speaks volumes to them and to their character and to why they're here and to the value that they have for our community.

For the officers that encounter the unsheltered

population every day, it's challenging. We've seen through our own analysis that our officers encounter these individuals about 17 times before they'll accept the service, right, so 17 encounters before they're willing to accept some type of social service through our unconventional approach, as that's partnering up with Merakey, our third service provider, and a police officer, right, that co-responder model that we're very proud of that we're setting a model for here in the state. And there is value to that.

Understanding that a lot of the individuals that we're encountering are suffering from not only their addiction physically but a poor mental hygiene, right, not being able to make correct decisions every day, so the officers that we have working that service detail, again I want to

tell all of you they're all volunteers. These are all that applied, interviewed and were vetted by the Inspector and the Captain to make sure that they have that correct mindset to be able to work in this space. And it is challenging work.

Seeing the amount of human suffering, first of all, that our community is subjected to every day, that keeps me up at night. Understanding that us as leaders are responsible to manage our way out of this, it's a huge weight. And it's a responsibility that me and my team do not take lightly, and we really press that upon our police officers reminding them that everyone is in this space should be treated with dignity and respect.

But that just doesn't go to the unsheltered or to the people suffering with addiction. It goes back to our community, right. All

the residents that are here, all the children that go to school in our area, the businesses that are trying to make an honest buck on the Avenue, they're all deserving of a certain quality of service that as a police department we're mandated to give them. So it is challenging work.

We do this work every day with that in our forethought making that a priority, but understanding that a lot of times as managers and leaders we have to play Solomon and split the baby, right, the rights of the individual that's suffering from addiction and the rights of our residents who are suffering through this as well. And that's challenging. And we all don't always get it right, but we try very hard to take every encounter on its own merit and treat everybody with respect and navigate that.

The officers on the service detail handle everything. You know, it's funny. True story, I was on the Avenue last week. One of the residents came up to me and said, Commissioner, I need a favor. And I'm very popular in this area so I get approached by a lot of folks.

I need you to introduce me to Sergeant Hannesson. I'm like, oh, okay, it's not me you want to meet. It's Sergeant Hannesson you want to meet. That goes to the work that him and his crew do every day, and they have really been a catch-all, like there are things we are creating for him every day to handle that's not in their job description. So not only are they leading that effort to have our first level of response dealing with the unsheltered, but they're partnering up with my colleagues here.

The other responsibility the Commissioner has tagged me with is this area has led the City consistently with homicides and shooting victims, I mean No. 1. 24th District, PSA No. 2 has been consistently No. 1 in violent crime for the last couple of years. So a large part of our strategy has been to come here and stabilize that, understanding that my colleagues next to me cannot come into this space and do their jobs effectively without making it safe for them. So that's also been a large part of our strategy, to come in and to just really stabilize the area and create that bubble for our folks to be able to come in and be able to be effective at their jobs.

You know, we're a month in. The class has graduated a month ago. I know our community is very eager to see immediate change. And I know it's not going as fast as

some folks had hoped it would be, but I'm here to tell that we're moving in the right direction.

I can tell you I know we're dealing with a lot of issues with displacement, and we knew displacement was going to happen, right. The challenges I've given Inspector Luca, Inspector Vann and Captain Bullick have been to make sure that we're fluid in our response. So we're very active with community through various means, either 911 -- many of our partners in the footprint contact us and let us know, hey, we've got an issue over here. We try to quickly respond immediately to provide the appropriate level of service that's needed, whether it be through enforcement, whether it be through the social outreach, whether it be contacting my colleagues here to provide some type of improvement to quality-

of-life issues through clean-ups or what have you.

I mean, but it is a lot of challenging work. And to say that the police have been saddled with doing a conglomeration of things is an understatement, right. We're no longer just the police officers. We're the social workers, the first responders. From soup to nuts, we do everything. But it's a challenge that we enjoy and really understand that the folks that we have working in this space right now I want you all to know, at the leadership level they all want to be here.

We've had the addition of the officers. June 17th they graduated, June 18th so we needed to have more sergeants to the mini station. Every single one of those sergeants are volunteers. They want to work here. Lieutenant Lisa Pittaoulis, the Lieutenant who runs

the area, you couldn't drag her out of here. She wants to be here every day. So my point is I just want you to understand the level of commitment that we have, the responsibility that we understand in meeting our oath both to the community at large, to the individuals that are suffering addiction and making sure that we're able to stabilize and make a difference.

COUNCILWOMAN LOZADA: Thank you for your testimony. Can you tell me, Deputy Commissioner, have people approached your officers and asked to be taken to treatment?

DEPUTY COMMISSIONER ROSARIO: I don't have specific numbers for you, but that's something that happens on a constant basis. And again, we're that first level of response, right. So whether it be we're contacting our network partners, we

have a lot of affiliations with our other folks that are involved here, a lot of the faith-based groups that come out here, we make those connections by any means possible. Understanding that when an individual approaches a police officer, whether they work night work or the last-out tour, the midnight shift, when that person finally says, hey, I need help, we have to take advantage of that.

We encourage our officers by any means necessary to either establish the connection, understanding that when someone needs help and they're coming to you right then and there, it's never good to say come back to me later tomorrow or I'll call you tomorrow and try to figure something out. We have to be immediate with our preparational services, so we have those assets and we're trying to build

additional assets, especially during the midnight shift. So we're currently in the process of working through Merakey to be able to provide an additional social service component during that last-out tour so that we're covering all shifts at all times.

COUNCILWOMAN LOZADA: Is there a point during the course of the day or during the course of the week that presents a challenge for you to connect people with services?

DEPUTY COMMISSIONER ROSARIO: I mean honestly, yeah, the weekends. The weekends are challenging for us. Right now the way our systems are set up, it's basically a Monday-through-Friday 16 hours. Sometimes we can enhance those outreaches if we make a request. And again, I'm not talking about police. I'm just talking about additional support.

But past that, on the weekends it's a little tougher for us to be able to access some of that support.

COUNCILWOMAN LOZADA: So when someone comes to you, when an individual on the street comes to a police officer and says, officer, I'm ready for treatment, and it's Saturday at 10 o'clock p.m., what does the officer do?

DEPUTY COMMISSIONER ROSARIO: So normally in that type of instance that's when we go to our other folks that we have on that. Prime example is we have resources, the connections that we have here at Rock Ministries, understanding that Rock has connections, a lot of those third-party providers also. So if we're not available to access our City agencies, a lot of times we'll access --

COUNCILWOMAN LOZADA: So every officer has a list of

providers that they can reach out to for services?

DEPUTY COMMISSIONER ROSARIO: So the Sergeants keep all that information handy so it's just a matter of the officer in the field, especially the newer folks that we have now that haven't built those relationships yet, they'll call the Sergeant or a lot of times they'll call one of the veteran officers and ask them, hey, we need a hook-up for this individual, how can we provide that service.

COUNCILWOMAN LOZADA: If you can provide this Committee with the same list that your officers have --

DEPUTY COMMISSIONER ROSARIO: Sure.

COUNCILWOMAN LOZADA: -- so that we can see who those providers are and how they compare to the list that we receive from DBHIDS and others that will testify today,

it will be greatly appreciated.

Are there members of the Committee that have questions?

The Chair recognizes Councilmember Squilla.

COUNCILMAN SQUILLA: Thank you. And thank you, Deputy, for all your hard work and for your responsiveness. It's so important. When people reach out and they have a chance, they know that they will get a response. And you and your officers have done an amazing job in that.

We are hearing some individuals at certain times, sort of what Councilmember Lozada was saying, weekends and overnight sometimes that we as a city are not providing those opportunities to either get a bed or go into treatment at that time.

So I hear that you see that as more of a challenge for you also. I mean, I want to take it

with our guys, our colleagues here, that maybe we have to then challenge our departments to have providers or put an RFP out for providers, somebody who can not only do the outreach overnight but also to be able to place people not just Monday to Friday but weekends, and somebody at 10 o'clock, 11 o'clock or 2 o'clock in the morning.

Now, you say you have a list of people to go. But those folks, when you contact those folks, are they able to then take those people even if our PAD at that point is not an available option?

DEPUTY COMMISSIONER ROSARIO: Correct.

COUNCILMAN SQUILLA: So where do those individuals go at that point?

DEPUTY COMMISSIONER ROSARIO: As I mentioned, there's a

lot of -- Sergeant Hannesson and Lieutenant Pittaoulis and their folks have a list of other providers, mainly the faith-based groups that operate in the area consistently. A lot of times on those nontraditional hours they can be responsive for us.

Part of my job when I was took this posting was to be deliberate and collaborative in meeting with a lot of members in our community. And today I'm over 120 individual meetings with members, whether it be individuals, businesses, churches, principals. They wanted to meet, we sat down and talked. So we built relationships that way.

There's a lot of individuals that are willing to participate and be a point of contact for us. So we've been able to have those relationships and use those nontraditional connections.

And again, that's really -- they're of a last resort so they're used during those nontraditional hours.

The mini station when it first started operating in 2021, my dream was it to be 7 days a week, 24 hours a day. But because of staffing, we couldn't fulfill that. The best I could give you was 16 hours, 5 days a week. And again, thanks to the Commissioner, he waved his wand and made stuff happen, understanding that in order for us to change, we had to step it up a notch. So we were able to increase our availability seven days a week, three shifts a day our folks are out there trying to answer the needs and be responsive to this community.

COUNCILMAN SQUILLA: Now, I think it's up to us to make sure our availability for these things, not just the unorthodox organizations or the religious

organizations or neighborhood organizations are going to take people in but people who actually have contracts from the City of Philadelphia to also be able to be available at those times, because you know when people need help it's just not 9-to-5, right, people need help at all times.

And so, maybe that's something we can work on too with DBHIDS and the Health Department and look at ways to how we can make sure that is also available not only for you but also for our other providers and people who are trying to get help on their own, and that's a very important process.

And we do appreciate those neighborhood connections and places just like this and other folks' places that may be able to take somebody in at 1 o'clock. But as a City-contracted provider, I don't know who we have to do that and

maybe that's something we can work on with us and DBHIDS and the Health Department. Thank you.

COUNCILWOMAN LOZADA: Thank you.

Are there other questions from the -- the Chair recognizes Councilmember Ahmad.

COUNCILWOMAN AHMAD: Thank you so much, Deputy Commissioner, for moving testimony to show what your officers face and we appreciate the work that's being done. Quick question about these recent sort of cleaning of the Avenue and people's concern has been people scattering other places. Have you seen any change in the activity from the dealer side after you have made these --

DEPUTY COMMISSIONER ROSARIO: Sure, yeah.

COUNCILWOMAN AHMAD: Is that a tangible something? Because when we're asked why are we doing

this if we're just scattering people around, to me it seems that we are messaging that we're just not going to do business as usual, you're going to have a presence and this is not going to be a comfortable place to do business. I just wonder if there were actual numbers to back that up to say, yes, you've moved the needle on at least the dealer activity?

DEPUTY COMMISSIONER ROSARIO: So numbers?

COUNCILWOMAN AHMAD: Meaning, you have -- I don't know how you assess what activity is, how you keep track of it, but whatever metric you have has the needle moved because of your presence in this community?

DEPUTY COMMISSIONER ROSARIO: Councilwoman, because of my intimate knowledge with this area I can tell you the 24th District -- so let me give you this

perspective. So there are 20 police districts in the city of Philadelphia. Each district has its own challenges, right, West Philly, North Philly, Northeast. And I dare so each of those Captains on average have five, seven, maybe eight different blocks that they have to kind of focus now, right, part of our pinpoint strategy that we utilize to kind of combat crime, they're the drivers for violent crime.

