COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

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HEARING OF THE HOUSE CHILDREN AND YOUTH COMMITTEE

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HARRISBURG, PENNSYLVANIA

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OPIOID ABUSE EPIDEMIC'S IMPACT ON INFANTS AND CHILDREN

BEFORE:

HONORABLE KATHARINE WATSON, MAJORITY CHAIRWOMAN
HONORABLE SCOTT CONKLIN, MINORITY CHAIRMAN
HONORABLE MATT DOWLING
HONORABLE MARCIA HAHN
HONORABLE BRETT MILLER
HONORABLE DAN MOUL
HONORABLE TEDD NESBIT
HONORABLE JACK RADER
HONORABLE GREG ROTHMAN
HONORABLE TODD STEPHENS
HONORABLE TARAH TOOHIL
HONORABLE VANESSA BROWN
HONORABLE PAMELA DeLISSIO
HONORABLE ISABELLA FITZGERALD
HONORABLE JARED SOLOMON

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SUBMITTED WRITTEN TESTIMONY

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1 P R O C E E D I N G S
2 * * *
3 MAJORITY CHAIRWOMAN WATSON: Ladies and
4 gentlemen, good morning. I would like to welcome
5 you to this public hearing that is convened by the
6 House Children and Youth Committee.
7 I'm State Representative Kathy Watson,
8 and it is my distinct pleasure to be back in
9 Harrisburg this morning and to be the Chairman of
10 the Children and Youth Committee for the
11 Pennsylvania House. I will later introduce my
12 partner in crime, the Democratic Chairman,
13 Representative Conklin.
14 I would like to remind you that this
15 hearing is being recorded. So I would ask if you
16 would please silence your cell phones. I'm sure
17 the ringers are lovely and we would enjoy hearing
18 them, but not during a meeting.
19 We're here to talk about something very
20 serious, long term, and in some ways, in my
21 perception, has gotten too little attention for
22 being so serious. It is a tragic consequence of
23 what we refer to as the, almost glibly now, we call
24 it the opioid addiction epidemic. And it's like
25 once we give it a name, okay, then I can kind of

1 put it over there because I've identified what it
2 is.
3 As I said, this is tragic; and in some
4 ways, it is silent. It is silent because those who
5 are its victim are infants and children. They
6 don't have a voice. They don't have a lobbyist.
7 They don't have a support group, really, to belong
8 to as such. Though, we have some people for you
9 today who are testifiers, who in a sense are their
10 lobbyists. They are people who have come to terms
11 with what is going on, and they are trying to do
12 their best to correct these issues and to provide
13 safety and permanency for these children.
14 We know that we have babies who are
15 born, newborns, who are suffering with withdrawal
16 from opioids. They were exposed to the drugs in
17 the womb. We've had, sadly, an uptick in
18 fatalities and near fatalities in infants and young
19 children. And those issues have been liked to
20 parental substance abuse.
21 Cases of child abuse and neglect linked
22 to parental substance abuse are increasing, as I
23 said. Also increasing, the number of children
24 being removed from their homes and placed in
25 protective custody because of the parent's drug

1 addiction.
2 And we all know that it certainly would
3 be best if children can remain in, I'll say the
4 home that they came home to from the hospital,
5 whatever that is, but they're not able to do that.
6 We've had our case workers and our children and
7 youth system somewhat overwhelmed in many counties
8 by this phenomenon.
9 We recognize that the children are
10 really the innocent victims. And we, as a
11 Commonwealth, do have a responsibility to protect
12 them, especially when they are birth through, let's
13 say, age six. I was asked yesterday, why are you
14 doing the hearing? And why are you, Kathy Watson,
15 pushing this?
16 And I said, because children don't have
17 a voice in Harrisburg; because this issue is
18 ongoing and growing and really hasn't gotten very
19 much attention, and I understand that because the
20 adults in the opioid crisis take up a lot of
21 attention, as well they should, but the youngest
22 need attention, too. And they can't speak for
23 themselves.
24 So it is, I believe, my job as
25 Chairwoman. I believe it is the job of this

1 Committee to be involved. And somebody said, well,
2 then what's the hearing about?
3 I said, on one level, it's public
4 education; we need everyone to understand what is
5 really going on. We need even family members of
6 those who are addicted to understand what is really
7 going on and what is the responsibility and what is
8 the responsibility of those of us as Pennsylvanians
9 to children, in a sense, we don't even know.
10 I have to put a plug in -- I will be
11 very brief -- for HB 235. That is the bill that
12 passed the House. It is my bill. It would form a
13 task force similar to the task force we had that
14 was so productive on child protection. We need a
15 task force for the victims of opioid addiction, the
16 children. And we need the best and the brightest
17 to give us their ideas, to spend the time, and to
18 come up with a plan that we could then use as a
19 blueprint and turn into additional laws that will
20 do the right thing.
21 And as I see the Secretary sitting back
22 there, recognizing we have a finite amount of
23 money, I'm all about, let's try to find the biggest
24 bang for that buck. I want evidence-based programs
25 that make a real difference in the lives of

