

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

7 (Yes.)

8 COUNCILWOMAN LOZADA: Yes,
9 better. Okay. Good morning,
10 everyone.

11 (Good morning.)

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

15 (Good morning.)

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

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

1 your name is called.
2 THE CLERK: Chairperson
3 Lozada.
4 COUNCILWOMAN LOZADA:
5 Present.
6 THE CLERK: Vice-Chair
7 Jones.
8 COUNCILMAN JONES: Present.
9 THE CLERK: Councilmember
10 Ahmad.
11 COUNCILWOMAN AHMAD:
12 Present.
13 THE CLERK: Councilmember
14 Driscoll.
15 COUNCILMAN DRISCOLL:
16 Present.
17 THE CLERK: Councilmember
18 Harrity.
19 COUNCILMAN HARRITY:
20 Present.
21 THE CLERK: Councilmember
22 Squilla.
23 (No response.)
24 COUNCILWOMAN LOZADA: Thank
25 you. A quorum of this Committee is

1 present and the hearing is now
2 called to order. This is the
3 public hearing on the Special
4 Committee on Kensington regarding
5 Resolution 240510.

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

8 THE CLERK: A resolution
9 authorizing the Special Committee
10 on Kensington to convene for the
11 purpose of investigating and
12 addressing the barriers to
13 accessing treatment beds in the
14 Kensington area.

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

24 I would like to welcome
25 everyone to the Special Committee

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

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

25 Today we will explore the

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

9 Vice-Chair.

10 COUNCILMAN JONES: Thank
11 you, Madam Chair.

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

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

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

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

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

25 It's not going to happen

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

10 Thank you, Madam Chair.

11 COUNCILWOMAN LOZADA: Thank
12 you.

13 The Chair recognizes
14 Councilmember Harrity.

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

22 UNIDENTIFIED SPEAKER: We
23 can't hear you.

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

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

13 COUNCILWOMAN LOZADA: The
14 Chair recognizes Councilmember
15 Ahmad.

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

25 Two, we're going to be

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

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

1 have a disorder.

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

17 Thank you, Madam Chair.

18 COUNCILWOMAN LOZADA: Thank
19 you, Councilmember.

20 The Chair recognizes
21 Councilmember Driscoll.

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

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

7 COUNCILWOMAN LOZADA: Thank
8 you, Councilmember Driscoll.

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

13 Will the Clerk please call
14 the first panel we have to testify
15 this morning on Resolution No.
16 240510.

17 THE CLERK: Yes, Madam
18 Chair.

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

22 DR. CARSON WEINSTEIN:
23 Thank you very much.

24 COUNCILWOMAN LOZADA: Good
25 morning. Please state your name

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

4 DR. CARSON WEINSTEIN:

5 Thank you. My name is Dr. Lara
6 Carson Weinstein. It's an honor to
7 speak with you here today. I'm a
8 family doctor and an addiction
9 medicine specialist. My career at
10 Jefferson is focused on improving
11 the health and the health care
12 experience of people with substance
13 use disorders and serious mental
14 illness.

15 Beside me are my
16 colleagues, Dr. Philip Durney from
17 Hospital Medicine and
18 Dr. Christopher Martin from
19 Psychiatry, who both lead the
20 inpatient Jefferson Addiction
21 Multi-disciplinary Consult Service,
22 and Dr. Megan Reed, Assistant
23 Professor of the Department of
24 Emergency Medicine.

25 We are passionate about our

1 work and strive to help improve the
2 lives of people who use drugs.
3 There are a few things on which we
4 can all agree. Addiction is a
5 complex and chronic disease of the
6 brain. Addiction in Philadelphia
7 is associated with astonishing
8 threats to physical health such as
9 limb-threatening wounds and severe
10 infections of bone, heart, brain
11 and spinal cord.

12 And finally, addiction and
13 associated physical illnesses are
14 treatable. The challenge comes not
15 from a lack of knowledge or
16 passion, but from a mismatch of
17 available resources and an outdated
18 system design, making it very
19 difficult to provide comprehensive
20 treatment within a system of
21 disjointed pieces of medical,
22 mental health and substance use
23 care.

24 We will focus our remarks
25 on the consequences of this

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

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

1 with ongoing supports.

2 Xylazine is intentionally
3 added to prolong the sedating
4 effects of fentanyl and has become
5 almost ubiquitous in the local drug
6 supply. Xylazine withdrawal causes
7 severe increases in blood pressure,
8 anxiety, irritability and
9 frequently complicates the
10 treatment of opioid withdrawal.

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

14 COUNCILWOMAN LOZADA: State
15 your name for the record please.

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

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

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

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

1 treatment for substance use
2 disorder.

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

9 DR. MARTIN:

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

23 Opportunities for intensive
24 inpatient substance use treatment
25 are lost because addiction

1 facilities are not equipped to
2 support people with medical or
3 psychiatric comorbidities,
4 including suicidality and are
5 locked patient psychiatric
6 facilities, which are increasingly
7 freestanding outside of medical
8 surgical settings, often do not
9 have the capability or expertise to
10 manage more complicated
11 detoxification or withdrawal
12 complaints.

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

25 All of this is to say that

1 while more rehabilitation beds may
2 be helpful for patients who have
3 severe medical or psychiatric
4 comorbidities, which frankly
5 describes the vast majority of the
6 patients we care for on our
7 addiction consultation service, we
8 have a dire need for rehabilitation
9 beds in the model of the DBHIDS
10 Level 4.0 post-acute program with
11 the expertise and motivation to
12 treat the increasingly complex
13 population we treat here in
14 Philadelphia. Expanding the
15 capabilities of such programs as
16 well as making them accessible to
17 our many patients not currently
18 eligible for City-funded
19 programming due to legal residence
20 established outside our city or
21 state or due to lack of compatible
22 insurance coverage.

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

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

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

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

1 The most powerful finding
2 from the study was that many people
3 aren't reaching inpatient beds in
4 the first place because of their
5 experiences of withdrawal during
6 the assessment process. There are
7 six City-run assessment centers
8 where someone has to physically go
9 to answer a series of questions
10 before they can enter treatment.
11 Some people said that once they
12 arrive the process could last up to
13 16 hours.

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

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

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

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

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

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

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

10 We need resources for
11 monolingual Philadelphians that
12 speak Spanish. People in our study
13 talked about many times where
14 people enter treatment and cannot
15 communicate with staff or their
16 peers in group. We need more
17 facilities for people who speak
18 other languages and more
19 programming specifically for
20 subpopulations of people accessing
21 treatment like LGBTQIA+ people,
22 people who are actively parenting
23 and more.

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

1 certified recovery specialist who
2 summed up a lot of what my
3 colleagues have been talking about
4 when he said, there's just not
5 enough, there's not enough detox
6 beds, there's not enough rehab
7 beds, especially with the opioids
8 that are out here now. We're
9 seeing flesh wounds where there's
10 tendons, there's bone, there's
11 major muscle damage, right.
12 There's only 70 beds that will take
13 patients like these, so a lot of
14 these people wind up discharging to
15 stay at skilled nursing facility,
16 if they're even willing to accept
17 them, because if you have substance
18 use disorder stamped on your chart,
19 nobody wants to deal with you. And
20 a lot of these patients wind up
21 being discharged back to shelters,
22 back to the flop house, back to the
23 streets.
24 These are really difficult
25 and complicated issues to tackle.

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

7 DR. CARSON WEINSTEIN:

8 Thank you, Dr. Reed.

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

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

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

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

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

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

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

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

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

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

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

1 your commitment to this crisis.

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

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

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

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

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

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

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

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

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

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

1 citywide system.

2 COUNCILWOMAN LOZADA: I
3 always find it interesting how --
4 and I mentioned this earlier. I
5 mentioned it multiple times. I
6 find it interesting how we can get
7 a flight anywhere, we can get an
8 Uber, we can get DoorDash, we can
9 get all of these services brought
10 to the area where it's nearest
11 where we are at the moment that we
12 need it, but when we're
13 experiencing a crisis and we can't
14 figure out how collectively we add
15 all of our information into one
16 place to be able to allow for a
17 police officer, outreach worker, a
18 resident, a family member, just
19 anybody to be able to figure out
20 where are these beds.

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

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

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

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

1 Councilmember, I'm ready for
2 treatment right now and it's
3 5 o'clock in the morning, I want to
4 be able to go into a location,
5 reserve that bed and have an
6 outreach worker come and pick that
7 person up immediately and take them
8 into the bed.

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

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

1 we can get to there.

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

13 DR. CARSON WEINSTEIN:

14 Dr. Durney.

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

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

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

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

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

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

6 The delay happens when
7 patients are looking for rehab, and
8 the rehab cannot accommodate the
9 medical complexity of the patient.
10 The Level 4 has been great for
11 that, but what's happening is
12 there's other levels that are
13 different criteria through ASAM
14 3.7, 3.5 which have their own
15 criteria and specifications.

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

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

7 COUNCILWOMAN LOZADA: Thank
8 you.

9 The Chair recognizes
10 Councilmember Harrity.

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

16 UNIDENTIFIED SPEAKER:
17 Can't hear you.

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

21 COUNCILMAN JONES: Test,
22 test.

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

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

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

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

1 adult or a child, you know.

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

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

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

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

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

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

3 I think there are a couple
4 of different routes into addiction
5 training. I think one of the
6 really interesting things about
7 addiction medicine and addiction
8 psychiatry training if you can come
9 in through the psychiatric
10 residency, you can come in through
11 a variety of medical or surgical
12 specialties as well as through
13 addiction medicine that are funding
14 for opportunities for that training
15 that involves giving up a year as
16 an attending. You have to motivate
17 people to seek that sort of
18 treatment -- or seek that sort of
19 education rather medication.

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

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

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

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

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

9 DR. CARSON WEINSTEIN:

10 Great. Thank you very much for
11 that question and for all the
12 questions. I want to make a really
13 important point, that I cared for
14 folks, as we all have, these wounds
15 go down to the tendon or bone. And
16 it has gotten to that point because
17 they are leaving unsheltered and
18 exposed to the elements.

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

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

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

1 Philadelphia. We can do anything.

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

5 (Applause.)

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

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

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

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

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

11 COUNCILMAN JONES: State
12 your name again.

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

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

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

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

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

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

1 take a patient.

2 COUNCILWOMAN LOZADA: Thank
3 you. The Chair recognizes
4 Councilmember Jones and then
5 Councilmember Ahmad.

6 COUNCILMAN JONES: Thank
7 you, Madam Chair.

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

17 So what I need a little bit
18 of clarity on is what is the
19 universe of need, what is the
20 universe of availability of beds,
21 what is the optimal time in your
22 professional opinion where someone
23 needs to stay in recovery to be
24 successful?

25 In another life I was on a

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

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

25 How do we triage and then

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

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

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

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

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

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

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

1 3.5 or 4 but there are patients who
2 can do very well at lower levels of
3 care because they have some of the
4 supports. So it helps guide
5 exactly what you're speaking to,
6 the resources to the people who
7 need it most and if patients are
8 maybe agreeable to a lower level of
9 care, outpatient, intensive
10 outpatient with the supports to
11 manage that, we get them to that
12 level of care as well. But many of
13 these patients need --

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

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

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

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

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

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

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

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

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

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

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

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

17 Councilmember Ahmad.

18 COUNCILWOMAN AHMAD: Thank
19 you, Madam Chair.

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

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

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

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

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

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

25 Like Dr. Martin was talking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 DR. CARSON WEINSTEIN:

13 Thank you.

14 COUNCILWOMAN AHMAD: Thank
15 you, Madam Chair.

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

25 And I think that it's

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

14 The Chair recognizes
15 Councilmember Driscoll.

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

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

25 DR. DURNEY: So depending

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

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

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

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

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

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

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

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

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

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

7 COUNCILMAN DRISCOLL: Sure.

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

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

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

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

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

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

10 COUNCILMAN DRISCOLL: Thank
11 you. Madam Chair.

12 COUNCILWOMAN LOZADA: Thank
13 you. The Chair recognizes
14 Councilmember Harrity.

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

1 consider using some of those
2 dollars that we currently have and
3 redirect them to creating
4 opportunities that would help
5 really address the crisis that we
6 have.

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

12 (Applause.)

13 COUNCILWOMAN LOZADA: When
14 I went to Council President and
15 said, Council President, we have a
16 Public Safety Committee that
17 responds to the public safety
18 issues in our city but we need a
19 special committee that will just
20 speak to the crisis that we're
21 experiencing in the Kensington
22 community and it needs to be
23 separate from the Public Safety
24 Committee.

25 I didn't have to advocate a

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

11 The Chair recognizes
12 Councilmember Harrity.

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

21 Before that time when my
22 father first got sober in early
23 '80s, he was a Vietnam vet
24 suffering from post-traumatic
25 stress, and the rule was no mind-

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

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

24 DR. MARTIN:

25 Dr. Christopher Martin. There are

1 a couple of injectable options.

2 There are multiple brand names for

3 buprenorphine which is the active

4 ingredient Suboxone that you

5 mentioned, so that can be given

6 monthly. And also, naltrexone.

7 Naltrexone, Vivitrol branded, has a

8 long-acted injectable form as

9 well --

10 COUNCILMAN HARRITY: That's

11 the one that (inaudible) --

12 DR. MARTIN: It blocks the

13 effect of it. There's an alcohol

14 treatment medication that will make

15 you physically ill.

16 COUNCILMAN HARRITY:

17 Because that's kind of a matter of

18 catch 22, right. Some of these

19 maintenance medicines actually make

20 people ill (inaudible) and I guess

21 it's just the -- I'm sorry. So

22 it's just the preference of the

23 client of which works better. So

24 in your opinion which medication

25 would be a better fit?

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

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

19 COUNCILMAN HARRITY: Okay.
20 Thank you.

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

24 Are there any other
25 questions from the Committee

1 members?

2 COUNCILWOMAN AHMAD:

3 (Inaudible).

4 COUNCILWOMAN LOZADA: There

5 being none and before the Clerk

6 calls the next panel, I'd like to

7 call Council President Kenyatta

8 Johnson for remarks.

9 (Applause.)

10 COUNCIL PRESIDENT JOHNSON:

11 Well, first I just want to say good

12 morning. I just wanted to take

13 time out of my schedule today to

14 come support the work that the

15 Special Committee of Kensington has

16 been doing and most importantly

17 just inspired and powered by your

18 leadership, so anything that I can

19 do to continue to be supportive of

20 your efforts.

21 I think when we talk about

22 breaking down barriers to treatment

23 we should be doing everything we

24 can to do possibly, especially

25 around the Kensington issue, but

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

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

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

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

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

7 (Applause.)

8 COUNCILWOMAN LOZADA: Thank
9 you, Council President.

10 Will the Clerk please call
11 the next panel to testify.

12 THE CLERK: Yes.

13 Dr. Maggie Lowenstein.

14 (Applause.)

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

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

1 COUNCILWOMAN LOZADA:

2 (Nodded affirmatively).

3 DR. LOWENSTEIN: Great.

4 Okay. Good morning, Councilmember
5 Lozada and members of the
6 Committee. And thanks for the
7 opportunity to testify on this
8 critical topic. I am a
9 Philadelphian and a resident in
10 Councilmember Squilla's District
11 and I'm also a addiction medicine
12 physician at Penn where I focus on
13 providing care for patients with
14 substance use disorders both in the
15 hospital as well as in outpatient
16 settings and focus on progress to
17 improve access to substance use
18 treatment.

19 Today I'm testifying on my
20 own behalf based on my experience
21 as an addiction treatment provider
22 and researcher for the past 10
23 years. Over this time I've
24 witnessed the severity of the
25 crisis in our city but also the

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

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

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

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

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

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

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

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

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

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

1 complications and reducing the
2 spread of diseases like HIV and
3 Hepatitis and we anticipate the
4 complications like wounds and
5 infections will become more
6 prevalent and severe in the absence
7 of sustainable funding for needle
8 exchange programs.

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

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

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

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

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

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

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

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

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

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

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

1 medication for opioid use disorder
2 improves outcomes for those living
3 with addiction. And what we really
4 need to think about is prioritizing
5 in our city same-day access to
6 these effective medications and
7 making it easier for people to stay
8 in treatment by adopting approaches
9 that prioritize medication support
10 as soon as possibly and deliver
11 care to people when and where they
12 need it. This includes same-day
13 initiation or re-initiation of
14 medications like methadone or
15 buprenorphine and use of adequate
16 and up-to-date doses of these
17 medications without restriction as
18 well as removing other outdated
19 policies that prevent people from
20 staying in treatments like
21 discharge for one episode of use,
22 like zero tolerance-type rules.

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

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

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

1 use disorder care and improving
2 social supports like housing.

3 We need to focus on high
4 quality evidence-based treatment
5 and low barrier access to
6 medications like buprenorphine and
7 methadone. We need to continue to
8 invest in comprehensive inpatient
9 and outpatient treatment service
10 for those with medical complexity.
11 Thank you again for the opportunity
12 to testify and I look forward to
13 your questions.

14 COUNCILWOMAN LOZADA: Thank
15 you for your testimony.

16 (Applause.)

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

25 A year ago we met with a

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

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

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

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

6 DR. LOWENSTEIN: Sure.

7 Those are great questions. So I
8 think the first question of just
9 sort of how we address some of the
10 barriers to beds, I would just
11 amplify some of the comments made
12 by my colleagues on the prior
13 panel. I think more transparency
14 around sort of how people can get
15 referred, where their space is
16 important.

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

1 wound care, administer medications,
2 things like that.

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

14 Those who are in the
15 hospital we can keep them and
16 continue to medically stabilize
17 them while they're admitted. For
18 those coming from the community
19 seeking treatment, it's difficult
20 to ask for someone to sit for 15,
21 20, 30 hours waiting for a bed
22 without any sort of treatment. So
23 if there are ways that we could --
24 they don't necessarily have to be
25 in a bed, but if there are ways we

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

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

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

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

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

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

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

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

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

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

1 day, 7 days a week?

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

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

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

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

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

18 COUNCILWOMAN AHMAD: Yes.

19 COUNCILWOMAN LOZADA: The
20 Chair recognizes Councilmember
21 Ahmad.

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

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

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

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

13 As far as the medical
14 treatment, we do recommend sort of
15 long-term prescribed medications
16 for opioid use disorders,
17 buprenorphine and methadone. And
18 those are administered in, you
19 know, buprenorphine can prescribed
20 in many different settings,
21 including primary care where I do
22 it. Methadone can be administered
23 in methadone clinics and both are
24 set up to do longitudinal
25 treatment.

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

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

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

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

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

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

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

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

11 Thank you, Madam Chair.

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

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

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

1 those who are suffering from

2 addiction or those who need it?

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

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

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

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

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

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

19 COUNCILWOMAN LOZADA: The
20 Chair recognizes Councilmember
21 Driscoll.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 COUNCILWOMAN LOZADA: The
16 Chair recognizes Councilmember
17 Harrity.

18 COUNCILMAN HARRITY: Hello.
19 How are you today. So there's been
20 a lot of talk about the beds but
21 also the outpatient programs.
22 Actually the first place I ever
23 went was Penn's outpatient program
24 on 40th and Market back then in the
25 '80s.