The 24th District had about over 200 narcotics corners, right. And they've been dealing with that for the last four or five years. And it seems after COVID and the civil unrest it really exploded. We call Allegheny Avenue from G Street to Jasper the Flea Market, right, because there's just so many different organizations that will go out there and sell. And it's frustrating to me as a police

officer, right, to tackle that effectively, so it's hard for me to quantify that for you.

I can tell you what we've been doing is exactly what you're saying. We're trying to reset the norms. And to Councilwoman Lozada's point, it's not acceptable in the Northeast, it's not acceptable in South Philly. And I've been reminding my team that it's not acceptable here and we really have to start changing that narrative through enforcement.

COUNCILWOMAN AHMAD: No, thank you because we asked early in the morning about what is happening if you're just scattering people from one place to another. But there's a much bigger message out there which you articulated and I believe in saying it is not business as usual. This is not a forgotten corner. We're not just going to put everybody in there and

forget about you and I thank you for doing that.

One way to measure it would be to look at it as 200 corners were reduced in numbers. That would be one way to assess --

DEPUTY COMMISSIONER ROSARIO: That's part of the analysis that we're in the process of doing.

COUNCILWOMAN AHMAD: When we can message that to the community at large, it says that some work is happening. People find it hard to believe that work is happening. And every day your officers are working so hard. It would be good to be able to tell the rest of the city this is what was done, this is what has happened, this is the outcome. It is working at least in this frame. So I thank you for the work and we would like to message out your good work.

DEPUTY COMMISSIONER ROSARIO: Thank you. And we're just getting started.

COUNCILWOMAN AHMAD: Thank you, Madam Chair.

COUNCILWOMAN LOZADA: Are there other questions for Deputy Commissioner Rosario?

DEPUTY COMMISSIONER ROSARIO: Thank you. It was my pleasure.

COUNCILWOMAN LOZADA: I'd like to recognize Controller Christie Brady who has joined us. Thank you so much for being with us this afternoon.

(Applause.)

COUNCILWOMAN LOZADA: I'd like to just stay on topic with the police and the work that they're doing. I'd like to just ask a question to our friends over at the PAD program. We talked a lot about beds today. We talked a lot about getting people in treatment and

some of the challenges that they experience.

Can you, along with our friends at Merakey, can you guys talk to us about what some of the challenges are when the PD brings individuals to you that qualify to be a part of PAD and what happens when you make those calls and you can't get them into any type of program? What's the process?

There is a perception that officers will bring individuals to your door because they want to avoid being arrested. And then soon as the officers turn their backs, these folks then decide, no, I don't want services, I want to come back out. Tell us about that process of people coming into your doors and what happens. And what are some of the challenges that you experience for those individuals that actually stay and want to see services?

MS. ANDERSON: Good afternoon, everyone. My name is Joelle Anderson. I'm an Operations Manager for the Office of Public Safety for the PAD Unit. So some of the challenges that we see in the community is that with the constant change of the drug supply so when a person is going through withdrawal, time is of the essence. We don't have time to wait until the next business day.

If a person is ready to get into treatment, we contact Merakey. We let them know of the situation. The police do their thing with them and explain the PAD program, but we probably got about 45 minutes, if that, to get that person to treatment or get that person set up.

We also act as the buffer between the community and the police when getting diversions as well. We let them know if you run

into any issues along the way, you call me, you call one of my colleagues. They get our information and they keep us updated every step of the way of their process. If something goes wrong when they enter into treatment, they let us know. We intervene and we fill those gaps.

Also, when they go over to Merakey, Merakey, they do a quick intake. Like I said, time is of the essence. And then we'll get them off to detox treatment, things of that nature. Also, outside of arrest diversions are our social diversions, where any person in the city of Philadelphia can come up to a police officer or come to us -- I'm stationed out of the 24th, 25th Districts. They can come into the district and not have any police contact as far as getting their record ran and things like that and ask for services.

It could be mental health. It could be immigration papers. It could be a mother and children who's experiencing domestic violence, for example, and then we will connect them to one of our five providers, Merakey, Salvation Army, One Day At A Time, ODAAT, Prevention Point.

Also, if a person is trying to get out of the Kensington corridor, we have a new site at 16th and Susquehanna, our ODAAT-PAD site, where we have beds available right then and there where they can come. It's a quick intake. We start the process of getting their treatment plan started, whether there's warrants, whatever the case may be. And then they can go ahead take a shower, lay down, sleep it off. And then the next morning the case managers at ODAAT will get the process started. Everything is in realtime. We don't wait.

Everything is in realtime. We don't have time to wait and debate and things of that nature. We get it down right then and there.

Also, for our social diversions we also have our mobile resource fairs where we're having our next resource fair at Frankford and Cottman tomorrow where we meet the people literally where they're at and all of our providers, the police, the CERT team, the PAD officers, Salvation Army, Merakey, various providers throughout the entire city come and meet the people where they're at and help the people navigate various systems of things that they need.

COUNCILWOMAN LOZADA: How many people do you think that you provide services to a day, individual people, unique individual people? How many people do you think that you all provide services to a day?

MS. ANDERSON: Per day that definitely varies. I can definitely look into that and get you those numbers. But at our resource fairs, we service -- because everyone signs in, we service no less than 100 people at our resource fairs in a matter of three hours.

To date, I can give you some numbers. So to date from the beginning of January until now, we have engaged with 3,935 people. We have linked 1,973 people to services. 209 of those people have been to the CRC. 681 people have been into inpatient. So I did want to answer Councilman Squilla's question when I got to it. 268 people have been connected to IOP, which is ongoing. 227 social diversions and then social services are 588.

COUNCILWOMAN LOZADA: So into actual beds you all have

gotten?

MS. ANDERSON: Into inpatient, 681 people from January until now.

COUNCILWOMAN LOZADA: And that's from January to now?

MS. ANDERSON: Correct, yes.

COUNCILWOMAN LOZADA: And you all as a -- or you or whoever you connected them to, you're able to see how they've continued in their --

MS. ANDERSON: Yes, correct. Be it our peer support, our great staff, our great case managers, whether it be Salvation Army, ODAAT, Prevention Point, University of Penn as well, we're able to literally follow them every step of the way, can tap in at any time and ask can I get an update on so-and-so, can I get an update on this person's progress.

We also get monthly reports

from each provider that give us a detailed breakdown of how many people we serviced in a month. And we also have our data from when we do our mobile resource fairs with the Office of Public Safety.

COUNCILWOMAN LOZADA: Thank you. Thank you for coming prepared.

(Applause.)

COUNCILWOMAN LOZADA: The Chair recognizes Councilmember Squilla.

COUNCILMAN SQUILLA: Just to go back on that too, because that's sort of what we were talking about, how many people to what levels of care, right. So how many people went into 3.7 WMs, how many people went into 3.5s, how many people went into 3.1s. You don't have to say that now. But if you can just provide that to the Chair, I think it's important for us to see that, because then also how

many people completed then, right.

Since you follow them all the way through, how many people stayed the whole 30 days, right, how many people went from a 3.7 to 3.5 and then a 3.1. And then we could then see. Because as you heard from the earlier panels, and I wasn't here but I know some of the programs that they run, as we look through the continuum of care how we're trying to follow folks through that process where we need to improve on, we could then hopefully be able to dictate that by stating where people are falling off, where they're continuing and hopefully that'll help make our decision, help our providers make decisions where do we have to put more resources at.

MS. ANDERSON: Understood. And just piggyback off of that, that's where myself, my colleagues, other APMs, James Williams, Noah

White, Louis Soto and Kenneth Walker, that's where we come in at. When there are gaps, that's when they contact us and they will let us know like I'm having a problem, it can be any type of situation, but that's where we come in and we help fill those gaps to get that person to the next level and we follow them.

It's not just a one-and-done situation. We're not looking at them as just a number, you understand what I'm saying. And to take it a step further, when you look a person in their eyes and you tell them I've been there, that starts to break those walls down and they understand that this person really cares, this person really understands what I'm going through.

COUNCILMAN SQUILLA: So you probably see some areas where people are falling off, right?

MS. ANDERSON: Yes.

COUNCILMAN SQUILLA: So you see that, so that would also be helpful to us and to our providers and people who are helping. So whenever we see a big increase where they get into a certain space and then they either disappear or not doing it, that's where we will need you to hopefully engage additional resources to help that individual.

MS. ANDERSON: Yeah. And I'm sorry, just to add on I would say mothers and children, that's another barrier that we -- especially a mother that may be a domestic violence victim and that has multiple children, that's where Salvation Army will come in. But as far as navigating the landscape, trying to get them housed as soon as possible or trying to get them away from -- they're fleeing, they're ready to get out, that is a

barrier that we have seen in the past, and that's something that I have spoken with Councilwoman Lozada about in the past, and that's something that we're trying to fill those gaps with as well.

COUNCILWOMAN LOZADA: Merakey, would you like to add to what some of the challenges are? You all seem to be able to connect people to the services that others seem to have challenges with. Are there challenges that you all experience when you're connecting people to services? And if you don't experience challenges and you're successful, you're so successful at connecting people to these beds that are apparently a problem, how are you guys able to do so? What are you all doing that's different than other providers to be able to connect people to the services they need?

MS. LUNDY: My name's

Natasha Lundy. I am the PAD Director under Merakey. I wouldn't say that we're doing anything different or anything better. It is just networking sometimes. Sometimes when we do have difficulties with beds, it is just a matter of calling our APMs or our City resources to locate these beds.

There are often times, as was mentioned before, where the level of care doesn't necessarily match. That is absolutely a thing where we need a 3.5 bed but there's only Level 4s or a 3.7 bed and there's only Level 4s. And I know that that is kind of facility restrictions and things like that. Some people have medical levels. Some people don't. So it really just depends on where exactly we are referring to.

Most of my staff is ASAM-certified so when we're doing an

assessment, it is an ASAM assessment. We do have those struggles where we call the insurance company, they do want a flip of services or the treatment provider themselves will say, hey, I have a 3.7 bed if CBH will approve it, we got you. But then we got to kind of figure out or send to a CRC --

COUNCILMAN SQUILLA: Or compromise because we don't have availability in the needed area.

MS. LUNDY: I'm sorry. Say that again.

COUNCILMAN SQUILLA: That's more like a compromise because we don't have the availability in the assessed area.

MS. LUNDY: Sometimes it is a compromise. Sometimes it's beyond our scope and we do have to refer to a CRC, but we try the best that we can around the systems that are in place right now.

COUNCILWOMAN LOZADA: I think part of the conversation that we are going to have to have as a Committee and with our counterparts is how do we change this level structure, right. And going back to the very beginning of this hearing, how do we make a bed a bed in order to respond to the person's need at that moment, right.

It doesn't make sense to me and to a lot of other people, right, when you have someone that has been suffering and living in addiction for so many years and finally they are there and they say, I want help now. And we're saying to them, you got to be a Level 4 or you got to be a Level 5. You know, how dare us minimize their need in order to get them into a bed.

My question is if this person's level of need is greater than that of the bed that is

available once they get into -- okay, so you made the compromise and you got them into that bed, what happens when that person is in that bed and that provider then says, wait a minute, this person's need is greater than what I'm getting paid for?

MS. LUNDY: Then those doctors there would evaluate and call the insurance to make appropriate recommendation.

COUNCILWOMAN LOZADA: Have we ever experienced a situation such that the insurance says, you need to get them out of that bed or we can't provide that level of service? What happens in that case?

MS. LUNDY: Not in my experience that has not. Not that I know of at the PAD office that has not occurred. Typically in the few times that it has happened where we had to do a lesser level

of care, typically the provider then will call the insurance company and get it flipped up or send them to the hospital, whatever is needed in that moment.

COUNCILWOMAN LOZADA: So they are removed from the bed and potentially sent to a hospital where their --

MS. LUNDY: If it's needed.

COUNCILWOMAN LOZADA: -- level of care would be greater?