1 children. And I have lots more I could read, that
2 and was written for me, and I'm not going to do
3 that.
4 I would say that my -- one of my heroes
5 in this whole issue has always been -- well, let's
6 see, he was former State Representative, former
7 State Senator, former judge, former president
8 judge, and former district attorney, David Heckler
9 from Bucks County.
10 When he was Chairman of the Child
11 Protection Task Force, he made the statement -- and
12 I've used it always -- that it's the prism or the
13 glasses that I use, and that is not for the
14 convenience of the adults, but for the protection
15 of the children, those who can't speak for
16 themselves; that's our job.
17 So I am delighted that we have this
18 morning, we have people who have done just that.
19 This is a chock-full hearing. I'm going to ask, if
20 you would, ladies and gentlemen who are here, I
21 think we're going to let all our testifiers testify
22 first because some need to be back, literally turn
23 around, leave here, and start driving back.
24 I would ask that our Executive Director,
25 if you would have questions that you want, can you

1 write them out for Greg, and Greg will forward them
2 to some of our testifiers. I just want to make
3 sure, that above all, I get everybody in with what
4 you have to say. Because in a lot of ways, you're
5 doing the public teaching, as I said, the public
6 education for us today. You will educate the
7 Committee, but you will also educate the public who
8 will see this.
9 Before -- we have two things to do that
10 are important, one of which is that I would like to
11 formally introduce my counterpart, Chairman Scott
12 Conklin, Democratic Chairman. And sir, maybe you
13 would like to make some remarks, and then we will
14 have the Secretary call the roll.
15 Thank you.
16 MINORITY CHAIRMAN CONKLIN: Thank you,
17 Chairwoman Watson. I want to thank you for having
18 this meeting today.
19 I want to thank the members for coming.
20 But most of all, I want to thank the panelists for
21 showing up.
22 As my co-chairwoman clearly stated, the
23 problem is today -- and I think one of the things
24 we have to remember most is the fact that folks who
25 are addicts, it's not a life choice; it's a

1 disease. And a disease left unchecked will
2 continue to spread and grow. We have now
3 decided -- and that's why I'm so proud of the lady
4 next to me -- that it's time to take this head-on,
5 take this disease on. Life choices, we can change;
6 diseases have to be taken care of from the inside
7 and through prevention.
8 So I want to thank you all for coming
9 here today. But most of all, I want to thank the
10 other legislators and the folks who are
11 participating for remembering that this is a
12 disease. It's not a life choice, and we have to
13 treat this as such.
14 Thank you.
15 MAJORITY CHAIRWOMAN WATSON: All right.
16 (Roll-call was taken.)
17 MAJORITY CHAIRWOMAN WATSON: Thank you
18 very much.
19 This morning, we are going to start by
20 welcoming two esteemed physicians from UPMC Health
21 System in Pittsburgh. Dr. Michael England is with
22 the Pregnancy Recovery Center at Magee-Womens
23 Hospital. Dr. Debra Bogen is with Children's
24 Hospital of Pittsburgh.
25 The Pregnancy Recovery Center at

1 Magee-Womens Hospital is the first and only one of
2 its kind in the southwest Pennsylvania region,
3 providing office space treatment, behavioral health
4 counseling, social services, and prenatal care to
5 pregnant and post-partum women with Opioid Use
6 Disorder.
7 And I think I like that Opioid Use
8 Disorder. I get the point of that. It follows
9 something that Representative Conklin said.
10 I want to thank you both for -- as we
11 investigated and found who we wanted to talk to, I
12 thank you for changing your schedules to come to
13 Harrisburg to join us this morning. You may begin
14 when ready.
15 Thank you.
16 DR. ENGLAND: Thank you, and it's an
17 honor being here today.
18 My name is Michael England. I'm an
19 obstetrician/gynecologist by training. I've been
20 in practice for about 25 years. About 15 years
21 ago, I joined the University of Pittsburgh
22 Magee-Womens Hospital. During this time, I've
23 noticed the change in the epidemic of Opioid Use
24 Disorder.
25 I've taken care of a large number of

