HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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Opioid Abuse Epidemic's Impact on Infants and Children

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House Children and Youth Committee

Main Capitol Building
Room 60, East Wing
Harrisburg, Pennsylvania

Wednesday, September 28, 2016 - 9:00 a.m.

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COMMITTEE MEMBERS PRESENT:

Honorable Katharine M. Watson, Majority Chairwoman
Honorable Harry Lewis, Jr.
Honorable David M. Maloney, Sr.
Honorable Brett R. Miller
Honorable Dan Moul
Honorable Tedd C. Nesbit
Honorable David Parker
Honorable Kristin Phillips-Hill
Honorable Jack Rader, Jr.
Honorable Greg Rothman
Honorable Rick Saccone
Honorable Todd Stephens
Honorable Tarah Toohil
Honorable Scott Conklin, Minority Chairman
Honorable Leanne Krueger-Braneky
Honorable Pamela A. DeLissio
Honorable Stephen McCarter
Honorable Joanna E. McClinton

1300 Garrison Drive, York, PA 17404
717.764.7801

Key Reporters

keyreporters@comcast.net

COMMITTEE STAFF PRESENT:

Greg Grasa
Majority Executive Director

Meredith Schuler
Majority Legislative Administrative Assistant

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MAJORITY CHAIRWOMAN WATSON: Ladies and gentlemen, may we begin, please, because we have, I'm not sure one would say an aggressive agenda, a monumental agenda, but we have a lot to cover in two hours to then get to the floor.

Let me do this officially now. Good morning to all of you. Welcome to the public hearing that is being convened by the House Children and Youth Committee. I do forget, sometimes, to introduce myself. My name is State Representative Kathy Watson. It's my distinct pleasure to be back in Harrisburg. Some of you know, you have no idea how pleasurable it is to be back in Harrisburg for me personally. But to preside over this very -- It is a very important hearing on a very important and sometimes overlooked topic.

Pennsylvania, sadly, has been one of the states that's hardest-hit by the epidemic of heroin and prescription opioid abuse, and an addiction is plaguing our society. Plaguing is exactly the word to use. One of the more tragic consequences of this epidemic, but as I said, I think, overlooked at times, is the devastating impact that this epidemic has had on infants and children, and it

continues to have devastating consequences.

Newborns are suffering through withdrawal from opioids because they were exposed to the drugs in the womb. Fatalities and near fatalities of infants and young children have been linked to parental substance abuse. Cases of child abuse and neglect linked to parental substance abuse are increasing, and we have the statistics you will hear from some of the folks testifying today.

As the numbers of children being removed from their homes and have been placed in protective custody because of their parents' drug addiction and, I will add, inability to care for them properly. These children are the innocent victims of the opioid abuse epidemic, and sadly, they are often overlooked in the discussions that we are having and discussions on how to curb the epidemic.

I had one friend who said to me, it's the collateral damage; not a term I like very well when it's in war, but, ladies and gentlemen, we are talking about infants and young children, particularly up to five years of age.

We, as a Commonwealth, we believe, have a responsibility to protect them; protect them as

children and protect them, because what we know is, if not taken care of and if not protected; if you look only at a balance ledger line in the budget, it will cost a lot more later. That's why, as Chairman of this committee, I felt it was particularly imperative for our committee to focus on this particular aspect of the crisis because, truthfully, others, and we've looked at legislation, are not focused there. But, we are the Children and Youth Committee. This is our focus and our area of expertise once we hear from some of the people that we will today.

Actually, I've introduced legislation, House Bill 2345, because I believe that we can do for this what we did with child abuse; that is, form a task force, have it ongoing and meet; and out of that, develop meaningful legislation. Please understand, the hearing today is critically important because we have a lot to learn. But, in no means is it, well, we've all heard this and now we can go ahead and do everything. I see this as a step process to make sure we do the right thing, the long-lasting thing.

But, this morning we start with being very fortunate because we have a number of experts

and practitioners who are on the front lines of the crisis. That's why we asked them to join us. And they're going to present testimony from a health-care perspective and a child welfare perspective. They'll shed light on the magnitude of the problem and strategies that have been working to improve the safety, the well-being and the permanency of children who are adversely affected by their parents' substance abuse disorders.

At a future time, I would also hope some of you are very interested in grandparents. That's another offshoot of this crisis. We have an ever-increasing number of grandparents who are raising grandchildren because their child, their adult child, is not capable of taking care of their grandchildren.

And, yet, as you remember, we had some hearings, those of you who've been on the committee for a while, you remember that we talked to -- they don't get help for raising those grandchildren. And yet, none of them, regardless how they prepared for, I refer to it as older age; not old. But, in any event, regardless how they prepared for it, they never prepared that they would be raising a family again. So, that will be an offshoot that we

will get into, and some of you may have some legislation for that.

As I said to you, I think this is a very complex problem that is often not looked at, but we're starting today. We have a full agenda. We're just about on time, so let's begin with testimony. Therefore, to lead off --

I'm sorry. My partner here, Representative Conklin, did you want to add something?

MINORITY CHAIRMAN CONKLIN: My Co-Chair, Madam Chairwoman, I think you've done an excellent job of getting it started, and it's time that we allow the folks to take over.

MAJORITY CHAIRWOMAN WATSON: All right. We shall rock and roll.

But to lead things off, then, I would like to welcome Doctor Kim Costello. Doctor Costello is Director of Neonatology at St. Luke's University Health Network; a member of the Pennsylvania Chapter of the American Academy of Pediatrics, which I certainly know well. Former president has her office two doors down from mine, so she stops in regularly to update me, which is a good thing.

Doctor Costello, would you come forward? You are welcomed, and you can begin your testimony when ready.

DOCTOR COSTELLO: Good morning, everyone.

MAJORITY CHAIRWOMAN WATSON: Good morning. It's like church. You want an answer, but you get about five.

DOCTOR COSTELLO: Right. (Laughter).

So, thank you so much for inviting me to help discuss this issue that I feel so very passionately about.

I wanted to first show you, and I can certainly distribute this later, but this evidence was just published in the recent days, and I think it's very telling. In Pennsylvania, between fiscal year 2000 and 2015, the rate of neonatal hospital stays related to substance use increased by 250 percent; from 5.6 to 19.5 per 1,000 neonatal stays.

Also, between 2000 and 2015, the rate of neonatal abstinence syndrome increased from 1.6 to 16 per 1,000 neonatal stays, which is an increase of 870 percent. And then, to put that into dollar signs, overall, neonatal hospitalizations related

to substance use added 27,000 hospital days, which is an additional payment amount to an estimated $20 million. So, this is just a little bit of what we are discussing today.

Infants with neonatal abstinence syndrome is a growing problem amongst our precious infants. The drug epidemic is not only affecting adults but women who are using or abusing narcotics and having unplanned pregnancies at an alarming rate, and children are being born exposed to and often dependent to the narcotics. It's estimated that more than 20,000 children are born to opioid-dependent women in the United States every year. These numbers are likely underestimated, as we do not have a good tracking system from state to state, and certainly not in Pennsylvania.

The CDC states that one infant in every 25 minutes in the United States suffers from neonatal abstinence syndrome. We do not have reliable data yet in Pennsylvania, but we're certainly getting there. We do know that at least 7,500 infants were diagnosed with neonatal abstinence syndrome in Pennsylvania between 2010 and 2014, according to Medicaid data. This data does not include infants who are not receiving

Medicaid.

We also know that one of the top three reasons for an infant or a child to be removed from their home is due to substance abuse by the parent, according to the Pennsylvania Department of Human Services. These babies are at high risk of dying or being neglected, not from NAS, but because their parents have an altered mental state on these medications and are co-sleeping with their babies, causing suffocation, shaking them when frustrated, and due to an overall lack of coping mechanisms and resources to learn good parenting skills.

In 2015, the Association of State and Territorial Health Officials released a document titled, House State Health Departments Can Use the Spectrum of Prevention to Address Neonatal Abstinence Syndrome, which I have with me today, and it's a valuable resource in helping states tackle this monumental problem.

Neonatal abstinence syndrome, also called NAS, is a postnatal drug withdrawal syndrome that occurs primarily among opioid-exposed infants shortly after birth, according to the American Academy of Pediatrics. Some examples of these medications or illicit drugs are heroin, morphine,

OxyContin, oxycodone, methadone, Subutex, Suboxone; some stimulants such as methamphetamines, and sedatives such as Valium, Ambien, and some antidepressants can also contribute to these symptoms.

As part of the Pennsylvania Premie Network, we surveyed all birthing hospitals in Pennsylvania, with 55 of the 101 hospitals responding. Forty-five of the 55 hospitals who responded did not universally drug screen pregnant women. Sixteen of the 55 hospitals did not have staff trained to assess for NAS. The majority of the responding hospitals only kept the infants in the hospital for 48 hours, regardless of any drug exposure. Most frightening, though, there was seven of the 55 responding hospitals did not refer at-risk mothers or newborns to support services either before or after discharge. This survey revealed that we need a standard process amongst our birthing hospitals to better help our infants and children.

When an infant is born to a mother using opiates, the baby is typically born at term, although pre-term birth is a high risk due to maternal lack of prenatal care and risky behaviors.

The infant may not show any signs of withdrawal for the first 24 hours until the drug levels start to decline.

Mothers are encouraged to breastfeed, as long as illicit drugs are not being used by the mother. The reason for this is because a small amount of the narcotic passes through the breast milk and helps in the weaning process for the baby. Mothers are encouraged to provide skin-to-skin care to help comfort the infant, keep the room dimly lit and cool in order to aid in comfort measures.

After the first 24 hours of life, typically, withdrawal symptoms become more apparent, which include restlessness, rapid breathing, loose stools, vomiting, excessive crying, difficulty latching to the breast, fevers, lack of sleep, increased muscle tone, sneezing, sweating and scratching their faces due to inconsolable. We, in neonatology, use the Finnegan Neonatal Abstinence Scoring System, which is a clinical tool used to uniformly score the infant's withdrawal symptoms. Once scores are consistently elevated, then treatment is considered.

The health care profession does not have a standard approach to the treatment of NAS. The

Pennsylvania Premie Network of the American Academy of Pediatrics, Vermont Oxford Network, CDC and others are trying to gather expert opinion and standardize NAS treatment for a variety of reasons. Parents need a consistent message from the health care community. Standardization has also been shown to lead to better outcomes, decreased length of stay, and the ability to anticipate care by the family.

Some hospitals, such as St. Luke's in Bethlehem and Allentown, offer prenatal consults for pregnant women using opioids so the expectations and treatments are understood prior to delivery, which decreases anxiety, decreases anger and decreases confrontations with the medical team.

Babies should remain hospitalized for the first five days of life in order to be fairly certain that the infant will not need treatment. NAS can lead to seizures ultimately, so these symptoms need to be watched closely. When a parent knows about the five-day stay--at most, Pennsylvania-birthing hospitals; not all because, remember, this is not standardized yet--then they can arrange care for their other children, family members, to decrease the burden and encourage

families to bond.

Let me tell you about a baby in the NICU recently. This baby was born to a mother who was using heroin until the second trimester and then was placed on methadone in order to help with her addiction. Tommy, which, obviously, is not his real name, was born healthy but started to withdraw on day of life 2. He screamed with high-pitched cries. His cheeks were scratched open by his constant movements and his nails scratching his face. He didn't sleep longer than 30 minutes at a time and had diarrhea.

His scores quickly shot up and was brought to the NICU for treatment. He was placed on morphine but needed higher dosing due to severe symptoms. The nursing staff wrapped him tightly in his blankets in order to comfort him, and he needed to be held and rocked constantly to provide some comfort. Whenever he ate, he would vomit until the symptoms were better controlled. His parents visited sparingly, but when they did, they were often found asleep or groggy due to the medication they were receiving every morning.

