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I am Cheryl Andrews, Executive Director for Washington Drug Alcohol Commission. The Commission is a 501c3 and serves as the Single County Authority or SCA for Washington County. A portion my testimony will focus on the efforts of the Single County Authority, therefore, I thought it might be a good idea to provide some history on the SCA.

In 1972, the Commonwealth of PA established the Single State Agency, at that time it was the Bureau of Drug and Alcohol Program under the Department of Health. At the same time, the Single County Authority (SCA) was established to implement substance abuse prevention, intervention and treatment services through county-based planning and management. Act 63, the PA Drug and Alcohol Abuse Control Act, requires the now newly established Department of Drug and Alcohol Programs to develop a state plan for the oversight of all aspects of drug and alcohol abuse and dependence programs which include: prevention, intervention, treatment, rehabilitation, research, education, and training. The Single County Authority is charged with carrying out the state plan at the local level. The current opioid epidemic presents one of the greatest challenges ever faced by our communities. Medicaid expansion presents an opportunity for the SCA to respond to individuals and families who face addiction and to improve outcomes for long term recovery.

There are 47 SCA's throughout the Commonwealth of PA. Some of the Commonwealth's 67 counties have opted to share administrative costs by creating multi-county administrative units, which are referred to as "joinders." The SCA is uniquely positioned to assess the needs, support the community partnerships, build capacity, assist with the planning and implementation of resources and provide monitoring to ensure quality of service. The SCA has formed community

partnerships and with over 40 years of experience—the SCA is remains an integral part of the solution to this epidemic.

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In many ways, Pennsylvania is light years ahead of many states when it comes to the drug and alcohol treatment infrastructure; however, there are challenges that remain before us. The only answer to these challenges is “Systems Collaboration,” to include policy makers, law enforcement, courts, healthcare system, and the human services delivery system, etc.. I shared information about the SCA because I firmly believe that the SCA’s throughout the Commonwealth stand as the viable infrastructure to affect the most change yet we are widely underutilized and exist well beneath the level of our potential. Some major issues that need addressed most direly are:

Bed Availability

- Individuals with commercial coverage (private insurance) get priority over Medicaid or county funded people due to the treatment provider receiving a higher reimbursement rate (per diem) from the commercial plan. This disparity results in discriminatory practices and a disparity in accessibility for those in the most critical need.
- We need more beds and OP treatment facilities. Promise ID’s can take up to 6 months to clear for new providers to enter the marketplace. The Promise ID is needed to bill the HealthChoices program for Medicaid patients. Many providers go under before they see one client.
- Providers that are entering should be vetted better by a local entity, such as the SCA, prior to being granted a license. DDAP makes licensing decisions without tapping the SCA for supplemental information to ensure the quality and motivation of the providers.
- Using “crisis detox” units should be explored to bridge the gap between need and availability of treatment. If someone seeking help can’t get it within the window of desperation they are seeking it, they will disappear only to re-emerge at their next interface within some part of the “system” or worse they will die.
- No one should complete short-term residential level of care without being offered Vivitrol prior to discharge. Short term treatment is nothing but a liability for opiate users. It only increases the likelihood of overdose without Vivitrol.

Improve Linkages Between Points of Interface

- The warm hand off mandate from DDAP is excellent in theory but nearly impossible to execute in isolation. All stakeholders at all know intercept points must have a basic understanding of addiction and where to send someone for help.
- A successful emergence from this epidemic truly depends on stakeholders’ ability to interact with and treat people at all points in the system: at hospitals and health

care providers' offices, in jails and other areas of the criminal justice system, in the community—at churches or human services agencies, at schools and places of employment.

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- There must be communication at the state and local levels to ensure that stakeholders along the continuum of care are informed about what others are doing, this allows all systems to be well-informed and pick up where another has left off and to ensure there are no gaps in care. I am not a firm believer in big government but there needs to be more coordinated efforts and sharing of the resources at the state level.

Medication Assisted Treatment

- Our nation has flooded the market with buprenorphine products. The patient limit was recently nearly tripled with no additional safeguards in place surrounding the misuse, abuse, and diversion of these products.
- Research exists that demonstrates that methadone is more cost effective, retains more individuals in treatment for longer periods of time and produces overall better outcomes, yet buprenorphine products continue to be marketed by the same strategies of the opioids that started this crisis in the first place.
- We should make decisions on MAT based upon objective data and research. Perhaps buprenorphine would be more effective if it were regulated and distributed more like methadone? Moreover, it was initially developed to be a taper and now, in many cases, it is being used as drug replacement therapy or maintenance drug.

Overdose Data

- Overdoses affect every community in our state. This stark reality is especially difficult to accept because SUD is preventable and treatable.
- Consistent reporting of overdose death data is key to informing public health and public safety, prevention, and intervention efforts, more importantly, there is a need for overdose survivor data.
- Develop a data system where information can be inputted
- Implement cross-disciplinary protocols for all first responders, emergency room doctors, and non-ems responders to ensure that OD survivor data is collected and reported in the same fashion. Ideally, there would be a central data system, with stakeholder accessibility.

Silos

- For the better part of the last two decades the SCA and other drug and alcohol professionals have struggled to break down silos in the systems of healthcare, mental health, public funding, criminal justice, and the court system.
- Every system seems to be offering a remedy to this epidemic, often, at the exclusion of the very department that was created to be the single driver for all substance-use related policy—Department of Drug and Alcohol Programs. To bring about effective change, the role of DDAP should be expanded and the SCA should remain the conduit for the efforts and funding at the local level.

In conclusion, I firmly believe that coordinated and complimentary steps which, when taken together, will set in motion a public health and public safety partnership which will significantly increase productive interventions, we will save lives. Our state should foster a community-based continuum of care model where families and individuals in recovery have a voice and play an integral part in the treatment and recovery protocols. By working together we can develop policies and programs that focus on SUD research, prevention, and treatment with the goal of saving lives.