1 patients in my own private practice. And because
2 of this, I was asked to join the Pregnancy Recovery
3 Center three years ago at the initiation. My
4 predecessor, Dr. English, has now retired, and I'm
5 now the Medical Director of the program.
6 Dr. English had the benefit of
7 foresight, seeing that there was a problem that was
8 obviously becoming an epidemic. He understood that
9 there was a group of young ladies that were often
10 forgotten, pregnant women with Opioid Use Disorder.
11 And he developed a medical home model for treatment
12 of these patients.
13 The goal was to reduce NAS, Neonatal
14 Abstinence Syndrome. The goal also was to reduce
15 poor pregnancy outcomes, polysubstance abuse,
16 infections, legal issues, personal trauma,
17 overdose, along with the NAS.
18 We are here today because of the
19 epidemic that was caused by a confluence of five
20 major factors. One, in the late 1990s, the
21 American Pain Society came up with the fifth
22 clinical sign, making us as physicians and
23 healthcare providers more aware of pain treatment.
24 Unfortunately, that went awry.
25 Aggressive marketing by the

1 pharmaceutical companies, at the same time, a lack
2 of education by healthcare providers about the
3 opioid pain medication and misinformation from the
4 pharmaceutical companies, the inexpensive and
5 greater quality of heroin that became available in
6 the market, and last but not least, patient
7 satisfaction, grading physicians on how they treat
8 the patient. And unfortunately, one of those is
9 how they treat pain.
10 Physicians don't like patients to have
11 pain. Patients don't want pain. And if that's not
12 addressed well, obviously it's poor scores for the
13 physicians. And unfortunately, some of our incomes
14 are based on these scores. So there needs to be a
15 disconnect at some point.
16 Just brief information about the
17 epidemic. What struck me very early in my career
18 with this was, in the early 1970s, the United
19 States, basically five percent of the world's
20 population, used about five percent of opioid
21 prescriptions. By 2014, our population increased
22 by about 10 percent, still about five percent of
23 the world's population. Now, we consume over 80
24 percent of prescription opioid medications
25 throughout the world.

1 During this time period, there's been a
2 quadrupling of prescriptions for physicians -- or
3 patients with this steady state of chronic pain; it
4 hasn't changed -- and unfortunately with that, the
5 quadrupling of the overdose deaths.
6 In Allegheny County, in which we
7 practice, for every overdose death, there's 2.6
8 overdoses with patients surviving. Obviously, we
9 need to increase that number. And obviously, there
10 are things we can do to help out with that. One is
11 Naloxone.
12 There are some things that I think we
13 can do to help decrease the trend of this epidemic.
14 One is -- which you guys have mentioned right off
15 the bat -- is recognize that this is a chronic
16 medical illness. This is not a moral failing of
17 the patient.
18 Unfortunately, these patients have an
19 illness, just like we have with: diabetes, asthma,
20 or hypertension. They need treatment. Whether
21 that's medication, a physical change, counseling,
22 or a combination of all of these, they need to be
23 treated as a chronic illness.
24 Two, we need to destigmatize the
25 illness. Patients are afraid to tell it to their

1 physicians. They're afraid to ask for care. And
2 then the general population looks down on these
3 patients.
4 We don't routinely look down on our
5 asthmatics. We don't routinely look down on our
6 diabetics. But, boy, if you come in and say, I
7 have an opioid use disorder, there's a change in
8 the personality in the office at that point.
9 Whether that's the administration, staff, the
10 physician, the nursing, there's a change. It's
11 palpable.
12 We need to provide adequate therapy,
13 proven therapy. In the past, it was always detox,
14 detox, detox. And that's probably not the best
15 therapy for these patients. Medical-assisted
16 therapy needs to be available throughout the State,
17 throughout the country. Obviously, we have the
18 foresight in this State of having Centers of
19 Excellence. The State has recognized this issue
20 and is trying to provide therapy throughout the
21 State.
22 With this, behavioral therapy is very
23 important. It's just not about giving them the
24 medication. They have to be educated about the
25 illness. They have to understand their illness.

1 They have to know what their triggers are; and they
2 have to have plans when those triggers are met to
3 avoid relapse.
4 Education. Education to the patient.
5 Education to the family. Whether that's their
6 partner, whether that's a grandparent, they need to
7 be educated about the illness. Again, destigmatize
8 the illness for the patient.
9 And one important thing is the medical
10 care practice. The physicians, you know, the
11 mid-level providers have to understand this is an
12 illness. There was a survey about 10 years ago
13 that surveyed physicians about the illness, asking
14 whether this was a true illness or a lapse of moral
15 fiber. Forty-five percent of the physicians said
16 this is not a true illness. We need to educate our
17 providers.
18 We need to basically discuss about
19 prescribing medications, the opioid itself, safe
20 storage of the medication, asking the patient
21 whether they're pregnant or not or planning to
22 become pregnant, disposal of the medication.
23 Seventy percent of the medications that we write as
24 physicians, basically are not used, and then are
25 misused after; obviously, inadequate storage and