Tommy suffered in the NICU for over a month. At times, it brought the staff to tears

because it's heartbreaking to see an innocent baby suffer in this way. Social workers were involved and Children's Services as well. However, the family was cleared for discharge. Unfortunately, we saw in the newspaper that Tommy died before his first birthday while sleeping on the couch with his mother. We need to ask ourselves if we are all doing everything that we can to help protect these babies.

Once an infant meets criteria to start treatment, they're often transferred to the NICU, the Neonatal Intensive Care Unit, which is often noisy and bright and not comforting to these babies at all. Hospitals are not yet equipped to handle the volume of these babies in other areas of the hospital.

Morphine is the initial drug of choice for treatment of NAS, according to the American Academy of Pediatrics and many reports. Once morphine is started and the NAS symptoms are controlled, then the medication is weaned very slowly, taking, on average, two, three, maybe six weeks before being able to be discharged home.

Hospitals do not have resources needed to adequately counsel the families and prepare them

for parenting a baby with NAS. Social workers and Children's Services are involved, but children are often released to their parents due to the overcrowded system and immediate lack of harm. We see too many stories in the news of infants dying in the care of their parents who are using or abusing drugs, whether prescription or illicit.

It is our job as human beings to protect these children and give the families the resources they need to become better parents. This epidemic has hit all families, in all zip codes, of all ethnicities and all income levels. We need resources to stop the problem in the first place; to screen all women of childbearing age, in order to eliminate profiling, and get these women the help that they need. Infants impacted often have developmental issues that need to be addressed. This becomes a lifelong condition for them with behavior and learning problems that can affect them well into adulthood.

We need to come together as a state to stop this epidemic and help protect the innocent in this terrible public health war we are being faced with today. This requires a multi-disciplinary approach, as current supports for these children

and families are woefully inadequate to meet the need.

Thank you so much.

MAJORITY CHAIRWOMAN WATSON: Doctor Costello, thank you. I'm not sure we -- I'm thanking you for some of the statements, in the sense of how awful and how sad it is for these children, but I thank you for bringing real-life experience to our attention.

Ladies and gentlemen of the committee, if it is okay, we plan to go through everybody. Would you write down your question so that, at the end, you can specifically direct it? Our testifiers have agreed that they would stay, but I want to make sure we hear from everybody and you get something of a full picture.

So, don't go anywhere, Doctor Costello.

DOCTOR COSTELLO: Thank you.

MAJORITY CHAIRWOMAN WATSON: Next, then, I'd like to welcome Doctor Amanda Flicker, a member of the Pennsylvania Section of the American Congress of Obstetricians and Gynecologists.

Doctor Flicker, good morning. Please begin your testimony when ready, and we thank you for being here.

Doctor Flicker: Thank you for having me.

Good morning, Chairwoman Watson, Chairman Conklin and other members of the committee. I greatly appreciate the opportunity to come and talk to you about a health epidemic that we see every day when we open a newspaper, when we read a medical journal, when we hear about the great work that's going on in our state through the Department of Health and through legislation that's already been passed. Things like the Prescription Drug Monitoring Program, the Centers of Excellence, are all strides towards helping the opioid epidemic that we're now facing.

But what I really want to focus on today is the unique opportunities and challenges that we face in caring for the pregnant population, because many of the aspects of their care are different than that of non-pregnant persons. And I appreciated hearing the testimony of Doctor Costello, but now we're gonna take a step back and talk about the pregnant mom, before the baby is even born, and ways we can help and support the mother.

So, I am an obstetrician who practices

in Allentown, Pennsylvania, but I'm here today representing the Pennsylvania Section of the American Congress of Obstetricians and Gynecologists. So, collectively, I am here representing over 1,300 women's health care physicians and other partners in women's health.

So, as an organization obviously vested in the well-being of pregnant and postpartum women, we surely agree that this issue needs attention, and we really want to draw the focus on our patients. We recognize the growing epidemic that we're seeing, and specifically in our population.

Doctor Costello shared a lot of the statistics that affect the newborn. We've seen a quadrupling of babies that are requiring treatment for NAS over a decade, and this is largely due to the increased use of opioids by pregnant women. We have seen, obviously, firsthand the devastation. She shared the stories of newborn suffocation.

But, recently, in my own institution, we had a mother who suffered an overdose in the second trimester of her pregnancy and was maintained on life support through the duration of her pregnancy so we could ultimately deliver her baby at full term, and then the family withdrew support, and the

patient died after she delivered. So, it's killing moms and it's killing babies.

So, at this time, we welcome the opportunity to partner with the Department of Health and partner with the legislature to create solutions to the problem in caring for our women.

So, talking about treatment, while the standard of care for opioid use disorders in non-pregnant patients is detoxification, that is not the recommended standard of care for treatment in pregnant persons. It is actually medication-assisted therapy with either buprenorphine or methadone. Withdrawal and detoxification is discouraged in pregnancy, primarily due to the high relapse rates that are seen, either during the course of the pregnancy or afterwards in the postpartum period, which many of us recognize as a time of extremely high physical and emotional stress.

It can also be associated with adverse obstetric events, including placental abruption, growth restriction and pregnancy loss. So, detoxification is not the recommended solution from the American Congress of Obstetricians and Gynecologists. Chronic untreated heroin use can

also cause obstetric problems, including growth restriction and many of the other things we've already mentioned.

So, it is much safer for our pregnant women to be placed on medication-assisted therapy with controlled doses of known substances, including methadone or buprenorphine. So, while methadone we have much more experience with, the movement is now towards using buprenorphine, which is commonly known as Subutex. You may have heard it referred to as that.

So, buprenorphine is less likely to be abused. It has less -- lower rates and less severe cases of neonatal abstinence syndrome and is less likely to be diverted. It also encourages higher compliance because patients can receive a prescription for a week at a time, as opposed to methadone, which is a daily-observed therapy.

So, in conjunction with the medication therapy -- Opioid Use Disorder is a disease, but it requires multi-disciplinary approaches to care. And so, in addition to the addiction medicine, it's also recommended to use behavioral health and counseling services for the patient, as well as her family unit, and also social services to provide

the additional resources that she and her family may need.

So, although the pregnant women, and women who have custody of their children, are more likely to be compliant with substance abuse treatment, there are multiple barriers to access in care for our patients; one, of which, is the stigma associated with it. The others include fear of prosecution, fear of losing custody of their children, and inability to enter treatment programs that are saturated with the number of people who are requiring these services. Additionally, they don't want to be separated from their families. They want to stay together. And so, inpatient treatment facilities are often a challenge for them, and they're geographically remote.

I personally had a patient who was traveling over an hour every day, both ways, to pick up her methadone dose each day. So, she would put her kindergartner on the bus, drive to her methadone clinic, take her pill, drive home from the methadone clinic to get her son off the bus. And if anything went wrong in that, she would miss getting her child and then have the issues of, you know, abandonment or other things that may go along

with that. And I asked her, do you have a job? She basically said, how can I have a job? This is my job now, is trying to coordinate my family and get back and forth for the treatment that I need.

So, we recommend that solutions focus on comprehensive, non-punitive health care for the mother and family together, including, as I've mentioned already, medication-assisted therapy with substance abuse counseling, behavorial health therapy and social services.

So, I've talked about some of the challenges that are associated with managing our obstetric patients, but, additionally, there's an opportunity here. So, many women are more motivated to take care of themselves while they're pregnant. We see people quit smoking. We see women motivated to eat more healthy and try to lose weight.

Additionally, more women are more motivated to tackle their substance abuse disorders while they're pregnant. So, it's a time of high-frequency visits and contact with health care when patients may have more motivation and willingness to seek treatment. So, we must educate our providers about the scope of the disease and help

set up a way to use nonjudgmental inquiry to engage them in the system.

Efforts to criminalize patients, as we've talked about, are more likely to deter patients from care, so they'll either not come for pre-natal care at all, or they won't tell me that they're using these substances, where I might have an opportunity to get her on a safe and consistent dosing regimen to prevent the untoward outcomes that we have talked about. They need specialized treatment services that will prevent them from separation from their families and that are accessible.

Another challenge that our patients face is in accessing the methadone clinics. Not only is the geography problem, but some programs are unwilling to accept pregnant patients at all. Some buprenorphine providers are unwilling to prescribe to obstetric patients due to medical-legal risks and concerns. And along with that, buprenorphine prescribers have a cap on the number of patients that they can prescribe to at any given time, and they're saturated right now because there's so many patients needing this service.

Our professional society is actually

running programs to educate obstetrical providers to become buprenorphine prescribers as well. But that's not my area of expertise, and so, we need to provide more.

So, I thank you at this time for the opportunity to share with you information about treating our patients. I do think we can set up centers in the community to provide this comprehensive care. There are centers all over the country that are already doing this really well; in New Hampshire, at Boston Medical Center, Magee right here locally in Pennsylvania, and other more remote ones. I think one of the most telling lines that I've heard from the program in Oregon is that, we need to nurture and protect the mother if we want her to nuture and protect her child.

So, I thank you for the opportunity to share some insight into the care of the obstetric patients, and I'll be able to stay to answer any questions you may have.

MAJORITY CHAIRWOMAN WATSON: Thank you very much, Doctor Flicker. We appreciate your insight. I particularly learned something because I had been told that, oh, if you are pregnant you move to the front of the line, and you just told

me, absolutely not, they can't get treatment in places and whatever. So, I think we need to explore that personally.

DOCTOR FLICKER: They move to the front of the line often for inpatient detoxification programs, but that's not --

MAJORITY CHAIRWOMAN WATSON: That's not healthy for a baby.

DOCTOR FLICKER: -- therapy. Yeah.

MAJORITY CHAIRWOMAN WATSON: Got it. Thank you.

Next we're going to hear from Ashlee Homer, Pediatric Acute Care Registered Nurse at Penn State Hershey Medical Center. Ashlee is also a member of the Pennsylvania State Nurses Association.

I should say, when you go back and talk to your people at the association, it was, indeed, probably almost three years ago, definitely two, that nurses came to me about this issue. And, quite frankly, in my area, said to me: I'm tired of putting babies in a car seat, and, yes, it's in correctly, but I know I'm sending them home with people who can't really take care of them and this baby. And, yet, that's the law and that's what I

have to do.

That's what got me, because I really hadn't considered and I wasn't as aware. And then, of course, the onslaught of grandparents coming into our office, as I'm sure is true with many of my colleagues, and saying, I've got the grandchildren, but what can I do and I don't have help, and all of those things.

So, thank your association or someone in there who came and hit the mark. They got to me, and I was -- Once I started to think and look, yes, I couldn't let it go.

Please begin, and thank you very much for being here.

MS. HOMER: Thank you, Chairwoman Watson. Good morning to everybody.

My name is Ashlee Homer. I'm a Pediatric Acute Care nurse at Penn State Hershey Medical Center, so just very close to the Capitol here. You've heard all the statistics of the NAS situation in Pennsylvania. I'm here to give my personal registered nurse experience. And just this weekend, I took care of an NAS baby for my three shifts for a week. So, it's very on the forefront of what I do.

Taking care of NAS babies requires extra resources, which is why PSNA comes to mind. Each baby responds to withdrawal in a different way. Nurses must find the balance between meeting the medical and social needs for each baby and their family, while determining how best to provide nursing care for each one individually. Some infants do better with nearly constant movement while holding them. Others do better in a dark, quiet, non-stimulating room.

It is heartbreaking to watch these smallest patients cry inconsolably and feed uncoordinated. This can cause growth delays, tremors and sometimes seizures. The child may also experience very limited to no bonding with its parents or family if none is available.

NAS babies often start their care in a neonatal ICU, which can take away resources from other critically-sick newborns. When census in a NICU increases, it is the NAS babies that are moved to another unit to continue their treatment; a unit like I work on. Once moved, these babies are often cared for by a nurse who has three other patients who also require substantial nursing care.