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

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

1 these people?

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

9 COUNCILMAN HARRITY: It's
10 personal.

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

1 capacity.

2 COUNCILMAN HARRITY: Thank
3 you.

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

7 (No response.)

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

11 (Applause.)

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

15 THE CLERK: Commissioner
16 Marquita Williams, Deputy
17 Commissioner Amanda David, Andrew
18 Devos, followed by David Holloman,
19 Deputy Commissioner Pedro Rosario,
20 Joelle Anderson and Noelle Foizen.

21 (Applause.)

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

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

4 DR. WILLIAMS: Good
5 afternoon.

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

9 DR. WILLIAMS: Hello. Can
10 you hear me?

11 COUNCILWOMAN LOZADA:
12 (Nodded affirmatively).

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

1 was unable to attend today.

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

15 DBHIDS' approach is to
16 enhance the continuum of service
17 options in which the level of
18 service matches the behavioral
19 health needs and circumstances of
20 individuals seeking behavior health
21 services. CBH, DBHIDS' contracted
22 Medicaid-managed care organization,
23 has served as a cornerstone of
24 Philadelphia's behavioral health
25 system maintaining a comprehensive

1 network of approximately 200
2 behavioral health providers.

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

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

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

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

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

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

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

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

1 need.

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

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

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

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

9 The ASAM criteria include
10 requirements for developing four
11 levels of recovery-oriented,
12 evidence-based SUD treatment
13 services, each designed to meet an
14 individual's specific treatment
15 needs. The ASAM criteria covers
16 SUD screening and assessment
17 diagnosis and a determination of
18 the best level of care for an
19 individual based on their current
20 symptoms.

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

1 treatment as medically necessary
2 before the individual can receive
3 the treatment.

4 This year, 2024, we removed
5 prior authorization for medically
6 managed withdrawal management
7 formerly referred to as detox. CBH
8 also removed prior authorizations
9 for Level 3.5 ASAM care, which
10 includes medically-managed
11 residential SUD care for
12 individuals with serious
13 psychological or social issues who
14 need 24-hour oversight and who are
15 at risk for imminent danger to
16 themselves or others.

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

25 DBH has also taken various

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

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

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

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

6 When an in-county provider
7 is at capacity, CBH will authorize
8 an out-of-county bed-base level of
9 care. The CRC staff then works
10 with the out-of-county provider to
11 arrange transportation typically
12 provided by the provider to
13 transfer the member to the out-of-
14 county bed.

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

25 These were added to the bed

1 ability to the network in 2022.
2 We've increased the low-intensity
3 SUD residential treatment service
4 availability in 2022 through
5 expanding contracts with existing
6 providers. There are four new
7 regionalized intensive SUD
8 outpatient service programs. These
9 were also created in 2022 through
10 expanding contracts with in-network
11 providers.

12 We've increased our
13 outpatient addiction services also
14 in 2022 by expanding contractors
15 with additional in-network
16 providers such as the Wedge
17 Recovery Centers and Kirkbride.
18 These resulted in the Wedge
19 offering Medicaid-reimbursable
20 services at a new location and
21 enabled Kirkbride to expand their
22 outpatient SUD services, allowing
23 Kirkbride to provide a full
24 continuum of SUD services.

25 We've also increased our

1 partial hospitalization program
2 offerings, providing MAT in 2022
3 treatment for occurring treatment
4 and other behavior health
5 diagnosis. This has resulted in 50
6 additional SUD partial
7 hospitalization slots for CBH
8 members.

9 These services include
10 20-plus hours of weekly organized
11 outpatient treatment during the day
12 for people with SUD who need
13 intensive routine care but who do
14 require 24/7 attention in a
15 residential SUD facility. Further,
16 we've entered a contract or
17 contracts with out-of-network
18 providers to provide methadone
19 induction.

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

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

6 The mobile wound care vans
7 also provide physical health
8 clearance for admission into
9 substance use disorder programs
10 across the city. The mobile wound
11 care program partners with homeless
12 outreach, Rock Ministries, PDPH,
13 PPD, the Managing Director's Office
14 and community providers throughout
15 Philadelphia. This program has
16 partnerships with providers with
17 health systems throughout the city
18 as well.

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

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

6 In response, in 2023 DBHIDS
7 launched the Level 4 ASAM Post-
8 acute Wound Care program in
9 partnership CBH, Kensington
10 Hospital and Eagleville Hospital.
11 This innovative program provides
12 post-acute hospital-based SUD care
13 to individuals who need intravenous
14 antibiotics. To be eligible for
15 the program, an individual must
16 have been hospitalized in the
17 medical unit, have severe wounds
18 and need a PICC line for
19 intravenous antibiotics.

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

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

9 The DBHIDS Mobile Outreach
10 and Recovery Services Unit also
11 works to provide linkages to
12 recovery support and substance use
13 treatment. MORS has engaged over
14 2,000 individuals and facilitated
15 346 linkages treatment and is able
16 to facilitate more rapid access
17 into treatment by providing
18 assessments from within the
19 community.

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

1 with DBHIDS staff to assess the
2 barriers reported from both the
3 crisis centers and the treatment
4 providers to better understand the
5 concerns and possible challenges
6 leading towards long waiting times.
7 Based on the responses, a work
8 group including the providers will
9 work together in developing
10 processes to eliminate any gaps
11 that will impact the delivered
12 services.

13 Couples and families:
14 Treatment programs are for
15 individuals. However, Philadelphia
16 does offer several SUD programs
17 where women can receive treatment
18 with their children. In order to
19 ensure access for individuals
20 across the developmental life span,
21 we are working to advance maternal
22 health equity and access to SUD
23 treatment for mothers struggling
24 with addiction as another top
25 priority at DBHIDS.

1 In fact, in 2018 CBH
2 launched the Mommy Helping Hand
3 program. CBH Care managed,
4 coordinate care for pregnant and
5 postpartum birthing mothers with
6 SUD and other physical and
7 behavioral health conditions to
8 meet their multiple needs. Our
9 Care managers meet members in their
10 homes and in other community
11 settings, schedule doctors'
12 appointments, educate them on
13 health concerns and connect them to
14 community resources.

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

24 DBHIDS partners with many
25 local health care providers and

1 other organizations to connect our
2 members with immediate SUD care.
3 We work with surrounding counties
4 and take individuals from these
5 counties into programs that
6 contract with our insurances. If
7 someone from out of county is
8 uninsured, we will work with the
9 county, see what county authority
10 to get the individual placed in the
11 county of origin. DBHIDS works
12 with the court system, PPD, housing
13 and a number of other agencies to
14 support the navigation and needed
15 resources for all individuals in
16 need. We understand that this is a
17 complex challenging concern and it
18 takes a multi-layered solution.

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

1 with you, the Mayor's
2 Administration and other
3 stakeholders to address the SUD and
4 our behavior health challenges
5 facing Kensington and our great
6 city.

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

17 COUNCILWOMAN LOZADA: Thank
18 you so much for your testimony.
19 I'm going to move to have questions
20 asked of Dr. Williams by the panel
21 and then we are going to take a
22 30-minute break, and then we will
23 return to hear the rest of the
24 panel and then move on to public
25 testimony.

1 Thank you so much for being
2 with us.

3 DR. WILLIAMS: Thank you.

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

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

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

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

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

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

1 through our system.

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

10 And so, there's a lot of
11 conversation about what's
12 available, when people want it and
13 what's not available. But if you
14 look at our website every day, the
15 number is there around how many
16 beds are available. And it seems
17 to be typically somewhere around
18 100 beds. What that also means is
19 that if we have 1874 beds and only
20 100 beds available, at any given
21 time you have 1700 people moving
22 through the treatment continuum.

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

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

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

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

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

14 DR. WILLIAMS: Yeah.

15 COUNCILWOMAN LOZADA: Would
16 you say consistently on a daily
17 basis, consistently on a weekly
18 basis, on a monthly basis --

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

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

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

1 evening. In the morning, it was
2 108 beds. So it moves up and down
3 as people move in and out of the
4 treatment, the level of care that
5 they're in.

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

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

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

15 MS. DAVID: Quarterly.

16 DR. WILLIAMS: Quarterly we
17 do --

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

25 COUNCILWOMAN LOZADA: In

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

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

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

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

25 DR. WILLIAMS: I don't have

1 the number of providers in the
2 Kensington community, but there are
3 80 as to the treatment providers.

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

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

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

23 DR. WILLIAMS: Right.

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

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

13 MR. HOLLOMAN: Good
14 morning, Council Chairperson
15 Lozada. Dave Holloman, Interim
16 Executive Director for the Office
17 of Homeless Services. Just want to
18 report on the number, according to
19 our point-in-time count which the
20 Office of Homeless Services
21 continuum of care is mandated to do
22 one count per year, the number of
23 people that were counted this past
24 January that were unsheltered was
25 976.

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

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

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

1 to 600 that's in the Kensington
2 area.

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

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

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

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

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

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

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

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

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

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

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

17 COUNCILWOMAN LOZADA:

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

22 DR. WILLIAMS:

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

1 it to you.

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

6 COUNCILMAN HARRITY: I do.

7 COUNCILWOMAN LOZADA: The
8 Chair recognizes Councilmember
9 Harrity.

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

25 DR. WILLIAMS: When we say

1 121 beds, those are substance use
2 disorder treatment beds. And
3 Amanda I think has some additional
4 information.

5 MS. DAVID: So for the 3.5
6 beds, we had 77. For 3.7,
7 medically-monitored intensive
8 inpatient services we have 10. For
9 3.7 WM, we had 30. The ACM 4.0,
10 medically-managed intensive
11 outpatient, this morning we had 1.
12 Now, we have 12 I got a
13 notification on. And then ACM 4.0
14 withdrawal management is 3.

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

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

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

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

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

1 we've talked about, those are very
2 medically-intensive beds. Those
3 are people that have chronic
4 medical. They're going to need
5 24/7 staffing. And it really
6 aligns with the staffing. That's
7 part of what some of the medical
8 professionals this morning were
9 talking about, making sure somebody
10 with a PICC line can go into a
11 place where they're going to be
12 able to get that kind of treatment
13 and have doctor care 24/7. So it's
14 a continuum of care, kind of less
15 intensive to more intensive.

16 COUNCILMAN HARRITY: It
17 kind of baffles me because I see
18 these poor individuals every day
19 and by my layman diagnosis of
20 looking at them and interacting
21 with them, they're all 3.7 to 4.0.
22 So why are we even messing around
23 with the other stuff, you know what
24 I'm saying? Let's make them all
25 3.7 and be done with it and get

1 everybody into treatment. I just
2 don't --

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

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

17 MR. DEVOS: Correct.

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

25 MR. DEVOS: I would agree

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

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

21 So my thing is why are we
22 even bothering with the other
23 stuff. Let's just make them all
24 3.7, 4.0 and send them. If the
25 beds are there, just send them all

1 in.

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

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

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

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

19 COUNCILWOMAN LOZADA:
20 There's a crisis in Kensington.
21 There's a crisis in Kensington.
22 We've been talking about the crisis
23 for years. You all have \$1.7
24 billion in a budget, \$1.7 billion.
25 There's a crisis in Kensington.

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

5 DR. WILLIAMS: I appreciate
6 that.

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

10 DR. WILLIAMS: We recognize
11 it.

12 COUNCILWOMAN LOZADA: We
13 can't keep coming to hearings -- we
14 cannot keep coming to hearings and
15 not have any information.
16 Commonsense answers to very
17 commonsense everyday questions that
18 we have asked multiple times. All
19 of these questions, all of these
20 questions I asked during the budget
21 hearings. These are common sense.
22 We need to respond to the crisis
23 that we have. We have talked about
24 the barriers that we have. Why
25 haven't we responded to them

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

3 We have providers. How
4 many providers are here? Who's
5 getting the money? Who are they
6 responding to? Are we responding
7 to 1,000 people, to the 976 people
8 that we say or are the same five
9 providers responding to the same
10 200 people? And if they are, then
11 let's shift the money.

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

16 (Applause.)

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

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

4 (Applause.)

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

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

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

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

13 DR. WILLIAMS: Yeah.

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

25 If we have to shift how

1 we're giving people money to be
2 able to provide services, then as a
3 Committee we need to be able to do
4 that. We can't do it if you're not
5 being transparent. And so, I want
6 to for the life of me -- I don't
7 want to have a heart attack up here
8 today. But I want to make sure
9 that people that come up here
10 today -- we're recessing, we are
11 going to recess and we're going to
12 come back. We're going to recess
13 for 30 minutes. But I don't expect
14 people to come up here to tell me
15 you don't have the information.
16 You've had a year, a year to
17 respond and find the information.
18 I know you don't. I know
19 you haven't had a year. And I
20 recognize that there are people in
21 this Administration that have not
22 been in their positions for a long
23 time, but you knew what the issues
24 were coming in. You know what the
25 issues are coming in. And you've

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

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

14 (Applause.)

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

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

20 COUNCILWOMAN LOZADA: Yes,
21 ma'am.

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

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

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

22 COUNCILWOMAN LOZADA: A
23 large part of it.

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

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

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

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

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

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

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

14 COUNCILWOMAN AHMAD: Total
15 across the city?

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

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

1 number for you, but it doesn't mean
2 tomorrow that we're going to need
3 800 beds. We have to make sure
4 that we have a number of beds ready
5 for the people who present
6 themselves at a specific moment in
7 time and we have had that.

8 We not only have these 121
9 beds, but we have out-of-network
10 beds and we have surge beds. We're
11 waiting for this big surge and
12 making partnerships and contracts
13 with people for that time to come.
14 So I want you to understand that
15 we're thinking about it in the same
16 way that you're thinking about it
17 and holding these spaces for the
18 time that will come. But I think
19 it's faulty to think that if you
20 have this group that they're going
21 to need that number of beds in that
22 same day.

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

1 828 people from living unsheltered
2 in the streets of Kensington.

3 DR. WILLIAMS: Yes, I
4 agree.

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

9 DR. WILLIAMS: Got it.

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

19 DR. WILLIAMS: Got it.

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

24 (Lunch recess.)

25 COUNCILWOMAN LOZADA: We're

1 going to get ready to begin and
2 continue our hearing. This public
3 hearing of the Special Committee on
4 Kensington is regarding Resolution
5 240510.

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

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

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

1 DBHIDS.

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

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

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

14 MR. DEVOS: Thank you,
15 Commissioner.

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

20 MS. ANDERSON: Joelle
21 Anderson.

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

1 Commissioner Williams gave her
2 testimony. My colleague didn't
3 have an opportunity to ask
4 questions. And so, I'd like to
5 recognize Councilmember Dr. Nina
6 Ahmad to proceed with her
7 questions.

8 COUNCILWOMAN AHMAD: Thank
9 you, Madam Chair.

10 Good afternoon. Thank you
11 for being here.

12 DR. WILLIAMS: Good
13 afternoon.

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

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

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

3 MS. DAVID: 28.

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

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

1 3.5, so there's a different level
2 of services that go because of the
3 way that they're identified.

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

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

24 It is actually just a 1, 2,
25 3, 4, 5 kind of count where we

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 need.

2 Thank you, Madam Chair.

3 DR. WILLIAMS: Thank you,
4 Councilwoman.

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

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

1 information, where can we find that
2 information? When can we have that
3 information?

4 I think it's important that
5 those very basic questions are
6 answered because like all of you,
7 we on this Committee have a
8 responsibility to respond to
9 community residents, right. And if
10 we're going to town halls, if we're
11 going to community meetings and
12 people are consistently telling us
13 this is a good provider, that's a
14 bad provider, this is a provider
15 that's not really doing what they
16 say that they're doing and they're
17 continuing to receive contracts, it
18 becomes a problem, right.

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

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

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

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

1 services to this community, right.

2 Can we all agree on that?

3 DR. WILLIAMS: Yes.

4 COUNCILWOMAN LOZADA: And

5 so, these are questions that this

6 community has had for a long time.

7 And I need to know that you know

8 who your providers are who are

9 here, that you recognize that they

10 are your providers, that you

11 recognize how much money you're

12 paying them, that you know the

13 services that we expect them to be

14 delivering to the people of this

15 community. And that if you realize

16 that they are not providing these

17 services, that we create mechanisms

18 that will allow us to redirect

19 those dollars. And it shouldn't

20 matter to us who the hell that

21 person is connected to, who they

22 know, how long they've been in the

23 system, right. It shouldn't matter

24 to us.

25 What should matter to us is

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

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

20 (Applause.)

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

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

11 (Applause.)

12 COUNCILWOMAN LOZADA: It's
13 common sense.

14 DR. WILLIAMS: Right.

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

1 holy shit. I don't want that.
2 That's not who I am. As an
3 individual, that's not who I am.
4 I want you to understand
5 that I'm going to hold you
6 accountable. And I want to be held
7 accountable too. I do, right. I
8 don't want people to be freaked out
9 when I walk into a room because I'm
10 going to ask them a question that
11 they don't know an answer to. Yes,
12 you do. You know I'm going to ask.
13 You know because I've asked before,
14 right. And you know because we
15 have a responsibility to the
16 people.
17 We have a responsibility to
18 change what has been happening here
19 for a really long time. And so, I
20 want to do this together. I never
21 want people to feel like I got them
22 because I don't want to have you.
23 That's not the kind of business
24 that I want to be in. But I do
25 want you to know that I'm going to

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

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

10 DR. WILLIAMS: Yes.

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

25 So I'm going to allow you

1 the floor. Thank you very much.

2 DR. WILLIAMS: Thank you,
3 Councilwoman. We appreciate that.
4 And I appreciate your passion every
5 time I see you, right. We want the
6 same things. We wanted the same
7 things yesterday. We want the same
8 things today.

9 In our plight to make sure
10 that we're doing things better,
11 we're doing many of the things that
12 you're talking about, looking at
13 our providers, making sure the ones
14 that are bad actors are out of our
15 system, looking at the small
16 providers that maybe don't have the
17 capacity and infrastructure of some
18 of the larger ones but they're
19 doing great work, they have great
20 outcomes. And we've been looking
21 at ways to bring them into our
22 system. There are a number of
23 things that CBH has been doing to
24 make it a lot easier to become a
25 provider as well as that DBH has

1 been doing with BIPOC providers.

2 And so, I wanted to let you know
3 that we hear you and we're right
4 there with you.

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

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

1 that with my team and your team.

2 COUNCILWOMAN LOZADA: Thank
3 you.

4 DR. WILLIAMS: Yes.

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

14 But here in 19134, we have
15 APM which as both a substance use
16 outpatient program and a mental
17 health outpatient program. We have
18 Beacon Point Recovery, which has
19 120 SUD beds and broken out by 90
20 of them are 3.5 and 30 of those are
21 3.7 WM, withdrawal management which
22 used to be known as detox.

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

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

9 We have Esperanza, which is
10 a federally qualified health
11 center. They also do medication-
12 assistive treatment there. Very
13 small mental health outpatient
14 program called Get Well, which is
15 really just one psychiatrist.
16 Hispanic Community Counseling which
17 has three mental outpatient
18 locations here. And finally in
19 19134, PHMC has Pathways to
20 Recovery which is the substance use
21 disorder partial hospital program
22 that has 60 slots. That's where
23 people can go up to 20 hours or
24 more per week.