MS. LUNDY: If it's needed. Because some providers don't always have -- not every provider has the exact same level of care. And Eagleville has the level that can handle acute medical care. Kirkbride can't handle that in their facility. They don't have lev -- you know what I mean. It just really depends on the facility that you're referring to what beds are available and what we can actually do to service the

participant at that time.

Sometimes it is just talking to the intake worker, okay, what can we do. Sometimes it is getting them to a CRC and having the doctor-to-doctor conversation, because that is a thing with the insurance company, which I very much understand with high utilization and AMAs and things like that. That is 1,000 percent a thing where sometimes the insurance company wants to try a lower level of care first like an outpatient methadone opposed to the inpatient, where it does happen. Again, not on us but it does happen. So we just work it the best we can at that point.

COUNCILWOMAN LOZADA: I'm looking forward to the day when a bed is a bed. When a bed is a bed and people go into that bed and receive whatever level of care it is that will determine a successful

healthy journey of recovery for them. I'm looking forward to that. I'm going to remain optimistic. Thank you so much to PAD and Merakey.

MS. LUNDY: Can I just say one more thing to add to that? I do think a recommendation that would help a lot would be the aftercare process and maybe case management for the shelter system. A lot of times people are discharged with not the supports -- I believe the doctor said it this morning, they don't have the support when they leave rehab. So they can stay at the self-helps and the Kirkbrides for 90 days, but if they don't have anything when they come out, they're right back in the same situation.

COUNCILWOMAN LOZADA: Thank you for that. Thank you. Thank you so much for that. Thank you, Merakey. Thank you, PAD. Thank

you, Deputy Commissioner.

Let us move to the MDO and Office of Homeless Services. Mr. Holloman, would you please state your name for the record and start your testimony.

MR. HOLLOMAN: Good afternoon, everyone, Chair Lozada and members of Council here. First and foremost, I just want to apologize to the community for the trauma that you have been facing for years. I have been doing this work for a while. I've been working with a number of these partners here and have been fortunate of also working in the hospital settings and understand some of the challenges that's there. But again, I understand your frustration. I think it's admirable that you're continuing to beat this drum because change is needed in this community and we're looking forward to being part of

that solution to help break down barriers to think about things different.

I think one of the things that I heard earlier today is that there isn't one model. I think we need to think about this in many models that bring about different ways of success. Kensington over the last several years, especially in 2018 when we had the heightened of the large encampments under the bridge when we shut down Gurney Street.

We saw a difference in the drug supply of the heroin to the tranq to the fentanyl, and those approaches take all different methods. You also have Kensington where not everybody here are Philadelphians. There are people here from surrounding counties because of the drug supply and also some of them may be on private insurances, things that create

barriers. So I'm looking forward to talking about what solutions we should be thinking about as a collective community, but again the Office of Homeless Services is here to be partners.

COUNCILWOMAN LOZADA: Thank you so much for that. I think one of the questions that I have for you, Dave, is your outreach teams are out there on a regular basis. What's the shift? What are their working hours? When can or when should we be able to see your outreach workers out in the community? And what is their feedback when they are trying to get people into treatment and are told, yes, there's a bed, no, there's a bed, this level bed, that level bed? What do they do then?

MR. HOLLOMAN: Thanks for that question. So we operate the Encampment Resolution Team. The regular homeless outreach teams are

through the Department of Behavioral Health Intellectual Disabilities. However, our Encampment Resolution Team works with Sergeant Hannesson and various other teams such as CLIP and I think they do for what they have a pretty good job.

They run into challenges too with trying to get people in when there isn't a bed available. I think some of the struggles that they have, especially in the early morning when people -- you hear this term a lot -- people want to get well. So if you don't capitalize on that hour by the time they get up and until the time they get to a bed, that is a problem.

Many of the folks that I hear from directly, and I even come out with the team, is that many of the folks don't want to sit for a six- to eight-hour assessment because of the withdrawals that

they go through. And so, what we try to do is work with the Merakey team, see where like at Prevention Point where they can do some dosing to give people comfort so they can go into a 2B or a 3C level of care. I think they need more of that. I hear that directly from my team, how do you get people a level of comfortability without having them to go through the act of withdrawal.

The best time of the day and our team is out there from 7:00 a.m. to 4:00 p.m. on a daily basis, unless we see a time where there's a spike or we're conducting some type of special operation with law enforcement or during a quality-of-life event where we may say, hey, we're going to double up these shifts there.

Right when we did the last encampment resolution on April 4th, prior to that I authorized not only

my Encampment Resolution Team but staff from my intake at the shelters to do outreach 16 hours a day in this community. That made a significant imprint on this community. We were able to engage so many people and get people into services during that time.

Now, if we had the ability to double up an Encampment Resolution Team because they have the ability to do service day clean-up, they're a little bit more -- in my thing, a little bit more aggressive with trying to engage people to get people in, I think that would be helpful. But again, they come with a different philosophy. They're under the direction of One Day At A Time. So as you heard earlier today, they're already locked into a number of different systems that they're able to get beds and access to.

COUNCILWOMAN LOZADA: Can

you tell me why there is a difference in assessments? Why do some assessments take 15, 20 minutes or immediate and there are other assessments that take six to eight hours if the service that's needed is exactly the same?

MR. HOLLOMAN: Yeah, so it really depends. So a lot of folks in this area go to the CRC. CRC is designed to deal with a multitude of behavioral health challenges, and sometimes it depends on the day. One of the things in my experience for a number of years from the 5th of the month to about the 22nd of the month, most of the people who receive some type of entitlement benefit are out of their money. So you start to get an influx of more people that come into those assessments, and especially CRCs that are coming in to get treatment.

And so, when you have

people who are struggling with addiction along with behavioral health challenges going to a CRC that may only be equipped to deal with a certain number of foot traffic in there because they're dealing with the traffic the night before, that can create problems.

The other thing, if a person has, whether it's CBH, Magellan, Bravo or private payer, those all play a significant factor. One of the things they talked about was what does a person call in, they look at their clinical history, whether they recently had an AMA, were they connected to IOP. Some insurance won't pay for certain levels of care if a person looks to be a frequent flyer that comes out.

And then the other problem, we really need to make a dissemination between short-term rehab beds versus long-term and

detox beds. There's always -- and I think I can attest to this -- by 11:00 a.m., every day probably by that time most detox beds are completely gone because most people want to get well. There's a disconnect when people talk about the availability of short-term rehab, which is 2B, 3C, 3A and all of those levels up. There's capacity there but most people again can't sit long enough to get that assessment or get well soon enough to get to those beds.

And the other challenges there, which I control in my system, shelters save lives but the reality is you need to invest in long-term housing so people can get connected to a well ecosystem to maintain their recovery and sobriety.

COUNCILWOMAN LOZADA: Are there any questions from members of the Committee?

The Chair recognizes Councilmember Nina Ahmad.

COUNCILWOMAN AHMAD: Thank you, Madam Chair.

Good afternoon. I want to thank you for your testimony. The overlap of your intake with the CBH intake, are you very distinct or do you hand over work to each other? How does that process work?

MR. HOLLOMAN: So we're very distinct. Shelters are first come, first serve. We have intake and after hours, which our traditional intake hours are 7:00 a.m. to 5:00 p.m. and then after hours kick in. Shelters are designed to assess anyone. They do not provide medical services in there because they don't have that expertise, but we work with DBH, our counterparts.

If someone comes in and throughout their assessments and a social worker says, hey, I'm

struggling with behavioral health challenges such as substance abuse, we're able to work directly with our partners to them referred to the resources that is available for them.

COUNCILWOMAN AHMAD: So is there any hiccups in that process with timing or availability that would be smoother so that folks here specifically in Kensington, should there be like a parallel service at the same time frames because you're probably encountering a lot of people with SUD?

MR. HOLLOMAN: So let me give you a capacity snapshot. The Office of Homeless funds 2,926. A breakdown of that is 1,383 family beds. Of that, 200 DBHIDS beds which are specialized. There's 1453 single beds. On each given day, we have about a 93 percent utilization rate.

The average length of time that a person stays in a long-term bed and shelter is about 132 days right now. And so, our beds turn over about four times per year so there's always a need for more.

COUNCILWOMAN AHMAD: So that means that overlap could be very useful so your beds can be opened up for people who don't have SUD?

MR. HOLLOMAN: Absolutely.

COUNCILWOMAN AHMAD: So we need to work on that. Thank you.

COUNCILWOMAN LOZADA: What happens if someone comes in -- and I think you touched on this a little bit. What happens if I am a DV victim but I also suffer from substance abuse disorder and I also have open wounds but I show up at the shelter, at a shelter, right, what happens in that situation?

And tell me where your intake, your central intake -- I

remember when I did Constituent Services at 1401 Cherry Street. You walked into there, we knew send everybody to 1401, they're going to tell you where to go, right. Does that still exist? Is there a priority if I am a -- if I'm suffering from substance abuse, if I'm a DV victim, if I have all of these wounds, is there a priority to get me -- and I'm walking into the shelter which means I'm saying, hello, I need help and I want it now and I have all of these other existing issues that I'm bringing with me, is there a prioritized list that this individual goes to?

MR. HOLLOMAN: Yeah. So all of our intake sites anyone can go, whatever agenda that you identify with. One of the things we try to do is have people access. In that situation that you just described, the first thing that intake is going to do is do what

they call an assessment of that person. Is their substance abuse right now and the medical needs are more prevalent than the DV. DV shelters are set up to be specialized. There's legality issues there. There's survivor's things there.

There are certain requirements that only allows you to place someone in a DV shelter. In that situation there if I was someone was doing the intake, the first thing that I'm probably going to address, more likely going to address is that substance abuse issue.

The reason why I want to do that is I want to try to get you stabilized in a hospital setting or a recovery-based setting and then address that DV issue because now I have other clinical support that's surrounded around you. The reason why you probably will not

automatically put that person in a DV shelter -- I'm almost 100 percent sure on this -- is, one, there's state law that prohibits without that legality issue that's at play of placing someone there because you have to keep in mind there may be other people's lives at risk and someone who's not ready or potentially would stay there could also jeopardize others who are in a domestic violence situation. But the first thing a person should do or any social worker or intake worker should be assessing that from a pyramid-based model on what is the most pressing need first and try to get the referral.

That's why early on I always state that we have to do better assessments of people and try to get them stabilized. The key is not to -- you want to help them right in that moment, but you

want to set them up for success and put them on the right track. And so, that assessment is so critical and what's available to them.

And part of this is about, you hear that term networking and communicating with different partners, that is so critical. We have all housing case managers in our shelters. Some of them have behavioral health case managers in there. If they're coming during the traditional hours, we should be able to connect that person right away to the necessary resources that they should have. And after hours is a little bit different because you're just trying to get that person off the street in that moment to save their lives.

COUNCILWOMAN LOZADA: You're under the umbrella of government, right. DBHIDS is under the umbrella of government. CBH is under the umbrella of government.

Police is under the umbrella of government. Do you all share with each other what beds you all have available? Is there a transparent process for that and do you communicate with one another when this person is looking for a bed? And I'm not talking about a coded bed. I'm just talking about a bed.

Do you all communicate with each other to say, hey, tonight I have 25 beds and Sergeant Hannesson or any of your officers 2 o'clock in the morning come across someone that is ready to get into a bed, this is where you can go?

MR. HOLLOMAN: We can do a lot better in terms of communicating on that. I think we communicate, but it doesn't -- in my opinion, I think that area can be actually much better on how we do that, especially with all the partners that are in that system there.

COUNCILWOMAN LOZADA: And would you benefit from what we've talked about earlier which is a dashboard that would be accessible to everyone --

MR. HOLLOMAN: Oh, absolutely.

COUNCILWOMAN LOZADA: -- around just available beds?

MR. HOLLOMAN: Oh, absolutely.