1 disposal.
2 And Debra will mention something about
3 young children getting ahold of the parent's
4 medication and overdosing. Again, education to the
5 patients about safe storage of the medication and
6 disposal of the medication.
7 Encourage the use of the Prescription
8 Drug Monitoring Program. It's been in existence
9 here for about six months. It's been something I
10 noticed right off the bat, catching my own patients
11 that have been doctor shopping. It's a worthy
12 tool. We need to use it and basically use it more
13 and encourage it.
14 We need to encourage physicians to ask
15 questions about substance use; most of us don't.
16 Quick four questions: parents, partner, past use,
17 present use. It takes me three to four minutes to
18 ask the question, and it opens the door for the
19 patient.
20 If I ask them a question, they're
21 willing to give me some information. If I don't
22 ask the question, they're embarrassed to ask for
23 help. And again, increased use of medical-assisted
24 therapy; whether that's Buprenorphine, Methadone,
25 Vivitrol, these are proven forms of therapy.

1 I'm here because of the Pregnancy
2 Recovery Center. I think this is a program that
3 needs to be spread throughout the State and
4 throughout the country. We've had multiple
5 programs throughout the State and country come
6 visit us. It's a model that can be reproduced in a
7 variety of different ways. It doesn't have to be
8 identical, but it provides good, comprehensive care
9 to the patient that is pregnant.
10 Fortunately, for us, we have the Centers
11 of Excellence grant, and we're able to expand our
12 program to five satellite areas in three counties
13 around Pittsburgh. We've also opened up a
14 non-pregnant program for womens care, which will
15 allow us to take care of our patients after
16 pregnancy, allow us to give gynecological care, pap
17 smears, birth control for these patients so they
18 don't get pregnant again until they want to get
19 pregnant -- and treatment of sexually-transmitted
20 infections.
21 So thank you for your time. I'm glad
22 you guys are interested in this issue, and I thank
23 you for that.
24 MAJORITY CHAIRWOMAN WATSON: Dr. Bogen.
25 DR. BOGEN: Good morning. And thank you

1 so much for allowing me to come here. I'm really
2 thrilled that Harrisburg and the State government
3 is really interested in the outcomes of these
4 children.
5 So I am a general pediatrician, and I do
6 practice both at Magee-Womens Hospital and at
7 Children's in the capacity of a general
8 pediatrician. So I see newborns at the
9 Magee-Womens Hospital newborn nursery, and then I
10 care for them long-term in my practice, which is
11 part of a large teaching practice at Children's
12 Hospital.
13 And I have had a strong interest in this
14 population for the last 15 to 18 years. When I
15 came to Pittsburgh, I had come here from Baltimore.
16 And as many of you may know, Baltimore has long had
17 a heroin problem. During my training, I took care
18 of many, many children who were exposed to heroin
19 at the time.
20 When I moved to Pittsburgh,
21 interestingly, I didn't see much heroin use. It
22 was a very different population. But in around
23 2002-2003, we started to see a climb in that. I
24 was doing research related to maternal depression
25 and its impact on child health outcomes. And

1 recognizing the rising tide that we were starting
2 to see, I really switched my research interest to
3 this patient population. So I have been focused on
4 these women and children now for about 15 years in
5 my research, and they're a wonderful population to
6 work with.
7 And as you all said, this is a disease.
8 And what I love about working with this patient
9 population is that women are highly motivated by
10 their pregnancies. For many women, they name their
11 children things like Joy and Hope because when they
12 get pregnant, and they have an opioid use disorder,
13 they get this passion. They want to be good
14 mothers. They want to raise healthy children.
15 And unfortunately, many of them have
16 come from homes where they didn't have that
17 themselves, and they want to give their children
18 the best outcome. And so the reason I love working
19 with them is because I see this opportunity to
20 really change the lives of families in a really
21 positive way.
22 So we all know that during pregnancy,
23 women stop almost all of their bad behaviors. Half
24 of women who smoke, stop smoking. They cut down on
25 their alcohol use. They stop their alcohol use.

1 And that's true with Opioid Use Disorder. Women
2 seek out treatment during pregnancy, but we don't
3 do a very good job at keeping women in treatment
4 after delivery. And in order to keep the family
5 unit together, we have to really address the
6 postpartum period for women and families just like
7 we do pregnancy. So pregnancy, women get this huge
8 investment because of the physical connection with
9 their babies. And we need to maintain that after
10 delivery to maintain the family unit.
11 And so I just want to tell you briefly
12 two, I think, stories about patients that I've
13 cared for that really describe the spectrum of what
14 we see. So one of my patients, Isaac, was born to
15 a woman who was adopted at birth herself. She
16 never knew why she was adopted. And she was raised
17 in a very loving, kind, and supportive home. And
18 she had continue continuity of care. She had the
19 same parents her whole life.
20 And then when she was a teenager, she
21 began to experiment with drugs. She never really
22 understood why, but she was sort of drawn to it.
23 And unfortunately, she developed a pretty
24 significant substance use disorder and wound up
25 going to prison. And in prison, she actually met