25 In 19125, COMHAR has

1 another mental health outpatient
2 program. We have a mental health
3 outpatient provider called Emilio
4 Medical Group. And then one of our
5 largest providers in our network
6 which is Temple Episcopal which has
7 as well as -- they have the Temple
8 faculty practice plan, which is
9 kind of the doctor group like we
10 said with Jefferson this morning.
11 They also have a mental health
12 outpatient clinic. They have the
13 crisis response center, a large
14 acute inpatient psychiatric
15 program. Then they also have
16 something called an Extended Acute,
17 which is a psychiatric program for
18 people who need longer term --

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

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

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

5 COUNCILWOMAN LOZADA:
6 (Nodded affirmatively).

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

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

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

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

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

1 has one mental health outpatient
2 program and three substance use
3 disorder outpatient programs in the
4 19124. We can get those to you as
5 well.

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

14 Are they providing services
15 to 200 individual clients? Are
16 they providing services to the same
17 200 clients, right? How often are
18 these clients frequent flyers? And
19 do you even do an assessment of
20 these individual providers? And if
21 so, give us a report back on how is
22 that assessment, what do you
23 assess, how do you make decisions
24 to shift dollars. I want to know
25 everything you know about these

1 individual people, right.

2 If they provide beds, if
3 they're responsible for beds, how
4 many beds are they responsible for?
5 What are the challenges that
6 they're experiencing when people
7 are reaching out to them to get
8 people into these beds, what are
9 the challenges?

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

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

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

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

6 The Chair recognizes
7 Councilmember Harrity.

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

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

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

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

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

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

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

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

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

3 MS. DAVID: Yes.

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

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

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

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

13 COUNCILMAN HARRITY: No,
14 this is done --

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

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

20 MR. DEVOS: No.

21 COUNCILMAN HARRITY: Then
22 how can they make that decision?

23 MR. DEVOS: I
24 understand your concern.

25 COUNCILMAN HARRITY: Then

1 there's no way to make that
2 decision.

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

6 COUNCILMAN HARRITY: You
7 understand what I'm saying?

8 MR. DEVOS: Yep,
9 absolutely.

10 COUNCILMAN HARRITY:
11 Absolutely ludicrous and this is
12 quite frankly bullshit, you know
13 what I mean. We're talking about
14 families here. I don't care what
15 it is. If the person on the ground
16 says this should be a 3.7 and
17 somebody else is changing it to a
18 3.5, that is not right. The person
19 who is physically in front of the
20 person should be the person making
21 that decision.

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

24 MR. DEVOS: No, understood.

25 COUNCILMAN HARRITY: -- I'm

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

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

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

17 MR. DEVOS: Correct.

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

21 MR. DEVOS: Correct.

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

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

1 for that.

2 MR. DEVOS: No, I
3 completely understand your
4 frustration.

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

10 UNIDENTIFIED SPEAKER:
11 Can't hear.

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

25 There's no way somebody can

1 make an assessment over the phone
2 not even looking at a person,
3 seeing what the physical condition
4 that they're in is and then make an
5 informed judgment of their
6 treatment should be cut down from
7 3.7, 3.5 when they haven't had a
8 chance to observe the person in
9 person. That's not acceptable.

10 COUNCILWOMAN LOZADA: Thank
11 you, Councilmember.

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

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

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

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

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

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

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

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

1 their next level of care.

2 COUNCILMAN SQUILLA: The
3 reason why I'm asking that question
4 is we have people who are unhoused
5 and people who have told us that
6 they have nowhere to go, yet they
7 will be assessed as IOP, MAT. And
8 we don't see how that is possible
9 for that person to get the
10 successful care that they need in
11 order to get the help that they
12 need. So we want to understand why
13 they're being assessed at that
14 level knowing what their situation
15 is and then how we could help to
16 change that. And I know we have
17 available beds so it's not because
18 we don't have enough beds
19 available, right. So what is the
20 reason why it seems like these
21 folks that really have nowhere to
22 go are still being assessed at that
23 level?

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

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

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

10 MR. DEVOS: Sure.

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

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

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

6 There are people -- we're
7 going to get the unique number of
8 people served by provider for the
9 Councilperson. I think it would
10 also be good for us to look at how
11 many people -- because we have over
12 8,000 people who were in bed-based
13 substance use services. But that
14 just represents the unique people
15 that have that service. Some of
16 them might have been in three times
17 in the year. So I think that's
18 compelling information.

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

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

24 COUNCILMAN SQUILLA: Unique
25 not --

1 MR. DEVOS: Correct, yep.

2 But some of them may have been in
3 more than one time.

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

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

15 COUNCILMAN SQUILLA: 8,000
16 unique individuals?

17 MR. DEVOS: Yeah.

18 COUNCILMAN SQUILLA: And
19 you have both those numbers?

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

1 things on the backend. We --

2 COUNCILMAN SQUILLA: What
3 is working, what is not working,
4 right.

5 MR. DEVOS: Correct.

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

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

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

1 right?

2 MR. DEVOS: Right.

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

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

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

11 MR. DEVOS: (Nodded
12 affirmatively).

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

16 MR. DEVOS: Correct.

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

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

5 COUNCILWOMAN LOZADA: And I
6 think that speaks to the why we
7 need to know who the providers are,
8 who they're serving, what level of
9 services and have the capacity to
10 be able to be redivert if we find
11 that we're not getting what we
12 need, right. It's because of
13 reasons as basic and as simple as
14 those that the Councilmember has
15 just finished describing, right.
16 And so, getting us that information
17 is extremely important for us to
18 continue to be able to do the work
19 that we know to need to do in order
20 to improve quality of life for
21 those who are suffering in
22 addiction and the people of this
23 community. So thank you so much.
24 We look forward to receiving that
25 information.

1 COUNCILMAN SQUILLA:

2 (Inaudible).

3 COUNCILWOMAN LOZADA: And

4 we talked about that, right,

5 providing resources for them to

6 continue on their road to

7 successful healthy living.

8 I'd like us to,

9 Mr. Clerk -- are there any other

10 questions for DBHIDS?

11 COUNCILWOMAN AHMAD: I

12 don't know if this is the right

13 place to ask this question, but you

14 all obviously will be involved in

15 this case. I wanted to ask about

16 the issue of (inaudible) and what's

17 your role in that and what is the

18 outcome for patients who are

19 (inaudible). So I don't know if

20 this is the right panel to ask

21 this. So through your

22 disaggregating of data, do you have

23 this type of patient who

24 involuntarily is taken in and

25 subjected to (inaudible)?

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

13 COUNCILWOMAN AHMAD: Being
14 treated.

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

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

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

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

25 MR. DEVOS: For

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

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

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

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

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

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

1 been a bill already.

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

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

19 MR. DEVOS: Correct.

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

1 there, and we need to know to put
2 this much money in this individuals
3 who are treated, this is they are
4 being tracked one year out, six
5 months out, whatever the case. We
6 need that data. We just need to
7 know what is happening with
8 patients that you're treating
9 because that should determine how
10 you're awarded contracts to these
11 providers. But you must have that
12 data, am I correct, that you are
13 tracking their progress and who
14 they're treating and what the
15 outcome for those patients are.
16 You have that data?

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

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

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

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

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

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

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

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

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

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

16 MR. DEVOS: A profile of
17 the provider of their number of
18 critical incidents, the number of
19 complaints.

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

1 and Accountability Collaborative.
2 They do a multi-level review for
3 all of our levels of care, and it
4 assesses the provider where they do
5 a clinical tour, they do a clinical
6 record review, staff file reviews,
7 conversations with individuals
8 receiving services. They do a
9 living review with talks to the
10 indiv -- they review the record,
11 they talk to the individual, they
12 talk to the individual's counselor,
13 they talk to the individual's
14 counselor's supervisor to make sure
15 all the information matches. And
16 then a credentialing status is
17 determined by that along with
18 whatever's happened with them
19 related to quality and compliance,
20 so there's a --

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

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

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

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

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

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

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

8 Thank you, Madam Chair.

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

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

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

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

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

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

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

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

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

1 have.

2 COUNCILWOMAN LOZADA: --

3 unless there's something extremely
4 serious. And what I want people to
5 understand is that this is a new
6 Administration, this is a new day
7 and I don't care who you know and
8 who you don't know and how long
9 you've been a provider. If you're
10 not handling your business in this
11 community, then you shouldn't get a
12 contract, right. It's that simple.

13 (Applause.)

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

25 We're really great at, oh,

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

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

23 MR. DEVOS: And we can get
24 you that.

25 COUNCILWOMAN LOZADA: --

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

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

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

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

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

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

23 COUNCILWOMAN LOZADA: Thank
24 you.

25 Are there any additional

1 questions for this particular part
2 of the panel?

3 There being none --

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

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

13 COUNCILMAN SQUILLA: No.

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

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

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

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

1 want to apologize to our officers.
2 I know that the 25th Police
3 District is having an extremely
4 important event today where they
5 are hosting a community block party
6 and many of our officers are here
7 and can't attend. And that's an
8 extremely important event because
9 they recognize that community
10 residents are sometimes living in
11 communities or in neighborhoods on
12 blocks that are occupied by
13 individuals that don't allow them
14 to come freely out of their homes
15 or kids can't play out in the
16 street. And the 25th Police
17 District has year after year
18 ensured that the community has a
19 day for them to feel like they can
20 run and jump and play and be in the
21 community together, and that is
22 happening today and many of them
23 are here with us and can't
24 participate.

25 So I want to make sure that

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

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

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

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

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

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

16 What are the challenges
17 that some of your officers
18 experience getting people into
19 beds, getting people into some of
20 those services that they
21 desperately need?

22 DEPUTY COMMISSIONER

23 ROSARIO: Good afternoon,
24 Councilwoman and body. It's a
25 privilege to be here before you

1 today to be able to speak before
2 you in our community and provide
3 you with a significant update. To
4 answer your question, first of all,
5 I want to acknowledge that I have
6 Inspector Bullick -- Inspector Luca
7 -- sorry, I promoted him --
8 Inspector Luca, Captain Bullick,
9 Lieutenant Pittaoulis, Sergeant
10 Hannesson, Lieutenant Casale. I
11 really want you guys to understand
12 what we are trying to create here,
13 the type of atmosphere
14 understanding that the community of
15 Kensington has been an afterthought
16 for such a long time, right. And
17 under the leadership of Mayor
18 Parker and Commissioner Bethel has
19 been made a priority again to
20 re-establish a certain quality of
21 life, a certain expectation of
22 public service from its police.

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

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

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

24 For the officers that
25 encounter the unsheltered

1 population every day, it's
2 challenging. We've seen through
3 our own analysis that our officers
4 encounter these individuals about
5 17 times before they'll accept the
6 service, right, so 17 encounters
7 before they're willing to accept
8 some type of social service through
9 our unconventional approach, as
10 that's partnering up with Merakey,
11 our third service provider, and a
12 police officer, right, that
13 co-responder model that we're very
14 proud of that we're setting a model
15 for here in the state. And there
16 is value to that.

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

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

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

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

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

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

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

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

1 The other responsibility
2 the Commissioner has tagged me with
3 is this area has led the City
4 consistently with homicides and
5 shooting victims, I mean No. 1.
6 24th District, PSA No. 2 has been
7 consistently No. 1 in violent crime
8 for the last couple of years. So a
9 large part of our strategy has been
10 to come here and stabilize that,
11 understanding that my colleagues
12 next to me cannot come into this
13 space and do their jobs effectively
14 without making it safe for them.
15 So that's also been a large part of
16 our strategy, to come in and to
17 just really stabilize the area and
18 create that bubble for our folks to
19 be able to come in and be able to
20 be effective at their jobs.

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

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

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

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

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

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

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

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

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

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

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

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

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

15 DEPUTY COMMISSIONER
16 ROSARIO: I mean honestly, yeah,
17 the weekends. The weekends are
18 challenging for us. Right now the
19 way our systems are set up, it's
20 basically a Monday-through-Friday
21 16 hours. Sometimes we can enhance
22 those outreaches if we make a
23 request. And again, I'm not
24 talking about police. I'm just
25 talking about additional support.

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

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

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

24 COUNCILWOMAN LOZADA: So
25 every officer has a list of

1 providers that they can reach out
2 to for services?

3 DEPUTY COMMISSIONER

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

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

19 DEPUTY COMMISSIONER

20 ROSARIO: Sure.

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

1 it will be greatly appreciated.

2 Are there members of the
3 Committee that have questions?

4 The Chair recognizes
5 Councilmember Squilla.

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

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

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

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

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

19 DEPUTY COMMISSIONER

20 ROSARIO: Correct.

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

24 DEPUTY COMMISSIONER

25 ROSARIO: As I mentioned, there's a

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

9 Part of my job when I was
10 took this posting was to be
11 deliberate and collaborative in
12 meeting with a lot of members in
13 our community. And today I'm over
14 120 individual meetings with
15 members, whether it be individuals,
16 businesses, churches, principals.
17 They wanted to meet, we sat down
18 and talked. So we built
19 relationships that way.

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

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

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

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

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

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

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

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

4 COUNCILWOMAN LOZADA: Thank
5 you.

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

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

21 DEPUTY COMMISSIONER

22 ROSARIO: Sure, yeah.

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

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

12 DEPUTY COMMISSIONER

13 ROSARIO: So numbers?

14 COUNCILWOMAN AHMAD:

15 Meaning, you have -- I don't know
16 how you assess what activity is,
17 how you keep track of it, but
18 whatever metric you have has the
19 needle moved because of your
20 presence in this community?

21 DEPUTY COMMISSIONER

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

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

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

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

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

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

1 forget about you and I thank you
2 for doing that.

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

7 DEPUTY COMMISSIONER

8 ROSARIO: That's part of the
9 analysis that we're in the process
10 of doing.

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

1 DEPUTY COMMISSIONER

2 ROSARIO: Thank you. And we're
3 just getting started.

4 COUNCILWOMAN AHMAD: Thank
5 you, Madam Chair.

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

9 DEPUTY COMMISSIONER

10 ROSARIO: Thank you. It was my
11 pleasure.

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

17 (Applause.)

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

1 some of the challenges that they
2 experience.

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

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

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

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

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

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

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

1 It could be mental health.

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

10 Also, if a person is trying
11 to get out of the Kensington
12 corridor, we have a new site at
13 16th and Susquehanna, our ODAAT-PAD
14 site, where we have beds available
15 right then and there where they can
16 come. It's a quick intake. We
17 start the process of getting their
18 treatment plan started, whether
19 there's warrants, whatever the case
20 may be. And then they can go ahead
21 take a shower, lay down, sleep it
22 off. And then the next morning the
23 case managers at ODAAT will get the
24 process started. Everything is in
25 realtime. We don't wait.

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

5 Also, for our social
6 diversions we also have our mobile
7 resource fairs where we're having
8 our next resource fair at Frankford
9 and Cottman tomorrow where we meet
10 the people literally where they're
11 at and all of our providers, the
12 police, the CERT team, the PAD
13 officers, Salvation Army, Merakey,
14 various providers throughout the
15 entire city come and meet the
16 people where they're at and help
17 the people navigate various systems
18 of things that they need.

19 COUNCILWOMAN LOZADA: How
20 many people do you think that you
21 provide services to a day,
22 individual people, unique
23 individual people? How many people
24 do you think that you all provide
25 services to a day?

1 MS. ANDERSON: Per day that
2 definitely varies. I can
3 definitely look into that and get
4 you those numbers. But at our
5 resource fairs, we service --
6 because everyone signs in, we
7 service no less than 100 people at
8 our resource fairs in a matter of
9 three hours.

10 To date, I can give you
11 some numbers. So to date from the
12 beginning of January until now, we
13 have engaged with 3,935 people. We
14 have linked 1,973 people to
15 services. 209 of those people have
16 been to the CRC. 681 people have
17 been into inpatient. So I did want
18 to answer Councilman Squilla's
19 question when I got to it. 268
20 people have been connected to IOP,
21 which is ongoing. 227 social
22 diversions and then social services
23 are 588.

24 COUNCILWOMAN LOZADA: So
25 into actual beds you all have

1 gotten?

2 MS. ANDERSON: Into
3 inpatient, 681 people from January
4 until now.

5 COUNCILWOMAN LOZADA: And
6 that's from January to now?

7 MS. ANDERSON: Correct,
8 yes.

9 COUNCILWOMAN LOZADA: And
10 you all as a -- or you or whoever
11 you connected them to, you're able
12 to see how they've continued in
13 their --

14 MS. ANDERSON: Yes,
15 correct. Be it our peer support,
16 our great staff, our great case
17 managers, whether it be Salvation
18 Army, ODAAT, Prevention Point,
19 University of Penn as well, we're
20 able to literally follow them every
21 step of the way, can tap in at any
22 time and ask can I get an update on
23 so-and-so, can I get an update on
24 this person's progress.

25 We also get monthly reports

1 from each provider that give us a
2 detailed breakdown of how many
3 people we serviced in a month. And
4 we also have our data from when we
5 do our mobile resource fairs with
6 the Office of Public Safety.

7 COUNCILWOMAN LOZADA: Thank
8 you. Thank you for coming
9 prepared.

10 (Applause.)

11 COUNCILWOMAN LOZADA: The
12 Chair recognizes Councilmember
13 Squilla.

14 COUNCILMAN SQUILLA: Just
15 to go back on that too, because
16 that's sort of what we were talking
17 about, how many people to what
18 levels of care, right. So how many
19 people went into 3.7 WMs, how many
20 people went into 3.5s, how many
21 people went into 3.1s. You don't
22 have to say that now. But if you
23 can just provide that to the Chair,
24 I think it's important for us to
25 see that, because then also how

1 many people completed then, right.

2 Since you follow them all
3 the way through, how many people
4 stayed the whole 30 days, right,
5 how many people went from a 3.7 to
6 3.5 and then a 3.1. And then we
7 could then see. Because as you
8 heard from the earlier panels, and
9 I wasn't here but I know some of
10 the programs that they run, as we
11 look through the continuum of care
12 how we're trying to follow folks
13 through that process where we need
14 to improve on, we could then
15 hopefully be able to dictate that
16 by stating where people are falling
17 off, where they're continuing and
18 hopefully that'll help make our
19 decision, help our providers make
20 decisions where do we have to put
21 more resources at.

22 MS. ANDERSON: Understood.
23 And just piggyback off of that,
24 that's where myself, my colleagues,
25 other APMs, James Williams, Noah

1 White, Louis Soto and Kenneth
2 Walker, that's where we come in at.
3 When there are gaps, that's when
4 they contact us and they will let
5 us know like I'm having a problem,
6 it can be any type of situation,
7 but that's where we come in and we
8 help fill those gaps to get that
9 person to the next level and we
10 follow them.

11 It's not just a
12 one-and-done situation. We're not
13 looking at them as just a number,
14 you understand what I'm saying.
15 And to take it a step further, when
16 you look a person in their eyes and
17 you tell them I've been there, that
18 starts to break those walls down
19 and they understand that this
20 person really cares, this person
21 really understands what I'm going
22 through.