COUNCILWOMAN LOZADA: All right. Thank you so much for your testimony.

The Chair recognizes Councilmember Squilla.

COUNCILMAN SQUILLA: Thank you. And thank you, Dave, always for your responses too. I know we are constantly working with your office on issues and concerns, and your whole team has been very responsive and it's a challenging job.

But as we heard, I think

the goal through this whole thing is stop working in silos. Like everybody was doing good work on their own, and we're not picking on any providers or anything, but we weren't coordinating efforts and collaborating with each other.

Do you think -- as far as with your encampment resolutions and working with folks, do you think that there is a model that we could change or a policy that we could change that would make it better to coordinate with other providers to be able to help the people who you engage to get them into services that are needed, without getting in trouble?

MR. HOLLOMAN: I was about to say, like --

COUNCILWOMAN LOZADA: Get in trouble.

MR. HOLLOMAN: This is Dave speaking. I do think in this neighborhood here we should create

a pilot. One of the things I heard about earlier and hopefully that my colleagues from Project HOME talk about, so when we did an encampment resolution April 4th, we know that there are people that were going to scatter to other different neighborhoods and blocks.

I think police can probably share this. I think PAD can probably share this. We should know where there are spikes at. One of the things that we have in this community here and I give credit to the Administration trying to build this wellness ecosystem, but we have a PAD site here now. We have a number of different wound care vans that are in this area that have the ability to do MAT, suboxone, buprenorphine, again the goal here is to make people comfortable to get them to that bed.

We should be thinking about

how do we look at maybe a four or five block radius, use the PAD site, use one of these wound care vans that are in this area, maybe stick them there. You have clinicians there. You have doctors that are there. Let's look at for the next three months and say, okay, instead of having an officer, two officers because there's two officers that come off street and go to the CRC, they're in there for about eight hours. How about us go to the PAD site, dose someone there while they're doing the ASAM and try and get them into a bed, that's much quicker.

By the time you go to the CRC, again keep in mind you're dealing with everything. And that time to get to the CRC is about eight hours. But we have resources and we know if I walk out of this corner here and ride down there, there's probably 50 people around

the corner or 60 people on these small blocks. We should literally target maybe four or five blocks here and do something unique. Take one of those wound care vans.

We have the best institutions around, Penn, Jefferson who testified earlier here tody. See if they will be willing to dose much quicker at a PAD site. This way it makes it much easier for when they're calling around and saying, hey, do you have a 3.5 bed. I already made this person comfortable to come in. This way if they need to get stepped up to a higher level from a 3.5 to a 4.0, now they're under the care under medical eyes so they can monitor those vitals, withdrawal symptoms. But they're in a medical institution.

But the key there is that they're reducing their anxiety away in a CRC or in an assessment site

for eight hours. That's Dave speaking. Again, I don't know if that would work, but I think we should try different models. Models are made to be shaped, rebroken. So what if we fail. If we have two persons, we learned something from that.

COUNCILMAN SQUILLA: I think one thing we learned, what we were doing wasn't working so I think new ideas, if it doesn't work, it's not a problem. But I do think that the idea of combining those resources to help make those folks that are suffering through that phase of where they are able to then get the treatment instead of losing them at that time when it's taking too long to get them where they need to be and then make sure those beds are also available so they can get transported to them or whatever assessment, level of care is required.

MR. HOLLOMAN: And I'm not putting that all on the treatment system. If we create a model like that, I'm willing to move some of our intake workers, some of our teams there because somebody may not want that level of care. They just need a bed, long-term bed from a shelter standpoint. We're willing again to bring resources to the staff to move staff there so it will be a whole well ecosystem of not just DBH but it will be OHS, the Health Department should be there, a combination of the different agencies.

COUNCILMAN SQUILLA: Thank you.

COUNCILWOMAN LOZADA: Thank you so much. That makes a lot of sense, and sometimes we struggle with basic commonsense things in order to improve quality of life. And so, I'm hopeful that our government is going to move towards

some commonsense practices.

The only question that I have for Noelle because I know that you've managed some of the opioid settlement dollars, and earlier we mentioned just the need to be able to pay for some of these commonsense practices, right. How do we ensure that some of those opioid settlement dollars that are coming into our city are used very specifically to address some of the changes that we need to make within this community to be able improve quality of life? What are some of the challenges that you see and what prevents us from being able to use funds for things like a dashboard or for us to be able to work with providers who are doing that great work but are very small and very grassroots? What is preventing us from allocating those dollars to them?

MS. FOIZEN: Everybody,

good afternoon. Noelle Foizen, Director of the First Response Unit. So thank you so much for that question. So up until this point we have received $33 million from the National Distributor settlement. We're going to receive an additional 20 million in the fall and that's a separate settlement. That's a Walgreens settlement.

The difference between the two settlements is that the National Distributor settlement has allowable uses. And so, you actually find them online but it's a list of bucketed items of things that we can use our dollars on. The Walgreens settlement has no allowable uses tied to it so we can put that towards anything that we think will help with the fight in the city of Philadelphia.

Up to this point, of the 33 million we have received 14 million

of supported treatment and recovery-focused housing. 8 million of that has gone towards the Office of Homeless Services to support recovery-focused housing. The additional 4 million, they're just receiving that so that has not been spent yet. And 6 million has gone towards increasing access to treatment. And so, a portion of that 6 million has been supporting the Kensington wound care van that DBHIDS spoke to, increasing the bup dosage at the prison and also launching oral methadone.

You asked -- there's really not much that's stopping us from doing additional things with the money. It's just a finite amount of dollars so up until this point we've tried to prioritize funding towards treatment but also spending towards prevention and trying to make sure that we're trying to avoid additional people using drugs

and trying to save lives and reduce overdoses as well.

There's definitely the possibility that moving forward we can reprioritize, especially with as we're looking at our practices and doing evaluations and figuring out what's effective and what's not, there's always the opportunity to fund additional programs moving forward.

One thing I did want to share with this group just because it's something that our team has been speaking about a lot with Deputy Commissioner Rosario and Chief Public Safety Director Geer has been up until this point all the teams are doing everything they can with the resources that they have, but it does feel like a little bit like a one-size-fit-all model and we're not resourced appropriately to have a more nuanced approached.

But something that might be more effective is thinking about if we have an individual that has only been in Kensington for two weeks, that's a different situation than someone that's been there for two years, right. So trying to figure out what are the different populations within that subgroup of individuals that are unsheltered here and what are the different intervention strategies. And that's something DC Rosario and Director Geer have been very interested in learning more about.

COUNCILWOMAN LOZADA: Thank you so much for that. I think that part of what we want to start talking about is how do we use some of those funds that we can use for things that are going to help providers that are going to help those who are doing the very necessary work to be able to respond to the crisis that is

happening in Kensington, right.

And so, we are going to probably call on you to help us figure out what is the path forward, how do we take some of the ideas that we have discussed here today, which I think have been some really good ones, right, how do we move them forward.

When we came here a year ago, some community residents spoke about some very low-hanging fruit. And I think that some of the things we heard today I think are very easy for us to be able to put in place, but of course it is going to depend on some money, right. And while that's frustrating that we don't do certain things because we say we can't find the money.

We know that there's money available that the City received as a result of what the City allowed to happen here, right. And so, we should be able to use that money to

be able to respond and fix what we have caused. And so, this Committee will be calling on you and on members of your team to be able to help us move some of these ideas forward with that pot of money that is flexible.

Are there any other questions for anyone on this panel from any of the members of the Committee?

COUNCILMAN SQUILLA: Just real quick because we did get notice that there was rejection to some of the opioid dollars that were spent. What happens in that case?

MS. FOIZEN: So the Law Department and the Administration is looking at our options. But there's an appeal process that the Trust has in place.

COUNCILMAN SQUILLA: So the City will appeal that denial?

MS. FOIZEN: I have to

follow up with the Mayor's Office on that, but yeah.

COUNCILMAN SQUILLA: All right.

COUNCILWOMAN LOZADA: Thank you. Thank you to all of you for your testimony today. Thank you for joining us. We will be reaching out probably to each one of you at some point. Thank you.

Will the Clerk please call the names of the next panel.

THE CLERK: Yes, Madam Chair.

Dr. Deja Gilbert and Warren Roy.

COUNCILWOMAN LOZADA: Thank you for being with us today. Please state your name for the record and begin your testimony. I ask you to speak right directly into the microphone because we want to be able to hear all the great things you have to say.

DR. GILBERT: Can you hear

me okay?

COUNCILWOMAN LOZADA: Yes.

DR. GILBERT: Dr. Deja Gilbert, President and CEO of Gaudenzia.

MR. ROY: Warren Roy, Business Development Manager at Gaudenzia.

COUNCILWOMAN LOZADA: Thank you for being with us today. Please begin your testimony.

DR. GILBERT: I do just want to note for the record my full testimony is on file and documented. I'm going to focus a little bit more on some of the topics that we've been talking about today in order to kind of get straight to the point and deal with some of the issues that have come up.

Gaudenzia, for those of you who don't know, was founded in 1968. Over the last 56 years our agency has continually evolved

adapting its capacity, reach and treatment model to meet the growing needs of our clients. Today we are the Commonwealth's largest nonprofit provider of evidence-based treatment for substance use and co-occurring disorders offering a full continuum of care that includes residential, outreach treatment, medication-assisted treatment and an expansive array of emergency, transitional and permanent supportive housing programs in this area through contracts and partnerships in the city of Philadelphia and the Commonwealth of Pennsylvania.

Recognizing there's no one-size-fit-all approach to treatment and recovery, Gaudenzia offers specialized programs to meet the needs of a diverse range of client population, including pregnant and parenting women with

their children and re-entry populations as well.

Gaudenzia admitted a total of 2,773 clients to programs for treatment and mental health housing programs in Philadelphia alone throughout the 2024 fiscal year, with an additional 2,196 admitted to our emergency housing program and 151 households served in transitional and permanent-supportive housing programs.

While the need for low-barrier, evidence-based treatment like that which Gaudenzia offers has never been greater, our treatment programs consistently operate below their average capacity. In 2024 fiscal year, Gaudenzia Philadelphia-based treatment program saw a daily average utilization rate of just 72 percent of our total bed availability. This trend in underutilization is not unique to

Gaudenzia. People need more time to recover and authorizations in order to get that time.

With those grappling with homeless and behavioral health needs, Gaudenzia is prepared to provide crucial alternatives to incarceration that foster readiness and acceptance of treatment over time. From a provider's standpoint, organizations like Gaudenzia and many of our partners and other providers in the area need an increased ability to engage clients in care as quickly as possible with reduced administrative burden on program staff and greater emphasis on swift, direct care at the front end of the treatment continuum. A time when a client's decision to enter and remain in treatment is often own at its most fragile point. We must continue to work in this direction to streamline an

effective low-barrier continuum with reduced wait times and immediate access to life-saving medications like buprenorphine, naltrexone, methadone and naloxone.

Internally Gaudenzia has addressed many of these barriers with a 24/7 treatment and referral helpline which assists callers with screening, referrals, insurance authorizations and securing transportation to treatment, but we recognize these barriers may exist for other treatment providers throughout the City.

Our agency also recognizes an opportunity for streamline coordination between referral sources, agents of the City and treatment providers by creating a centralized online tool reflecting realtime accurate data on available services and provider capacity throughout the Greater Philadelphia region.

In closing, I will say this: We here at Gaudenzia have beds. Providers have beds. We also have a 24/7/365-day-a-year helpline that we can admit a patient to at any point immediately. What we need is communication on availability, faster access to care, decreased administration burden, approval for both the initial authorization and ongoing authorizations of continuing care and support for long-term full continuum care of services if we actually want to make a meaningful change. This is not a one-and-done, fix it and move on. We have to invest in long-term care in order to make some changes.