1 her biological mother, who it turns out, they look
2 very much alike and people figured it out. And so
3 she met her mother and realized that that was not
4 the life she wanted. And she sort of understood
5 that she had this genetic predisposition for the
6 disease, but had been raised by a loving family.
7 And when she got out of prison, she
8 found herself pregnant about six months later, had
9 started to slip back into substance use, and got
10 into medication-assisted treatment. And I will be
11 happy to say that she has now a healthy 7-year-old
12 that she is raising. She's gotten married, has a
13 full-time job. And she and her son are doing
14 extremely well.
15 On the other hand, I have another
16 patient who grew up and had a daughter named
17 Theresa. And that mother had grown up in a home
18 that was very broken up, and she really never had
19 the consistency of care and love. And also,
20 struggled with Substance Use Disorder; in and out
21 of treatment her whole life; got into
22 medication-assisted treatment during the end of her
23 pregnancy; was placed in a lovely residential
24 treatment program, but it was a very short
25 residential treatment program.

1 And after delivery, she was given eight
2 weeks in a residential treatment program after only
3 having been sort of really doing well for about
4 four weeks before delivery. So 12 weeks after
5 really getting her life in order, she was put back
6 into sort of transitional housing. And although
7 she took her baby home with her for two months, by
8 the four-month visit, she and her baby were
9 separated and the mother was back incarcerated, and
10 the child was in the foster care system.
11 And those are the two extremes, and I
12 think it really talks to the point of you need to
13 develop relationships early in life. And if you
14 don't develop those relationships and that secure
15 attachment, you don't go on to have healthy adult
16 lives. And so we really need to focus, when we
17 think about children, on how to provide them really
18 steady and consistent care from loving adults. And
19 that means if we take the time to treat a mother in
20 pregnancy, we need to make sure that that mother
21 and child and the father, if they're around, and
22 grandparents, really have a supportive parenting
23 environment. And we need to teach women how to
24 care for their babies.
25 You know, I always say, even in the best

1 of homes, babies don't come with books on how to
2 raise them. You need people to help you. And so
3 these women need a particular help. And there is
4 some very lovely evidence that attachment-based
5 treatments really, parenting attachment, really
6 does help outcomes. So I implore you to think
7 about really evidence-based treatment for these
8 families, things like early intervention, tracking,
9 parenting programs, more residential treatment
10 programs for long-term care. Let's invest in our
11 children and their families because economically it
12 makes sense, and from a social standpoint it makes
13 sense, and it's just the right thing to do.
14 So I would be happy to answer any
15 questions. Thank you.
16 MAJORITY CHAIRWOMAN WATSON: Thank you
17 both very much.
18 I think an initial question would be,
19 Dr. England, you had mentioned something about your
20 program, but can you describe -- and you said it
21 could be replicated, maybe not in its entirety, but
22 other -- can you give us a little, like what's
23 really in that program, what's required?
24 DR. ENGLAND: It's one of the few
25 programs that encompasses all womens care during

1 pregnancy. We take care of their medical-assisted
2 therapy needs. We use Buprenorphine, and we're
3 able to stabilize the patient. If you really think
4 about these patients in their daily lives when
5 they're using opioids, heroin, they're short-acting
6 drugs. These drugs have to be dosed either three
7 or four times daily. So there's drug seeking
8 behavior before that time. They have to go out and
9 buy their medication -- or their drugs. So they go
10 into areas that are probably not the safest place
11 for pregnant women or any women to be.
12 Two, is they have to obtain money to
13 obtain the drugs. Addiction by itself is the
14 ability to lose normal function due to multiple
15 other issues, obviously with Opioid Use Disorder,
16 it's the opioids. These patients lose jobs. They
17 have three options to earn money. One is steal.
18 Two is prostitute. Three is sell. So that puts
19 them at risk for legal issues, infections. And
20 they just don't have the time to get opioid care
21 because they're out doing all of these other
22 activities.
23 Medical-assisted therapy is a
24 long-acting medication. It stabilizes them, allows
25 them to use that free time that they now have to

1 get into obstetrical care. Obstetrical care
2 reduces the risk for the newborn. Okay. Increased
3 baby size, increase the term of the pregnancy,
4 gestational age, decreased pre-term deliveries,
5 decreased chance for abruptions and basically
6 stillborns. So good obstetrical care, important;
7 medical-assisted therapy allows them to get into
8 counseling. Behavioral health therapy, very
9 important for these patients.
10 The medication stuff stabilizes their
11 addiction. It helps them prevents withdrawal.
12 Most of these patients, when you talk to them, are
13 not trying to get high anymore. They're just
14 trying to prevent the withdrawal symptoms. And it
15 allows them to get into counseling.
16 As we mentioned before, most of these
17 patients don't have normal upbringings. They have
18 a family history of Substance Use Disorder.
19 They've witnessed trauma themselves or were
20 witnesses of trauma. Fifty-five to 95 percent of
21 these patients have been abused or witnessed
22 trauma. Fifty percent of these patients have some
23 sort of behavioral health issue, major depression,
24 post traumatic stress disorder. So those issues
25 need to be addressed.