23 COUNCILMAN SQUILLA: So you
24 probably see some areas where
25 people are falling off, right?

1 MS. ANDERSON: Yes.

2 COUNCILMAN SQUILLA: So you
3 see that, so that would also be
4 helpful to us and to our providers
5 and people who are helping. So
6 whenever we see a big increase
7 where they get into a certain space
8 and then they either disappear or
9 not doing it, that's where we will
10 need you to hopefully engage
11 additional resources to help that
12 individual.

13 MS. ANDERSON: Yeah. And
14 I'm sorry, just to add on I would
15 say mothers and children, that's
16 another barrier that we --
17 especially a mother that may be a
18 domestic violence victim and that
19 has multiple children, that's where
20 Salvation Army will come in. But
21 as far as navigating the landscape,
22 trying to get them housed as soon
23 as possible or trying to get them
24 away from -- they're fleeing,
25 they're ready to get out, that is a

1 barrier that we have seen in the
2 past, and that's something that I
3 have spoken with Councilwoman
4 Lozada about in the past, and
5 that's something that we're trying
6 to fill those gaps with as well.

7 COUNCILWOMAN LOZADA:

8 Merakey, would you like to add to
9 what some of the challenges are?
10 You all seem to be able to connect
11 people to the services that others
12 seem to have challenges with. Are
13 there challenges that you all
14 experience when you're connecting
15 people to services? And if you
16 don't experience challenges and
17 you're successful, you're so
18 successful at connecting people to
19 these beds that are apparently a
20 problem, how are you guys able to
21 do so? What are you all doing
22 that's different than other
23 providers to be able to connect
24 people to the services they need?

25 MS. LUNDY: My name's

1 Natasha Lundy. I am the PAD
2 Director under Merakey. I wouldn't
3 say that we're doing anything
4 different or anything better. It
5 is just networking sometimes.
6 Sometimes when we do have
7 difficulties with beds, it is just
8 a matter of calling our APMs or our
9 City resources to locate these
10 beds.

11 There are often times, as
12 was mentioned before, where the
13 level of care doesn't necessarily
14 match. That is absolutely a thing
15 where we need a 3.5 bed but there's
16 only Level 4s or a 3.7 bed and
17 there's only Level 4s. And I know
18 that that is kind of facility
19 restrictions and things like that.
20 Some people have medical levels.
21 Some people don't. So it really
22 just depends on where exactly we
23 are referring to.

24 Most of my staff is ASAM-
25 certified so when we're doing an

1 assessment, it is an ASAM
2 assessment. We do have those
3 struggles where we call the
4 insurance company, they do want a
5 flip of services or the treatment
6 provider themselves will say, hey,
7 I have a 3.7 bed if CBH will
8 approve it, we got you. But then
9 we got to kind of figure out or
10 send to a CRC --

11 COUNCILMAN SQUILLA: Or
12 compromise because we don't have
13 availability in the needed area.

14 MS. LUNDY: I'm sorry. Say
15 that again.

16 COUNCILMAN SQUILLA: That's
17 more like a compromise because we
18 don't have the availability in the
19 assessed area.

20 MS. LUNDY: Sometimes it is
21 a compromise. Sometimes it's
22 beyond our scope and we do have to
23 refer to a CRC, but we try the best
24 that we can around the systems that
25 are in place right now.

1 COUNCILWOMAN LOZADA: I
2 think part of the conversation that
3 we are going to have to have as a
4 Committee and with our counterparts
5 is how do we change this level
6 structure, right. And going back
7 to the very beginning of this
8 hearing, how do we make a bed a bed
9 in order to respond to the person's
10 need at that moment, right.

11 It doesn't make sense to me
12 and to a lot of other people,
13 right, when you have someone that
14 has been suffering and living in
15 addiction for so many years and
16 finally they are there and they
17 say, I want help now. And we're
18 saying to them, you got to be a
19 Level 4 or you got to be a Level 5.
20 You know, how dare us minimize
21 their need in order to get them
22 into a bed.

23 My question is if this
24 person's level of need is greater
25 than that of the bed that is

1 available once they get into --
2 okay, so you made the compromise
3 and you got them into that bed,
4 what happens when that person is in
5 that bed and that provider then
6 says, wait a minute, this person's
7 need is greater than what I'm
8 getting paid for?

9 MS. LUNDY: Then those
10 doctors there would evaluate and
11 call the insurance to make
12 appropriate recommendation.

13 COUNCILWOMAN LOZADA: Have
14 we ever experienced a situation
15 such that the insurance says, you
16 need to get them out of that bed or
17 we can't provide that level of
18 service? What happens in that
19 case?

20 MS. LUNDY: Not in my
21 experience that has not. Not that
22 I know of at the PAD office that
23 has not occurred. Typically in the
24 few times that it has happened
25 where we had to do a lesser level

1 of care, typically the provider
2 then will call the insurance
3 company and get it flipped up or
4 send them to the hospital, whatever
5 is needed in that moment.

6 COUNCILWOMAN LOZADA: So
7 they are removed from the bed and
8 potentially sent to a hospital
9 where their --

10 MS. LUNDY: If it's needed.

11 COUNCILWOMAN LOZADA: --
12 level of care would be greater?

13 MS. LUNDY: If it's needed.
14 Because some providers don't always
15 have -- not every provider has the
16 exact same level of care. And
17 Eagleville has the level that can
18 handle acute medical care.
19 Kirkbride can't handle that in
20 their facility. They don't have
21 lev -- you know what I mean. It
22 just really depends on the facility
23 that you're referring to what beds
24 are available and what we can
25 actually do to service the

1 participant at that time.

2 Sometimes it is just
3 talking to the intake worker, okay,
4 what can we do. Sometimes it is
5 getting them to a CRC and having
6 the doctor-to-doctor conversation,
7 because that is a thing with the
8 insurance company, which I very
9 much understand with high
10 utilization and AMAs and things
11 like that. That is 1,000 percent a
12 thing where sometimes the insurance
13 company wants to try a lower level
14 of care first like an outpatient
15 methadone opposed to the inpatient,
16 where it does happen. Again, not
17 on us but it does happen. So we
18 just work it the best we can at
19 that point.

20 COUNCILWOMAN LOZADA: I'm
21 looking forward to the day when a
22 bed is a bed. When a bed is a bed
23 and people go into that bed and
24 receive whatever level of care it
25 is that will determine a successful

1 healthy journey of recovery for
2 them. I'm looking forward to that.
3 I'm going to remain optimistic.
4 Thank you so much to PAD and
5 Merakey.

6 MS. LUNDY: Can I just say
7 one more thing to add to that? I
8 do think a recommendation that
9 would help a lot would be the
10 aftercare process and maybe case
11 management for the shelter system.
12 A lot of times people are
13 discharged with not the supports --
14 I believe the doctor said it this
15 morning, they don't have the
16 support when they leave rehab. So
17 they can stay at the self-helps and
18 the Kirkbrides for 90 days, but if
19 they don't have anything when they
20 come out, they're right back in the
21 same situation.

22 COUNCILWOMAN LOZADA: Thank
23 you for that. Thank you. Thank
24 you so much for that. Thank you,
25 Merakey. Thank you, PAD. Thank

1 you, Deputy Commissioner.

2 Let us move to the MDO and

3 Office of Homeless Services.

4 Mr. Holloman, would you please

5 state your name for the record and

6 start your testimony.

7 MR. HOLLoman: Good

8 afternoon, everyone, Chair Lozada

9 and members of Council here. First

10 and foremost, I just want to

11 apologize to the community for the

12 trauma that you have been facing

13 for years. I have been doing this

14 work for a while. I've been

15 working with a number of these

16 partners here and have been

17 fortunate of also working in the

18 hospital settings and understand

19 some of the challenges that's

20 there. But again, I understand

21 your frustration. I think it's

22 admirable that you're continuing to

23 beat this drum because change is

24 needed in this community and we're

25 looking forward to being part of

1 that solution to help break down
2 barriers to think about things
3 different.

4 I think one of the things
5 that I heard earlier today is that
6 there isn't one model. I think we
7 need to think about this in many
8 models that bring about different
9 ways of success. Kensington over
10 the last several years, especially
11 in 2018 when we had the heightened
12 of the large encampments under the
13 bridge when we shut down Gurney
14 Street.

15 We saw a difference in the
16 drug supply of the heroin to the
17 tranq to the fentanyl, and those
18 approaches take all different
19 methods. You also have Kensington
20 where not everybody here are
21 Philadelphians. There are people
22 here from surrounding counties
23 because of the drug supply and also
24 some of them may be on private
25 insurances, things that create

1 barriers. So I'm looking forward
2 to talking about what solutions we
3 should be thinking about as a
4 collective community, but again the
5 Office of Homeless Services is here
6 to be partners.

7 COUNCILWOMAN LOZADA: Thank
8 you so much for that. I think one
9 of the questions that I have for
10 you, Dave, is your outreach teams
11 are out there on a regular basis.
12 What's the shift? What are their
13 working hours? When can or when
14 should we be able to see your
15 outreach workers out in the
16 community? And what is their
17 feedback when they are trying to
18 get people into treatment and are
19 told, yes, there's a bed, no,
20 there's a bed, this level bed, that
21 level bed? What do they do then?

22 MR. HOLLOMAN: Thanks for
23 that question. So we operate the
24 Encampment Resolution Team. The
25 regular homeless outreach teams are

1 through the Department of
2 Behavioral Health Intellectual
3 Disabilities. However, our
4 Encampment Resolution Team works
5 with Sergeant Hannesson and various
6 other teams such as CLIP and I
7 think they do for what they have a
8 pretty good job.

9 They run into challenges
10 too with trying to get people in
11 when there isn't a bed available.
12 I think some of the struggles that
13 they have, especially in the early
14 morning when people -- you hear
15 this term a lot -- people want to
16 get well. So if you don't
17 capitalize on that hour by the time
18 they get up and until the time they
19 get to a bed, that is a problem.

20 Many of the folks that I
21 hear from directly, and I even come
22 out with the team, is that many of
23 the folks don't want to sit for a
24 six- to eight-hour assessment
25 because of the withdrawals that

1 they go through. And so, what we
2 try to do is work with the Merakey
3 team, see where like at Prevention
4 Point where they can do some dosing
5 to give people comfort so they can
6 go into a 2B or a 3C level of care.
7 I think they need more of that. I
8 hear that directly from my team,
9 how do you get people a level of
10 comfortability without having them
11 to go through the act of
12 withdrawal.

13 The best time of the day
14 and our team is out there from
15 7:00 a.m. to 4:00 p.m. on a daily
16 basis, unless we see a time where
17 there's a spike or we're conducting
18 some type of special operation with
19 law enforcement or during a
20 quality-of-life event where we may
21 say, hey, we're going to double up
22 these shifts there.

23 Right when we did the last
24 encampment resolution on April 4th,
25 prior to that I authorized not only

1 my Encampment Resolution Team but
2 staff from my intake at the
3 shelters to do outreach 16 hours a
4 day in this community. That made a
5 significant imprint on this
6 community. We were able to engage
7 so many people and get people into
8 services during that time.

9 Now, if we had the ability
10 to double up an Encampment
11 Resolution Team because they have
12 the ability to do service day
13 clean-up, they're a little bit
14 more -- in my thing, a little bit
15 more aggressive with trying to
16 engage people to get people in, I
17 think that would be helpful. But
18 again, they come with a different
19 philosophy. They're under the
20 direction of One Day At A Time. So
21 as you heard earlier today, they're
22 already locked into a number of
23 different systems that they're able
24 to get beds and access to.

25 COUNCILWOMAN LOZADA: Can

1 you tell me why there is a
2 difference in assessments? Why do
3 some assessments take 15, 20
4 minutes or immediate and there are
5 other assessments that take six to
6 eight hours if the service that's
7 needed is exactly the same?

8 MR. HOLLOMAN: Yeah, so it
9 really depends. So a lot of folks
10 in this area go to the CRC. CRC is
11 designed to deal with a multitude
12 of behavioral health challenges,
13 and sometimes it depends on the
14 day. One of the things in my
15 experience for a number of years
16 from the 5th of the month to about
17 the 22nd of the month, most of the
18 people who receive some type of
19 entitlement benefit are out of
20 their money. So you start to get
21 an influx of more people that come
22 into those assessments, and
23 especially CRCs that are coming in
24 to get treatment.

25 And so, when you have

1 people who are struggling with
2 addiction along with behavioral
3 health challenges going to a CRC
4 that may only be equipped to deal
5 with a certain number of foot
6 traffic in there because they're
7 dealing with the traffic the night
8 before, that can create problems.

9 The other thing, if a
10 person has, whether it's CBH,
11 Magellan, Bravo or private payer,
12 those all play a significant
13 factor. One of the things they
14 talked about was what does a person
15 call in, they look at their
16 clinical history, whether they
17 recently had an AMA, were they
18 connected to IOP. Some insurance
19 won't pay for certain levels of
20 care if a person looks to be a
21 frequent flyer that comes out.

22 And then the other problem,
23 we really need to make a
24 dissemination between short-term
25 rehab beds versus long-term and

1 detox beds. There's always -- and
2 I think I can attest to this -- by
3 11:00 a.m., every day probably by
4 that time most detox beds are
5 completely gone because most people
6 want to get well. There's a
7 disconnect when people talk about
8 the availability of short-term
9 rehab, which is 2B, 3C, 3A and all
10 of those levels up. There's
11 capacity there but most people
12 again can't sit long enough to get
13 that assessment or get well soon
14 enough to get to those beds.

15 And the other challenges
16 there, which I control in my
17 system, shelters save lives but the
18 reality is you need to invest in
19 long-term housing so people can get
20 connected to a well ecosystem to
21 maintain their recovery and
22 sobriety.

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

1 The Chair recognizes

2 Councilmember Nina Ahmad.

3 COUNCILWOMAN AHMAD: Thank
4 you, Madam Chair.

5 Good afternoon. I want to
6 thank you for your testimony. The
7 overlap of your intake with the CBH
8 intake, are you very distinct or do
9 you hand over work to each other?
10 How does that process work?

11 MR. HOLLoman: So we're
12 very distinct. Shelters are first
13 come, first serve. We have intake
14 and after hours, which our
15 traditional intake hours are
16 7:00 a.m. to 5:00 p.m. and then
17 after hours kick in. Shelters are
18 designed to assess anyone. They do
19 not provide medical services in
20 there because they don't have that
21 expertise, but we work with DBH,
22 our counterparts.

23 If someone comes in and
24 throughout their assessments and a
25 social worker says, hey, I'm

1 struggling with behavioral health
2 challenges such as substance abuse,
3 we're able to work directly with
4 our partners to them referred to
5 the resources that is available for
6 them.

7 COUNCILWOMAN AHMAD: So is
8 there any hiccups in that process
9 with timing or availability that
10 would be smoother so that folks
11 here specifically in Kensington,
12 should there be like a parallel
13 service at the same time frames
14 because you're probably
15 encountering a lot of people with
16 SUD?

17 MR. HOLLOMAN: So let me
18 give you a capacity snapshot. The
19 Office of Homeless funds 2,926. A
20 breakdown of that is 1,383 family
21 beds. Of that, 200 DBHIDS beds
22 which are specialized. There's
23 1453 single beds. On each given
24 day, we have about a 93 percent
25 utilization rate.

1 The average length of time
2 that a person stays in a long-term
3 bed and shelter is about 132 days
4 right now. And so, our beds turn
5 over about four times per year so
6 there's always a need for more.

7 COUNCILWOMAN AHMAD: So
8 that means that overlap could be
9 very useful so your beds can be
10 opened up for people who don't have
11 SUD?

12 MR. HOLLOMAN: Absolutely.

13 COUNCILWOMAN AHMAD: So we
14 need to work on that. Thank you.

15 COUNCILWOMAN LOZADA: What
16 happens if someone comes in -- and
17 I think you touched on this a
18 little bit. What happens if I am a
19 DV victim but I also suffer from
20 substance abuse disorder and I also
21 have open wounds but I show up at
22 the shelter, at a shelter, right,
23 what happens in that situation?

24 And tell me where your
25 intake, your central intake -- I

1 remember when I did Constituent
2 Services at 1401 Cherry Street.
3 You walked into there, we knew send
4 everybody to 1401, they're going to
5 tell you where to go, right. Does
6 that still exist? Is there a
7 priority if I am a -- if I'm
8 suffering from substance abuse, if
9 I'm a DV victim, if I have all of
10 these wounds, is there a priority
11 to get me -- and I'm walking into
12 the shelter which means I'm saying,
13 hello, I need help and I want it
14 now and I have all of these other
15 existing issues that I'm bringing
16 with me, is there a prioritized
17 list that this individual goes to?

18 MR. HOLLOMAN: Yeah. So
19 all of our intake sites anyone can
20 go, whatever agenda that you
21 identify with. One of the things
22 we try to do is have people access.
23 In that situation that you just
24 described, the first thing that
25 intake is going to do is do what

1 they call an assessment of that
2 person. Is their substance abuse
3 right now and the medical needs are
4 more prevalent than the DV. DV
5 shelters are set up to be
6 specialized. There's legality
7 issues there. There's survivor's
8 things there.

9 There are certain
10 requirements that only allows you
11 to place someone in a DV shelter.
12 In that situation there if I was
13 someone was doing the intake, the
14 first thing that I'm probably going
15 to address, more likely going to
16 address is that substance abuse
17 issue.

18 The reason why I want to do
19 that is I want to try to get you
20 stabilized in a hospital setting or
21 a recovery-based setting and then
22 address that DV issue because now I
23 have other clinical support that's
24 surrounded around you. The reason
25 why you probably will not

1 automatically put that person in a
2 DV shelter -- I'm almost 100
3 percent sure on this -- is, one,
4 there's state law that prohibits
5 without that legality issue that's
6 at play of placing someone there
7 because you have to keep in mind
8 there may be other people's lives
9 at risk and someone who's not ready
10 or potentially would stay there
11 could also jeopardize others who
12 are in a domestic violence
13 situation. But the first thing a
14 person should do or any social
15 worker or intake worker should be
16 assessing that from a pyramid-based
17 model on what is the most pressing
18 need first and try to get the
19 referral.

20 That's why early on I
21 always state that we have to do
22 better assessments of people and
23 try to get them stabilized. The
24 key is not to -- you want to help
25 them right in that moment, but you

1 want to set them up for success and
2 put them on the right track. And
3 so, that assessment is so critical
4 and what's available to them.

5 And part of this is about,
6 you hear that term networking and
7 communicating with different
8 partners, that is so critical. We
9 have all housing case managers in
10 our shelters. Some of them have
11 behavioral health case managers in
12 there. If they're coming during
13 the traditional hours, we should be
14 able to connect that person right
15 away to the necessary resources
16 that they should have. And after
17 hours is a little bit different
18 because you're just trying to get
19 that person off the street in that
20 moment to save their lives.

21 COUNCILWOMAN LOZADA:
22 You're under the umbrella of
23 government, right. DBHIDS is under
24 the umbrella of government. CBH is
25 under the umbrella of government.

1 Police is under the umbrella of
2 government. Do you all share with
3 each other what beds you all have
4 available? Is there a transparent
5 process for that and do you
6 communicate with one another when
7 this person is looking for a bed?
8 And I'm not talking about a coded
9 bed. I'm just talking about a bed.

