Testimony
Center for Rural Pennsylvania
PUBLIC HEARING - Heroin and Opioid Addiction Treatment and Recovery
Scranton, PA
July 29, 2015

John Knowles, CADC
Senior Marketing Representative
Clearbrook Treatment Centers

Chairman Yaw, Vice Chairman Wozniak, and other distinguished members of The Center for Rural Pennsylvania Board of Directors, thank you for the opportunity to appear before you today to discuss the explosive growth of Heroin/Opioid/Opiate addiction treatment and recovery. As a provider of substance abuse services for almost 30 years I have witnessed numerous changes in using habits of the population we serve, but none instills the level of concern and fear that Heroin/Opioid/Opiate addiction does. Pennsylvania is home to some of the highest quality, cost effective care for substance abusers and their families. We possess some of the finest laws for treatment reimbursement and yet we continue to climb the statistical ladder for use, abuse and overdoses from these substances. If the history of developing policy for drug addiction has taught us anything, it is that ***we cannot prescribe or arrest our way out of this epidemic.***

According to the Centers for Disease Control and Prevention (CDC), approximately 100 Americans died from drug overdose ***every day*** and enough prescription painkillers were prescribed to medicate every American adult around-the-clock for a month. The Office of National Drug Control Policy cites that heroin and prescription drug overdoses contribute to

more than half of the 38,300 overdose deaths in 2010. Drug overdose deaths now outnumber deaths from gunshot wounds or motor vehicle crashes.

At Clearbrook Treatment Centers these facts are reflected in the histories of patients seeking treatment. Approximate figures for 2013 indicate that 56% of admitted patients reported that Heroin, Prescription Narcotics or Opiates were their drug(s) of choice. Of this number approximately 69% were males and 31% females. In 2014 the figure climbed to 59% of admitted patients reporting that Heroin, Prescription Narcotics or Opiates were their drug(s) of choice, while the gender breakdown remained the same, approximately 69% male and 31% female. These figures reflect a nearly 30% increase over previous years. We believe this is an accurate reflection of most Pennsylvania inpatient providers and in some cases the figures are higher.

These patients present with unique immediate and post-acute withdrawal symptomology including poor self-esteem, a flat affect and depressed mood. These factors often lead to patients developing a desire to leave treatment prematurely and a feeling of hopelessness that recovery cannot occur for them. In addition, many of these referrals are also using Benzodiazepines such as Xanax and Librium in order to quell the symptoms of withdrawal This creates even greater danger as the withdrawal from these drugs is life threatening. We expect to see an increase in multi substance abuse and addiction in Heroin/Opiate/Opioid addicted patients as users look to enhance the high and minimize the discomfort of withdrawal. As with the Crack epidemic in the late 1980's, we as a treatment industry are struggling to keep

pace and unique to this epidemic are a confluence of circumstances that have complicated access issues to proper levels of care.

Late 2014 and early 2015 have begun to demonstrate the impact of parity laws and "Obamacare" on providing reimbursement and access to care. Pennsylvania is home to the Act 106 law, a bill that mandates minimum benefits for treatment of alcohol and drug addiction. The act requires specific coverage of drug and alcohol treatment services in certain group insurance policies or contracts. Currently the Act only represents a portion of the insured public and gaps in the bill exclude non-group policy holders, individuals in self-funded plans, individuals insured by out of state employers, Medicare and Medicaid recipients. Many law enforcement, judiciary and health professionals are unaware of the gaps in mandated coverage which can lead to misconceptions about how and when to place a patient. The issue can arise when addicted clients who are incarcerated and many third party payers, both private and public, can view the time spent in jail as detox and this negates the need for inpatient care. Delays in processing potential patients through the system can lead to denial of higher levels of care and because of ability to access third party insurance, severely limits access to other funding sources. The patient languishes in jail rather than accessing treatment. Providing a layer of early intervention at time of arrest/committal can increase the number of addicted offenders who can secure treatment with non-public funds.

Many of the new Affordable Care Act plans provide coverage, but, require large out of pocket and deductible charges – it is not unusual for a working class patient to have a five thousand dollar threshold before being able to access the benefit. In addition, these plans are often non-

group policies and therefore not eligible for the mandated benefits of Act 106. Amending the act to assure that every insured citizen of Pennsylvania has a right to substance abuse treatment coverage is an essential component to addressing this epidemic.

A further limit to accessing care has occurred with the emergence of significant changes in how the treatment field operates. In the inpatient field there has been a significant increase of investor funded mergers and acquisitions over the last 12-18 months. The balance of nonprofit and for profit providers has shifted and led to aggressive marketing campaigns by well financed private, for profit providers, primarily from Florida and California, to lure patients to their programs. These programs, referred to as the "Florida Model" skirt managed care policy and procedure by masking the type of care provided through provision of 'Scholarships" for housing and maximizing reimbursement of patient's outpatient and medical testing benefits such as urine drug screens. These market forces have dramatically shifted the payer mix of many providers who cannot sustain levels of service for free and reduced fee care patients – a population that is increasing because of exhausting of benefits. Often a patient will stay in these program for 30-60 days or until their benefits are exhausted, and return to Pennsylvania with no benefits, at any level, to continue on in treatment. This type of patient will be in greater need of a highly structured, concrete, simple and repetitive program of recovery that can last between 24-60 months with various levels of therapy and case management provided through a step down continuum. Most treatment professionals agree that the time directly following residential care is the most vulnerable time for relapse and with Heroin/Opiate/Opioid addicted patients the incidence of overdose is highest due to patients perception that they can use at levels similar to those just prior to treatment.

Thank you for the opportunity to provide testimony to highlight these areas of concern. You have my commitment to work with your Committee and its staff to forge a strong and productive relationship going forward. I look forward to answering any questions.

John Knowles, CADC