Last winter, our unit had three NAS

babies at the same time. In speaking with the NICU nurse manager, they have, on average, two NAS babies every week. That's just at one institution. That doesn't account for those still in women's health or those on my unit who never even went to the NICU. Since the census was high in the NICU, those infants were sent to us. In assigning nurses, the three babies had to be divided to spread the workload and the heartbreak amongst our nurses that were on duty that day. Each patient was unique and at a different point in their treatment plan.

We had extreme ends of the optimal-family-environment spectrum represented by these babies. On the extremely positive end, one family went to their appointments every day to continue their own addiction treatment, and they were very active in the baby's care and treatment. They demonstrated that they had positive plans for their new family, which included extended family. Since this baby has left our unit, we received an update that she was doing great and developing well at home with mom and dad.

This particular story was very distressing to our staff, knowing the mother and

father both battled addiction that started with prescribed opioid pain medications for legitimate injuries sustained in military work. An addiction started and when they were unable to obtain more prescription medications, they resorted to illegal substances. Both parents started treatment just prior to discovering the mother was pregnant. They continued their therapy and medication treatment throughout the pregnancy. This addiction scenario may have been prevented if opioids had been prescribed more carefully initially.

On the other end of the spectrum, we cared for a baby whose treatment was extended and complicated. He was with us for approximately two months. During this time, we were very concerned at the lack of family involvement. Foster care placement was considered for this child.

Even after these patients complete their treatment, some continue to have ongoing neurologic problems. They all require intensive follow-up appointments to ensure adequate childhood growth and development and often slip through the system.

Simply being an NAS baby does not mean that the family loses custody of the child. As health care providers, we try to keep the family

together when it is safe to do so. However, the impact on the family is enormous. Most women expect to go home three days after delivering their new baby. Yet, NAS babies can require one to two weeks or more of intensive treatment prior to discharge. There are often financial concerns related to the increased length of stay and the cost of the care. If the baby is transferred to the NICU, it's thousands of dollars a day just to have that NICU bed, and those are extra costs to the health insurer, the family, the state Medicaid program and all of our taxpayers.

Unfortunately, not every baby is born into an ideal family. These are the babies that we, as nurses, all want to take home with us to provide a safe and stable environment. As nurses, we do our best to facilitate positive family bonding for these very special little ones. Yet, repeatedly caring for these patients and their families causes increased nurse compassion fatigue and moral distress.

It is my hope for the future that we can decrease the incidence of NAS in our smallest patients and that opioids are more carefully prescribed and monitored by physicians and

providers to achieve the best possible patient outcomes. More careful prescribing and monitoring of opioid use will benefit not only these infants but those who care for them and, of course, their families.

Thank you for the opportunity to share my experience of working with NAS babies and their families.

MAJORITY CHAIRWOMAN WATSON: Miss Homer, thank you very much. Again, ladies and gentlemen, write down Miss Homer's name, the questions you have, and we'll get to it at the end. Everybody will have an opportunity.

Let's get the perspective from people that have been sort of talked about but didn't have a chance, yet, to say anything, and that would be health care insurers. Doctor Lily Higgins is Medical Director of AmeriHealth Caritas -- Wow, this gets really long. Let's go. AmeriHealth Caritas' Keystone First Medicaid Health Plan. I think that covers, meaning that they have one person to do the jobs of three or four.

DOCTOR HIGGINS: Yes.

MAJORITY CHAIRWOMAN WATSON: I got it. All right. Good morning and welcome, Doctor

Higgins. Please begin your testimony when ready.

DOCTOR HIGGINS: Thank you. Good morning, and thank you for the opportunity to speak in front of the committee. I'm Doctor Lily Higgins. I'm the Market Chief Medical Officer for Keystone First Health Plan, which is a member of AmeriHealth Caritas, which is Pennsylvania's largest Medical Assistance managed care health plan.

Keystone First currently serves more than 400,000 Medical Assistance recipients in southeast Pennsylvania, which is located in Bucks, Chester, Delaware, Montgomery and Philadelphia counties. We also, in total, cover under the umbrella of AmeriHealth Caritas family companies, we serve over 600,000 members in Pennsylvania.

In my role as Market Chief Medical Officer, I'm responsible for Keystone First quality assurance efforts and the management of its relationship with the local medical community, including primary care providers, specialists and hospitals. Additionally, I am accountable for providing strategic focus to ensure improved population health.

I just want to share with you, I'm a

pediatrician. I'm also a fellow of American Academy of Pediatrics, and I serve on the board of the Pennsylvania Chapter of the March of Dimes and also on the Pennsylvania Premie Society.

While the members of this committee are more than familiar with opiate crisis gripping every community across the Commonwealth and, for that matter, the nation, it is my hope that the work of Keystone First and our comments here today are valuable to the members of the committee as they chart the Commonwealth causes in battling this epidemic.

I'm going to cover three topic areas. One, I'm going to describe the role of Keystone First and our parent company, AmeriHealth Caritas, in the HealthChoices Program. Two, I'll discuss some of the signature programs and best practices that we have implemented. And three, I'll provide with you some recommendations on program reform and redesign that may influence your work as legislators in addressing the opiate crisis.

So, Keystone First originated as Mercy Health Plan right here in Pennsylvania. The Commonwealth is not just a market we serve but has been our home for three decades. We were founded

as a voluntary Medical Assistance managed care plan in 1983 by the Sisters of Mercy to serve the low-income residents of west Philadelphia. Since then, AmeriHealth Caritas has become a national leader as a Medicaid managed care organization.

Currently, we serve your constituents in 47 counties under the name of Keystone First AmeriHealth Caritas of Pennsylvania and also a behavioral health subsidiary, PerformCare. As an MCO, we offer all the benefits and services of regular Medical Assistance, plus special programs and benefits that are only available to our members. We aim to provide a medical home that helps our members access the services they need. We provide extensive programs to help our members prevent illness and injury so they can live healthier lives.

Throughout our growth, we have maintained a strong focus on our mission: To serve the least advantaged and make a positive difference in their lives. The dedication is borne from our beginning as a small community health plan focused on serving the poor and is today driven forward by a combination of proven expertise from focus on designing a person's centered innovations that

deliver holistic care and service.

We are also nationally known. We serve over 19 states, including Washington, D.C. We also manage long-term service and support. We also have a dual special needs program, SNP, and Medicare-Medicaid plans known as MMPs, and we also have a pharmacy benefit management program called PerformRX.

So, to achieve a person's centered holistic approach, care must be integrated among physical and behavioral health MCOs, county resources, providers and families. With this in mind, I'd like to discuss some of our signature programs and best practices that we have implemented.

While the opiate epidemic has only recently gained national attention, it is something that we, in the Medicaid community, have been battling for decades. Beginning in 2014, as a response to the increasing intensity of this epidemic, we created an internal work group that meets biweekly to identify, develop and execute strategies to combat opiate abuse among our members.

I'm going to talk about the journal

posted to provide the contacts and then discuss initiative focus on infants and mothers.

It is also important not to overlook the partnership necessary with other stakeholders outside of the health care sphere that address the social determinants which may impede positive outcomes: School districts, law enforcement, housing services, legislators, administrators; another key role in achieving this success.

Through a partnership with Pennsylvania's health insurers, the Pennsylvania Commission on Crime and Delinquency, the Pennsylvania District Attorneys Association, and Pennsylvania Chiefs of Police Association, we made Naloxone available to law enforcement, first responders and anyone else who may be in position to assist an individual at risk of experiencing an opiate-related overdose. This partnership has served more than a thousand lives that would have otherwise been lost to opiate overdose in a little more than one year.

In Philadelphia, Keystone First is partnering with Community Behavior Health in the treatment of opiate addiction. Due to the bifurcated nature of the Medical Assistance program

in Pennsylvania, physical health MCOs, like Keystone First, pay for medications used to treat those that are dependent on opiates such as buprenorphine, while behavioral health MCOs, like Community Behavioral Health, provide the counseling services. The new arrangement with CBH provides coordinated care management for members with high physical health and high behavioral health needs to improve overall health outcomes and reduce substance use disorders.

We are working to create a partner -- We're working to create a participating provider network that would provide high-quality, efficient care to our members and incentivize quality outcomes in the provision of the appropriate medication and counseling.

Additionally, we provide support to our providers and the training necessary to receive their Drug Enforcement Administration provider number, a requirement to prescribe drugs like Suboxone.

I'm going to talk a little bit about our program specific to mothers and infants, our maternity addiction and neonatal abstinence syndrome program. In this effort, Keystone First

is partnering with high-volume hospitals that treat NAS babies. We identify the pregnant moms who are abusing drugs and start them on treatment in collaboration with behavioral health, and then treat the infants with NAS with medications such as morphine. This is a comprehensive program that treats substance abuse issues directly and without delay, seeking to ensure the best outcome for children born to mothers with substance abuse (sic) disorder.

Following our treatment, our partnership allows a comprehensive discharge planning to address not just substance use disorder of the mother but also the increased risk of postpartum depression and the connection that's needed for community and parenting support.

Another example of our collaboration is our work with Pennsylvania Premie Network. We recognize the increase of NAS in our community. We partnered with Pennsylvania Premie Network three years ago to direct the spotlight on the unique issues premature infants and their families face, including continuity of care, access to care and available resources. Pennsylvania Premie Network will do this through raising awareness, delivering

education, promoting collaboration among stakeholders throughout Pennsylvania.

A few years ago, we hosted NAS Symposium, Understating the Care and Management of the Addicted Mother and Baby. We had over 600 participants via webinar and on-site in Philadelphia and Harrisburg. This symposium consists of a network reception, lectures and panel discussion on strategies to decrease local practice variation, enforce a safe patient discharge.

In total, we had over 11 external speakers in this symposium to speak to an audience of neonatologists, pediatricians, obstetricians, nurses and nurse practitioners, NICU and newborn nurse staff, early intervention and other professionals and agencies serving premature infants and their families.

To conclude, I'd like to first commend DHS on the work they have been doing to fight opiate abuse in Pennsylvania and of the following recommendation:

Federal regulations, commonly referred to 42 CFR Part 2 program, govern-health providers and health plans may share information related to their patients and family treatment for substance

use disorder. Despite this federal protection, the Commonwealth confidentiality regulations are much stricter governing the release of information between providers, MCOs and other relevant stakeholders.

Absent written consent, physical and behavioral health MCOs and providers are prohibited from sharing information that may identify members seeking or participating in substance abuse treatment. While well-intent (sic), this extra level of restriction is often a barrier to comprehensive care management, the reduction of care gaps and overall positive outcomes.

I recommend the members of this committee consider means to permit the necessary exchange of information, while still being mindful of individual's right to privacy.

MAJORITY CHAIRWOMAN WATSON: Doctor Higgins, thank you very much. And I did, when you finished, I went, wow, that's easier said than done, because we know trying to, sometimes, untangle the federal and the state requirements is -- I liken it to spaghetti that's somehow congealed in the bottom of the pan and you need to get it apart.

But, we thank you for your recommendation. We will certainly, I'm sure, have discussions on that. Thank you very much. Please stay for any questions that --

DOCTOR HIGGINS: Yes, I will.

MAJORITY CHAIRWOMAN WATSON: -- our members might have.

I should also say, ladies and gentlemen, you've seen people come in and out. This, typically, is a morning. From 9 to 11, any member could have three voting meetings or something at one time. So you see people leave and then you see them come back, and you wonder, that seemed like a long coffee break. There's not coffee involved. It's trying to get everywhere on time, and it's really difficult to do, but we're trying.

Now, we've heard how health care providers have witnessed and certainly experienced opioid abuse, the epidemic, and its specific problems for infants and children. I'd like to shift the focus a little in our hearing and then look at, what has it done to our human services system, because they are struggling to meet the increased demands for service and for placement precipitated by the opioid abuse epidemic.