10 Do you all communicate with
11 each other to say, hey, tonight I
12 have 25 beds and Sergeant Hannesson
13 or any of your officers 2 o'clock
14 in the morning come across someone
15 that is ready to get into a bed,
16 this is where you can go?

17 MR. HOLLOMAN: We can do a
18 lot better in terms of
19 communicating on that. I think we
20 communicate, but it doesn't -- in
21 my opinion, I think that area can
22 be actually much better on how we
23 do that, especially with all the
24 partners that are in that system
25 there.

1 COUNCILWOMAN LOZADA: And
2 would you benefit from what we've
3 talked about earlier which is a
4 dashboard that would be accessible
5 to everyone --

6 MR. HOLLOMAN: Oh,
7 absolutely.

8 COUNCILWOMAN LOZADA: --
9 around just available beds?

10 MR. HOLLOMAN: Oh,
11 absolutely.

12 COUNCILWOMAN LOZADA: All
13 right. Thank you so much for your
14 testimony.

15 The Chair recognizes
16 Councilmember Squilla.

17 COUNCILMAN SQUILLA: Thank
18 you. And thank you, Dave, always
19 for your responses too. I know we
20 are constantly working with your
21 office on issues and concerns, and
22 your whole team has been very
23 responsive and it's a challenging
24 job.

25 But as we heard, I think

1 the goal through this whole thing
2 is stop working in silos. Like
3 everybody was doing good work on
4 their own, and we're not picking on
5 any providers or anything, but we
6 weren't coordinating efforts and
7 collaborating with each other.

8 Do you think -- as far as
9 with your encampment resolutions
10 and working with folks, do you
11 think that there is a model that we
12 could change or a policy that we
13 could change that would make it
14 better to coordinate with other
15 providers to be able to help the
16 people who you engage to get them
17 into services that are needed,
18 without getting in trouble?

19 MR. HOLLOMAN: I was about
20 to say, like --

21 COUNCILWOMAN LOZADA: Get
22 in trouble.

23 MR. HOLLOMAN: This is Dave
24 speaking. I do think in this
25 neighborhood here we should create

1 a pilot. One of the things I heard
2 about earlier and hopefully that my
3 colleagues from Project HOME talk
4 about, so when we did an encampment
5 resolution April 4th, we know that
6 there are people that were going to
7 scatter to other different
8 neighborhoods and blocks.

9 I think police can probably
10 share this. I think PAD can
11 probably share this. We should
12 know where there are spikes at.
13 One of the things that we have in
14 this community here and I give
15 credit to the Administration trying
16 to build this wellness ecosystem,
17 but we have a PAD site here now.
18 We have a number of different wound
19 care vans that are in this area
20 that have the ability to do MAT,
21 suboxone, buprenorphine, again the
22 goal here is to make people
23 comfortable to get them to that
24 bed.

25 We should be thinking about

1 how do we look at maybe a four or
2 five block radius, use the PAD
3 site, use one of these wound care
4 vans that are in this area, maybe
5 stick them there. You have
6 clinicians there. You have doctors
7 that are there. Let's look at for
8 the next three months and say,
9 okay, instead of having an officer,
10 two officers because there's two
11 officers that come off street and
12 go to the CRC, they're in there for
13 about eight hours. How about us go
14 to the PAD site, dose someone there
15 while they're doing the ASAM and
16 try and get them into a bed, that's
17 much quicker.

18 By the time you go to the
19 CRC, again keep in mind you're
20 dealing with everything. And that
21 time to get to the CRC is about
22 eight hours. But we have resources
23 and we know if I walk out of this
24 corner here and ride down there,
25 there's probably 50 people around

1 the corner or 60 people on these
2 small blocks. We should literally
3 target maybe four or five blocks
4 here and do something unique. Take
5 one of those wound care vans.

6 We have the best
7 institutions around, Penn,
8 Jefferson who testified earlier
9 here today. See if they will be
10 willing to dose much quicker at a
11 PAD site. This way it makes it
12 much easier for when they're
13 calling around and saying, hey, do
14 you have a 3.5 bed. I already made
15 this person comfortable to come in.
16 This way if they need to get
17 stepped up to a higher level from a
18 3.5 to a 4.0, now they're under the
19 care under medical eyes so they can
20 monitor those vitals, withdrawal
21 symptoms. But they're in a medical
22 institution.

23 But the key there is that
24 they're reducing their anxiety away
25 in a CRC or in an assessment site

1 for eight hours. That's Dave
2 speaking. Again, I don't know if
3 that would work, but I think we
4 should try different models.
5 Models are made to be shaped,
6 rebroken. So what if we fail. If
7 we have two persons, we learned
8 something from that.

9 COUNCILMAN SQUILLA: I
10 think one thing we learned, what we
11 were doing wasn't working so I
12 think new ideas, if it doesn't
13 work, it's not a problem. But I do
14 think that the idea of combining
15 those resources to help make those
16 folks that are suffering through
17 that phase of where they are able
18 to then get the treatment instead
19 of losing them at that time when
20 it's taking too long to get them
21 where they need to be and then make
22 sure those beds are also available
23 so they can get transported to them
24 or whatever assessment, level of
25 care is required.

1 MR. HOLLOWMAN: And I'm not
2 putting that all on the treatment
3 system. If we create a model like
4 that, I'm willing to move some of
5 our intake workers, some of our
6 teams there because somebody may
7 not want that level of care. They
8 just need a bed, long-term bed from
9 a shelter standpoint. We're
10 willing again to bring resources to
11 the staff to move staff there so it
12 will be a whole well ecosystem of
13 not just DBH but it will be OHS,
14 the Health Department should be
15 there, a combination of the
16 different agencies.

17 COUNCILMAN SQUILLA: Thank
18 you.

19 COUNCILWOMAN LOZADA: Thank
20 you so much. That makes a lot of
21 sense, and sometimes we struggle
22 with basic commonsense things in
23 order to improve quality of life.
24 And so, I'm hopeful that our
25 government is going to move towards

1 some commonsense practices.

2 The only question that I
3 have for Noelle because I know that
4 you've managed some of the opioid
5 settlement dollars, and earlier we
6 mentioned just the need to be able
7 to pay for some of these
8 commonsense practices, right. How
9 do we ensure that some of those
10 opioid settlement dollars that are
11 coming into our city are used very
12 specifically to address some of the
13 changes that we need to make within
14 this community to be able improve
15 quality of life? What are some of
16 the challenges that you see and
17 what prevents us from being able to
18 use funds for things like a
19 dashboard or for us to be able to
20 work with providers who are doing
21 that great work but are very small
22 and very grassroots? What is
23 preventing us from allocating those
24 dollars to them?

25 MS. FOIZEN: Everybody,

1 good afternoon. Noelle Foizen,
2 Director of the First Response
3 Unit. So thank you so much for
4 that question. So up until this
5 point we have received \$33 million
6 from the National Distributor
7 settlement. We're going to receive
8 an additional 20 million in the
9 fall and that's a separate
10 settlement. That's a Walgreens
11 settlement.

12 The difference between the
13 two settlements is that the
14 National Distributor settlement has
15 allowable uses. And so, you
16 actually find them online but it's
17 a list of bucketed items of things
18 that we can use our dollars on.
19 The Walgreens settlement has no
20 allowable uses tied to it so we can
21 put that towards anything that we
22 think will help with the fight in
23 the city of Philadelphia.

24 Up to this point, of the 33
25 million we have received 14 million

1 of supported treatment and
2 recovery-focused housing. 8
3 million of that has gone towards
4 the Office of Homeless Services to
5 support recovery-focused housing.
6 The additional 4 million, they're
7 just receiving that so that has not
8 been spent yet. And 6 million has
9 gone towards increasing access to
10 treatment. And so, a portion of
11 that 6 million has been supporting
12 the Kensington wound care van that
13 DBHIDS spoke to, increasing the bup
14 dosage at the prison and also
15 launching oral methadone.

16 You asked -- there's really
17 not much that's stopping us from
18 doing additional things with the
19 money. It's just a finite amount
20 of dollars so up until this point
21 we've tried to prioritize funding
22 towards treatment but also spending
23 towards prevention and trying to
24 make sure that we're trying to
25 avoid additional people using drugs

1 and trying to save lives and reduce
2 overdoses as well.

3 There's definitely the
4 possibility that moving forward we
5 can reprioritize, especially with
6 as we're looking at our practices
7 and doing evaluations and figuring
8 out what's effective and what's
9 not, there's always the opportunity
10 to fund additional programs moving
11 forward.

12 One thing I did want to
13 share with this group just because
14 it's something that our team has
15 been speaking about a lot with
16 Deputy Commissioner Rosario and
17 Chief Public Safety Director Geer
18 has been up until this point all
19 the teams are doing everything they
20 can with the resources that they
21 have, but it does feel like a
22 little bit like a one-size-fit-all
23 model and we're not resourced
24 appropriately to have a more
25 nuanced approached.

1 But something that might be
2 more effective is thinking about if
3 we have an individual that has only
4 been in Kensington for two weeks,
5 that's a different situation than
6 someone that's been there for two
7 years, right. So trying to figure
8 out what are the different
9 populations within that subgroup of
10 individuals that are unsheltered
11 here and what are the different
12 intervention strategies. And
13 that's something DC Rosario and
14 Director Geer have been very
15 interested in learning more about.

16 COUNCILWOMAN LOZADA: Thank
17 you so much for that. I think that
18 part of what we want to start
19 talking about is how do we use some
20 of those funds that we can use for
21 things that are going to help
22 providers that are going to help
23 those who are doing the very
24 necessary work to be able to
25 respond to the crisis that is

1 happening in Kensington, right.

2 And so, we are going to
3 probably call on you to help us
4 figure out what is the path
5 forward, how do we take some of the
6 ideas that we have discussed here
7 today, which I think have been some
8 really good ones, right, how do we
9 move them forward.

10 When we came here a year
11 ago, some community residents spoke
12 about some very low-hanging fruit.
13 And I think that some of the things
14 we heard today I think are very
15 easy for us to be able to put in
16 place, but of course it is going to
17 depend on some money, right. And
18 while that's frustrating that we
19 don't do certain things because we
20 say we can't find the money.

21 We know that there's money
22 available that the City received as
23 a result of what the City allowed
24 to happen here, right. And so, we
25 should be able to use that money to

1 be able to respond and fix what we
2 have caused. And so, this
3 Committee will be calling on you
4 and on members of your team to be
5 able to help us move some of these
6 ideas forward with that pot of
7 money that is flexible.

8 Are there any other
9 questions for anyone on this panel
10 from any of the members of the
11 Committee?

12 COUNCILMAN SQUILLA: Just
13 real quick because we did get
14 notice that there was rejection to
15 some of the opioid dollars that
16 were spent. What happens in that
17 case?

18 MS. FOIZEN: So the Law
19 Department and the Administration
20 is looking at our options. But
21 there's an appeal process that the
22 Trust has in place.

23 COUNCILMAN SQUILLA: So the
24 City will appeal that denial?

25 MS. FOIZEN: I have to

1 follow up with the Mayor's Office
2 on that, but yeah.

3 COUNCILMAN SQUILLA: All
4 right.

5 COUNCILWOMAN LOZADA: Thank
6 you. Thank you to all of you for
7 your testimony today. Thank you
8 for joining us. We will be
9 reaching out probably to each one
10 of you at some point. Thank you.

11 Will the Clerk please call
12 the names of the next panel.

13 THE CLERK: Yes, Madam
14 Chair.

15 Dr. Deja Gilbert and Warren
16 Roy.

17 COUNCILWOMAN LOZADA: Thank
18 you for being with us today.
19 Please state your name for the
20 record and begin your testimony. I
21 ask you to speak right directly
22 into the microphone because we want
23 to be able to hear all the great
24 things you have to say.

25 DR. GILBERT: Can you hear

1 me okay?

2 COUNCILWOMAN LOZADA: Yes.

3 DR. GILBERT: Dr. Deja

4 Gilbert, President and CEO of

5 Gaudenzia.

6 MR. ROY: Warren Roy,

7 Business Development Manager at

8 Gaudenzia.

9 COUNCILWOMAN LOZADA: Thank
10 you for being with us today.

11 Please begin your testimony.

12 DR. GILBERT: I do just
13 want to note for the record my full
14 testimony is on file and
15 documented. I'm going to focus a
16 little bit more on some of the
17 topics that we've been talking
18 about today in order to kind of get
19 straight to the point and deal with
20 some of the issues that have come
21 up.

22 Gaudenzia, for those of you
23 who don't know, was founded in
24 1968. Over the last 56 years our
25 agency has continually evolved

1 adapting its capacity, reach and
2 treatment model to meet the growing
3 needs of our clients. Today we are
4 the Commonwealth's largest
5 nonprofit provider of
6 evidence-based treatment for
7 substance use and co-occurring
8 disorders offering a full continuum
9 of care that includes residential,
10 outreach treatment,
11 medication-assisted treatment and
12 an expansive array of emergency,
13 transitional and permanent
14 supportive housing programs in this
15 area through contracts and
16 partnerships in the city of
17 Philadelphia and the Commonwealth
18 of Pennsylvania.

19 Recognizing there's no
20 one-size-fit-all approach to
21 treatment and recovery, Gaudenzia
22 offers specialized programs to meet
23 the needs of a diverse range of
24 client population, including
25 pregnant and parenting women with

1 their children and re-entry
2 populations as well.

3 Gaudenzia admitted a total
4 of 2,773 clients to programs for
5 treatment and mental health housing
6 programs in Philadelphia alone
7 throughout the 2024 fiscal year,
8 with an additional 2,196 admitted
9 to our emergency housing program
10 and 151 households served in
11 transitional and permanent-
12 supportive housing programs.

13 While the need for
14 low-barrier, evidence-based
15 treatment like that which Gaudenzia
16 offers has never been greater, our
17 treatment programs consistently
18 operate below their average
19 capacity. In 2024 fiscal year,
20 Gaudenzia Philadelphia-based
21 treatment program saw a daily
22 average utilization rate of just 72
23 percent of our total bed
24 availability. This trend in
25 underutilization is not unique to

1 Gaudenzia. People need more time
2 to recover and authorizations in
3 order to get that time.

4 With those grappling with
5 homeless and behavioral health
6 needs, Gaudenzia is prepared to
7 provide crucial alternatives to
8 incarceration that foster readiness
9 and acceptance of treatment over
10 time. From a provider's
11 standpoint, organizations like
12 Gaudenzia and many of our partners
13 and other providers in the area
14 need an increased ability to engage
15 clients in care as quickly as
16 possible with reduced
17 administrative burden on program
18 staff and greater emphasis on
19 swift, direct care at the front end
20 of the treatment continuum. A
21 time when a client's decision to
22 enter and remain in treatment is
23 often won at its most fragile
24 point. We must continue to work in
25 this direction to streamline an

1 effective low-barrier continuum
2 with reduced wait times and
3 immediate access to life-saving
4 medications like buprenorphine,
5 naltrexone, methadone and naloxone.

6 Internally Gaudenzia has
7 addressed many of these barriers
8 with a 24/7 treatment and referral
9 helpline which assists callers with
10 screening, referrals, insurance
11 authorizations and securing
12 transportation to treatment, but we
13 recognize these barriers may exist
14 for other treatment providers
15 throughout the City.

16 Our agency also recognizes
17 an opportunity for streamline
18 coordination between referral
19 sources, agents of the City and
20 treatment providers by creating a
21 centralized online tool reflecting
22 realtime accurate data on available
23 services and provider capacity
24 throughout the Greater Philadelphia
25 region.

1 In closing, I will say
2 this: We here at Gaudenzia have
3 beds. Providers have beds. We
4 also have a 24/7/365-day-a-year
5 helpline that we can admit a
6 patient to at any point
7 immediately. What we need is
8 communication on availability,
9 faster access to care, decreased
10 administration burden, approval for
11 both the initial authorization and
12 ongoing authorizations of
13 continuing care and support for
14 long-term full continuum care of
15 services if we actually want to
16 make a meaningful change. This is
17 not a one-and-done, fix it and move
18 on. We have to invest in long-term
19 care in order to make some changes.

20 I'll turn it over to you.
21 So we are here in the streets of
22 Kensington. You're here every week
23 at this point?

24 MR. ROY: Yes.

25 DR. GILBERT: So firsthand

1 trying to work with individuals,
2 one of the things that came up was
3 the PAD program, which is an
4 amazing program and Warren attends
5 their weekly meetings there. But
6 as we are not one of the providers,
7 that availability for the immediate
8 call, we need someone, we need a
9 bed is not there.

10 I was able to connect today
11 actually with someone who --
12 specifically to women and children.
13 We have a center right around the
14 corner here on Tioga where we can
15 take women immediately. We have
16 availability up to three children.
17 And they didn't know we were there
18 because we're not in that initial
19 five. And so, the communication
20 and coordination needs to be
21 available to everyone so that
22 everyone can understand if we're
23 not that initial network, that
24 doesn't mean that other providers
25 aren't available. So the

1 discrepancy between the
2 availability of beds versus do we
3 know who to call when is the
4 problem.

5 COUNCILWOMAN LOZADA: Are
6 you a member of the City's network?

7 DR. GILBERT: We are a
8 provider for CBH. We are
9 contracted. We are not a member of
10 the five identified facilities
11 (inaudible) but we participate. We
12 go to the meetings and offer
13 services.

14 COUNCILWOMAN LOZADA: How
15 many beds do you all have access to
16 on a daily basis?

17 DR. GILBERT: Just in
18 Philadelphia, I have 223 beds in
19 Philadelphia. That does not
20 include our long-term housing,
21 which I believe we have another
22 couple of hundred.

23 COUNCILWOMAN LOZADA: And
24 how often are those beds not
25 filled?

1 DR. GILBERT: We are
2 operating over the entire last
3 fiscal year at about 72 percent
4 occupancy. So my actual occupancy
5 for my Philadelphia programs was
6 159.51 and total past days, 223.
7 And we offer all levels of care.

8 COUNCILWOMAN LOZADA: And
9 how often do you all communicate or
10 do you communicate with the
11 outreach workers, the people on the
12 ground to say, hey, Gaudenzia is
13 here, we have capacity, we're ready
14 right now to take in anybody,
15 here's my contact information, I'm
16 up the street or around the corner?
17 How often do you do that and how is
18 the response?

19 MR. ROY: The vacant bed
20 list is sent out to the provider
21 CBH, DBHIDS Monday through Friday.
22 That's sent out every day, how many
23 beds we have in the Philadelphia
24 area. And in our programs in West
25 Chester, Lower Bucks, that's sent

1 out daily.

2 If I may, I was a Division
3 Director, the Director at
4 Gaudenzia. I retired in 2021. In
5 my heart because I've been in
6 Kensington, I used to shoot drugs
7 in Kensington. I've been out of
8 Kensington for 28 years. I worked
9 with Gaudenzia since 2004. I'm
10 retired. I probably should be home
11 taking a nap right now and my wife
12 thinks I'm crazy, but it's in my
13 heart.

14 As Councilmember Harrity
15 and I talked, everyone out there is
16 3.7, whether or not you want to be
17 a 3.7 withdrawal management or a
18 3.7 medically-monitored program. I
19 think the funding may be the issue
20 and we heard that a little earlier.