1 And again, one thing I mentioned before
2 is they have to understand their illness, why did
3 they start the use, what are their triggers for the
4 use? And then if the trigger is attained, how do
5 they manage, or we're just going to have this
6 vicious circumstance. So the Pregnancy Recovery
7 Center allows us to take care of the opioid needs,
8 the medical-assisted therapy needs. They get into
9 behavioral counseling with WPIC in Pittsburgh. And
10 we have a social service program that can take care
11 of the legal issues, transportation issues, housing
12 issues, all of these other issues that are
13 basically concurrent with their illness.
14 MAJORITY CHAIRWOMAN WATSON: Thank you.
15 I think that gives us a little more.
16 Representative Toohil, you had a
17 question.
18 REPRESENTATIVE TOOHIL: Thank you,
19 Madam Chair.
20 To both doctors, I think the programs
21 that you're talking about sound like a wonderful
22 opportunity for someone that's ready and is there.
23 What percentage of the drug-addicted
24 population, like a mother who's going through drug
25 addiction and is pregnant, what percentage of the

1 population is even ready for a program like yours?
2 DR. ENGLAND: The literature out there
3 tells me about 10 percent of patients that have
4 Substance Use Disorder are in therapy. As
5 Dr. Bogen mentioned, we're in a great situation at
6 the PRC. Patients that are pregnant want healthy
7 babies. Okay. No matter what, they tend to want
8 to change their lifestyle for their offspring.
9 So they come in and basically ask for
10 therapy. We have a good success rate, but that's
11 50 percent of our patients actually complete our
12 program. Most patients -- or people say that's
13 terrible. Well, when you're talking about
14 Substance Use Disorder, that's actually a fairly
15 good number. Thirty-five percent of our babies
16 born through our program do have NAS. That means,
17 basically, 65 percent are without NAS afterwards.
18 That number is excellent for Buprenorphine.
19 Our non-PRC patients that are using
20 Buprenorphine by other providers have an NAS rate
21 of 45 percent. Methadone in our hospital has an
22 NAS rate of 55 percent. So the program works. As
23 we mentioned, we sort of have a selection bias. We
24 have patients that come in and ask for our care.
25 There are patients that obviously don't get care

1 and use methadone or other options, where probably
2 they're not getting the good behavioral health care
3 that they're getting with us.
4 DR. BOGEN: Can I just clarify?
5 So Neonatal Abstinence Syndrome, or NAS,
6 often it's confusing. Some people say that every
7 baby with chronic opioid exposure has NAS. And as
8 an experienced pediatrician, if you lined up 100
9 babies in the nursery and asked me to pick out the
10 ones that were withdrawing from opioids, I could
11 probably tell you them.
12 So some people define NAS by chronic
13 opioid exposure; and some only define it if the
14 baby is treated for withdrawal with a medication.
15 So what Dr. England was saying is his rates are of
16 treatment for NAS. So again, there's a lot of
17 controversy on the definition of NAS, but treatment
18 for NAS, those are the rates.
19 To answer your question about the
20 proportion of women. So at Magee, we have about
21 350 women a year who come in with opioid -- chronic
22 opioid use or Substance Use Disorder. Among those,
23 over 90 percent have sought medication-assisted
24 treatment during their pregnancy. So the vast
25 majority of women are seeking treatment. Very few

1 women are walking in off the street now not having
2 sought care.
3 So I think the answer is almost every
4 woman who has Substance Use Disorder and finds
5 herself pregnant seeks care and wants to get
6 treatment.
7 Would you agree?
8 DR. ENGLAND: I would agree with that.
9 Overall, 10 percent of the population
10 that has Substance Use Disorder get treatment, but
11 in our hospital, obviously with pregnant women, it
12 is higher.
13 REPRESENTATIVE TOOHIL: But it would be
14 10 percent of pregnant women, correct?
15 DR. ENGLAND: No. Ten percent of the
16 population that has Opioid Use Disorder --
17 REPRESENTATIVE TOOHIL: Okay.
18 DR. ENGLAND: -- in females.
19 DR. BOGEN: But in pregnancy, it
20 flips --
21 REPRESENTATIVE TOOHIL: Females.
22 DR. BOGEN: -- because women are
23 motivated for change. So it's this unique
24 opportunity and time to catch them.
25 REPRESENTATIVE TOOHIL: Okay.