I'll turn it over to you. So we are here in the streets of Kensington. You're here every week at this point?

MR. ROY: Yes.

DR. GILBERT: So firsthand

trying to work with individuals, one of the things that came up was the PAD program, which is an amazing program and Warren attends their weekly meetings there. But as we are not one of the providers, that availability for the immediate call, we need someone, we need a bed is not there.

I was able to connect today actually with someone who -- specifically to women and children. We have a center right around the corner here on Tioga where we can take women immediately. We have availability up to three children. And they didn't know we were there because we're not in that initial five. And so, the communication and coordination needs to be available to everyone so that everyone can understand if we're not that initial network, that doesn't mean that other providers aren't available. So the

discrepancy between the availability of beds versus do we know who to call when is the problem.

COUNCILWOMAN LOZADA: Are you a member of the City's network?

DR. GILBERT: We are a provider for CBH. We are contracted. We are not a member of the five identified facilities (inaudible) but we participate. We go to the meetings and offer services.

COUNCILWOMAN LOZADA: How many beds do you all have access to on a daily basis?

DR. GILBERT: Just in Philadelphia, I have 223 beds in Philadelphia. That does not include our long-term housing, which I believe we have another couple of hundred.

COUNCILWOMAN LOZADA: And how often are those beds not filled?

DR. GILBERT: We are operating over the entire last fiscal year at about 72 percent occupancy. So my actual occupancy for my Philadelphia programs was 159.51 and total past days, 223. And we offer all levels of care.

COUNCILWOMAN LOZADA: And how often do you all communicate or do you communicate with the outreach workers, the people on the ground to say, hey, Gaudenzia is here, we have capacity, we're ready right now to take in anybody, here's my contact information, I'm up the street or around the corner? How often do you do that and how is the response?

MR. ROY: The vacant bed list is sent out to the provider CBH, DBHIDS Monday through Friday. That's sent out every day, how many beds we have in the Philadelphia area. And in our programs in West Chester, Lower Bucks, that's sent

out daily.

If I may, I was a Division Director, the Director at Gaudenzia. I retired in 2021. In my heart because I've been in Kensington, I used to shoot drugs in Kensington. I've been out of Kensington for 28 years. I worked with Gaudenzia since 2004. I'm retired. I probably should be home taking a nap right now and my wife thinks I'm crazy, but it's in my heart.

As Councilmember Harrity and I talked, everyone out there is 3.7, whether or not you want to be a 3.7 withdrawal management or a 3.7 medically-monitored program. I think the funding may be the issue and we heard that a little earlier.

We initially started coming into Kensington when Jose Benitez was at Prevention Point. He invited us down here and we came down. We did a presentation to all

the staff, and I was given a cubicle at Prevention Point to come down here every Tuesday.

So I come down on Tuesday at the PAD meeting. Everyone knows about the services we have. I talk about the bed situation we have on Tuesdays and I'm available at Prevention Point for any referrals that may come through Prevention Point, Merakey, you name it, whoever's at the PAD meeting.

That's why I'm scratching my head. There's beds available. Deja and I were talk -- beds are available. I think the funding may be the issue. And the other issue is I think we need to make it more inviting for people to come into treatment, because I mean sometimes people don't want to come into treatment. That's the bottom line.

If everybody out there wanted to come into treatment, we wouldn't have no beds. I think we

need to figure out, and Deja and I were talking about, how can we make it more inviting. One of the things that we started doing was, and because I'm in a kind of unique way, I can call Division Director down 1306. I know how many beds -- because beds fill and people leave and come and go as we're speaking now. I can call down there -- if somebody wants to go into treatment, I send them down there.

We have a 24-hour helpline. And again, the number is 484-938-1881 where we can get a person into treatment within one hour. We can do the assessment -- the screening, assessment and we can have them placed within an hour. We even will send Uber to pick them up. The key is getting them there. We can't wait. We don't wait. If somebody wants to go to treatment, I send them down 13th and Spring Garden. And like

you said, a bed is a bed.

And I mean I might get fired, but I know how we used to do it. If we had a 3.7 bed or back then it was called something -- we were using a PCPC. If we had a bed in detox and no more beds in our inpatient program, we would put them in that bed overnight and work out all that other stuff tomorrow. I mean it's that simple.

And right now again, I just send them on down, let them do all the clinical -- I mean, we have to get paid. I mean, that's a reality. But I think there has been situations where I think all organizations have to have some type of we used to call it scholarship. Even if a person doesn't have funding, we have relationships with BHSI, Single County authority in Philadelphia. We have relationships with all the other counties' Single County

Authority.

BHSI will pay for a person if they live in Cleveland and they're caught up in Kensington using opioids, they will fund them, they will fund them. I mean, we have connections where we call and say this is the deal, can you help us and it works out.

Again, I'm not saying we're perfect, but I think that -- the folks that we work with that are in Kensington -- and the other piece is it ain't just Kensington now. I live in South Philly. Broad and Snyder is a little Kensington. 60th and Market, West Philly, Lancaster Avenue, they're all little Kensingtons.

My thing is -- I was riding down Point Breeze -- I like to tell stories and I know we got to go. Deja got to leave. I'm riding down Point Breeze Saturday, and I thank God for Carlos at Prevention Point.

I got a case of Narcan in the trunk of my car. I'm going to a meeting and it's a guy underneath the water plug and I'm thinking they getting ready to drown him, he's out, he overdosed. And I said, let me stop. Gave them the Narcan. They gave him one shot and he came back.

This is more than money. This is more than -- to me as far as I'm concerned this is about helping folks. I wouldn't be working for Gaudenzia if it wasn't an organization that I thought that was here to help folks. I left Gaudenzia once and went to a for-profit and it was about money with them and I came back to Gaudenzia.

I don't know how much more we can say except that we have beds and if you need people to come into treatment, we can get them in. And this is the big boss.

DR. GILBERT: I think just

to sum it up, it's about communication and figuring out those people who are out there every day on the street, they don't want to call 10 places and be shuffled around. When they have someone in front of them, they need some sort of database, some sort of phone number to say I don't care, I know I have someone in front of me that I need to get somewhere, you all figure it out. And right now we don't have a coordinated way of doing that. We have a few -- we have a couple this and a couple that, but it's really not coordinated. So when these are full, who's next in line and it has to be minutes. It can't be hours. It cannot take three hours to figure out who has a bed because that individual is back on the street. They are not coming with you.

COUNCILMAN SQUILLA: And

everybody has to see the same information. Everybody has to see it realtime.

DR. GILBERT: Yes, absolutely. It should not be that complicated.

COUNCILWOMAN LOZADA: And I think that's what we're working towards. We're working towards eliminating the barriers to get into these beds, the codes that dictate when a person can get into what bed, and we are working towards a dashboard or realtime location where anyone, a provider, an outreach worker, an elected, a family member can go into and say, where can I take my loved one who has called me to say they're ready right now and get them there. And regardless of what type of bed it is, you get them into that bed, stabilize them and then move them into the more appropriate space, if necessary. That makes a lot of

sense to us.

And as I mentioned earlier, sometimes the commonsense things are the most difficult to get to, right, but we're committed to that right now. I think that it is important because as I mentioned earlier, we have a crisis here that we are going to respond to and we have to do things differently.

And so, I would appreciate if you leave your information with my team. We get called often too. People communicate with me on social media to say, Councilwoman, I'm ready now, I don't know where to go. Councilwoman, there are people that are living on my sidewalk because they were moved from a different place, and I've had a conversation with them and they are ready now, where do I send them, who do I call.

I think part of the challenges that we experience and

as a community and as electeds is that during that time frame of 10:00 p.m. to 5:00 a.m., there's really no one we can call, there's really nowhere we can go, there's nowhere we can send them --

DR. GILBERT: But there is.

COUNCILWOMAN LOZADA: And there is, right. But what we're hearing today is that there is a disconnect of there's a lack of communication --

DR. GILBERT: Correct.

COUNCILWOMAN LOZADA: -- which proves to us that what we've been saying for a long time is right, we're on the path to listening to ourselves and community residents who have said we need a one-stop shop where everyone can see what is available and where it is available at, and people should be able to hold that bed with a touch of a button and advise your organization that John

Smith is on his way --

DR. GILBERT: Absolutely.

COUNCILWOMAN LOZADA: -- or we should be able to reserve that bed and an outreach worker should be able to say, I'm on my way with John Smith, right, and that bed should come out of that pool of availability because we do that for a lot of other social desires. And so, we're going to figure this out. Thank you so much for your testimony.

DR. GILBERT: Thank you.

COUNCILWOMAN LOZADA: Are there questions from members of my Committee?

The Chair recognizes Councilmember Harrity.

COUNCILMAN HARRITY: Yeah. I mean, thank you for your work. I'm familiar with Gaudenzia. You guys have been around for a long time. How long have you actually been in this area? I know it's

been a long time.

DR. GILBERT: Our first location was Philadelphia.

COUNCILMAN HARRITY: Yeah, Philadelphia and actually Kensington you created a few years --

DR. GILBERT: We now have 110 programs.

COUNCILMAN HARRITY: So who are the five that PAD is dealing with?

DR. GILBERT: I'm not sure.

MR. ROY: I think it was mentioned earlier.

COUNCILMAN HARRITY: It just seems ridiculous. Sometimes we get something, an interaction that somebody had with one of those organizations. Most of the time they're telling us that there was no availability of a bed. So if there's only five that they're going through and we know that those five are always filled up, I

think we need to add six, seven, eight, nine or ten to that list.

DR. GILBERT: Correct. They're doing amazing work.

MR. ROY: And I think initially when the -- I actually brought a friend of mine, he used to be the Trial Commissioner, Keith Smith. He helped develop the PAD program. I brought him down and he was like, well, I helped to write the grant for it. I think that those five agencies were in the initial grant and that's why you have five agencies.

Folks know about Gaudenzia. I'm at the PAD meeting, again a couple of -- I mean, your dashboard will be great, again, a 24-hour, 7-day-a-week dashboard. One of the things, Tuesday I'm going to drop off stacks of our business cards that has the helpline on it, the 24-hour -- that way the police department, if they need more, we

can get them more and just drop them off at the police district. That way their officers can just pass them out, because we know about the 75 new police officers that were hired.

COUNCILMAN HARRITY: So you got 28 percent availability. So what you're saying --

DR. GILBERT: That's just in Philadelphia.

COUNCILMAN HARRITY: -- you're not looking at their numbers. You're saying if there's a detox bed open and you can get somebody in it for a day or so until you figure out where the new bed is available, let's stick them in there. That's the kind of people I want to deal with, people that say, hey, this is what's got to be done, this is what we're going to do no matter what the ups and downs of it is, no matter what the cost of it is, no matter if

we're going to lose a couple of dollars for a day or two --

COUNCILWOMAN AHMAD: We will figure it out.

COUNCILMAN HARRITY: -- or not. That's the kind of provider we're talking about.

COUNCILWOMAN LOZADA: How often do you all respond to individuals who come into your system that are from another county, another state, another country? And how hard is it for you to relocate them? Do you relocate them or do you use the services, the resources that we have here?

I ask that question because we are always in contact with individuals who come from other counties. Just the other day I was contacted by someone who was looking for someone from Italy, who found themselves here thanks to the exploitation of many who think that

it's okay to display what is happening here and then attract others to want to come, touch and feel what is here.

So this individual, part of his story is he doesn't want to go back home, right. He doesn't want to be relocated. My issue is that that shouldn't be a choice, right. You come here, you have occupied this space in this community for long enough. You don't belong here. You don't have anybody here, so you're depleting our resources. And we experience that often. Maybe not as drastic as another country, but from the other counties, right.

So how do we work with you all as service providers to say, we brought you into this bed because you were ready, we responded to your crisis situation, you're stable and your entire circle of friends and family and your origins

come from another county, how do we do a warm handoff or do you do a warm handoff to that county so that that individual can be connected to their loved one so they can become a part of their journey?