21 We initially started coming
22 into Kensington when Jose Benitez
23 was at Prevention Point. He
24 invited us down here and we came
25 down. We did a presentation to all

1 the staff, and I was given a
2 cubicle at Prevention Point to come
3 down here every Tuesday.

4 So I come down on Tuesday
5 at the PAD meeting. Everyone knows
6 about the services we have. I talk
7 about the bed situation we have on
8 Tuesdays and I'm available at
9 Prevention Point for any referrals
10 that may come through Prevention
11 Point, Merakey, you name it,
12 whoever's at the PAD meeting.

13 That's why I'm scratching
14 my head. There's beds available.
15 Deja and I were talk -- beds are
16 available. I think the funding may
17 be the issue. And the other issue
18 is I think we need to make it more
19 inviting for people to come into
20 treatment, because I mean sometimes
21 people don't want to come into
22 treatment. That's the bottom line.

23 If everybody out there
24 wanted to come into treatment, we
25 wouldn't have no beds. I think we

1 need to figure out, and Deja and I
2 were talking about, how can we make
3 it more inviting. One of the
4 things that we started doing was,
5 and because I'm in a kind of unique
6 way, I can call Division Director
7 down 1306. I know how many beds --
8 because beds fill and people leave
9 and come and go as we're speaking
10 now. I can call down there -- if
11 somebody wants to go into
12 treatment, I send them down there.

13 We have a 24-hour helpline.
14 And again, the number is
15 484-938-1881 where we can get a
16 person into treatment within one
17 hour. We can do the assessment --
18 the screening, assessment and we
19 can have them placed within an
20 hour. We even will send Uber to
21 pick them up. The key is getting
22 them there. We can't wait. We
23 don't wait. If somebody wants to
24 go to treatment, I send them down
25 13th and Spring Garden. And like

1 you said, a bed is a bed.

2 And I mean I might get
3 fired, but I know how we used to do
4 it. If we had a 3.7 bed or back
5 then it was called something -- we
6 were using a PCPC. If we had a bed
7 in detox and no more beds in our
8 inpatient program, we would put
9 them in that bed overnight and work
10 out all that other stuff tomorrow.
11 I mean it's that simple.

12 And right now again, I just
13 send them on down, let them do all
14 the clinical -- I mean, we have to
15 get paid. I mean, that's a
16 reality. But I think there has
17 been situations where I think all
18 organizations have to have some
19 type of we used to call it
20 scholarship. Even if a person
21 doesn't have funding, we have
22 relationships with BHSI, Single
23 County authority in Philadelphia.
24 We have relationships with all the
25 other counties' Single County

1 Authority.

2 BHSI will pay for a person
3 if they live in Cleveland and
4 they're caught up in Kensington
5 using opioids, they will fund them,
6 they will fund them. I mean, we
7 have connections where we call and
8 say this is the deal, can you help
9 us and it works out.

10 Again, I'm not saying we're
11 perfect, but I think that -- the
12 folks that we work with that are in
13 Kensington -- and the other piece
14 is it ain't just Kensington now. I
15 live in South Philly. Broad and
16 Snyder is a little Kensington.
17 60th and Market, West Philly,
18 Lancaster Avenue, they're all
19 little Kensingtons.

20 My thing is -- I was riding
21 down Point Breeze -- I like to tell
22 stories and I know we got to go.
23 Deja got to leave. I'm riding down
24 Point Breeze Saturday, and I thank
25 God for Carlos at Prevention Point.

1 I got a case of Narcan in the trunk
2 of my car. I'm going to a meeting
3 and it's a guy underneath the water
4 plug and I'm thinking they getting
5 ready to drown him, he's out, he
6 overdosed. And I said, let me
7 stop. Gave them the Narcan. They
8 gave him one shot and he came back.

9 This is more than money.
10 This is more than -- to me as far
11 as I'm concerned this is about
12 helping folks. I wouldn't be
13 working for Gaudenzia if it wasn't
14 an organization that I thought that
15 was here to help folks. I left
16 Gaudenzia once and went to a
17 for-profit and it was about money
18 with them and I came back to
19 Gaudenzia.

20 I don't know how much more
21 we can say except that we have beds
22 and if you need people to come into
23 treatment, we can get them in. And
24 this is the big boss.

25 DR. GILBERT: I think just

1 to sum it up, it's about
2 communication and figuring out
3 those people who are out there
4 every day on the street, they don't
5 want to call 10 places and be
6 shuffled around. When they have
7 someone in front of them, they need
8 some sort of database, some sort of
9 phone number to say I don't care,
10 I know I have someone in front of
11 me that I need to get somewhere,
12 you all figure it out. And right
13 now we don't have a coordinated way
14 of doing that. We have a few -- we
15 have a couple this and a couple
16 that, but it's really not
17 coordinated. So when these are
18 full, who's next in line and it has
19 to be minutes. It can't be hours.
20 It cannot take three hours to
21 figure out who has a bed because
22 that individual is back on the
23 street. They are not coming with
24 you.

25 COUNCILMAN SQUILLA: And

1 everybody has to see the same
2 information. Everybody has to see
3 it realtime.

4 DR. GILBERT: Yes,
5 absolutely. It should not be that
6 complicated.

7 COUNCILWOMAN LOZADA: And I
8 think that's what we're working
9 towards. We're working towards
10 eliminating the barriers to get
11 into these beds, the codes that
12 dictate when a person can get into
13 what bed, and we are working
14 towards a dashboard or realtime
15 location where anyone, a provider,
16 an outreach worker, an elected, a
17 family member can go into and say,
18 where can I take my loved one who
19 has called me to say they're ready
20 right now and get them there. And
21 regardless of what type of bed it
22 is, you get them into that bed,
23 stabilize them and then move them
24 into the more appropriate space, if
25 necessary. That makes a lot of

1 sense to us.

2 And as I mentioned earlier,
3 sometimes the commonsense things
4 are the most difficult to get to,
5 right, but we're committed to that
6 right now. I think that it is
7 important because as I mentioned
8 earlier, we have a crisis here that
9 we are going to respond to and we
10 have to do things differently.

11 And so, I would appreciate
12 if you leave your information with
13 my team. We get called often too.
14 People communicate with me on
15 social media to say, Councilwoman,
16 I'm ready now, I don't know where
17 to go. Councilwoman, there are
18 people that are living on my
19 sidewalk because they were moved
20 from a different place, and I've
21 had a conversation with them and
22 they are ready now, where do I send
23 them, who do I call.

24 I think part of the
25 challenges that we experience and

1 as a community and as electeds is
2 that during that time frame of
3 10:00 p.m. to 5:00 a.m., there's
4 really no one we can call, there's
5 really nowhere we can go, there's
6 nowhere we can send them --

7 DR. GILBERT: But there is.

8 COUNCILWOMAN LOZADA: And
9 there is, right. But what we're
10 hearing today is that there is a
11 disconnect of there's a lack of
12 communication --

13 DR. GILBERT: Correct.

14 COUNCILWOMAN LOZADA: --
15 which proves to us that what we've
16 been saying for a long time is
17 right, we're on the path to
18 listening to ourselves and
19 community residents who have said
20 we need a one-stop shop where
21 everyone can see what is available
22 and where it is available at, and
23 people should be able to hold that
24 bed with a touch of a button and
25 advise your organization that John

1 Smith is on his way --

2 DR. GILBERT: Absolutely.

3 COUNCILWOMAN LOZADA: -- or

4 we should be able to reserve that

5 bed and an outreach worker should

6 be able to say, I'm on my way with

7 John Smith, right, and that bed

8 should come out of that pool of

9 availability because we do that for

10 a lot of other social desires. And

11 so, we're going to figure this out.

12 Thank you so much for your

13 testimony.

14 DR. GILBERT: Thank you.

15 COUNCILWOMAN LOZADA: Are

16 there questions from members of my

17 Committee?

18 The Chair recognizes

19 Councilmember Harrity.

20 COUNCILMAN HARRITY: Yeah.

21 I mean, thank you for your work.

22 I'm familiar with Gaudenzia. You

23 guys have been around for a long

24 time. How long have you actually

25 been in this area? I know it's

1 been a long time.

2 DR. GILBERT: Our first
3 location was Philadelphia.

4 COUNCILMAN HARRITY: Yeah,
5 Philadelphia and actually
6 Kensington you created a few
7 years --

8 DR. GILBERT: We now have
9 110 programs.

10 COUNCILMAN HARRITY: So who
11 are the five that PAD is dealing
12 with?

13 DR. GILBERT: I'm not sure.

14 MR. ROY: I think it was
15 mentioned earlier.

16 COUNCILMAN HARRITY: It
17 just seems ridiculous. Sometimes
18 we get something, an interaction
19 that somebody had with one of those
20 organizations. Most of the time
21 they're telling us that there was
22 no availability of a bed. So if
23 there's only five that they're
24 going through and we know that
25 those five are always filled up, I

1 think we need to add six, seven,
2 eight, nine or ten to that list.

3 DR. GILBERT: Correct.
4 They're doing amazing work.

5 MR. ROY: And I think
6 initially when the -- I actually
7 brought a friend of mine, he used
8 to be the Trial Commissioner, Keith
9 Smith. He helped develop the PAD
10 program. I brought him down and he
11 was like, well, I helped to write
12 the grant for it. I think that
13 those five agencies were in the
14 initial grant and that's why you
15 have five agencies.

16 Folks know about Gaudenzia.
17 I'm at the PAD meeting, again a
18 couple of -- I mean, your dashboard
19 will be great, again, a 24-hour,
20 7-day-a-week dashboard. One of the
21 things, Tuesday I'm going to drop
22 off stacks of our business cards
23 that has the helpline on it, the
24 24-hour -- that way the police
25 department, if they need more, we

1 can get them more and just drop
2 them off at the police district.
3 That way their officers can just
4 pass them out, because we know
5 about the 75 new police officers
6 that were hired.

7 COUNCILMAN HARRITY: So you
8 got 28 percent availability. So
9 what you're saying --

10 DR. GILBERT: That's just
11 in Philadelphia.

12 COUNCILMAN HARRITY: --
13 you're not looking at their
14 numbers. You're saying if there's
15 a detox bed open and you can get
16 somebody in it for a day or so
17 until you figure out where the new
18 bed is available, let's stick them
19 in there. That's the kind of
20 people I want to deal with, people
21 that say, hey, this is what's got
22 to be done, this is what we're
23 going to do no matter what the ups
24 and downs of it is, no matter what
25 the cost of it is, no matter if

1 we're going to lose a couple of
2 dollars for a day or two --

3 COUNCILWOMAN AHMAD: We
4 will figure it out.

5 COUNCILMAN HARRITY: -- or
6 not. That's the kind of provider
7 we're talking about.

8 COUNCILWOMAN LOZADA: How
9 often do you all respond to
10 individuals who come into your
11 system that are from another
12 county, another state, another
13 country? And how hard is it for
14 you to relocate them? Do you
15 relocate them or do you use the
16 services, the resources that we
17 have here?

18 I ask that question because
19 we are always in contact with
20 individuals who come from other
21 counties. Just the other day I was
22 contacted by someone who was
23 looking for someone from Italy, who
24 found themselves here thanks to the
25 exploitation of many who think that

1 it's okay to display what is
2 happening here and then attract
3 others to want to come, touch and
4 feel what is here.

5 So this individual, part of
6 his story is he doesn't want to go
7 back home, right. He doesn't want
8 to be relocated. My issue is that
9 that shouldn't be a choice, right.
10 You come here, you have occupied
11 this space in this community for
12 long enough. You don't belong
13 here. You don't have anybody here,
14 so you're depleting our resources.
15 And we experience that often.
16 Maybe not as drastic as another
17 country, but from the other
18 counties, right.

19 So how do we work with you
20 all as service providers to say, we
21 brought you into this bed because
22 you were ready, we responded to
23 your crisis situation, you're
24 stable and your entire circle of
25 friends and family and your origins

1 come from another county, how do we
2 do a warm handoff or do you do a
3 warm handoff to that county so that
4 that individual can be connected to
5 their loved one so they can become
6 a part of their journey?

7 DR. GILBERT: Great
8 question. There's a couple of
9 caveats on that one. So I will go
10 into it a little bit. We do have
11 the benefit of being a larger
12 organization, so we do cover most
13 counties in the state of
14 Pennsylvania, all the way up to
15 Erie and then to our neighboring
16 states as well, so Maryland, D.C.,
17 Delaware.

18 So we do have that ability
19 to have coordinated care, to work
20 with them publicly to say what does
21 the best path forward look like for
22 you. There are a lot of
23 individuals here specifically in
24 Kensington that are not from
25 Kensington.

1 COUNCILWOMAN LOZADA: Can
2 you say that again? Say it really,
3 really loud.

4 DR. GILBERT: There a lot
5 of individuals here that are not
6 from Kensington. This is their
7 home right now. What is best for
8 them, it's case-by-case. But
9 typically an individual who is
10 afforded time to heal, time to
11 recover, to build their lives, to
12 go back to school, that ability to
13 reintegrate and become a force in
14 society, one, it means time but
15 typically it means a different
16 location, not always, but sometimes
17 it's helpful to get away.

18 You mentioned people,
19 places and things. If you got out
20 there on that street, some of them
21 are used to a cycle. They're used
22 to, okay, I'm going to go in here,
23 I'm going to get my medication
24 because I don't have my \$20 to hold
25 off withdrawal, but they're going

1 to kick me out after a couple of
2 days because I won't have courage
3 and I'll just go right back to the
4 street, so they know that.

5 So to get serious with the
6 people that are out there, we need
7 to actually get serious and we need
8 to say, we're going to give you
9 care, we're going to give you an
10 opportunity. Day one, that's not
11 their mindset, but over time people
12 will heal. Their minds will clear.

13 They will be able to say,
14 hey, I'm being afforded an
15 opportunity, what's the best path
16 forward for my future and my life,
17 and that's where we see success.
18 But when we stick to these
19 regimented you have 3 days for
20 this, 15 days for this level and
21 then you're going to have to figure
22 out where to live because you know
23 they don't have anywhere to live
24 and nobody's planning for that. So
25 unless we think about that as the

1 issue, we're not going to get
2 anywhere. But if all we need to do
3 is think about that full continuum
4 as the issue, we're going to make a
5 lot of headway.

6 MR. ROY: And if folks, and
7 if I can add this again, if they're
8 in Kensington and they have no
9 insurance, they may be from Camden
10 or whatever, the Single County
11 Authority will pick them up --

12 DR. GILBERT: We can cov --
13 yeah.

14 MR. ROY: We can press on
15 that. I mean, we have folks that
16 were --

17 DR. GILBERT: There are
18 funds available for someone who is
19 here who has nothing. We will
20 figure it out. There are other
21 providers who can do the exact same
22 thing. They can figure it out and
23 access the resources. No funding
24 is not an excuse not to get care
25 because we can help to get funding.

1 COUNCILWOMAN LOZADA: Thank
2 you.

3 Are there additional
4 questions from members of the
5 Committee?

6 Thank you so much for being
7 with us today.

8 COUNCILWOMAN AHMAD: I have
9 a quick question. How do you
10 measure success for the industry?

11 DR. GILBERT: The industry
12 is interesting, but we do have a
13 very robust research department
14 that is tracking our outcomes. So
15 they're tracking -- there's
16 different measures of success is
17 the answer. Is success abstinence?
18 Well, not if they're still homeless
19 living on the street and unhealthy,
20 but they may be abstinent from
21 drugs, but is that success? What
22 does that look like. So we measure
23 multiple layers of success so that
24 it is not a very easy, yes, you're
25 successful or, no, you're not. But

1 if you measure just abstinence, I
2 can get that number for you.

3 COUNCILWOMAN AHMAD: Well,
4 we're looking to see if all this
5 work to see is there a population
6 of people who are self-medicating
7 because of all this. Is it
8 sustained in recovery and are you
9 seeing a reduction of people who
10 are needing services that --

11 DR. GILBERT:
12 Unfortunately, no, there's not a
13 reduction in utilization. That's
14 why we continue to have -- that's a
15 much bigger conversation which I'm
16 happy to have offline, but --

17 COUNCILWOMAN AHMAD: We can
18 talk later about that, yes.

19 DR. GILBERT: Ultimately,
20 we would not be here if we didn't
21 think that we were helping
22 contribute to the solution.

23 COUNCILWOMAN AHMAD: Thank
24 you.

25 MR. ROY: A lot of people

1 think it's summertime, people don't
2 go into treatment. I've seen
3 summers where a lot of people are
4 in treatment. It's just -- to me
5 if they show up, they want to come,
6 that's success because at least
7 they have a little bit of what we
8 are offering and they know where
9 they can come and get help.

10 We have packages for you
11 too and I also dropped a couple
12 cards off with your staff back
13 there.

14 COUNCILWOMAN LOZADA: Leave
15 them with my staff on the side
16 there. Thank you so much. Thank
17 you for your testimony today.

18 DR. GILBERT: Thank you so
19 much.

20 MR. ROY: Thank you.

21 COUNCILWOMAN LOZADA: Will
22 the Clerk please call the next
23 panel to testify.

24 THE CLERK: Yes, Madam
25 Chair.

1 The next panel is Eric
2 Gremminger and Sarah Deutchman.
3 And following Mr. Gremminger's
4 opening testimony, there will be a
5 short presentation.

6 COUNCILWOMAN LOZADA: Thank
7 you for being with us today.
8 Please state your name for the
9 record and begin your testimony.

10 MR. GREMMINGER: Thank you,
11 Chairperson Lozada and the
12 Committee, for the opportunity to
13 testify today. My name is Eric
14 Gremminger. I am the CEO and
15 co-founder of ERPHealth, a
16 Philadelphia-based digital
17 behavioral health community. I'm
18 also a certified drug and alcohol
19 counselor.

20 I have with me Sarah
21 Deutchman, Chief Operating Officer
22 for Pyramid Healthcare, who will
23 speak on behalf of Pyramid's work n
24 the Kensington community, their use
25 of our technology and their

1 commitment to enhancing bed
2 availability in Philadelphia.

3 We were contracted by
4 Chairperson Lozada to establish a
5 bed management solution that would
6 display realtime information on
7 what beds are available to those in
8 the Kensington area seeking help
9 for substance use disorders and
10 mental health condition.

11 There is a tremendous need
12 for this, because when an
13 individual reaches out for help,
14 they're often at a critical point
15 in their addiction journey. This
16 moment of readiness to change
17 should be capitalized on
18 immediately as the window of
19 willingness may close quickly.

20 This isn't possible if bed
21 availability isn't visible and
22 accurate. I commend Chairperson
23 Lozada and the Committee for
24 recognizing the value of realtime
25 bed visibility. To a person in

1 their darkest days of addiction, a
2 bed represents a chance at a new
3 life. It represents potentially
4 freedom from active addiction. It
5 represents hope.

6 I know firsthand the value
7 of it. In addition to being a
8 clinician, I'm also a person in
9 long-term recovery from substance
10 abuse disorder. For many years I
11 was stuck in the vicious cycle of
12 addiction, and I wouldn't be here
13 today if it weren't for family,
14 friends and a community that
15 believed in me when I couldn't
16 believe in myself and made
17 available resources that were
18 personalized to meet my specific
19 needs.

