

Testimony

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Testimony Regarding the Accessibility of Treatment Services in Chester County
In Response to HR 590 of 2016
Before the Members of the HR Task Force
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Thank you for opportunity to provide testimony regarding treatment access issues in Chester County, as the Task Force explores this issue on a statewide basis. Chester County has exceptional strengths, including in our drug and alcohol service system. However, in this testimony, I am going to focus on the significant challenges we face regarding treatment access. Specifically, I will focus on treatment access issues, including assessments, for individuals in our publicly funded system as well as include some relevant discussion about those with commercial insurance and other resources.

Briefly, Chester County is located in Southeastern Pennsylvania, is a fairly large County consisting of 759 square miles, and consists of a mixture of urban and rural areas. The estimated population as of 2014 was 512,784, consisting of approximately 86% white, 7% Latino/Hispanic, 6% African American, with “others” comprising the remaining 1%. The average household income is \$86,000 although according to the most recent census information, an estimated 7% of the population is identified as living in poverty.

Chester County is one of the wealthiest, best educated and healthiest in the state, but we are not immune to substance abuse disorders, including the disease of addiction, nor the opiate epidemic currently challenging the nation.

Based on estimates of the Prevalence of Substance Abuse Disorders (Dependence or Abuse) of Illicit Drugs or Alcohol as reported in the 2012-2013 National Survey on Drug Use and Health (NSDUH) , approximately 8% of our population ages 12 and above have a substance abuse disorder. This totals over 35,000 residents. When considering this with the estimate that 1 in 4 people are impacted by addiction, there are over 107,000 residents in the County impacted by their own or another’s addiction.

As we know, the impact of this disease is far reaching; affecting individuals, families, and communities as well as numerous health and human services systems, and others including law enforcement and criminal justice, public health and the medical field, to name a few.

As we also know, treatment is critical to addressing this disease and the devastation it creates. The full continuum of treatment, including medication assisted treatment and recovery supports must be available and must be of the highest quality; it must be accessible; and it must be provided at the appropriate level of care and for the appropriate length of time. And it’s the accessibility issues/challenges that are of increasing concern, and the focus of this testimony.

In Chester County, access to the services funded by our department (which is also the Single County Authority, or SCA, for Chester County) is primarily through five (5) outpatient programs located geographically throughout the County, which was implemented to enhance accessibility. Assessments are completed and referrals made as appropriate, to any level of treatment. These same providers are access points for our Medicaid population as well as some commercially insured residents. The goal of the SCA is to provide timely assessments and admissions to treatment to individuals based on their needs; same day for individuals in a crisis situation and within 3 – 4 days at most, for most others. Additionally, emergency rooms in the five (5) County hospitals may assess and refer directly to detox for cases that come in after hours.

Despite our goal, we have been experiencing an increase in the time to access assessments (our policy is within 3 days for non-emergent needs) and even more so, for admissions to treatment once an assessment is completed.

Through a survey of our assessment providers in mid-August we found the following:

- Two of our five (5) assessment sites were scheduling initial appointments for assessment, more than 7 days from the time of initial call; and another averaging over 4 days.

Interestingly, two (2) of these providers have been involved in a project to increase initial show rates and engagement. This has been successful, but they are now struggling with a demand that exceeds resources.

- Each had at least one publicly funded person awaiting admission to a residential treatment facility, and a total of 10 – 12 people were awaiting admissions throughout the system. This included at least 4 individuals in need of detox; 2 for opioids.

Further data review has shown:

- Since the beginning of this calendar year, the average wait time for admission into residential services was 4 days; this was following an assessment. However, as the year has progressed we are seeing longer delays for admission, including for detox.
- Some individuals waited longer than 10 days, with lack of bed availability appearing to be a more consistent reason as the year progressed.
- Of greater concern, are those individuals who we lose while waiting despite efforts to engage them in interim services. (These were not calculated into the waiting time noted above).

As of the writing of this testimony we are finding daily, that many providers do not have beds available until mid-to-late September and some into October. This means waits for individuals in the community as well as in the prison, where we complete a large number of assessments.

Regarding residents with commercial insurance, although I can't speak to the specifics of all commercial insurance benefits, what I know from the SCA perspective, both anecdotally and from our own experience is:

- There is an increase in requests for "public" (SCA) funding assistance for individuals with insurance, because the insurance is either: denying services; benefits are limited and exhausted;

or more frequently now, deductibles and/or co-payments are so high people are unable to pay them and subsequently unable to access services.

As an example of the high co-pays and deductibles, and the impact this can have on individuals, families and systems, I'd like to briefly share the following case which I was consulted on as I was preparing for this testimony:

I received a call from a Common Pleas Judge asking for help in determining funding options for a 49 year old woman, incarcerated at the prison for multiple, high blood alcohol level, DUIs. In addition to a severe alcohol problem, she had a mental health diagnosis and was on medications. Her son had called the police to report her driving under the influence, (possibly in an effort to save her life). She was assessed as needing long-term residential treatment.

The woman was insured but had a \$4,000 deductible after which she would have a 20% co-pay, none of which she was capable of paying.

When reviewing the case with my staff, it was found that the three (3) residential providers contacted, that could meet her needs, had waiting lists of at least 4 – 6 weeks. One was not even accepting referrals at that time. As a result of her legal status at the time, she was eventually released from custody on the Scram continuous alcohol monitoring system (an electronic home monitor with alcohol use detection capability), with supervision by adult probation and a referral to outpatient treatment while awaiting admission to rehab.

What do we see with this example? Among other things:

- Inability to access treatment despite having insurance
- The individual was released to the community, rather than a direct admission to treatment
- A serious addiction problem faced by the individual and family
- Public funding assistance explored/requested to take place of insurance
- The Criminal justice system dealing with a person with serious addiction
- Actually, a much more common occurrence than thought to be

In attempting to understand why we are now facing the accessibility challenges, of note are the following:

- Substance abuse/addiction has become more complex, both in the types of drugs being used and the needs of those using (e.g. mental health, medical, trauma...).
- Opioid/Overdose epidemic has increased the demand for treatment.
- A decrease in available beds as some providers moves to accepting private pay/commercial insurance only.
- Workforce issues including frequent shortages in staff; "aging" staff; low pay; complex client needs, and an increase in requirements for assessment and funding access, to name a few.
- The historical underfunding of the publicly funded drug and alcohol system.
- Medicaid expansion, which has increased the number of individuals eligible for Medicaid coverage and subsequently able to access needed treatment services.
- Affordable Care Act, which now allows young adults to remain on their parents insurance until age 26, thereby providing a resource not previously available.

- Philosophical change in the criminal justice system, where in Chester County there is greater emphasis on diversion to treatment instead of incarceration.
- Rates/reimbursement issues.
- Outreach, engagement, and retention initiatives which improve quality and prognosis, but are now creating demand beyond the resources available.

In closing, our goal in Chester County is to provide clinically appropriate, accessible services, including same day access to care for urgent situations; and for a time we were able to achieve that goal. This is no longer the case, as we continue to see increased demand, increased complexity in need and financing, and workforce shortages. Unfortunately, this is occurring at a time when we can least afford to have the access barriers we are experiencing.

Thank you for your time.