1 DR. BOGEN: Yeah.
2 MAJORITY CHAIRWOMAN WATSON: I would
3 like to thank you both for being here and traveling
4 here. I know you need to get back. But again,
5 thank you so much. And certainly, we will hear, I
6 am sure, more about your program.
7 Thank you.
8 DR. ENGLAND: Thank you.
9 DR. BOGEN: Thank you.
10 MAJORITY CHAIRWOMAN WATSON: As we
11 switch gears here, we are very fortunate to have
12 with us this morning the Secretary of Pennsylvania
13 Department of Human Services, Mr. Ted Dallas.
14 Mr. Dallas has been with us before and
15 has always been good when we asked, to come in, on
16 a cane or not on a cane. But in any event,
17 Mr. Secretary we welcome you. I believe you can
18 introduce the young woman accompanying you.
19 We appreciate you testifying this
20 morning. We're anxious to learn about really the
21 Department's work in addressing more this
22 particular facet of the opioid use epidemic because
23 that's really where our focus is perhaps a little
24 narrow, but I would suggest to you it's on that
25 which has had no focus up until now. So we are

1 most interested for you to begin. And we will be
2 listening.
3 Thank you, sir.
4 SECRETARY DALLAS: Good morning,
5 Chairwoman Watson, Chairman Conklin, members of the
6 Committee, Committee staff, as well. Thank you for
7 the opportunity to testify here today.
8 I'm Ted Dallas, Secretary of the
9 Department of Human Services. And the young lady
10 to my right is Deputy Secretary Utz, who is the
11 real expert on the child welfare system. We're
12 going to split up our testimony today a little bit.
13 I'm going to do some of the background and some
14 overview information. Kathy is going to get down
15 into the details of what the State's approach is.
16 So first, before I dig into the
17 testimony, I think I just wanted to comment on the
18 previous testimony. I thought that it was a great
19 choice to have Magee and the folks from there and
20 from out in Pittsburgh. In many ways, they are
21 leaders in dealing with substance-exposed newborns.
22 In fact, we consider Magee one of, you know -- it
23 was a little hard to hear in the background with
24 the air conditioner -- but the doctor who was
25 testifying, we consider Magee a Center of

1 Excellence for pregnant women with Opioid Use
2 Disorder.
3 I know he mentioned the Centers of
4 Excellence that the General Assembly provided money
5 for last year and that are rolling out now. We are
6 getting close to our 1,000th person seen at those
7 Centers of Excellence now as they ramp up. But
8 Magee, in many ways, is I think one of the Centers
9 of Excellence not just for Pennsylvania, but for
10 the country. So I wanted to thank them for their
11 work and a lot of the testimony they provided here
12 today.
13 You started off in your opening
14 statement talking about the impact of the opioid
15 crisis. We all know the impact across
16 Pennsylvania, across the country. It's all walks
17 of life. It's no longer just an urban problem or a
18 low-income problem. Everybody is dealing with
19 this.
20 But I think it was the Wall Street
21 Journal that said that one of the echoes of the
22 opioid crisis is the impact on the child welfare
23 system. And if it wasn't the Wall Street Journal,
24 I'm sorry for whichever newspaper it was, in their
25 editorial. I think that's the case.

1 I think you see the child welfare system
2 dealing with this in a way that maybe they haven't
3 before. But when we address these issues, the
4 first and most important thing to remember, and I
5 think it's with any human service or social
6 service, is one size doesn't fit all. So I think
7 when Cathy is talking a little bit, you'll see that
8 we have a multifaceted approach.
9 Human beings often defy being put into
10 categories. We resist it, and with good reason.
11 Everybody is a little different. I think when I go
12 through some of the numbers that I'll go through,
13 you'll see that in some cases in the child welfare
14 system, there's a removal or a child is accepted in
15 the service because of a substance use disorder.
16 Sometimes it's a substance use disorder combined
17 with other factors of neglect.
18 So it really is -- it's something that
19 resists saying, this is what you do when there's a
20 substance-exposed newborn, or there's a child -- or
21 parent who has a substance use disorder. So the
22 numbers I'm about to talk about are not meant to
23 define a problem, but just to give some background.
24 We're not minimizing it. We're not sort of looking
25 at it one way. We'll just give you some numbers of