20 While access to beds is a
21 necessary first step, it's not
22 sufficient on its own. To have
23 lasting change is critical that
24 when possible we're matching
25 individuals to personalized

1 culturally appropriate care. In
2 other words, we have to get the
3 right people in the right beds for
4 them.

5 While in the past this was
6 difficult, advances in technology
7 have made it possible to prioritize
8 both access and ensure personalized
9 high quality care at the same time.
10 I've seen this firsthand in
11 treatment centers like Pyramid
12 Healthcare who are being
13 transparent with their outcomes in
14 using data to individualize the
15 experience for people based on
16 their specific diagnostic type,
17 gender, age and cultural
18 background.

19 I recommend that in
20 addition to offering access to
21 beds, that a measurement-based care
22 process is implemented right from
23 the start. There are three
24 immediate benefits to providers
25 that are measuring outcomes of

1 care.

2 Number one, it improves the
3 engagement of the person in care
4 because treatment plans are being
5 purpose-filled based on their
6 specific needs. It also gives them
7 an understanding that they have to
8 have an active role in treatment if
9 it's going to be successful.

10 Clinically speaking we call that
11 personal agency, so when they
12 (inaudible) the personal agency.

13 Number two, it provides the
14 treatment center with realtime
15 updates. So the clinicians can
16 modify the treatment plan as the
17 person is progressing throughout
18 care. So they can see what's
19 working and what's not working and
20 iterate as necessary.

21 And number three, the
22 identified population health data
23 can be shared with this Committee
24 to inform future prioritization and
25 resource allocation. I'm a

1 passionate advocate for outcome-
2 focused care because I've seen the
3 impact that it can have in our
4 community.

5 So my company specializes
6 in measuring outcomes in addiction
7 treatment in mental health
8 facilities around the nation. We
9 had a third-party data scientist
10 come in recently, and they reviewed
11 a sample of 50,000 completed PHQ-9,
12 GAD-7 and substance use skill, so
13 they validated assessments.

14 They found that providers
15 who are supported by our platform
16 reduced depression in their
17 patients by 32 percent, reduced
18 anxiety in their patients by 30
19 percent and reduced craving for
20 primary drug of choice by 40
21 percent.

22 Individual providers like
23 Pyramid Healthcare are using our
24 tool to improve the quality of
25 their care and can be a referral

1 source for individuals seeking care
2 while ensuring that they're getting
3 a personalized experience. The
4 technology is also able to connect
5 individuals to outreach
6 specialists, harm reduction experts
7 and other key stakeholders pre and
8 post-treatment, ensuring a
9 collaborative care experience by
10 including local resources that have
11 existed for many years in the
12 Kensington area and are uniquely
13 qualified to work with this
14 population.

15 Improving the quality of
16 care will also create bed
17 availability by reducing recidivism
18 rates. The National Institute on
19 Drug Abuse use or NIDA estimates
20 that relapse rates for addiction
21 are between 40 to 60 percent.
22 While there are many factors that
23 can lead to a relapse, it's a very
24 complex condition.

25 I believe that

1 nonpersonalized care and lack of
2 outcome tracking by treatment
3 centers are major contributors to
4 treatment failures. By measuring
5 and improving outcomes, we can
6 reduce recidivism and create bed
7 availability.

8 Here's an example using
9 simple math. If there are 1,000
10 beds occupied in the Philadelphia
11 area and 500 of those beds are
12 recidivism so people who've been to
13 treatment multiple times to no
14 effect, by improving the quality of
15 care and reducing the recidivism
16 beds by just 10 percent, it's
17 achievable. By just 10 percent,
18 that will free up 50 beds for
19 individuals seeking care. That's
20 50 more people off the streets of
21 Kensington. 50 more people who
22 have a chance to have freedom from
23 addiction.

24 This is not a quick fix,
25 but a long-term innovative solution

1 to a problem that's been addressed
2 the same way for years. People
3 want to know what's going to be
4 different this time. I live five
5 minutes from here with my wife and
6 our six-month-old son. We've lived
7 in this area for 11 years. We love
8 the neighborhood. I plan to raise
9 my son in the area.

10 And I truly believe that
11 there will be a time when I can
12 tell my son about how Kensington
13 once was and how it's improved so
14 much, and I truly believe that this
15 starts with this Committee but also
16 with thinking differently about
17 this issue and coming up with
18 innovative solutions.

19 Thank you again,
20 Chairperson Lozada and the
21 Committee, for allowing me to
22 testify today. I have a short
23 presentation and then I look
24 forward to answering questions.

25 I'm happy to take questions

1 while we wait for the presentation.

2 COUNCILWOMAN LOZADA: So
3 thank you so much for being with us
4 today. Thank you for the time that
5 you've invested in listening to my
6 frustrations, listening to some of
7 the challenges that the community
8 has expressed, and thank you for
9 the work that you all have put into
10 creating a dashboard, the dashboard
11 that we've heard so much about, the
12 need for a dashboard, the need for
13 a one-place space where everyone
14 can go to, to find the beds that
15 are necessary to put people on the
16 path to a successful helpful
17 journey.

18 The presentation is up.
19 And so, we'll go to your
20 presentation and then we'll come
21 back to questions.

22 MR. GREMMINGER: Excellent.
23 So just starting on the left here,
24 an individual. We heard a lot of
25 testimony today about how we have

1 community outreach on the street.
2 We also have individuals from
3 Pyramid Healthcare that can help
4 with this.

5 But we found somebody in
6 need, the community outreach
7 specialist, we asked them a series
8 of questions just to see are they
9 willing to accept treatment. If
10 not, that gets documented as a
11 refusal and goes to this dashboard.
12 Do they need medical care, are
13 there wounds that need to be healed
14 up before they go to treatment. If
15 that's the case, button's hit and
16 we can triage and identify
17 available beds that can do that.

18 And this third category
19 here, treatment. So once we are
20 able to identify that it's not
21 Category 1 or 2, we can put them
22 directly into touch with -- and
23 I'll let Sarah speak to Pyramid
24 Healthcare's role in this -- with a
25 specialist at Pyramid Healthcare or

1 whoever's participating in this
2 process so they can do an ASAM and
3 determine the best level of care
4 for this individual.

5 The beauty of the entire
6 process is we're able to aggregate
7 all of that information in realtime
8 and provide it to this Committee
9 and any other stakeholders who are
10 participating, so we can see
11 realtime bed updates. Next slide
12 please. So we can see realtime bed
13 visibility. And we can also see
14 just down below the quality of care
15 that's being offered.

16 A great point was made
17 early on, well, what determines if
18 a provider is good enough even
19 participating, isn't there some
20 sort of criteria or benchmark.
21 Right now there's not because we
22 really don't have a way to gauge
23 their clinical performance so we're
24 strictly looking at claims or
25 re-admits. There's a lot of

1 variables other than that that we
2 should be looking at that. So we
3 make that visible as well. I think
4 it's important to talk about, but I
5 know priority right now is this
6 realtime bed visibility.

7 We are the aggregate, and
8 we talked about a lot of silos that
9 are working on this. I say pencils
10 down, stop working on it, we have
11 the solution. Let's bring
12 everybody together and work off of
13 this infrastructure that's in
14 existence right now that's across
15 the country. This is what we
16 specialize in. This is what we do.
17 And then the last slide is just a
18 clearer view of this bed
19 availability. Time-stamped and
20 available for you all and every
21 other stakeholder. I'm happy to
22 take questions.

23 COUNCILWOMAN LOZADA: Thank
24 you. Thank you for this. Can you
25 tell me is this used somewhere? Is

1 this currently being used somewhere
2 and what has been the outcome? How
3 successful have they've been using
4 this?

5 MR. GREMMINGER: Well, I
6 shared the statistics with the
7 third-party data scientists as it
8 relates to reduction and symptoms,
9 which is the primary use. So what
10 we do as a technology company, we
11 work with providers, payers,
12 whatever government agencies and
13 when we sit down and we say, what's
14 the goal here, what do you like to
15 accomplish, and then we build out
16 that process.

17 So we have the realtime --
18 the realtime bed visibility we
19 would build in. The
20 infrastructure's being used by
21 thousands of patients daily, so the
22 capabilities are there. This right
23 here will be built out specifically
24 for this community.

25 COUNCILWOMAN LOZADA: The

1 Chair recognizes Councilwoman Nina
2 Ahmad.

3 COUNCILWOMAN AHMAD: Thank
4 you. Thank you so much for putting
5 your thoughts in a graph and
6 diagram. We just heard from a
7 provider before you and when I
8 asked them about how do we assess,
9 there was not a good answer, right.
10 And maybe there's different levels
11 of assessment. How do you build in
12 your model here what are you
13 assessing? Are there different
14 types of assessments or is there
15 one kind of method we can use by
16 saying, for example, here in
17 Kensington if we were to see over
18 time starting today in another year
19 what has the change been in say,
20 here's one of the characteristics
21 that people in active use, right.
22 Can we from this data just you pull
23 out and say, we can look at this
24 measure, this measure and be able
25 to assess the health of Kensington?

1 MR. GREMMINGER: I will
2 answer it from a functionality
3 perspective and perhaps Sarah can
4 answer it from intaking somebody
5 and what they would look at. So
6 from a functionality perspective,
7 we're able to customize the
8 assessments.

9 So I had mentioned GAD-7
10 PHQ-9 standards, psychometrically
11 validated screener for depression.
12 Well, we would also want to look at
13 other probably very specific things
14 that need to be addressed in the
15 Kensington area, so we would build
16 out that assessment with the
17 specific data points that you all
18 would want to see along with I
19 would imagine the treatment
20 providers and then we would have
21 the ability to instantly select a
22 time range, hit enter and have that
23 information available to you.

24 COUNCILWOMAN AHMAD: One of
25 the caveats in doing this is the

1 quality of data and biases built
2 into who's uploading the data,
3 right. So I just hope that all our
4 systems have that caveat built in
5 so we can control for that. I
6 mean, data is data. You can slice
7 it and dice it any which way you
8 want to see it, so there's an issue
9 with that as well.

10 So while we applaud this
11 way of being able to visualize and
12 seeing realtime, I just want to
13 know that there are built-in
14 protections to catching these
15 things in terms of particular
16 interested bias built into the data
17 uploader who is doing that
18 information.

19 MS. DEUTCHMAN: I think I
20 can maybe shed some light on that.
21 So the clinical assessment tools
22 are self-directed by the individual
23 participating in treatment, so it's
24 a little unlike an individual
25 counseling session where there's

1 collaborative notetaking where a
2 client is responding and I'm
3 documenting that response.

4 So as the clients are
5 completing these assessments
6 individually, the data tends to be
7 less bias for that reason. But at
8 Pyramid Healthcare we have hundreds
9 of thousands of other clinical
10 assessment measures that we've
11 accumulated. We've been in one
12 common electronic health record for
13 years and years and years. We have
14 tons of data. But this visual, the
15 ease of use and the ease of client
16 interaction is something that we
17 haven't experienced until we
18 started working with ERP team. So
19 I'll call that out as a
20 differentiator as well, the ease of
21 use, the visuals, the realtime
22 access to data, the sophistication
23 of the tool, the way that we can
24 customize the data sets that we
25 want to see on a level that we

1 haven't experienced with our
2 electronic health record.

3 COUNCILWOMAN AHMAD: And
4 how user-friendly is it in terms of
5 we have resistance as you've
6 probably heard all through the day
7 of everybody doing their own thing,
8 and everyone thinks they're great
9 in what they're doing but there's
10 no way we can measure it if stacked
11 up against each other.

12 So how is it adaptable? Is
13 it a service you sell and we go
14 into the company where the place is
15 and you manage that space or do
16 they actually take a program and
17 they manage it themselves?

18 MR. GREMMINGER: So just
19 from a user experience perspective,
20 it was built to be able to be used
21 by anybody as easily as possible.
22 So 2024-looking technology, so
23 you'll see some EMRs kind of looks
24 like Windows 95 a little bit.
25 We've built it very specifically

1 with a consumer mindset in place,
2 because we're counting on once
3 their in-treatment patient
4 reported, so this means that it has
5 to be relevant and exciting, what
6 they're used to seeing on their
7 smartphone. So very user-friendly
8 in that capacity.

9 We have APIs where we
10 connect to existing technologies.
11 But the important thing is we heard
12 from so many great providers today.
13 But if they're building their own
14 technology, they have a technology,
15 and we're an agnostic company where
16 the input doesn't matter where they
17 came from. What we're able to do
18 is aggregate and provide you with
19 an objective third-party data set
20 which we don't have a pony in this
21 race. We just want to see
22 transparency as community -- our
23 headquarters, we were founded in
24 Philadelphia.

25 As I said, I live five

1 minutes away. This is meaningful
2 to us, so we're willing to work
3 with anybody to make this very
4 necessary dashboard available.

5 COUNCILWOMAN AHMAD:

6 Including government. You had our
7 Department of Behavioral Health
8 here, right. I would think this
9 should be at forefront of the
10 \$1. something billion budget to
11 have this already. We don't.
12 We're still kind of almost like
13 paper reports coming in kind of
14 situation, it seems like it. I
15 don't know because I haven't seen
16 anything.

17 So I really think we need
18 to up the ante in a very big way if
19 they're going to be able to put
20 Philadelphia in realtime. We can't
21 wait for all this, are you going to
22 give me this data, are you going to
23 give that data. This is 2024 and
24 we have these things available.

25 It just frustrates me that

1 we're not able to serve the real
2 need because of bureaucracy getting
3 in the way. So I yield my time.

4 MR. GREMMINGER: I agree.
5 I second that.

6 COUNCILWOMAN AHMAD: But
7 it's possible, what you're showing
8 me is it's possible to do this.
9 It's a matter of will and it's a
10 matter of whether we're willing to
11 accept new ways of doing things and
12 the transparency because that makes
13 yourself -- all of this will
14 immediately show us right away
15 who's doing what and how successful
16 it is and you don't have to have a
17 period to do that, you just click a
18 button and that's where we need to
19 be.

20 COUNCILWOMAN LOZADA: Thank
21 you. Thank you for your question.

22 Have you all had an
23 opportunity -- your company has
24 been in Philadelphia for how many
25 years?

1 MR. GREMMINGER: I've been
2 doing this for 10 years myself, but
3 we've been officially really doing
4 this type of technology starting in
5 2019.

6 COUNCILWOMAN LOZADA: So
7 have you had the opportunity to --
8 I'm sure that, you know, I've only
9 been in office for 20 months.

10 COUNCILWOMAN AHMAD:
11 Five-and-a-half months.

12 COUNCILWOMAN LOZADA: Five-
13 and-a-half months, right.
14 Councilmember has been here for
15 years. Councilmember Harrity's
16 also new. But have you had an
17 opportunity -- this conversation as
18 you heard earlier today, this is a
19 conversation and a problem that has
20 been existing for years.

21 Have you all or has your
22 company had an opportunity to ever
23 bring your product in front of City
24 government. And if so, what was
25 the response?

1 MR. GREMMINGER: No, we
2 have not. And this is our first
3 opportunity. And really because of
4 this Special Committee having
5 Pyramid as a partner and bed
6 availability, it was a salient
7 instance of where we had a great
8 partner and the existing
9 infrastructure where we can make an
10 immediate impact we believe here.
11 So this is kind of our first foray
12 into government. I do believe CBH,
13 DBH and everybody who's up here
14 earlier would benefit immensely
15 from this technology.

16 COUNCILWOMAN LOZADA: Thank
17 you so much. We look forward to
18 continuing the conversation with
19 you. Definitely want to make sure
20 that we connect with you in the
21 future and maybe bring some of our
22 City departments, DBH, CBH, Office
23 of Homeless Services, the Police,
24 maybe bring you to a conversation
25 hosted by the Special Committee

1 just to talk in more detail about
2 what this could potentially look
3 like in the future to figure out
4 how we can move this into a
5 reality, right.

6 I think that everyone
7 agrees that we need to be able to
8 access beds differently. We need
9 to be able to look at the numbers
10 and where we need to make
11 adjustments for improvements,
12 right. We need to track our
13 providers better. Regardless of
14 whether the bed is here in
15 Philadelphia County or in a
16 neighboring county, we should be
17 able to have access to that. Our
18 outreach workers should be able to
19 have easier access when they
20 encounter someone who's ready and
21 who's ready now.

22 How do we provide our
23 outreach workers who are out there
24 every day building and establishing
25 these relationships with

1 individuals who are living
2 unsheltered, how do we provide our
3 outreach workers with another tool
4 for their toolbox, right.

5 We talked often about
6 creating legislation that will add
7 to the toolbox to make it easier
8 for us to respond and restore the
9 quality of life in Kensington. And
10 I think having a place where our
11 outreach workers could access where
12 this bed is at any time of the day
13 to me would make it much easier for
14 us to connect individuals to the
15 resources that they needed.

16 So I look forward to
17 continuing the conversation.
18 Again, my deepest gratitude to you
19 and your team having invested so
20 much time to create an application
21 like this one that can really help
22 us get there. Is it perfect right
23 now? No, but I think that the
24 willingness and the capacity is
25 there. So I look forward to

1 calling back on you with a larger
2 group of individuals that could
3 help this really be what we need to
4 respond to the crisis that we have
5 in Kensington. Thank you so much
6 for being with us today.

7 MR. GREMMINGER: Thank you
8 very much for having us.

9 COUNCILWOMAN LOZADA: Thank
10 you.

11 COUNCILWOMAN AHMAD: And
12 (inaudible).

13 MR. GREMMINGER:
14 Immediately.

15 COUNCILWOMAN AHMAD:
16 (Inaudible).

17 MR. GREMMINGER: Exactly.
18 And again, it just exists. It's
19 really just about modifying it and
20 purpose-building it for what we're
21 looking to achieve here, but the
22 technology is in existence, it's
23 driving better patient care, you
24 know, tangible proof that this
25 works to improve the outcomes of

1 patients. So it's really just
2 the --

3 COUNCILWOMAN LOZADA: We're
4 a city of the first class. And
5 somebody said earlier, we're
6 Philadelphia, we can do anything.
7 And so, this is part of anything we
8 can do. Thank you so much again
9 for being with us today.

10 Mr. Clerk, are there other
11 panels that we are to hear from
12 today?

13 THE CLERK: Madam Chair,
14 there are no further witnesses
15 testifying on the resolution.

16 COUNCILWOMAN LOZADA: I
17 can't find my script. But there
18 being no more panels to hear from
19 today, we will move into public
20 comment. If there is anyone here
21 that is interested in public
22 comment but has not signed up,
23 members of my team are over here
24 and can get you on the list.

25 Will the Clerk please call

1 the first person on the list for
2 public comment. And I'm going to
3 ask so that we can move this a
4 little quicker, I want to be
5 respectful of people's time as far
6 as I don't want to overstay our
7 welcome here.

8 We're going to call five
9 people at a time. And if you guys
10 can just sit here and be prepared
11 to give your public comment in a
12 row, it will be extremely helpful,
13 there at the microphone or
14 whatever. We just want to make
15 sure that we have multiple people
16 ready to go and that you know that
17 you are next.