So, let's start at our county level, where everything seems to start in Pennsylvania. And would we welcome, please, then, Kim Rogers. Kim is the administrator of Washington County Children and Youth Services. Miss Rogers, if you would come forward.

MS. ROGERS: I'm ready.

MAJORITY CHAIRWOMAN WATSON: I'm looking over you, Miss Rogers. I'm going, okay, nobody got up. What is going on?

I want to thank you for making the trip to Harrisburg. I think that you provide for us, really, the understanding that, yes, some are in big counties; some are in small. But, regardless what county you're in, you are dealing with this crisis and you are dealing with these children. So please begin. Thank you.

MS. ROGERS: Thank you. Good morning, Chairwoman Watson, Co-Chair Conklin, Mr. Grasa, and the Honorable Committee. Thank you for this opportunity today.

I am the agency administrator for Washington County Children and Youth Services. I have served in this capacity for four years now. Prior to this, I was an intake supervisor and a

caseworker for Allegheny County Office of Children, Youth and Family Services for almost 20 years.

I'd like to talk to you today, though, about the impact of opioids in the Washington County child welfare system. That includes the increased volume of referrals we've received, the increased number of children that are entering placement; our attempts to address this, the cost to address this, and our perceived need.

In Washington County, we've had a tremendous impact of parental opioid dependency, especially over the last two years. In the past year, since August of 2015, we had 357 overdoses. We've also had at least three near fatalities of children. One did involve a mother who was using opioids. We have had multiple concerns reported to us, and we are watching our staff go through those concerns and try to work through the impact that it has on children and on parents.

I spoke with our district attorney, Gene Vittone, earlier this week, and he recounted, last month a 9-1-1 call that was received by two young children, ages 5 and 6. They called 9-1-1 because their parent had overdosed and was sitting on the couch in the living room, and that's the reality of

what's happening to our child welfare system. Our young children are the ones calling 9-1-1, and they were crying and screaming, and it was really difficult to make out what they were saying because they're watching their parents die.

I'm watching our staff. Our staff are holding these young infants that we have in our care. They're trying to feed them. They're trying to find family and relatives and kinship providers to place with.

I'm also reading our newspaper articles that we have. We have newspaper articles in relation to Washington County that says, the heroin epidemic is toll: One county, 70 minutes, eight overdoses; from the Washington Post, by Larry Bernstein. We have local papers that say, the cost of addiction: Heroin leading to more CYS cases; from Barbara Miller, the Observer-Reporter.

Every year, we consistently receive more referrals than the preceding years. In four years, we went from working with about 1,600 children annually to now working with close to 4,000 children, with a staff of 103. These 103 staff have worked in the past year with close to 2,000 children, each of these families having very

complex needs.

So, we wanted to look closely at, who are these children, who are these families, and what is the primary reason for their referral to our agency, and we found that the primary referral reason is parental substance abuse, with the second being neglect, and we do have some concerns that maybe that neglect is in relation to parental substance abuse.

In 2014, we received 381 specific referrals about parents using addictive substances. In 2015, we received 788. That's a near double within just one year. And this year alone, we're projected to hit over 811 referrals, and maybe even more than that, very specific to parental substance abuse and the impacts on the parents' ability to care for their children.

So, who are these referrals? We're finding children under the age of one who are born and identified as being affected by illegal substance abuse, and children under the age of one who have had withdrawal symptoms as a result of opiate exposure.

So, how many children just in Washington County alone are we talking about,

because that was a little bit about families and referrals, but now I want to be specific about how many kids that we are talking about for parental substance abuse. So, in 2014, 691; 2015, 1,400; and now, we're projected to have over 1,600 children impacted and referrals to our agency due to this epidemic. Again, this means one in every two children that are now referred to us are regarding their parents' substance abuse and its impact.

So, our mission is to preserve families wherever possible. But I'll be honest. Preserving families is quite difficult lately due to the opioid epidemic. How can we assure a child's safety when the parents are actively using opiates? Their motor skills and judgment are impaired. We find them incoherent, and we call that nodding off while we are trying to speak with them. Sometimes we find the children unsupervised, maybe in a car while their parents are passed out, or unsupervised in homes or left with unsuitable caregivers. We also find, sometimes, there's no food in the home.

So when these safety concerns arise, we do ask for the court's intervention and recommend a placement of the children. So when it comes to

parental opioid dependency, I will tell you that most often we are placing those children, and our staff do a very good job actively looking for the least restrictive placement for them possible so it lessens the trauma to a child. In that, we look for kinship caregivers, again, relatives and friends who are willing to care for the children. I've been told that Washington County's kinship care rates are among the highest in the state.

So let's talk about placements. From, let's see, fiscal year '12-13 to '14-15, our placements decreased in Washington County, and it resulted in a safer reduction of children in care. In the past two years, however, this has dramatically increased, and our placements went from a daily average of about 265 children in care to now about 309 children in care.

For the first time in several years, our placements were the highest in Washington County than it has ever been historically in Washington County. For the entire annual year, a non-duplicated child count, that means 513 children entered our care. The second highest referral was years ago at 511.

Sixty-five percent of those children in

placement are directly as a result of the impact of their parents' ability to care for them and not assuring their safety. In the past year alone, we've received 212 referrals regarding babies who were exposed to opioids. As you may guess, then, who are the children that we are placing in the age groups? We're placing children that are babies, all the way to eight years of age. The majority of those children are under the age of four.

We know that federal legislation, the Adoption and Safe Families Act, establishes time frames in which we move towards permanency, and we do believe children deserve to have timely permanency. And our first goal, though, is reunification with parents, and we can't achieve this, the request is the goal of adoption. That means, in the last four years, we went from having 22 children adopted in one year to now over 70; exactly at 71 last year. We project this trend will continue and that children will continue to be adopted.

So, we're trying, though, to work with this very difficult, complex concern, and we have some innovative ways that we're trying to address this opioid dependency. Judge Michael Lucas

reinstituted a local roundtable with a drug and alcohol workgroup to -- charged with tasking -- tasked with such efforts. Our contracted providers, who also work directly with parents and children, have developed programming combined with their evidence-based practices regarding substance abuse. JusticeWorks YouthCare built into their evidenced-based Nurturing Parenting Program a substance abuse component, and Adelphoi Village added in a drug and alcohol aspect into their multi-systemic therapy. As you know, then, our referrals to these programs have gone up and so has the cost for funding.

In collaboration with Washington County Drug and Alcohol Commission, we developed a program in which child welfare and drug and alcohol evaluators work together, in the same office, going into the field together, to break down those silos and improve our overall communication.

Though we are not the first county to do something of that measure, we have no problems stealing and no shame stealing from other people's ideas that will help us benefit our families and children. So we now have a drug and alcohol case manager. Their job is to do timely drug and

alcohol evaluations with parents, and they make treatment recommendations, and then they actually connect the parent to that treatment provider, hoping that success will increase in that aspect.

We also have a certified recovery specialist, a person who is in recovery herself, and she is assigned to work with moms. She helps support them and encourage them to either enter recovery and maintain sobriety. So, we have had some hope with that program. We have had children that have been able to stay safely with their parents and parents being in recovery.

So, we continue our efforts, because we are charged with that: Our reasonable efforts toward reunification and upholding our mission to preserve families. Again, we're seeing, most of our referrals are opiates as the second highest. THC is the first. But we are seeing, in the last four to six months, a surge of cocaine abuse. So, we have parents now testing positive for heroin and cocaine.

We also are in the beginning phase of working with Children's Institute of Pittsburgh and their Care Coordination Program to address NAS. The Children's Institute program provides care

coordination services for families with children who are born drug-exposed. They have a comprehensive assessment, and medical and psycho-social factors are considered to determine the frequency of their contact by the care team, and the care team is a social worker, health care provider and a registered nurse. They do go into the home. They also are in the office. They do meet with them, and they attend provider appointments.

The care team is supposed to help develop goals, in collaboration with the caregivers and with our county, which can be utilized in developing plans of safe care. The utilization of this program will promote the safety and well-being of all opiate-exposed children and their caregivers and encourage optimal child and family functioning.

Unfortunately, we have another obstacle to that. The child welfare budget is a two-year-projected budget. So, two years ago, we didn't see that this would be a program that we would utilize, so that means we don't have funding for this program. So, as an administrator, myself and the deputy then have to look at our current utilized programs and reallocate those resources to pay for

this one, which is very hard to do because you have to, then, prioritize which children you're really servicing.

I'd like to add another challenge that we've had. We've had over 20 new child welfare laws that have been enacted in the past 21 months, all the while we are trying to diligently manage the impact of heroin and opiates on our children in our community. We've had an increased number, so that means increased volume of work for our staff and increased number of children in placement.

The demands of our child welfare staff are high, and training is hard. You have to train them with the child welfare legislation laws, and you're also trying to train them on what is heroin, what does that look like, signs and symptoms and treatment. So, as a result, we believe that we have high turnover.

I believe revisiting the caseloads of direct practice staff, which are, right now, one to every 30 families; which, we know, every family in Washington County has about 1.98. So that's 60 children one worker could be working with. I believe revisiting those caseloads and reducing the number of families they work with is essential.

So, to end, we definitely see the impact of opioid dependency. Our volume is up. Our children are placed, and the cost of programming is high. We do need increased training for our staff, adequate quality level of training. We need to reduce our caseloads, and we need -- We're requesting higher reimbursement for funding for those casework positions.

We are fortunate to have our county commissioners, Commissioner Maggi, Irey-Vaughan and Shober, who have supported us and who are committed to the children and families.

I'd like to thank you again for allowing me this opportunity today to speak, and I thank everyone and everyone here for everything you do on behalf of children in the state. I welcome any questions at the end.

MAJORITY CHAIRWOMAN WATSON: Thank you very much, Miss Rogers. I think you've given us, certainly, a capsulized version that really is applicable to every county; maybe in different numbers and the percentages, but still all dealing with that. And, yes, we are the group that gave you those 24 -- 23, actually, only 23, new laws on child abuse.

I think what you see here is, what you have described at the end of your testimony, is really the microcosm of what we dealt with in the sense that, okay, we can do child abuse first. And like you, I don't think we were as critically-aware of the other -- what was coming on the horizon and the epidemic and how it would affect us.

Would we not have done the child abuse? No, because that had to be done. Much like, I believe, and I think many of my colleagues do, that this is the next thing we have to tackle because it impacts so many children and families across the state. And, perhaps, it's one of the least -- another one that nobody wants to really talk about. So we thank you for talking about it, bringing it to our attention and explaining what's going on at the county level. Thank you.

MS. ROGERS: Thank you very much.

MAJORITY CHAIRWOMAN WATSON: Next I certainly would welcome someone who is no stranger--And I am paying attention. She's coming now--testifying before the committee. Cathy Utz is Deputy Secretary at the Pennsylvania Department of Human Services. Her responsibility is the Office of Children, Youth and Families.

The Deputy Secretary has long been a vital partner. We won't say how long, though. In the efforts to improve the lives of children in Pennsylvania, we are very grateful, in a serious way, for your dedication and your interest in working with us.

So, good morning, Secretary Utz. It's always good to see you. We look forward to hearing your testimony, and please begin when you're ready.

DEPUTY SECRETARY UTZ: Thank you, Chairman Watson. Good morning, Chairman Conklin, committee members and staff.

On behalf of Secretary Dallas, I would like to thank you for the opportunity to testify today regarding the impact parental substance use has on children and families that are served by the child welfare system. I think we've heard a lot from the previous testifiers about the challenges that exist not only for, I think, the child welfare system but our health care providers as well.

Historically, families that are served through child welfare agencies, both nationally and in Pennsylvania, have underlying substance use disorder as one of the reasons for involvement. Recently, this trend continues to grow at an

alarming rate.

Based on data from 2002 to 2007, there was the National Survey on Drug Use and Health care (sic), and it reported that 8.3 million children under the age of 18 lived in a home with at least one substance-dependent or substance-abusing parent. Children who live with a parent or caregiver with a substance use disorder are at increased risk for maltreatment and entering the child welfare system.