DR. GILBERT: Great question. There's a couple of caveats on that one. So I will go into it a little bit. We do have the benefit of being a larger organization, so we do cover most counties in the state of Pennsylvania, all the way up to Erie and then to our neighboring states as well, so Maryland, D.C., Delaware.

So we do have that ability to have coordinated care, to work with them publicly to say what does the best path forward look like for you. There are a lot of individuals here specifically in Kensington that are not from Kensington.

COUNCILWOMAN LOZADA: Can you say that again? Say it really, really loud.

DR. GILBERT: There a lot of individuals here that are not from Kensington. This is their home right now. What is best for them, it's case-by-case. But typically an individual who is afforded time to heal, time to recover, to build their lives, to go back to school, that ability to reintegrate and become a force in society, one, it means time but typically it means a different location, not always, but sometimes it's helpful to get away.

You mentioned people, places and things. If you got out there on that street, some of them are used to a cycle. They're used to, okay, I'm going to go in here, I'm going to get my medication because I don't have my $20 to hold off withdrawal, but they're going

to kick me out after a couple of days because I won't have courage and I'll just go right back to the street, so they know that.

So to get serious with the people that are out there, we need to actually get serious and we need to say, we're going to give you care, we're going to give you an opportunity. Day one, that's not their mindset, but over time people will heal. Their minds will clear.

They will be able to say, hey, I'm being afforded an opportunity, what's the best path forward for my future and my life, and that's where we see success. But when we stick to these regimented you have 3 days for this, 15 days for this level and then you're going to have to figure out where to live because you know they don't have anywhere to live and nobody's planning for that. So unless we think about that as the

issue, we're not going to get anywhere. But if all we need to do is think about that full continuum as the issue, we're going to make a lot of headway.

MR. ROY: And if folks, and if I can add this again, if they're in Kensington and they have no insurance, they may be from Camden or whatever, the Single County Authority will pick them up --

DR. GILBERT: We can cov -- yeah.

MR. ROY: We can press on that. I mean, we have folks that were --

DR. GILBERT: There are funds available for someone who is here who has nothing. We will figure it out. There are other providers who can do the exact same thing. They can figure it out and access the resources. No funding is not an excuse not to get care because we can help to get funding.

COUNCILWOMAN LOZADA: Thank you.

Are there additional questions from members of the Committee?

Thank you so much for being with us today.

COUNCILWOMAN AHMAD: I have a quick question. How do you measure success for the industry?

DR. GILBERT: The industry is interesting, but we do have a very robust research department that is tracking our outcomes. So they're tracking -- there's different measures of success is the answer. Is success abstinence? Well, not if they're still homeless living on the street and unhealthy, but they may be abstinent from drugs, but is that success? What does that look like. So we measure multiple layers of success so that it is not a very easy, yes, you're successful or, no, you're not. But

if you measure just abstinence, I can get that number for you.

COUNCILWOMAN AHMAD: Well, we're looking to see if all this work to see is there a population of people who are self-medicating because of all this. Is it sustained in recovery and are you seeing a reduction of people who are needing services that --

DR. GILBERT: Unfortunately, no, there's not a reduction in utilization. That's why we continue to have -- that's a much bigger conversation which I'm happy to have offline, but --

COUNCILWOMAN AHMAD: We can talk later about that, yes.

DR. GILBERT: Ultimately, we would not be here if we didn't think that we were helping contribute to the solution.

COUNCILWOMAN AHMAD: Thank you.

MR. ROY: A lot of people

think it's summertime, people don't go into treatment. I've seen summers where a lot of people are in treatment. It's just -- to me if they show up, they want to come, that's success because at least they have a little bit of what we are offering and they know where they can come and get help.

We have packages for you too and I also dropped a couple cards off with your staff back there.

COUNCILWOMAN LOZADA: Leave them with my staff on the side there. Thank you so much. Thank you for your testimony today.

DR. GILBERT: Thank you so much.

MR. ROY: Thank you.

COUNCILWOMAN LOZADA: Will the Clerk please call the next panel to testify.

THE CLERK: Yes, Madam Chair.

The next panel is Eric Gremminger and Sarah Deutchman. And following Mr. Gremminger's opening testimony, there will be a short presentation.

COUNCILWOMAN LOZADA: Thank you for being with us today. Please state your name for the record and begin your testimony.

MR. GREMMINGER: Thank you, Chairperson Lozada and the Committee, for the opportunity to testify today. My name is Eric Gremminger. I am the CEO and co-founder of ERPHealth, a Philadelphia-based digital behavioral health community. I'm also a certified drug and alcohol counselor.

I have with me Sarah Deutchman, Chief Operating Officer for Pyramid Healthcare, who will speak on behalf of Pyramid's work n the Kensington community, their use of our technology and their

commitment to enhancing bed availability in Philadelphia.

We were contracted by Chairperson Lozada to establish a bed management solution that would display realtime information on what beds are available to those in the Kensington area seeking help for substance use disorders and mental health condition.

There is a tremendous need for this, because when an individual reaches out for help, they're often at a critical point in their addiction journey. This moment of readiness to change should be capitalized on immediately as the window of willingness may close quickly.

This isn't possible if bed availability isn't visible and accurate. I commend Chairperson Lozada and the Committee for recognizing the value of realtime bed visibility. To a person in

their darkest days of addiction, a bed represents a chance at a new life. It represents potentially freedom from active addiction. It represents hope.

I know firsthand the value of it. In addition to being a clinician, I'm also a person in long-term recovery from substance abuse disorder. For many years I was stuck in the vicious cycle of addiction, and I wouldn't be here today if it weren't for family, friends and a community that believed in me when I couldn't believe in myself and made available resources that were personalized to meet my specific needs.

While access to beds is a necessary first step, it's not sufficient on its own. To have lasting change is critical that when possible we're matching individuals to personalized

culturally appropriate care. In other words, we have to get the right people in the right beds for them.

While in the past this was difficult, advances in technology have made it possible to prioritize both access and ensure personalized high quality care at the same time. I've seen this firsthand in treatment centers like Pyramid Healthcare who are being transparent with their outcomes in using data to individualize the experience for people based on their specific diagnostic type, gender, age and cultural background.

I recommend that in addition to offering access to beds, that a measurement-based care process is implemented right from the start. There are three immediate benefits to providers that are measuring outcomes of

care.

Number one, it improves the engagement of the person in care because treatment plans are being purpose-filled based on their specific needs. It also gives them an understanding that they have to have an active role in treatment if it's going to be successful. Clinically speaking we call that personal agency, so when they (inaudible) the personal agency.

Number two, it provides the treatment center with realtime updates. So the clinicians can modify the treatment plan as the person is progressing throughout care. So they can see what's working and what's not working and iterate as necessary.

And number three, the identified population health data can be shared with this Committee to inform future prioritization and resource allocation. I'm a

passionate advocate for outcome-focused care because I've seen the impact that it can have in our community.

So my company specializes in measuring outcomes in addiction treatment in mental health facilities around the nation. We had a third-party data scientist come in recently, and they reviewed a sample of 50,000 completed PHQ-9, GAD-7 and substance use skill, so they validated assessments.

They found that providers who are supported by our platform reduced depression in their patients by 32 percent, reduced anxiety in their patients by 30 percent and reduced craving for primary drug of choice by 40 percent.

Individual providers like Pyramid Healthcare are using our tool to improve the quality of their care and can be a referral

source for individuals seeking care while ensuring that they're getting a personalized experience. The technology is also able to connect individuals to outreach specialists, harm reduction experts and other key stakeholders pre and post-treatment, ensuring a collaborative care experience by including local resources that have existed for many years in the Kensington area and are uniquely qualified to work with this population.

Improving the quality of care will also create bed availability by reducing recidivism rates. The National Institute on Drug Abuse use or NIDA estimates that relapse rates for addiction are between 40 to 60 percent. While there are many factors that can lead to a relapse, it's a very complex condition.

I believe that

nonpersonalized care and lack of outcome tracking by treatment centers are major contributors to treatment failures. By measuring and improving outcomes, we can reduce recidivism and create bed availability.

Here's an example using simple math. If there are 1,000 beds occupied in the Philadelphia area and 500 of those beds are recidivism so people who've been to treatment multiple times to no effect, by improving the quality of care and reducing the recidivism beds by just 10 percent, it's achievable. By just 10 percent, that will free up 50 beds for individuals seeking care. That's 50 more people off the streets of Kensington. 50 more people who have a chance to have freedom from addiction.

This is not a quick fix, but a long-term innovative solution

to a problem that's been addressed the same way for years. People want to know what's going to be different this time. I live five minutes from here with my wife and our six-month-old son. We've lived in this area for 11 years. We love the neighborhood. I plan to raise my son in the area.

And I truly believe that there will be a time when I can tell my son about how Kensington once was and how it's improved so much, and I truly believe that this starts with this Committee but also with thinking differently about this issue and coming up with innovative solutions.

Thank you again, Chairperson Lozada and the Committee, for allowing me to testify today. I have a short presentation and then I look forward to answering questions.

I'm happy to take questions

while we wait for the presentation.

COUNCILWOMAN LOZADA: So thank you so much for being with us today. Thank you for the time that you've invested in listening to my frustrations, listening to some of the challenges that the community has expressed, and thank you for the work that you all have put into creating a dashboard, the dashboard that we've heard so much about, the need for a dashboard, the need for a one-place space where everyone can go to, to find the beds that are necessary to put people on the path to a successful helpful journey.

The presentation is up. And so, we'll go to your presentation and then we'll come back to questions.

MR. GREMMINGER: Excellent. So just starting on the left here, an individual. We heard a lot of testimony today about how we have

community outreach on the street. We also have individuals from Pyramid Healthcare that can help with this.

But we found somebody in need, the community outreach specialist, we asked them a series of questions just to see are they willing to accept treatment. If not, that gets documented as a refusal and goes to this dashboard. Do they need medical care, are there wounds that need to be healed up before they go to treatment. If that's the case, button's hit and we can triage and identify available beds that can do that.

And this third category here, treatment. So once we are able to identify that it's not Category 1 or 2, we can put them directly into touch with -- and I'll let Sarah speak to Pyramid Healthcare's role in this -- with a specialist at Pyramid Healthcare or

whoever's participating in this process so they can do an ASAM and determine the best level of care for this individual.

The beauty of the entire process is we're able to aggregate all of that information in realtime and provide it to this Committee and any other stakeholders who are participating, so we can see realtime bed updates. Next slide please. So we can see realtime bed visibility. And we can also see just down below the quality of care that's being offered.

A great point was made early on, well, what determines if a provider is good enough even participating, isn't there some sort of criteria or benchmark. Right now there's not because we really don't have a way to gauge their clinical performance so we're strictly looking at claims or re-admits. There's a lot of

variables other than that that we should be looking at that. So we make that visible as well. I think it's important to talk about, but I know priority right now is this realtime bed visibility.

We are the aggregate, and we talked about a lot of silos that are working on this. I say pencils down, stop working on it, we have the solution. Let's bring everybody together and work off of this infrastructure that's in existence right now that's across the country. This is what we specialize in. This is what we do. And then the last slide is just a clearer view of this bed availability. Time-stamped and available for you all and every other stakeholder. I'm happy to take questions.

COUNCILWOMAN LOZADA: Thank you. Thank you for this. Can you tell me is this used somewhere? Is

this currently being used somewhere and what has been the outcome? How successful have they've been using this?

MR. GREMMINGER: Well, I shared the statistics with the third-party data scientists as it relates to reduction and symptoms, which is the primary use. So what we do as a technology company, we work with providers, payers, whatever government agencies and when we sit down and we say, what's the goal here, what do you like to accomplish, and then we build out that process.