18 MR. HOWARD: Check, check.

19 COUNCILWOMAN LOZADA:
20 Everyone will have two minutes to
21 give your comment. It's
22 unfortunate, but that's what we
23 need to do.

24 Mr. Clerk.

25 THE CLERK: Will Kevin

1 Howard, Lawrence Jackson, Kelcey
2 Leon, Gloria Hart and Sam Lou be
3 approach.

4 THE CLERK: Please state
5 your name for the record.

6 MR. JACKSON: Yes. I'm
7 Lawrence Jackson. So I just wanted
8 to say I'm a product of DBHIDS. I
9 came from Atlanta in October 2017,
10 to commit a crime, I got arrested.
11 I brought me from Atlanta a mental
12 health problem, a drug problem and
13 a criminal problem.

14 I went to jail. The police
15 recognized I had a drug problem. I
16 went to the homeless shelter. I
17 went to rehab. I went through
18 long-term Journey of Hope program.
19 And then I found an idea of what
20 recovery could be. I went to rehab
21 twice.

22 And I'm saying that to say
23 I became a recovery addict working
24 with Cultural Affairs. I became a
25 certified peer specialist. And

1 now, I'm a full-time employee with
2 the MORS Unit. All right. I'm
3 saying four years ago I was
4 homeless. I was matched to
5 independent housing. From there I
6 got a PHA voucher and rented a
7 home. And on May 10th I moved into
8 a brand new home through the help
9 of the City of Philadelphia through
10 the Department of Behavioral Health
11 and Intellectual Services. Thank
12 you.

13 COUNCILWOMAN LOZADA: Thank
14 you. Thank you for your testimony.
15 Thank you.

16 (Applause.)

17 MR. HOWARD: My name is
18 Kevin Howard. Can you hear me?
19 Testing 1, 2, 3. Hi. My name is
20 Kevin Howard. I've been in the
21 field for 30 years in addiction and
22 recovery. I'm a recovering person.
23 One of my concerns is that we
24 provide folks with medication.
25 It's very important because we are

1 losing people to withdrawal and we
2 are not capturing those people who
3 would otherwise be in treatment.

4 If medication is not at the
5 forefront, we're going to lose our
6 people. It has to be at the
7 forefront. Our providers have to
8 medicate these folks as quick as
9 possible. We need to have topnotch
10 customer service at the front door
11 because we're losing people if we
12 don't provide topnotch customer
13 service. So having said that,
14 those are two important things that
15 I wanted to relay to City Council.
16 Thank you so much.

17 COUNCILMAN AHMAD: Thank
18 you.

19 COUNCILMAN HARRITY: Thank
20 you.

21 COUNCILWOMAN LOZADA: Thank
22 you.

23 THE CLERK: Kelcey Leon.

24 (No response.)

25 THE CLERK: Gloria Hart.

1 (No response.)

2 THE CLERK: Will Ben F,
3 Larry Turetsky, Kate Magoffin and
4 Connor Sacconi approach. Please
5 state your name for the record.
6 Thank you.

7 MR. F: Hello. My name is
8 Ben F. I'm here with the
9 Abolitionist Law Center. I'd like
10 to speak to one of the greatest
11 barriers to treatment, the violence
12 that is inflicted on people who use
13 drugs of the PPD and the
14 Philadelphia Department of Prisons.

15 The increased
16 militarization and policing of
17 residents of Kensington both housed
18 and unhoused is the opposite of the
19 pathway to recovery and treatment.
20 Between June 18th and July 8th,
21 there was a 123 percent increase in
22 drugs in arrests for drug
23 possession in the 24th District
24 according to data from the
25 Philadelphia District Attorney's

1 Office.

2 Violence and harmful
3 interactions with the police and
4 the carceral system only disrupt
5 and traumatize the care that people
6 with complex medical conditions
7 need. There's also a misconception
8 that people who enter the jail will
9 receive treatment. As being heard
10 today, addiction is a complex
11 disease that requires
12 individualized care.

13 However, most people only
14 receive MOUD treatment a daily dose
15 of buprenorphine. There are also
16 long excruciating waits for
17 treatment. In 2023, there were 181
18 weekly backlog appointments for
19 MOUD treatment. While people are
20 not receiving their medication,
21 they are experiencing severe
22 withdrawal symptoms that include
23 vomiting, diarrhea, hallucinations
24 and nausea, suffering that is akin
25 to cruel and unusual punishment.

1 And at the same time large
2 numbers of people are getting
3 kicked off treatment once they get
4 it often without due process or
5 review. In 2021, 532 people or 41
6 percent of people who are giving
7 MOUD treatment then have their
8 medication ended which often can be
9 simply because of correctional
10 officer said so.

11 Philly jails are incredibly
12 unsafe, particularly for those who
13 struggle with addiction. Jails
14 have proven that they function so
15 poorly they cannot even provide
16 basic medical care. Since 2018 at
17 least 25 people have died in the
18 jails due to overdoses or other
19 drug-relates costs accounting for a
20 third of all deaths in facilities.

21 In 2021 or in 2020 more
22 people overdosed at CFCF over a
23 single weekend and three of them
24 died. Incarceration also increases
25 risk of death as soon as people are

1 released. Within the first two
2 weeks after release, the risk of
3 death of drug overdose is 12.7
4 times higher than the general
5 population.

6 We know what works. There
7 are harm reduction providers who
8 have longstanding trusting
9 relationships who can support
10 people to getting care. If
11 Philadelphia truly wants to address
12 this public health crisis, we also
13 have to end this criminalization
14 and use the money for dignified
15 treatment. Thank you.

16 COUNCILWOMAN LOZADA: Thank
17 you for your testimony.

18 MR. TURETSKY: My name's
19 Larry. I've been living about a
20 block from K&A for 13 years. I've
21 seen a lot. What can I say is that
22 I've been really impressed in the
23 two years, particularly the last
24 year, with the way things have been
25 improving. It smells better. It

1 looks better. There's a lot more
2 to go. Don't get be wrong.

3 I'm happy to give a
4 compliment. I'm also not shy about
5 criticizing, but I can see that our
6 alleyways have been clean. CLIP's
7 hazard department has been coming
8 around sanitizing. Streets have
9 been making more pick-ups. They're
10 actually taking the trash now.

11 And so, I commend the
12 Council, particularly Councilwoman
13 Lozada for -- something must have
14 changed. I assume it's her and
15 Mayor Parker and anyone else that's
16 been involved so I appreciate that.
17 It seems though the reason that
18 we're having this hearing is
19 because there's been a lack of
20 investment over the decades,
21 probably goes back to the '70s.
22 You can argue whatever number you
23 want, but since globalization.

24 But it seems like we're
25 just trying to reverse what should

1 have been done since 1970s, and
2 that is investing in long-term
3 public infrastructure. So streets,
4 the clean-up, maybe eventually we
5 can get into job training, early
6 childhood education, more parks or
7 cleaner parks I should say, usable
8 parks. And those are the kinds of
9 things that bring increased
10 property values and businesses.

11 Kensington and Port
12 Richmond were not always this way.
13 They were regional and national
14 centers for lots of industries like
15 fishing, ship-building. Tylenol
16 was invented 2,000 feet from here
17 in Kensington, McNeil
18 Pharmaceuticals. Lactose milk, if
19 you drink that or take lactose
20 tablets, that was invented here in
21 Kensington. And so, the Stetson
22 hat, the cowboy hat, that's not
23 from Texas. That's Kensington.
24 Stetson in Kensington used to be
25 the number one employer in the

1 country. It was bigger than Ford,
2 but globalization took it away.

3 But the point is we can go
4 back to that kind of time where we
5 can bring businesses, tax-based
6 population. The reason why
7 Kensington and Port Richmond were
8 even developed was because there
9 was employment and things to do
10 here. And I think we can take it
11 back to that.

12 And so, I appreciate the
13 investment. I think it's going to
14 be long-term. We're looking at
15 multiple years. You're going to
16 have to change the bureaucracy with
17 bed categorizations and whatever
18 CBH thinks they're doing over
19 there. I can't believe the guy
20 said COVID was a reason still two
21 years that they're behind on
22 treatments, and fix some of that
23 bureaucracy.

24 You have the budget, \$6.2
25 billion you have without raising

1 taxes, so thank you. But you now
2 have the money. I don't know if
3 you want to wait for Universal
4 Health Care. I think we got the
5 money to do it. And so, I think
6 that kind of persistent investment
7 is where I see -- because it's
8 already worked in the last two
9 years. That kind of persistent
10 investment is where we should be
11 going for the next few years, so
12 hopefully you'll keep at it and I
13 appreciate the out-of-the-box
14 thinking and money that's coming
15 our way. So please keep it up. It
16 has been improved. I've seen it,
17 lower crime, all that.

18 COUNCILWOMAN LOZADA: Thank
19 you for your testimony -- thank you
20 for your comment.

21 (Applause.)

22 MR. SACCONI: Hello. My
23 name is Connor. I'm a volunteer
24 with the Public Relations
25 Subcommittee, the Downtown

1 Philadelphia Area of Narcotics

2 Anonymous. Regrettably I was under
3 the impression that I was a panel,
4 but I guess I'm not which is okay.

5 Thank you for allowing me
6 to testify today about an issue
7 that is affecting many lives within
8 our city, homelessness and drug
9 addiction. Philadelphia is a city
10 that has stood together in the face
11 of adversity and we need to come
12 together to address this issue.

13 And I recognize Councilmembers
14 Driscoll, Lozada and Ahmad and the
15 work that you guys are doing,
16 extremely grateful.

17 Narcotics Anonymous has
18 been active in the city of
19 Philadelphia for 40 years and in
20 the Philly suburbs for over 50
21 years. We've been able to get past
22 all the barriers where diversity
23 has now become our strength.
24 Amazingly Narcotics Anonymous has
25 240 meetings weekly in the city of

1 Philadelphia.

2 As your resolution
3 outlines, the shortage of vacant
4 beds in homeless individuals is a
5 problem. This is exacerbated by
6 the fact that many of these
7 individuals are struggling with
8 addiction. The lack of option not
9 only leaves these individuals
10 without shelter but also without
11 the support they need to start the
12 recovery journey. This is --
13 Narcotics Anonymous can be a
14 resource.

15 NA is a nonprofit
16 community-based organization that
17 provides a network of individuals
18 battling addiction. We meet
19 regularly to help each other stay
20 clean. Through attending meetings,
21 NA can offer hope, where for many
22 there has not been hope for some
23 time.

24 This is how Narcotics
25 Anonymous can help, fellowship and

1 accountability. Narcotics
2 Anonymous provides a safe
3 environment where individuals can
4 share their experience and
5 struggles with others who have
6 faced similar challenges. This
7 support fosters a sense of
8 community and accountability.

9 Accessibility: NA meetings
10 are 100 percent free and widely
11 available. As I said throughout
12 the city, 240 meetings a week.
13 This makes them a readily available
14 resource for individuals that may
15 not have the means or the
16 willingness to go traditional
17 rehab. By utilizing existing
18 community spaces, NA can operate
19 without any financial investment
20 from the City.

21 Cooperation with existing
22 services: NA does not replace the
23 need for medical or residential
24 treatment programs, but can work in
25 cooperation with them by providing

1 ongoing support. NA gives
2 individuals a place to participate
3 in the recovery after leaving
4 treatment facilities, reducing the
5 likelihood of relapse and repeated
6 use of City resources.

7 Reduction of bed shortage
8 pressure: Encouraging
9 participation in NA can help reduce
10 the strain on the City's shelter
11 system. People who find stability
12 and support through NA are more
13 likely to secure permanent housing
14 and employment, thereby decreasing
15 the demand for emergency shelter
16 beds.

17 Community and giving back:
18 NA encourages members to become
19 active contributing members of
20 society. This not only benefits
21 the individuals but strengthens the
22 community by allowing an
23 environment of support and
24 recovery. Often times we find
25 members will see people that they

1 used to get high with that are
2 clean and doing well and say, what
3 are you doing. That goes for all
4 types of recovery.

5 I urge the City to consider
6 the following actions to support
7 Narcotics Anonymous into your
8 strategy for addressing
9 homelessness and addiction:
10 Awareness, increased awareness of
11 Narcotics Anonymous meetings
12 through City websites, shelters and
13 community centers. Ensure that
14 those who are in need know how or
15 where to access our meeting places.

16 Upon request, we have
17 posters with our information
18 available that we will be happy to
19 provide, meeting lists, business
20 cards which I brought some with me
21 that have a QR code that direct to
22 all the local meetings in the area.
23 We also have a huge volunteer base.

24 Providing information for
25 City services, and I'll wrap up

1 with this: Several city-run
2 organizations come into frequent
3 contact --

4 THE CLERK: I'm sorry,
5 Mr. Sacconi. We do have some other
6 speakers. I got to cut you out.

7 MR. SACCONI: Thank you
8 very much for my time. I have a
9 lot of information with me if you
10 guys are interested.

11 COUNCILWOMAN LOZADA: Thank
12 you so much for your testimony.
13 Your written testimony can be given
14 to the Clerk. He will make sure
15 that we put it on the record. And
16 my team is right over there at the
17 first table. Please feel free to
18 leave your information with them.
19 I'll make sure to share it.

20 MR. SACCONI: Thank you so
21 much.

22 COUNCILWOMAN LOZADA: Thank
23 you for joining us today.

24 MS. Magoffin: Good almost
25 evening, Council. I appreciable

1 you all hosting this hearing. My
2 name is Kate Magoffin. I'm a
3 social worker, an outreach worker.
4 I reach in our behavioral health
5 system as well. I train hundreds
6 of behavioral health staff a year
7 around topics of addiction, stigma,
8 trauma and organizational
9 management.

10 I know this hearing is
11 geared towards kind of accessing
12 beds, but I wanted to note the
13 importance of talking about what
14 happens when people are in those
15 beds and the quality of treatment
16 people have received, especially
17 when people leave AMA. I'm like
18 that's a huge deal in Philadelphia.

19 We need to actually be --
20 like, there's infrastructure in
21 Philly and we need to actually to
22 be talking about, that's great, get
23 people into beds, have whatever
24 outreach workers get people into
25 treatment. That's not going to

1 stop people from leaving AMA.

2 And so, just to note that a
3 little bit more, an example of that
4 is for a little bit over a year now
5 I've been part of some advocacy
6 efforts geared towards Penn
7 Medicine to improve conditions at
8 their HUP Cedar location. After
9 rerouting a majority of their psych
10 and detox patients there after they
11 closed down Reg 4 last summer.

12 Reg 4 was an 18-bed
13 inpatient rehab located in Penn
14 Presbyterian. Patients at Reg 4
15 had access on ICU, medical consults
16 like renal and cardio consults.
17 They were offered standardized
18 withdrawal management. They had
19 transparent competent staff and
20 they were generally cared for by
21 medically complex professionals.

22 I've talked with a lot of
23 people in Kensington when I've been
24 doing outreach for the last five
25 years. There were a lot of folks

1 that were like, oh, we like Penn
2 Presby. Penn Presby treated us
3 really well or Reg 4 treated us
4 really well.

5 So like I said, Penn Med
6 decided to shut that unit down and
7 did not replace those inpatient
8 beds. So now, many psych and detox
9 patients from around Philadelphia
10 are being routed to HUP Cedar to
11 its ED and new CRC.

12 I wanted to relay some
13 notes about the treatment that the
14 detox patients receive at HUP Cedar
15 from up here who works there. One,
16 HUP Cedar doesn't have inperson
17 medical consults which is a problem
18 for a medical complex needs of the
19 patients coming in.

20 The staff at HUP Cedar have
21 been known to cruelly Narcan people
22 when it wasn't necessary, and
23 treatment like that, word spreads.
24 So a lot of folks were like we're
25 going to HUP Cedar. Staff at Cedar

1 still don't have education around
2 xylazine, what it is, what xylazine
3 withdrawal looks like.

4 Also, because CRC only has
5 three beds and those three beds are
6 for 302 patients, sometimes people
7 go into the CRC as detox patients
8 and end up sitting in chairs for
9 multiple days only to leave and are
10 sometimes worse off than they were.
11 Again, just other things about
12 Cedar staff being rude and
13 dismissive. Also, a few weeks ago
14 there was an incident where a staff
15 member at Cedar dragged, and I
16 literally mean dragged on the
17 ground, a geriatric SUD patient out
18 of the building by her feet.

19 So notably, these are
20 conditions. Also, at HUP Cedar
21 eight months after a patient died
22 from medical neglect because staff
23 didn't call a code blue, after a
24 state inspection also ruled that
25 they found multiple other incidents

1 of patient neglect. And these
2 conditions that I just stated are
3 kind of current conditions.

4 I also just wanted to note
5 that the concept of kind of a bed
6 is a bed is not actually
7 necessarily helpful framing for
8 this issue --

9 THE CLERK: I'm sorry.
10 It's time --

11 MS. MAGOFFIN: But I --

12 THE CLERK: Sorry. I gave
13 you an extra one too. I'm sorry.
14 I have more, but thank you.

15 COUNCILWOMAN LOZADA: Thank
16 you for your testimony. Thank you.

17 THE CLERK: Would Gia Gale,
18 Shawn Ryan and Ketun Bonillos,
19 please come up.

20 (No response.)

21 THE CLERK: Going once,
22 twice, it's sold. It's sold,
23 Councilwoman. That's it.

24 COUNCILWOMAN LOZADA:
25 Mr. Clerk, are there any other --

1 THE CLERK: There are no
2 further witnesses, Madam
3 Chairwoman.

4 COUNCILWOMAN LOZADA: This
5 concludes the business before the
6 Special Committee on Kensington
7 today. Thank you all very much for
8 being in attendance with us. We
9 appreciate and value everything and
10 everyone who joined us today.
11 Thank you so much. Be safe getting
12 back home. Thank you.

13 Can I have a motion to
14 adjourn?

15 COUNCILMAN HARRITY: Motion
16 to adjourn.

17 COUNCILMAN DRISCOLL:
18 Second.

19 COUNCILWOMAN LOZADA: It
20 has been moved and properly
21 seconded that --

22 COUNCILMAN DRISCOLL: Aye.
23 (Special Committee on
24 Kensington concluded at 4:30 p.m.)

25

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

2 I, hereby certify that the proceedings
3 and evidence noted are contained fully and
4 accurately in the stenographic notes taken by
5 me in the foregoing matter, and that this is a
6 correct transcript of the same.
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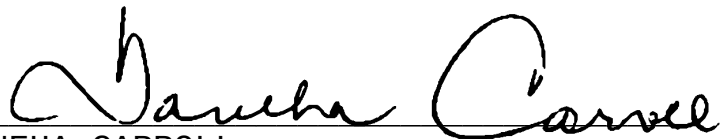
17

18 (The foregoing certification of this
19 transcript does not apply to any reproduction
20 of the same by any means, unless under the
21 direct control and/or supervision of the
22 certifying reporter.)

23

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25

A handwritten signature in black ink, reading "Taneha Carroll". The signature is fluid and cursive, with the first name "Taneha" and the last name "Carroll" clearly distinguishable.

TANEHA CARROLL
Court Reporter - Notary Public

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