A 2014 report issued by the Child Welfare Information Gateway indicates that the National Survey of Child and Adolescent Well-Being estimates that 61 percent of infants and 41 percent of older children in out-of-home care are from families with active alcohol or drug use. That study further found that the need for substance abuse services among in-home caregivers receiving child welfare services was substantially higher than that of adults nationwide, and that there were approximately 29 percent who were involved in child welfare, compared to 20 percent when they were talking about parents between the ages of 18 and 25. For almost 31 percent of all children placed in foster care in the nation, parental substance

abuse is a documented reason for re-entry.

According to the United States Department of Health and Human Services, maltreated children from substance-abusing parents are more likely to have poorer physical health, intellectual, social and emotional outcomes, and are at greater risk for developing substance use disorder. In addition, abused or neglected children from substance-abusing families are more likely to be placed in foster care, and are more likely to remain there for longer periods of time.

Pennsylvania data and information suggests similar trends. We've heard from Administrator Rogers about the impact of parental substance use in Washington County. I will tell you that it is the same across our state. Parental substance abuse, particularly drug use, is identified as the number 1 reason that children enter out-of-home care in the Commonwealth. As of March 31st, 2016, we had approximately 16,000 children in out-of-home placement. Of those, nearly 55 percent were placed as a result of parental substance abuse.

We also know that it's not the only reason for placement, but, for many of those

children, neglect is also part of the reason for their placement, and that's 25 percent of children are placed because of neglect. We know that, oftentimes, the two go hand in hand.

So now I'm going to go into some further analysis that we did, really, on the use of parental substance abuse. That further analysis regarding children entering out-of-home care as a result of parental drug use suggests that 32 percent had no other reason for placement. However, we also know that 24 percent entered out-of-home care as a result of parental drug use and neglect, and that 14 percent entered as a result of parental drug abuse and inadequate housing. Then, as you can see, there's oftentimes more than one reason for placement.

Children who are removed from their homes as a result of parental substance abuse tend to be younger than their peers in the overall foster care population. Fifty-nine percent of children entering care as a result of parental drug use were under the age of 10, compared to 52 percent for the general population of children in foster care. Forty-one percent were under the age of 6; 15 percent were under the age of 2.

The greatest variance is seen between the ages of 2 and 5. Twenty-six percent of children entering care in that age range were because of parental substance abuse, compared to 22 percent related to their peers.

We also looked at the length of time that children are spending in out-of-home care, and there's really little difference between the time that a child who is placed as a result of parental substance abuse stays in care compared to their peers. However, what we did find is that most children who are placed as a result of parental substance abuse are placed in a family-like setting, including pre-adoptive homes or foster family homes, and the data provided by counties suggests that 82 percent of children removed from their homes as a result of parental substance abuse are placed in family-like settings. So that's actually some good news for us that we see in this.

And, of those children placed in a family-like setting, 47 percent are placed with relative foster homes. Seventy-seven percent of all children in the foster care population are placed in a family-like setting, while only 42 percent of them are placed in the home of a

relative. When placement is warranted, as Kim Rogers talked about, our county Children and Youth staff work tirelessly to locate family members who are willing and able to provide care for those children.

Additionally, data suggests that children placed as a result of parental substance abuse have greater stability in their placement settings, likely because they are placed with relatives, and that 45 percent of those children remained in the same placement their entire length of time in care. So that's really great news compared to the 41 percent of children who do that as part of the general foster care population.

Placement stability is essential to successful outcomes for our children. Maintaining positive family connections is critical to their well-being. Ensuring that they have stability in their educational placements really promotes their academic success.

When we looked at outcomes for children in foster care and where they were returned, 58 percent of children in foster care are returned to their parents, while only 55 percent of children who are placed as a result of parental substance

abuse return home. Children who are removed as a result of parental substance abuse are a slightly higher rate for adoption than their peers.

Unfortunately, as we've heard, there are child fatalities and near fatalities associated with this epidemic as well. These cases are devastating, and they're closely reviewed by a team, both at the county level and at the state level, to identify what we could have done better to prevent them, what systems, services and communities can do, and families can do, to protect children impacted by addiction.

We actually convened a team about a year ago, and our Statewide Child Fatality and Near Fatality Trend Analysis Team is working to really expand and enhance our data collection not just on this population, but on all fatalities and near fatalities across our state. And, really, the mission of that team is to ensure that we're working with multiple-system partners to conduct an analysis so that we can learn about what we could do differently and make research-informed recommendations. Our team's members are broadly representative of the teams that are convened at the counties and include cross-system stakeholders

who have expertise in working with children and families.

And, as a result, one of the subsets that we're looking at is children who die or nearly die as a result of substance use disorder. In that, what we saw in that work thus far is that, there were seven substantiated child abuse cases where substance use was directly related for that child's death; not that it was part of it but directly related.

Each year, our county Children and Youth agencies serve a multitude of families, as we've heard, who are affected and impacted by substance use disorder. Now more than ever, we need a coordinated approach to service delivery. County Children and Youth agencies can't serve this population alone. Instead, cross-system cases are needed and are critical to child and family success. DHS is continuing to work with stakeholders at a systematic level to identify needs and gaps to better identify strategies to help us in this fight.

One of the things that I'll share is, I recently had a family member who lost her life, and it was a six-month process. As we sat in the

hospital, one of the things that I recognized was that, she had been receiving care from a cardiologist, a heart surgeon. She received care from a kidney specialist, a palliative care doctor, a GI doctor and, at the end, we were really working with hospice.

And what I think it underscores more than ever is that, when we look at it from a health-care perspective, there are multiple people who come and serve a family and work with that family. But that, when we look at situations where we have child fatalities or near fatalities or individuals that look (sic) in placement, we look to one system, often, when something doesn't go well, and that's our county Children and Youth agencies.

And so, I think that what we have to remember now more than ever is that it will require a cross-system approach. Our county Children and Youth agency staff do a magnificent job each and every day on the front lines, but they can't do it alone. They're not clinical experts in substance use disorder. They're not clinical experts in behavioral health issues, nor should they be. That it really is going to require that collaborative

team if we're going to really solve what I believe is a complex and serious problem.

And so, the Department of Human Services is willing to work with stakeholders inside and outside of state government, and has continued to do so to ensure that we're developing safe plans of care for children who are involved with our county Children and Youth agencies, particularly infants and young children. And following our work with our partners at the Department of Health, the Department of Drug and Alcohol Programs, our county Children and Youth agencies will issue some policy guidance that really speaks to and helps us, I think, understand this epidemic for what it really is. We know it doesn't discriminate, and it affects all Pennsylvanians from all walks of life; that rather than just treating addiction, we need to recognize that treating the entire person through a team-based approach is critical in our fight.

Our goal is to integrate behavioral health and primary care and, when appropriate, evidence-based medication-assisted treatment. By doing so, treatment will not only address the individual's substance use disorder but the

underlying physical and behavioral health issues that are often the root cause of addiction. This work is beginning through our Centers of Excellence that will serve as the central and efficient hub around which treatment revolves, and these centers will have navigators to assist people with their opioid substance use disorders through Medical Assistance, as well as ensuring that they receive the appropriate behavioral health and physical health care.

In closing, on behalf of the Department of Human Services, I would like to thank you for your dedication to the children and families of Pennsylvania. We've been long friends, and I look forward to our continuing relationship.

Thank you.

MAJORITY CHAIRWOMAN WATSON: Thank you, Madam Secretary. And again, we look forward to -- We will have time for questions and answers.

But, last but not least, we have a final presenter; someone who has done an incredible amount of research and outreach on the issue that is before us today. Cathleen Palm is the founder of the Center for Children's Justice. She's recognized as one of the preeminent child advocates

in Pennsylvania.

So, Cathy, good morning. Thank you for taking the time to join us today to share your insights and your information. Please begin.

MS. PALM: Thank you, Chairman Watson, Chairman Conklin and all the members. Today was one of those days where a four-lane highway means nothing if it's shut down in both directions. So, in some ways I was nervous. I was getting messages from the room, and I was like, the legislature, with all due respect, never works fast. So, I'm glad that I was able to get here.

MAJORITY CHAIRWOMAN WATSON: Sorry.

MS. PALM: But I should know, a teacher keeps everyone on check.

So, I am Cathy Palm from the Center for Children's Justice. More importantly, I always say to folks, the real hat I wear is, I'm the mother of three young children. And so, it is in that context that, you know, the center has always been about collaboration; how to get people that are in different -- So all of us are in a house, but we're in different rooms, so we're not talking to each other. How do we figure out to get doctors, researchers, early childhood program specialists in

the same room and say, what can we do on behalf of children and families?

We also have spent a lot of time -- Back in 2008, we worked to pass Act 33, which was the fatality review bill. In doing that, we started to notice -- I'm always cautious, because I have deep respect for real scientific researchers, but we started to notice a pattern or a trend where we would see infants who were dying, and when you traced it back, these were infants who were born and diagnosed with neonatal abstinence syndrome. They may have still been receiving methadone at the time of their death, but, technically, they weren't really getting on anyone's radar.

And we started with Gary Tennis at the Department of Drug and Alcohol, who's fantastic, and said, you know, you created this methadone review team and it's really good, but to be reviewed at that level, a fatality or a serious injury, has to be -- the cause of death has to be methadone. These babies were dying with some impact related to methadone or a substance, but it wasn't a cause effect.

So I wanted to set that as the context as to how we got into this debate, because I say to

people all the time, if somebody would have told me I was talking about this so much two years ago, I would have never believed them; in part, because we were working with all of you to change the child protection laws.

But that pattern of deaths got us back to, what's on the books in terms of federal laws, and what's on the books in terms of state laws? And so, we turned to former Congressman Greenwood, Jim Greenwood from Pennsylvania, and realized that, in 2003, he authored a federal law that really, really was so smart and so strategic and so not-ever implemented. What a shocker.

And so, when we went to him and we connected with him, and we spent the last two years thankful that he's committed to it. But it is this concept that, when a baby is born under one of three conditions--they've either been exposed prenatally to illicit drugs, they're in withdrawal from drugs, or they're on the fetal alcohol spectrum disorder--you have the health care providers who make a referral to the child protection agency, and then you have a plan of safe care developed.

So, the beauty of it is, if you look at

the congressional record, it was smart. This is a man who talked about housing. This is a man who talked about substance abuse treatment for moms. He talked about safety for babies; so, all of the different pieces of the puzzle that needed to come together.

The challenge was, in my mind, and if I had known Congressman Greenwood back then, I would have said, can we put it in the maternal and child health federal code instead of the child abuse and neglect code? And the reason is, automatically, people get uncomfortable, and rightfully so, because we don't want to say to the woman who has an addiction, which is a chronic, often relapsing disease, no different than diabetes or heart failure or other conditions: Hey, you know what, if you don't do what you need to do; if you're not in treatment, if you're not well, we might call it child abuse and neglect as to what happens to your child.

And so, fast forward, we worked with Congressman Greenwood. The President recently signed a federal law that updates the law that Congressman Greenwood put into place; in part, to say to states, we really have to get good about it.

Some of our friends in Congress kind of put the fingers back at the counties and pounded OCYF and other state partners over the head and said, they get money and they're not really doing anything on these plans of safe care. So we've been trying to be the reality check. And the reality check is, this state gets $1.4 million through CAPTA from the federal government, and then we --

You heard the woman from Washington County earlier. Then we see this huge uptick in the number of infants, the number of young kids who potentially need someone to come out and effectively assess them. And guess what? The $1.4 million is not getting the job done. And we're not the kind of people who always say it's about money. But if you really, really value that you want kids to be safe; you wanna send babies home, after weeks of around-the-care (sic) monitoring at in hospital, to a safe environment where mom and dad and babies are supported and healthy, you have to be real about matching some resources with that assessment.