So we have the realtime -- the realtime bed visibility we would build in. The infrastructure's being used by thousands of patients daily, so the capabilities are there. This right here will be built out specifically for this community.

COUNCILWOMAN LOZADA: The

Chair recognizes Councilwoman Nina Ahmad.

COUNCILWOMAN AHMAD: Thank you. Thank you so much for putting your thoughts in a graph and diagram. We just heard from a provider before you and when I asked them about how do we assess, there was not a good answer, right. And maybe there's different levels of assessment. How do you build in your model here what are you assessing? Are there different types of assessments or is there one kind of method we can use by saying, for example, here in Kensington if we were to see over time starting today in another year what has the change been in say, here's one of the characteristics that people in active use, right. Can we from this data just you pull out and say, we can look at this measure, this measure and be able to assess the health of Kensington?

MR. GREMMINGER: I will answer it from a functionality perspective and perhaps Sarah can answer it from intaking somebody and what they would look at. So from a functionality perspective, we're able to customize the assessments.

So I had mentioned GAD-7 PHQ-9 standards, psychometrically validated screener for depression. Well, we would also want to look at other probably very specific things that need to be addressed in the Kensington area, so we would build out that assessment with the specific data points that you all would want to see along with I would imagine the treatment providers and then we would have the ability to instantly select a time range, hit enter and have that information available to you.

COUNCILWOMAN AHMAD: One of the caveats in doing this is the

quality of data and biases built into who's uploading the data, right. So I just hope that all our systems have that caveat built in so we can control for that. I mean, data is data. You can slice it and dice it any which way you want to see it, so there's an issue with that as well.

So while we applaud this way of being able to visualize and seeing realtime, I just want to know that there are built-in protections to catching these things in terms of particular interested bias built into the data uploader who is doing that information.

MS. DEUTCHMAN: I think I can maybe shed some light on that. So the clinical assessment tools are self-directed by the individual participating in treatment, so it's a little unlike an individual counseling session where there's

collaborative notetaking where a client is responding and I'm documenting that response.

So as the clients are completing these assessments individually, the data tends to be less bias for that reason. But at Pyramid Healthcare we have hundreds of thousands of other clinical assessment measures that we've accumulated. We've been in one common electronic health record for years and years and years. We have tons of data. But this visual, the ease of use and the ease of client interaction is something that we haven't experienced until we started working with ERP team. So I'll call that out as a differentiator as well, the ease of use, the visuals, the realtime access to data, the sophistication of the tool, the way that we can customize the data sets that we want to see on a level that we

haven't experienced with our electronic health record.

COUNCILWOMAN AHMAD: And how user-friendly is it in terms of we have resistance as you've probably heard all through the day of everybody doing their own thing, and everyone thinks they're great in what they're doing but there's no way we can measure it if stacked up against each other.

So how is it adaptable? Is it a service you sell and we go into the company where the place is and you manage that space or do they actually take a program and they manage it themselves?

MR. GREMMINGER: So just from a user experience perspective, it was built to be able to be used by anybody as easily as possible. So 2024-looking technology, so you'll see some EMRs kind of looks like Windows 95 a little bit. We've built it very specifically

with a consumer mindset in place, because we're counting on once their in-treatment patient reported, so this means that it has to be relevant and exciting, what they're used to seeing on their smartphone. So very user-friendly in that capacity.

We have APIs where we connect to existing technologies. But the important thing is we heard from so many great providers today. But if they're building their own technology, they have a technology, and we're an agnostic company where the input doesn't matter where they came from. What we're able to do is aggregate and provide you with an objective third-party data set which we don't have a pony in this race. We just want to see transparency as community -- our headquarters, we were founded in Philadelphia.

As I said, I live five

minutes away. This is meaningful to us, so we're willing to work with anybody to make this very necessary dashboard available.

COUNCILWOMAN AHMAD: Including government. You had our Department of Behavioral Health here, right. I would think this should be at forefront of the $1. something billion budget to have this already. We don't. We're still kind of almost like paper reports coming in kind of situation, it seems like it. I don't know because I haven't seen anything.

So I really think we need to up the ante in a very big way if they're going to be able to put Philadelphia in realtime. We can't wait for all this, are you going to give me this data, are you going to give that data. This is 2024 and we have these things available.

It just frustrates me that

we're not able to serve the real need because of bureaucracy getting in the way. So I yield my time.

MR. GREMMINGER: I agree. I second that.

COUNCILWOMAN AHMAD: But it's possible, what you're showing me is it's possible to do this. It's a matter of will and it's a matter of whether we're willing to accept new ways of doing things and the transparency because that makes yourself -- all of this will immediately show us right away who's doing what and how successful it is and you don't have to have a period to do that, you just click a button and that's where we need to be.

COUNCILWOMAN LOZADA: Thank you. Thank you for your question.

Have you all had an opportunity -- your company has been in Philadelphia for how many years?

MR. GREMMINGER: I've been doing this for 10 years myself, but we've been officially really doing this type of technology starting in 2019.

COUNCILWOMAN LOZADA: So have you had the opportunity to -- I'm sure that, you know, I've only been in office for 20 months.

COUNCILWOMAN AHMAD: Five-and-a-half months.

COUNCILWOMAN LOZADA: Five-and-a-half months, right. Councilmember has been here for years. Councilmember Harrity's also new. But have you had an opportunity -- this conversation as you heard earlier today, this is a conversation and a problem that has been existing for years.

Have you all or has your company had an opportunity to ever bring your product in front of City government. And if so, what was the response?

MR. GREMMINGER: No, we have not. And this is our first opportunity. And really because of this Special Committee having Pyramid as a partner and bed availability, it was a salient instance of where we had a great partner and the existing infrastructure where we can make an immediate impact we believe here. So this is kind of our first foray into government. I do believe CBH, DBH and everybody who's up here earlier would benefit immensely from this technology.

COUNCILWOMAN LOZADA: Thank you so much. We look forward to continuing the conversation with you. Definitely want to make sure that we connect with you in the future and maybe bring some of our City departments, DBH, CBH, Office of Homeless Services, the Police, maybe bring you to a conversation hosted by the Special Committee

just to talk in more detail about what this could potentially look like in the future to figure out how we can move this into a reality, right.

I think that everyone agrees that we need to be able to access beds differently. We need to be able to look at the numbers and where we need to make adjustments for improvements, right. We need to track our providers better. Regardless of whether the bed is here in Philadelphia County or in a neighboring county, we should be able to have access to that. Our outreach workers should be able to have easier access when they encounter someone who's ready and who's ready now.

How do we provide our outreach workers who are out there every day building and establishing these relationships with

individuals who are living unsheltered, how do we provide our outreach workers with another tool for their toolbox, right.

We talked often about creating legislation that will add to the toolbox to make it easier for us to respond and restore the quality of life in Kensington. And I think having a place where our outreach workers could access where this bed is at any time of the day to me would make it much easier for us to connect individuals to the resources that they needed.

So I look forward to continuing the conversation. Again, my deepest gratitude to you and your team having invested so much time to create an application like this one that can really help us get there. Is it perfect right now? No, but I think that the willingness and the capacity is there. So I look forward to

calling back on you with a larger group of individuals that could help this really be what we need to respond to the crisis that we have in Kensington. Thank you so much for being with us today.

MR. GREMMINGER: Thank you very much for having us.

COUNCILWOMAN LOZADA: Thank you.

COUNCILWOMAN AHMAD: And (inaudible).

MR. GREMMINGER: Immediately.

COUNCILWOMAN AHMAD: (Inaudible).

MR. GREMMINGER: Exactly. And again, it just exists. It's really just about modifying it and purpose-building it for what we're looking to achieve here, but the technology is in existence, it's driving better patient care, you know, tangible proof that this works to improve the outcomes of

patients. So it's really just the --

COUNCILWOMAN LOZADA: We're a city of the first class. And somebody said earlier, we're Philadelphia, we can do anything. And so, this is part of anything we can do. Thank you so much again for being with us today.

Mr. Clerk, are there other panels that we are to hear from today?

THE CLERK: Madam Chair, there are no further witnesses testifying on the resolution.

COUNCILWOMAN LOZADA: I can't find my script. But there being no more panels to hear from today, we will move into public comment. If there is anyone here that is interested in public comment but has not signed up, members of my team are over here and can get you on the list.

Will the Clerk please call

the first person on the list for public comment. And I'm going to ask so that we can move this a little quicker, I want to be respectful of people's time as far as I don't want to overstay our welcome here.

We're going to call five people at a time. And if you guys can just sit here and be prepared to give your public comment in a row, it will be extremely helpful, there at the microphone or whatever. We just want to make sure that we have multiple people ready to go and that you know that you are next.

MR. HOWARD: Check, check.

COUNCILWOMAN LOZADA: Everyone will have two minutes to give your comment. It's unfortunate, but that's what we need to do.

Mr. Clerk.

THE CLERK: Will Kevin

Howard, Lawrence Jackson, Kelcey Leon, Gloria Hart and Sam Lou be approach.

THE CLERK: Please state your name for the record.

MR. JACKSON: Yes. I'm Lawrence Jackson. So I just wanted to say I'm a product of DBHIDS. I came from Atlanta in October 2017, to commit a crime, I got arrested. I brought me from Atlanta a mental health problem, a drug problem and a criminal problem.

I went to jail. The police recognized I had a drug problem. I went to the homeless shelter. I went to rehab. I went through long-term Journey of Hope program. And then I found an idea of what recovery could be. I went to rehab twice.

And I'm saying that to say I became a recovery addict working with Cultural Affairs. I became a certified peer specialist. And

now, I'm a full-time employee with the MORS Unit. All right. I'm saying four years ago I was homeless. I was matched to independent housing. From there I got a PHA voucher and rented a home. And on May 10th I moved into a brand new home through the help of the City of Philadelphia through the Department of Behavioral Health and Intellectual Services. Thank you.

COUNCILWOMAN LOZADA: Thank you. Thank you for your testimony. Thank you.

(Applause.)

MR. HOWARD: My name is Kevin Howard. Can you hear me? Testing 1, 2, 3. Hi. My name is Kevin Howard. I've been in the field for 30 years in addiction and recovery. I'm a recovering person. One of my concerns is that we provide folks with medication. It's very important because we are

losing people to withdrawal and we are not capturing those people who would otherwise be in treatment.

If medication is not at the forefront, we're going to lose our people. It has to be at the forefront. Our providers have to medicate these folks as quick as possible. We need to have topnotch customer service at the front door because we're losing people if we don't provide topnotch customer service. So having said that, those are two important things that I wanted to relay to City Council. Thank you so much.

COUNCILMAN AHMAD: Thank you.

COUNCILMAN HARRITY: Thank you.

COUNCILWOMAN LOZADA: Thank you.

THE CLERK: Kelcey Leon.

(No response.)

THE CLERK: Gloria Hart.

(No response.)

THE CLERK: Will Ben F, Larry Turetsky, Kate Magoffin and Connor Sacconi approach. Please state your name for the record. Thank you.

MR. F: Hello. My name is Ben F. I'm here with the Abolitionist Law Center. I'd like to speak to one of the greatest barriers to treatment, the violence that is inflicted on people who use drugs of the PPD and the Philadelphia Department of Prisons.

The increased militarization and policing of residents of Kensington both housed and unhoused is the opposite of the pathway to recovery and treatment. Between June 18th and July 8th, there was a 123 percent increase in drugs in arrests for drug possession in the 24th District according to data from the Philadelphia District Attorney's

Office.

Violence and harmful interactions with the police and the carceral system only disrupt and traumatize the care that people with complex medical conditions need. There's also a misconception that people who enter the jail will receive treatment. As being heard today, addiction is a complex disease that requires individualized care.