Ironically, you guys, in the next day or so, will vote on a bill that's about CAPTA compliance; about us being compliant with the

federal -- compliance with CAPTA. You're gonna have to tackle it again because the law changed this summer.

And so, it is just this evolving process of that it's not just the babies, though, that's what's brought us into this conversation. But it is.

Yesterday, in Tioga County, and I don't know if anybody -- I can't remember if anyone's from Tioga County. But we keep saying, we can't incarcerate our way out of this. And it's true. We can't incarcerate our way out of this epidemic.

But yesterday, a young mom was in before the courts. She's a heroin user, and she gave birth to a baby who died within hours of birth. She now faces criminal charges for bringing that baby into the world with heroin in the baby's system and having some type of -- contributing to the death of the baby.

I put that out there because one of the things we want to reinforce to people is, as we speak for babies, as we speak for children, to say, let's keep them safe, let's keep them healthy, let's keep them on our radar, we can't do that without recognizing they come connected to these

people called parents. Moms and babies, they don't often get -- Babies don't get here without moms. Moms need their babies. There's just so much that has been so difficult about all of this because, for --

Since 2003, we've oftentimes been divided into a camp of, are you on behalf of the mom, or is your client the child? And the reality is, we have to start to look at it and say, if you don't want babies like Brayden Cummings in Carbon County or Tymir Smith in Philadelphia; if you don't want babies like those little infants, who are barely months into their life, dying and all of us standing and screaming and saying, what a shock; if we don't want those babies to die, we have to get smarter about saying, how are we working with both mom and baby? And it has to be way upfront. It has to be way upstream.

We can't be -- With all due respect, we can't be saying, at the time a baby is born, spends three hours in -- three weeks in the NICU and now is ready to go home, we can't say to hospital staff, who are all stressed out about leaving that baby go, okay, you've done your job; move on. You can't say to Children and Youth, who doesn't have

the resources or the teaming or the expertise, now you take over. We really do need a collaborative approach.

And I know, Chairman Watson, you've introduced a resolution around a task force; that we've said this before, we were nervous about asking for another task force because, you know, it kind of resulted in a lot of loss the last time we asked for a task force.

I didn't bring it today, but we had one meeting of a very diverse group of stakeholders, and we just said, let's brainstorm for a little while what needs to be done, and I think you heard some of this this morning. There's confidentiality regulations. There's screening of moms. There's screening of babies. There's clinical issues. There's social issues. The Department of Corrections -- Tell me you cannot have this conversation without the Department of Corrections or the Department of Aging, because it is the grandparents who are raising these babies, often.

And so, when we got done after just an hour, we had so much chicken scratch and bubbles on a piece of paper that it really convinced us that, without some very strategic entity that had

ownership inside government and ownership outside of government, we weren't going to get anything strategic on this. And so, we would continue to push that for the moment, even as we continue to have a conversation with OCYF and others about how we move forward.

Some other things: Data. I'm sure people have spoken this morning about the Health Care Cost Containment data. It's really important. We would encourage people to look at Tennessee. We just did a forum on this last week. Putting data in real-time has made all the difference.

Everyone wanted to believe in Tennessee that the babies that were being born drug-exposed were being impacted by heroin. Guess what? When you get data and you get real details, you start to find out that 82 percent of the babies in Tennessee being born drug-exposed were being exposed to a drug that mom was legally prescribed, including things like hydrocodone and oxycodone.

So, one of the things that's beautiful about real-time data, and asking the Department of Health to make NAS a reportable health condition, is that you then can start to say, in real-time often, where is this happening? Where are babies

being born? What's the exposure? So data is a key piece, but that also requires you to back up a little bit and see if you can get the clinical community to kind of come to an agreement as to, what is NAS?

When you move beyond data and that realm, then you look into the plans of safe care that I talked about and Cathy Utz talked about, and the reality is, we don't know who does that. Cathy, I know, would say that that's the responsibility of child welfare. But, guess what? The beauty of this is, it doesn't have to be the responsibility of child welfare. They have to be a party. They have to be a party to the table, but we all know people get really nervous when the knock on door is from Children and Youth.

Imagine if the knock on the door was from a home-visiting nurse. What if the knock on the door was from someone like Chairwoman Watson, a former teacher, has some real interest in kids; has enough training and is a mandated reporter who's gonna be back in connection with the Children and Youth agency.

I just want to say, not to take too much more time, but we've got to start think innovative.

We've got to think collaboratively. We cannot allow ourselves to think of this as a child welfare issue. It is in no way a child welfare issue. This is a child safety issue. It is a health care issue, and we have to start to approach it that way, and we look forward --

I know you've been waiting for questions, so I'm gonna stop now and just say, again, it's been so amazing, the work that you're all doing. I hope today we'll hear the Governor use words like infants and babies and families that are raising their grandchildren, even as most of the focus, potentially, is on overdoses.

Thousands of people in Pennsylvania are dying of overdoses. Imagine if, on the death certificate, we checked off, were there any children in the home? Imagine if we knew how many times that that overdose led to a child being orphaned; a child having witnessed the death of a parent or a grandparent.

We have to start to get real; that connected to those overdoses are children who are hurting and families that really are broken apart and shattered. We have to take care of babies, and we have to take care of younger children and older

children and really start to be real; that this opiate epidemic has claimed many of them on so many levels.

Thank you.

MAJORITY CHAIRWOMAN WATSON: Thank you very much. Thank you for your effort to get here to begin with. Thank you for the work that you have done and will continue to do.

All right. Number 1, I forgot to take attendance. Now, people have been in and out, but I will check with our secretary. Do we have an up-to-date attendance, because we had lots of people here, and I believe we only had maybe two who were on leave or excused for the day.

Sadly, I know some people have questions, and we will get to those, and some have questions who left already. We will see to it if we can contact each of you. Would you who have testified, would you come forward; make it a little easier so people can see you and ask you a question? It seems kind of poor to have you pop up somewhere in the audience.

(The testifiers complied).

MAJORITY CHAIRWOMAN WATSON: And I suspect, if you don't have questions today, as you

read through testimony you will, so we will make Greg -- we will make the assumption that you get to Greg, and he will see that your questions are passed on to the appropriate testifier. So we can do that.

Now, I know that Representative Parker had his hand up, I think, with the first or second person. I'm going, no, no, we're not doing it now. So we're going to start with Representative Parker. And I saw Representative McCarter, Representative DeLissio--You're writing these down, Greg? We're good. All right--And Representative Braneky and my good friend, foster parent that she is, Representative Toohil. All right. We'll start with that group.

Representative Moul, how could I forget? Now, you all know where you come next because you're gonna make sure nobody gets ahead of you. So I'm gonna let this go.

Representative Parker, you're on.

REPRESENTATIVE PARKER: Thank you, Madam Chair.

And thank you to all the testifiers for your testimony. I have a question for Doctor Costello.

I'm from Monroe County, and the Pocono Medical Center, I had the privilege of touring their facility with, actually, Senator Casey. I guess you still call it the NICU, but I was impressed. They had five babies in there; three were addicted to heroin. But they had rocking chairs, dim lighting, special beds and seemed to have the care you need for what you were talking about.

You had mentioned you surveyed many hospitals, and 45 of them did not prescreen -- pre-drug screen (sic) for pregnant women. Of the 10 that did, do they all have these type of facilities, then, to follow up and give the kind of care that they need for the addicted babies?

DOCTOR COSTELLO: So, first of all, just for a matter of language, the babies are born dependent --

REPRESENTATIVE PARKER: Okay. I'm sorry.

DOCTOR COSTELLO: -- on narcotics. No, that's okay. But i think that's important because, you know, a lot of people say that the babies are addicted.

REPRESENTATIVE PARKER: Right.

DOCTOR COSTELLO: The babies are dependent on this because it is something that the families have used; the parents -- the mothers have used and then it gets to the baby. So it is very important.

As far as universal screening is concerned, yes, the mothers of those hospitals were screened. But, let's remember that screening doesn't always mean a urine test or a blood test. Sometimes the screening is just a questionnaire. And so, we could have screenings saying, do you use this, do you use that? Sometimes they say yes; sometimes they say no. So it's not necessarily the best tool.

But, when we look at everything that we're doing, we will say, is this mother screened? And there is no standard way of screening, so that was another one of the questions--I just didn't bring it up--is, how do you screen? So we do not have a universal drug screening as far as either blood or urine. And, oftentimes, who gets screened are people that may appear as if they have those issues, or, perhaps, it's in their medical records. So, we are missing a lot of women.

Now, of the 10 hospitals, did they have

the facilities that we have? Every facility is different as far as the level of support that they have, and it's also very dependent, truthfully, on the passion of the providers as far as pushing that issue. So, just because you have a NICU, just because you have a special care nursery doesn't necessarily mean that you get everybody involved that needs to be.

We know that we are mandatory reporters, so most of us do that. But, again, if you don't have the support, you might not, or you might pick and choose who gets reported and who doesn't.

REPRESENTATIVE PARKER: Okay.

DOCTOR COSTELLO: Does that answer your question?

REPRESENTATIVE PARKER: It does. So the screening, I was assuming it was urine or blood, as you have said. But any of those 10, it could just be asking a question?

DOCTOR COSTELLO: Correct.

REPRESENTATIVE PARKER: Okay.

DOCTOR COSTELLO: It could just be a survey.

REPRESENTATIVE PARKER: Yeah. Okay.

Madam Chair, am I allowed to ask anyone

else a question?

MAJORITY CHAIRWOMAN WATSON: Yes, you may. You've waited so long.

REPRESENTATIVE PARKER: Okay. Thank you.

A real quick one. Doctor Higgins, did you say you're from Washington County?

DOCTOR HIGGINS: No. I live near Philadelphia County.

REPRESENTATIVE PARKER: Oh, okay. That's all the way in -- All right.

DOCTOR HIGGINS: So I don't get a question now because I don't live -- (Laughter).

REPRESENTATIVE PARKER: Well, I was hoping to tie it in with Washington Children and Youth, but that won't work, because --

I did want to ask Kim Rogers about the Children and Youth and -- In that one -- the one paragraph here about -- you identify a lot of children under one year of age who are--I've got to use the right word; I wrote it down--dependent and what that involves. I wondered if Washington County has a hospital that has that extra care for these dependent babies, and then what that looks like for coordinating with Children and Youth

because we know we're giving them that care. And what could the legislature do to make that transition better, or what could Washington do, for that matter, if there is the confidentiality issues. So, if you can go ahead and speak to that.

MS. ROGERS: So, we are pretty fortunate that we are just south of Pittsburgh. I know one of our doctors had referred to Magee-Womens Hospital. That's pretty close for us, so we do have that.

That's also the beauty of our neonatal abstinence syndrome Program; that we are working closely with the Children's Institute, because they are reaching out to our local hospitals, such as Jefferson Hospital, to try to coordinate that. It's one thing for the Children's Institute and their physicians to reach out and try to bridge that gap in the insurance piece to that, and it's another for a child welfare administrator to call up and do that.

So, in partnership with the Children's Institute, we really would like additional hospitals to come on board with us and work more collaboratively.

REPRESENTATIVE PARKER: Okay. Because I

did speak to Doctor Higgins, if you could just give your thoughts on what we could do to help with the transition from the hospital to the Children and Youth program?

DOCTOR HIGGINS: So, in our collaboration with the top hospitals in the southeast zone where Keystone First is located, we have identified a couple of hospitals that are known to take care of maternity addiction. So, when you take care of maternity addiction, you won't have the NAS babies.

So, we like to start in the very beginning, when the mom gets pregnant, and working to identify moms that are on drugs or are addicted, to make sure that they navigate through the system where they have to work with the physical health, behavioral health, as well as all the community resources that are needed. So, in a couple of these hospitals, we are funding positions, navigators, peer specialists to help with these moms.

What we found from talking to OBGYNs in our area is, they don't really know what to do when a mom tells them, I am addicted on OxyContin; I'm on heroin. A lot of OBGYNs don't know where to

refer that mom. They don't know how to take care of these moms. So, we are sending them to hospitals that specialize in the care of these moms to provide the comprehensive services that are needed. Then, of course, once the baby is born, to make sure that they continue to get those services after delivery, they stay in the hospital and make sure they still continue to get the services, the comprehensive services, after delivery when they go home.

REPRESENTATIVE PARKER: Okay. Thank you. Yes, I apologize. Let me look at my sheet here.

MS. PALM: I just wanted to say something that I should have said when I spoke. One of the things that I think is really important for us, back to our kind of hand on the laws, is that, right now one of the things we should be worried about is how many of these babies are potentially off the radar. Because, one of the things that has happened is, a law that you all passed last year, unintended but potentially, a consequence of that has been that hospitals potentially don't make referrals if the baby is in withdrawal from a substance that mom took legally.

That requires people to talk to each other to know it was actually a legal prescription; that she was taking it as prescribed.

And so, even if the hospital calls Children and Youth, which is pretty overwhelmed at this point -- We've heard of counties where they're, essentially, kind of screening it upon hearing that the baby is in withdrawal from methadone. So that's a really important point because, when you think of methadone, you think very positive treatment resource for mom.

But it is also possible that we haven't differentiated. You could have a mom who is pregnant and using heroin. You could have a mom who's using heroin and has been using heroin for two to three year -- methadone, I'm sorry, and been in a treatment program for two or three years and is in a really pretty stable recovery.

Then you could have a mom who got pregnant, unintended, and let's be clear: About 86 percent of everybody who has a pregnancy and is using heroin is unintended. So, they have a pregnancy; it's unintended. They're maybe four months into their pregnancy. Now they go; they get care, and someone says, you can't be using heroin,

but you also can't stop cold turkey. And so, we need to do some type of conversion to methadone.

That mom on methadone, who delivers a baby four months later, may be a very different mom in terms of what she needs in terms of support and ongoing treatment than the mom who was receiving methadone and in treatment for two years, or even the mom who's using heroin.

And so, that's a really big challenge right now, is that, we have not sat around a table and talked about the fact that there is a very strong differentiation in some of these cases. Not every baby, potentially, needs to be referred to have a plan of safe care, but somehow we've got to get to some minimum triage, or some of these babies are going to be the babies that have really poor outcomes, including death, that was on no one's radar, really, because no one thought they had to make a call and no one thought they had to respond because it was a legal substance that the baby was in withdrawal from.

REPRESENTATIVE PARKER: Thank you, Ms. Madam Chairman.

MAJORITY CHAIRWOMAN WATSON: Thank you.

Mr. McCarter, you're next.

REPRESENTATIVE McCARTER: Thank you very much, Madam Chair.

Again, I want to thank all the testifiers for, obviously, adding a lot of information, very specific information, into the discussion taking place at the present moment.

And again, Cathleen, you've said a lot of what I surely feel, too, in terms of the questions that we have going forward. But my question, I guess, is really back, again, to Ms. Rogers in terms of the impact on the counties. I know that, in a few minutes, we're gonna hear from the Governor in terms of how, you know, we're going to be laying out. I think, at some point here, obviously, we have to deal with this problem in a broad way, in a spectrum way, in a collaborative way.

But I want to go back to the county administrators, because you took note of the fact that we have passed 24 new child welfare laws in the last couple of years. We're in the midst of, obviously, still trying to get the handle on some of the impacts of some of those. And as we pass laws coming up here, I think, dealing with this particular crisis, I want to talk a little bit

about the funding aspects, and the impact at the county level and what you've been experiencing, and the impact on other programs as well, as we start to move down this path without adding additional funding, if that be the case. You know, where and how much, and so forth, do we need to be able to do this effectively so that we don't lose the collaboration that we need and we don't lose all different aspects here of looking through the entire medical aspect of this, as well as the social aspects?

MS. ROGERS: So, I mean, we -- I don't know if we can have both ways. If you're looking at a child welfare system, we are capped at a certain amount of money that we have. And, again, that is --

I mean, we wrote our budget, just turned it in last month, for two years from now. I just told you, four to six months ago, cocaine is back in our county, and our parents are now testing positive for both heroin and cocaine. So, for me to project, as an administrator, any of the administrators, on what the potential programs will be and the opportunities for our families and our children to try to preserve them wherever possible,

first and foremost, and meet the needs of those children, it's really -- it's just really quite a difficult situation to be in.

So what we do is, we look internally, and we use our current practices, like the JusticeWorks, for instance. They have a Nurturing Parenting Program. It's a parenting program that's evidence-based, and it works with parents, moms, with their children. It's pretty intensive. It goes into their homes. They are now enhanced with adding a substance abuse component to it, recognizing that some of this really isn't just a parenting concern. It really is the impact of their youth, and how are we going to support and help them in their progress towards recovery so they can still be a parent to their child, because they're clearly bonded.

Our deputy this morning called me and said, I'm really concerned we're moving towards termination of parental rights for some parents. They see their children; they're there; they attend all the visits, but they just haven't entered any drug and alcohol treatment program.

So, what do we do? What's the answer to your question? Our evidence-based practice that we

currently use, we're starting to add in other components to it and enhancing that and working more collaboratively with our drug and alcohol systems, and we really bring everyone to the table. We have pretty good multi-disciplinary investigative team meetings once a month where we have about, I'd say, 15 to 20 other professionals, nurses from our local hospitals, district attorneys, early intervention, Head Start, drug and alcohol programs, behavioral health, there.

REPRESENTATIVE McCARTER: If I could just add one more piece to that, though. I mean, the impact of that, obviously, on other programs that you're carrying out, you're moving resources from one to another, and we're juggling back and forth, and we all realize that.

I think it's incumbent upon all of us to realize, as legislators, as we add into this and have to address this, we have to address the monetary issues as well, and to give you the resources necessary to carry this out; and again, through all of the people that are here, whether as nurses and so on, and realizing that we can't keep doing more with less, is really what it comes down to for all of the programs that we're trying to

carry out.

MS. ROGERS: Thank you. We agree. Thank you.

REPRESENTATIVE McCARTER: Thank you, Madam Chair.

MAJORITY CHAIRWOMAN WATSON: Thank you, Representative.

Representative Krueger-Braneky. I got the whole name right.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you, Madam Chair.

I just want to say one thing for the record. I appreciate the work of both Chairs. I believe this is the first time I've seen a hearing where all of the testifiers were women. So, thank you, both of you, for bringing so many women's voices to the table today.

Like my colleague, I also noted the number of new laws that a number of you referenced and then the tie to lack of funding. There was a statement that Doctor Flicker made that I just wanted to ask a follow-up question about; talking about cautioning against new legislation, and particularly in this environment, we've got an urgent issue. I've observed that, sometimes we, in

the legislature, like to make laws without getting input from the medical community, particularly in issues of women's health.

As we talk about cautioning against legislation that could interfere with treatment options, is there anything in particular that you would caution this committee against as we start to dive into these issues?

DOCTOR FLICKER: I think, in general, it's because the treatment algorithm for an obstetric patient is different. So, many of the funds and programs are centered on the warm hand-off, where you're taking somebody from an emergency department and getting them into an inpatient detoxification program. That's fabulous, except when you're pregnant; or, except -- And not just pregnant but, more importantly, the families who have other young children in the home. So, displacing that mother, who may or may not have additional family resources available to her to care for those children, now those children become the county's issue to place somewhere else.

There's very few facilities that will take the mothers with their children. And even if they do, now you've displaced that child out of

their home, out of their school. And so, I think a focus on outpatient non-detoxification, so medication-assisted therapy, is kind of what we're looking for.

So, all of the programs that we've heard so far are great. They just don't put the emphasis and focus on the obstetric patient where it's different. And I would submit to you that, if we enhanced our programs on substance abuse counseling, mental health in those women, maybe we'd have less cases that need to go to the Children and Youth in the first place.

The mothers that we are caring for were once children themselves, and many of the women who have substance abuse disorders started in families where there was child abuse or substance abuse in their homes. So, we need to protect them now because maybe we didn't protect them as well as they needed to be protected then. So, that's one thing.

I think family drug courts is another area that can be controversial for women because they often emphasize detoxification.

REPRESENTATIVE KRUEGER-BRANEKY: Okay. Thank you very much.

DOCTOR FLICKER: Thank you.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you, all of you.

MAJORITY CHAIRWOMAN WATSON: Thank you.

Representative DeLissio.

REPRESENTATIVE DeLISSIO: I'll be quick.

Doctor Costello, do you think there will be any pushback for standardization, when you talk about the screening and the lack of standardization that there is now, or would that be embraced?

DOCTOR COSTELLO: What we are finding is that it's starting to become embraced.

So, I just got back from a conference in Chicago for the Vermont Oxford Network, so that is a national body with over a thousand NICUs involved, both internationally and nationally. At the Vermont Oxford Network, there is a big push for standardization of neonatal abstinence syndrome.

When we call it standardization, it's really guidelines. It still gives physicians the liberty to do other things if that baby falls out of that. But, in general, if the baby falls into the guidelines, if we do things consistently and it works for that child, you know, it's very helpful. Physicians now are really embracing this because we

are seeing that the cases, usually from case to case, are fairly similar.

And, if we have a standardized process, then the families know, preemptively, what's going to happen. And so, it takes that level of anxiety down, and it also shortens the length of stay so that we can get these babies out of the hospital and back with their families. So, there are many reasons to standardize.

Our length of stay, obviously, from insurance companies, are always looked at as well, so there's a lot of positives to do this. You're always going to have pushback when there is any sort of standardization. But, in neonatal abstinence syndrome, that's something that physicians are looking for.

We do have some states -- Ohio does it very well; Illinois does it very well. And we are really getting together in Pennsylvania, because not only are we using our professional ties, but we are going to different societies like the American Academy of Pediatricians, like VON, and we are all getting together. And, thankfully, in neonatology, we are a very close-knit profession, so we're able to speak to each other and get our positive

experiences out there. We've really seen it being embraced.

REPRESENTATIVE DeLISSIO: And then, for Doctor Flicker, I heard you loud and clear when you said non-punitive. I think we flip from folks who may be addicted, abusers, dependent, and are very familiar with that punitive world, and they're just not going to make this assumption, because they're now pregnant, all of a sudden it's non-punitive. I just wanted to let you know, I heard that loud and clear; that this approach has got to be non-punitive for that population.

Personally, I think it should be less punitive for the whole population, because it is an addiction and a disease, but that's another discussion, but definitely for this.

Just a really quick comment. I know a young lady personally who has just started to work for UKOOA in the Philadelphia area. And to tell you the truth, when she took the job, I was very frightened for her. These are very complex, complicated issues. She's just starting out professionally, very bright and very intelligent, and I think she is professionally at risk, because the amount of support that she can be given is just

limited by the reality of the situation, particularly the financial resources, and these are real lives we're talking about.

She knows I sit on this committee. We talk about a lot of what she sees as it pertains and translates to policy. So, that collaboration piece is absolutely instrumental. It's gotta be cross-disciplinary and interdisciplinary.

So, thank you, Chairman, for holding this hearing.

MAJORITY CHAIRWOMAN WATSON: Thank you, Representative.

And finally, then, Representative Toohil. No, Representative Moul.

REPRESENTATIVE TOOHIL: She wasn't counting you.

MAJORITY CHAIRWOMAN WATSON: Guys, I'm working against the clock that I see all the time, and it's 11. So, talk fast.

REPRESENTATIVE TOOHIL: Thank you, Madam Chair. I'll try to just hit points quickly.

Really wonderful; so resourceful. This is excellent. People that know me personally, this is something that's very near and dear to me, so I am just elated at this panel. So thank you to both

chairmen.