However, most people only receive MOUD treatment a daily dose of buprenorphine. There are also long excruciating waits for treatment. In 2023, there were 181 weekly backlog appointments for MOUD treatment. While people are not receiving their medication, they are experiencing severe withdrawal symptoms that include vomiting, diarrhea, hallucinations and nausea, suffering that is akin to cruel and unusual punishment.

And at the same time large numbers of people are getting kicked off treatment once they get it often without due process or review. In 2021, 532 people or 41 percent of people who are giving MOUD treatment then have their medication ended which often can be simply because of correctional officer said so.

Philly jails are incredibly unsafe, particularly for those who struggle with addiction. Jails have proven that they function so poorly they cannot even provide basic medical care. Since 2018 at least 25 people have died in the jails due to overdoses or other drug-relates costs accounting for a third of all deaths in facilities.

In 2021 or in 2020 more people overdosed at CFCF over a single weekend and three of them died. Incarceration also increases risk of death as soon as people are

released. Within the first two weeks after release, the risk of death of drug overdose is 12.7 times higher than the general population.

We know what works. There are harm reduction providers who have longstanding trusting relationships who can support people to getting care. If Philadelphia truly wants to address this public health crisis, we also have to end this criminalization and use the money for dignified treatment. Thank you.

COUNCILWOMAN LOZADA: Thank you for your testimony.

MR. TURETSKY: My name's Larry. I've been living about a block from K&A for 13 years. I've seen a lot. What can I say is that I've been really impressed in the two years, particularly the last year, with the way things have been improving. It smells better. It

looks better. There's a lot more to go. Don't get be wrong.

I'm happy to give a compliment. I'm also not shy about criticizing, but I can see that our alleyways have been clean. CLIP's hazard department has been coming around sanitizing. Streets have been making more pick-ups. They're actually taking the trash now.

And so, I commend the Council, particularly Councilwoman Lozada for -- something must have changed. I assume it's her and Mayor Parker and anyone else that's been involved so I appreciate that. It seems though the reason that we're having this hearing is because there's been a lack of investment over the decades, probably goes back to the '70s. You can argue whatever number you want, but since globalization.

But it seems like we're just trying to reverse what should

have been done since 1970s, and that is investing in long-term public infrastructure. So streets, the clean-up, maybe eventually we can get into job training, early childhood education, more parks or cleaner parks I should say, usable parks. And those are the kinds of things that bring increased property values and businesses.

Kensington and Port Richmond were not always this way. They were regional and national centers for lots of industries like fishing, ship-building. Tylenol was invented 2,000 feet from here in Kensington, McNeil Pharmaceuticals. Lactose milk, if you drink that or take lactose tablets, that was invented here in Kensington. And so, the Stetson hat, the cowboy hat, that's not from Texas. That's Kensington. Stetson in Kensington used to be the number one employer in the

country. It was bigger than Ford, but globalization took it away.

But the point is we can go back to that kind of time where we can bring businesses, tax-based population. The reason why Kensington and Port Richmond were even developed was because there was employment and things to do here. And I think we can take it back to that.

And so, I appreciate the investment. I think it's going to be long-term. We're looking at multiple years. You're going to have to change the bureaucracy with bed categorizations and whatever CBH thinks they're doing over there. I can't believe the guy said COVID was a reason still two years that they're behind on treatments, and fix some of that bureaucracy.

You have the budget, $6.2 billion you have without raising

taxes, so thank you. But you now have the money. I don't know if you want to wait for Universal Health Care. I think we got the money to do it. And so, I think that kind of persistent investment is where I see -- because it's already worked in the last two years. That kind of persistent investment is where we should be going for the next few years, so hopefully you'll keep at it and I appreciate the out-of-the-box thinking and money that's coming our way. So please keep it up. It has been improved. I've seen it, lower crime, all that.

COUNCILWOMAN LOZADA: Thank you for your testimony -- thank you for your comment.

(Applause.)

MR. SACCONI: Hello. My name is Connor. I'm a volunteer with the Public Relations Subcommittee, the Downtown

Philadelphia Area of Narcotics Anonymous. Regrettably I was under the impression that I was a panel, but I guess I'm not which is okay.

Thank you for allowing me to testify today about an issue that is affecting many lives within our city, homelessness and drug addiction. Philadelphia is a city that has stood together in the face of adversity and we need to come together to address this issue. And I recognize Councilmembers Driscoll, Lozada and Ahmad and the work that you guys are doing, extremely grateful.

Narcotics Anonymous has been active in the city of Philadelphia for 40 years and in the Philly suburbs for over 50 years. We've been able to get past all the barriers where diversity has now become our strength. Amazingly Narcotics Anonymous has 240 meetings weekly in the city of

Philadelphia.

As your resolution outlines, the shortage of vacant beds in homeless individuals is a problem. This is exacerbated by the fact that many of these individuals are struggling with addiction. The lack of option not only leaves these individuals without shelter but also without the support they need to start the recovery journey. This is -- Narcotics Anonymous can be a resource.

NA is a nonprofit community-based organization that provides a network of individuals battling addiction. We meet regularly to help each other stay clean. Through attending meetings, NA can offer hope, where for many there has not been hope for some time.

This is how Narcotics Anonymous can help, fellowship and

accountability. Narcotics Anonymous provides a safe environment where individuals can share their experience and struggles with others who have faced similar challenges. This support fosters a sense of community and accountability.

Accessibility: NA meetings are 100 percent free and widely available. As I said throughout the city, 240 meetings a week. This makes them a readily available resource for individuals that may not have the means or the willingness to go traditional rehab. By utilizing existing community spaces, NA can operate without any financial investment from the City.

Cooperation with existing services: NA does not replace the need for medical or residential treatment programs, but can work in cooperation with them by providing

ongoing support. NA gives individuals a place to participate in the recovery after leaving treatment facilities, reducing the likelihood of relapse and repeated use of City resources.

Reduction of bed shortage pressure: Encouraging participation in NA can help reduce the strain on the City's shelter system. People who find stability and support through NA are more likely to secure permanent housing and employment, thereby decreasing the demand for emergency shelter beds.

Community and giving back: NA encourages members to become active contributing members of society. This not only benefits the individuals but strengthens the community by allowing an environment of support and recovery. Often times we find members will see people that they

used to get high with that are clean and doing well and say, what are you doing. That goes for all types of recovery.

I urge the City to consider the following actions to support Narcotics Anonymous into your strategy for addressing homelessness and addiction: Awareness, increased awareness of Narcotics Anonymous meetings through City websites, shelters and community centers. Ensure that those who are in need know how or where to access our meeting places.

Upon request, we have posters with our information available that we will be happy to provide, meeting lists, business cards which I brought some with me that have a QR code that direct to all the local meetings in the area. We also have a huge volunteer base.

Providing information for City services, and I'll wrap up

with this: Several city-run organizations come into frequent contact --

THE CLERK: I'm sorry, Mr. Sacconi. We do have some other speakers. I got to cut you out.

MR. SACCONI: Thank you very much for my time. I have a lot of information with me if you guys are interested.

COUNCILWOMAN LOZADA: Thank you so much for your testimony. Your written testimony can be given to the Clerk. He will make sure that we put it on the record. And my team is right over there at the first table. Please feel free to leave your information with them. I'll make sure to share it.

MR. SACCONI: Thank you so much.

COUNCILWOMAN LOZADA: Thank you for joining us today.

MS. Magoffin: Good almost evening, Council. I appreciable

you all hosting this hearing. My name is Kate Magoffin. I'm a social worker, an outreach worker. I reach in our behavioral health system as well. I train hundreds of behavioral health staff a year around topics of addiction, stigma, trauma and organizational management.

I know this hearing is geared towards kind of accessing beds, but I wanted to note the importance of talking about what happens when people are in those beds and the quality of treatment people have received, especially when people leave AMA. I'm like that's a huge deal in Philadelphia.

We need to actually be -- like, there's infrastructure in Philly and we need to actually to be talking about, that's great, get people into beds, have whatever outreach workers get people into treatment. That's not going to

stop people from leaving AMA.

And so, just to note that a little bit more, an example of that is for a little bit over a year now I've been part of some advocacy efforts geared towards Penn Medicine to improve conditions at their HUP Cedar location. After rerouting a majority of their psych and detox patients there after they closed down Reg 4 last summer.

Reg 4 was an 18-bed inpatient rehab located in Penn Presbyterian. Patients at Reg 4 had access on ICU, medical consults like renal and cardio consults. They were offered standardized withdrawal management. They had transparent competent staff and they were generally cared for by medically complex professionals.

I've talked with a lot of people in Kensington when I've been doing outreach for the last five years. There were a lot of folks

that were like, oh, we like Penn Presby. Penn Presby treated us really well or Reg 4 treated us really well.

So like I said, Penn Med decided to shut that unit down and did not replace those inpatient beds. So now, many psych and detox patients from around Philadelphia are being routed to HUP Cedar to its ED and new CRC.

I wanted to relay some notes about the treatment that the detox patients receive at HUP Cedar from up here who works there. One, HUP Cedar doesn't have inperson medical consults which is a problem for a medical complex needs of the patients coming in.

The staff at HUP Cedar have been known to cruelly Narcan people when it wasn't necessary, and treatment like that, word spreads. So a lot of folks were like we're going to HUP Cedar. Staff at Cedar

still don't have education around xylazine, what it is, what xylazine withdrawal looks like.

Also, because CRC only has three beds and those three beds are for 302 patients, sometimes people go into the CRC as detox patients and end up sitting in chairs for multiple days only to leave and are sometimes worse off than they were. Again, just other things about Cedar staff being rude and dismissive. Also, a few weeks ago there was an incident where a staff member at Cedar dragged, and I literally mean dragged on the ground, a geriatric SUD patient out of the building by her feet.

So notably, these are conditions. Also, at HUP Cedar eight months after a patient died from medical neglect because staff didn't call a code blue, after a state inspection also ruled that they found multiple other incidents

of patient neglect. And these conditions that I just stated are kind of current conditions.

I also just wanted to note that the concept of kind of a bed is a bed is not actually necessarily helpful framing for this issue --

THE CLERK: I'm sorry. It's time --

MS. MAGOFFIN: But I --

THE CLERK: Sorry. I gave you an extra one too. I'm sorry. I have more, but thank you.

COUNCILWOMAN LOZADA: Thank you for your testimony. Thank you.

THE CLERK: Would Gia Gale, Shawn Ryan and Ketun Bonillos, please come up.

(No response.)

THE CLERK: Going once, twice, it's sold. It's sold, Councilwoman. That's it.

COUNCILWOMAN LOZADA: Mr. Clerk, are there any other --

THE CLERK: There are no further witnesses, Madam Chairwoman.

COUNCILWOMAN LOZADA: This concludes the business before the Special Committee on Kensington today. Thank you all very much for being in attendance with us. We appreciate and value everything and everyone who joined us today. Thank you so much. Be safe getting back home. Thank you.

Can I have a motion to adjourn?

COUNCILMAN HARRITY: Motion to adjourn.

COUNCILMAN DRISCOLL: Second.

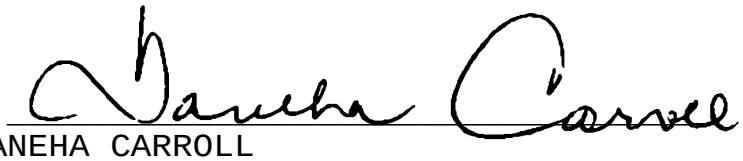
COUNCILWOMAN LOZADA: It has been moved and properly seconded that --

COUNCILMAN DRISCOLL: Aye.

(Special Committee on Kensington concluded at 4:30 p.m.)

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

I, hereby certify that the proceedings and evidence noted are contained fully and accurately in the stenographic notes taken by me in the foregoing matter, and that this is a correct transcript of the same.



TANEHA CARROLL
Court Reporter - Notary Public

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