I guess, a couple things, just speaking on funding and staffing issues, Washington County and all of Children and Youth. I think that if we look at this and say, hey, we're in crisis mode, we really need to take action on this. You're talking about biannual budgets, and I think it might only be with your county that it's a biannual budget; not every single county is that it might be a county issue. I'm not sure because I haven't had that complaint with some of our counties. Are they all biannual? A question for Cathy Utz.

DEPUTY SECRETARY UTZ: So they're not biannual. I think, in the term -- What Kim is talking about is that the needs be explained in the budget process. The way that it is currently in the state statute --

REPRESENTATIVE TOOHIL: Oh, okay.

DEPUTY SECRETARY UTZ: -- is that counties are submitting to us August 15th for their '17-18 budget. And so, what Kim is talking about is that, you have to sit and you have to project what you think you're going to need and/or be doing two years out. So, I think that's what we're talking about as part of the dilemma, this whole

projection.

So then Kim identified and said, you know what, I want to do this program. It wasn't part of her '16-17 budget. Yeah, I have to think about what years are in and get this straight. Wasn't part of her '16-17 budget, which is already set by the General Assembly, right through the state budget and the Governor, so that you have to then go back.

What I will say is that we have been fortunate that, while certain counties overspend, we also have certain counties who underspend, and we've been fortunate to be able to use that entire $2 billion of child welfare funds to shift resources at the state level. I think, perhaps, what we potentially and what Kim may be suggesting, is there a way to do that, not at the end of the year but, perhaps, up front. And so, I think there's ways that we would have to look at that differently, because you potentially impact on other counties. So, it's something that we've struggled with. We've been fortunate that, when we look at the entire child welfare budget as a whole, we've been able to support counties if they have overspent in their budgets.

Does that help?

REPRESENTATIVE TOOHIL: Okay. That helps. So, I think some of the problems we see with counties when they're trying to hire additional caseworkers, that sometimes it's a union job and you have to go through Civil Service. So I think at some point, we just have to say, hey, we're in crisis mode. We just need to take back all the bureaucratic layers because, even when trying to give someone a raise, that you're dealing with collective bargaining, and the union says, well, no, not just all the caseworkers. We want it for every single person that's in that union. So we have a lot of issues there that we really shouldn't have.

I don't know if we can have designated -- that the state is putting additional funding into the specialized -- the job roles that you were talking about, maybe then -- Because the state says, hey, we have money. We want to give you 80 percent of the salary for these new workers, and still, we're not getting the new caseworkers that we need. Definitely, it would be excellent. The whole hospice-type of thought of working together across disciplines is excellent. I think we should

definitely move in that direction.

I know with the nurses -- when you were addressing -- Miss Homer, when you were addressing just how much the staff there is affected. I know -- I had read in Tennessee that they had had a special cuddler program and that they were able to receive -- the hospital received a $1 million grant because they started this specialized cuddler program.

So I think, maybe, if we can look at that direction in bringing in retired nurses that are already certified and have all their waivers cleared, that our hospitals are going to be able to access more money and more funding, and maybe we can relieve some of the NICU nurses and just bring in some special help. I think it's something that we need to look at in all of our communities across the state of Pennsylvania.

Just information for the drug-addicted mothers who maybe are leaving the hospital with their children, it is a very high-stress situation, and I think we have to get them the help that they need. I think that's a direction we're going in and we all definitely want to help with.

Just foster parents and family members,

that they would be able to have more information so that they say, okay -- you know, they say, oh, well, you don't need the car seat -- help with the car seat, and you don't need the shaken baby video. But, just like we have that information, that, perhaps, if we had said something --

Because, all this information people say, oh yeah, the yawning with the baby or the muscles are very tight or the severe, severe diaper rash that nobody knows how to treat, that it just goes on for an entire year. Some foster parents have no idea. Some doctors have no idea. There are doctors out there that have great remedies for that; where there's, like, a special compounding -- compounded -- from a special pharmacy that does compounds, a diaper rash cream that you can get, but that information isn't shared.

I think if that was out there, that would ease that child's pain and really help in this really difficult situation. And that diaper rash cream, I think, is only just one little bit of information. It's like some people have the information and some people don't.

I wish this hearing was, like, for the entire day. I need Cathleen Palm's phone number so

I can be her best friend. But thank you so much for all of this and the tremendous job you're all doing.

MS. PALM: And I just want to say one thing about, you know -- Oftentimes, we look at laws and say, oh, you passed so many and it's putting a lot of burden on. But there is one of the laws that you passed that was about communication between Children and Youth and docs. And that law, now more than ever, is important because these babies are in the hospital around the clock; now they go home.

Well, it's not the NICU who's taking care of them anymore. It's the on-the-ground pediatrician. It's the on-the-ground family doc who, potentially, has no idea of knowing what this baby's been through or even, potentially, has their own experience with addiction treatment.

So, we have to really figure out how to connect those dots, too, so that the person who's continuing to care for that baby in the community has ongoing communication with CYS and CYS sees that person as an ongoing partner as well. So, the law is there. We just have to keep reinforcing it.

I see Cathy taking the mic, so --

DEPUTY SECRETARY UTZ: I was going to say, and I think Cathy raises a good point, but then we have to talk about -- one of the other testifiers actually talked about the confidentiality restrictions, particularly around substance use, drug and alcohol or alcohol abuse. Part of that is sometimes used as a barrier in the safe plan of care.

So, part of the conversation that we've been having is, how do we make sure that the information is shared among -- If you're going to have a safe plan of care that includes all of the individuals, how do we make sure that that information is shared? Because, part of what everybody who would be a member of that team for that particular child and family is going to need to understand, progress is part of that treatment. And if we don't have that information, then I'm not sure that everybody who's a member of that team is going to be equipped to say, here's what we need to do or where we need to go, and I think that's something that we're really gonna have to tackle is this whole barrier, real or perceived, of confidentiality.

MAJORITY CHAIRWOMAN WATSON: Thank you

very much.

Last but never, never least would be Vice Chairman Representative Moul.

REPRESENTATIVE MOUL: Thank you, Madam Chair. And I'm so tickled to see that you are back with us from your recovery.

In the interest of time, I'm going to make a statement, and I'll preface the statement with, thank you for what you do. Okay? I applaud each and every one of you for what you do.

I'm also going to say that we are out in the middle of the ocean with this, in a boat with a hole in the bottom of it the size of a soccer ball, and we've got a teaspoon to bail it out. The water coming in is the amount of drugs coming into our families and our communities, and the teaspoon is all we have for money to fix this problem. Okay?

What I've done over the summer -- Our Policy Chair had opioid hearings throughout the summer. I was privy to sit in on a couple of them. And who we don't see; who I don't see here today is the pharmaceuticals. Maybe there are.

But, just in my direct family, in my little circle, when I started going to these hearings and starting to really sink my teeth in

and talking about it at family gatherings, my daughter, who had a C-section last year, comes out and shakes a whole bottle of leftover opioids at me. My brother-in-law, who had a knee replacement, says, I've got a whole bottle left over, too. And I've got to start to wonder, why isn't these pharmaceuticals and the A.M.A. starting to sink their teeth into this saying, hey, we're creating a drug-addicted society and it's our fault.

I want to point the finger exactly where it belongs. You throw the candy in front of kids, eventually, they're gonna not want to do anything but eat candy, and that's where we're at today.

Now, if we don't fix that problem, your problem is just going to get compounded worse and worse and worse. And then Cathy is gonna come to guys like me and Kathy and Tara and Scott, and say, we need more money to fight this. And we're gonna say, gosh, we don't have any more money. We're tapped. That's where we're at.

It's a statement. Again, I don't mean to be accusatory to anyone, by all means. But, if we don't address the problem at the root, the weed is gonna keep growing.

DOCTOR COSTELLO: If I can just make a

quick comment about that.

REPRESENTATIVE MOUL: Please.

DOCTOR COSTELLO: So, I absolutely agree with you. There are some reports out there that say that the first time a child is exposed to narcotics is when their wisdom teeth are pulled out. And so, they get that first dose of narcotics then. And, because they're children, perhaps they don't think that there is going to be this issue.

My daughter had back surgery, and she was sent home with all sorts of narcotics. And then when her friends at school found out about it, then they wanted to start coming over. So guess what happened? It all went away, and she had to deal with it a different way, you know, because children know. They know, and then these children become pregnant, right?

REPRESENTATIVE MOUL: Absolutely.

DOCTOR COSTELLO: And then we have this -- We have to work on contraception. We need to stop the problem before it even starts. But, we are all here because we have the after-effects. We have the pregnant moms; we have the babies.

REPRESENTATIVE MOUL: And we have to deal with that side. We will never treat our way

out of this problem. We will never arrest our way out of this problem until we pull the root, and the root of the problem is flooding our marketplace and every medicine cabinet with way too much of this stuff.

One of the questions I asked one of the docs at one of our panels was, what did you prescribe -- And he was an older guy. What did you prescribe before opioids became such a big thing? He said, well, people just lived with a little more pain. Okay. So we're gonna fool our mind; we're gonna numb our mind.

Keep in mind, when you take the pill, it doesn't go to your knee. It doesn't go to your wisdom teeth. It goes into your brain. So, we're gonna alter our brain to kill the pain. Not saying that we don't need something, but this is destroying our society.

DEPUTY SECRETARY UTZ: And I think the other -- I totally agree with everything that's been said. So, I'm always a plug for listening to our older youth as well. And so, the data we said, is that there's about 16,000 kids in care. Eighty-two percent of those 16,000, parental substance abuse was part of it, right? And

52 percent were under the age of 10. So, we need to actually start listening to our kids, too. So, it's an issue with our babies, but it's an issue with all of our kids.

I had the opportunity to actually go and be with a group of folks in New York State over the past two days, and there were kids who talked. And there were four youth--They were New York State youth--who had been in care. Each of them talked about parental substance abuse as part of the reason that they entered care.

And, right now there's a young man who had started out in the foster care system; had a 1.4 grade point average as part of it; graduated from Yale and is now going to enroll in a doctoral program in Harvard. He wrote this book. I just started to read it last night. I just got it Monday. I'm, like, halfway through it already. And part of it is, it's an issue with babies, but it's also an issue with our teens. They are coming into care because of their parental drug addiction. And we know, right, it can be a cycle. So, we also have to start listening. So, I guess I would encourage you, too.

We have some wonderful youth across this

state who can testify in front of this committee about the impact it has had on them as youth in our system; not just the babies, right? Because, we know, if we're working with the babies, I think we have to make sure we have a two-prong approach.

REPRESENTATIVE MOUL: Can I throw one plug in here, Madam Chair, very quickly, if you don't mind?

Anybody that really cares about this that wants to understand this issue through the eyes of a drug-addicted youth, there was a program on PBS -- I can't remember if it was Night Line or -- Frontline, I think is what it's called. If you go under Frontline, it's called Chasing Heroin. It's a little over an hour long, I believe. I watched it through once. You'll really get a good idea of what it's like to be on the other side of this, and it's something that we really need to take seriously and do something about.

Thank you, Madam Chair. I've taken more than enough time.

MAJORITY CHAIRWOMAN WATSON: Thank you.

And thank you to all our testifiers for getting here; for staying here; for answering questions. We appreciate it.

This is the first go-around. This is not the end-all, the be-all. There will be other hearings. If I have my way, there will be a task force that will produce the kind of report that we used as a blueprint for child abuse, because I think this is an ongoing problem, as many of you have said.

We thank you for your time, your attention. And, ladies and gentlemen, we're on the floor, so we need to go. Thank you so much.

(At 11:09 a.m., the hearing concluded).

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C E R T I F I C A T E

I, Karen J. Meister, Reporter, Notary Public, duly commissioned and qualified in and for the County of York, Commonwealth of Pennsylvania, hereby certify that the foregoing is a true and accurate transcript, to the best of my ability, of a public hearing taken from a videotape recording and reduced to computer printout under my supervision.

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