1 what we've seen and what some of the impact is.
2 And then I think when you see some of
3 these things that will help get to some of the
4 things that Cathy will talk about, the State's
5 approach for these kids when they do enter the
6 child welfare system. So the numbers I'm about to
7 tell you are for calendar year 2015. We had about
8 8,000, just slightly under 8,000 general protective
9 services or GPS reports, where there was parental
10 substance abuse.
11 Now of those, Chairwoman Watson, you
12 mentioned very young children. About 10 percent,
13 or about 800 of those, were children under one.
14 There are smaller percentages that showed
15 withdrawal symptoms from those calls that we had.
16 It was four percent of those 8,000 calls that we
17 had. There are six percent that were identified as
18 having been affected by the substance use disorder;
19 and two percent where there were reports of child
20 abuse being substantiated as a result of the
21 substance use disorder or that the substance use
22 disorder was a contributing factor to the
23 determination of abuse.
24 So I think those numbers say we received
25 about 8,000 a year. That number is unfortunately

1 growing, as you mentioned, as substance abuse
2 continues to grow in Pennsylvania and across the
3 country. But not all of those reports are reports
4 that result in a finding of child abuse or require
5 a child to be taken out of their home. Again, this
6 is one of those areas where one size doesn't fit
7 all, and there are different ways to approach it
8 for different folks.
9 I know the folks from Magee talked about
10 medication-assisted treatment, about the need for
11 wraparound services, whether that's behavioral
12 health services. In some cases, it might be
13 physical health services, as well. But with the
14 substance use disorder, it really has to be
15 treating the whole person, and that's what's
16 inherent in the Center of Excellence approach that
17 we began rolling out this year.
18 Now, that's the -- those are the numbers
19 for the reports that come in. Now, the impact that
20 it has on the child welfare system is a little
21 different. We saw, in that same year, about 55
22 percent of the children who were moved from their
23 home, or in out-of-home placement, had substance
24 abuse by the parent involved, as either the primary
25 factor or one of the other factors. So 55 percent

1 is more than half. That's the impact it has on the
2 child welfare system.
3 Now, in many cases, that is the correct
4 thing to do and the right thing to do, but
5 Chairwoman Watson, you and I were talking before
6 the hearing, when you take a child out of the home,
7 whatever that home is, there is trauma that you do
8 to that child. And sometimes that's the best
9 decision you can make, but oftentimes, there are
10 other decisions you can make that can help that
11 child equally, and not take them out of the home.
12 When you look at that 55 percent, about
13 a third of those had no other removal reason noted.
14 So it was just the substance use disorder. We had
15 another 24 percent, where there was neglect on top
16 of a substance use disorder. And we had 14
17 percent, I think someone mentioned housing before
18 as, I think, as a need. About 14 percent also had
19 inadequate housing. So I think that helps the --
20 and there's a lot more detail that you could go
21 into, but I think it reinforces the point that
22 there are some times where substance use disorder
23 is the reason for coming into the child welfare
24 system or being taken out of the home, but
25 oftentimes there is other neglect that is there, as

1 well.

2 And some of the parents that are abusing

3 or neglecting their child are victims of abuse or

4 neglect. They have had that trauma inflicted on

5 them, and that has led to them abusing or

6 neglecting their child, as well. And then there

7 are also, a lot of times in the child welfare

8 system, there are issues of poverty. And that gets

9 to be a very tricky thing because it's a dangerous

10 thing to say that you're going to take a child away

11 from their parent because they're dealing with

12 issues of poverty. But then there's also issues of

13 safety that sometimes go along with that. And that

14 can be -- and a perfect example of that is

15 inadequate housing.

16 While we always have to focus on the

17 child, and the safety of the child has to be

18 prevalent, we also have to realize that there are

19 issues of poverty; there are issues of trauma with

20 those parents that lead up to those things. And a

21 system that I think works, addresses all of those

22 and understands those issues. So hopefully those

23 numbers help paint a little more -- put a little

24 more depth on the issue that Cathy faces in all of

25 the counties that provide this. I'm going to turn

1 this over to Cathy soon, but really, as we're
2 trying to figure this out, the thing that we always
3 come back to is, you can't be a one-size-fits-all
4 approach.
5 It can't be -- and I think
6 Chairwoman Watson, you were mentioning that it has
7 to be evidence-based. It has to be, here's the way
8 science and medicine tell us these are the things
9 that will help, and it can't just be this, we're
10 going to do X when we see Y. We have to really go
11 that extra level if we're going to help people.
12 So with that, I will turn it over to
13 Deputy Secretary Utz, and she will give you a
14 little more information about the approach the
15 State is taking at this time.
16 DEPUTY SECRETARY UTZ: Good morning.
17 So I think that the -- we've all been
18 here talking about the Child Abuse Prevention and
19 Treatment Act and the changes that have occurred
20 over time. And again, there were amendments in
21 June of 2016, and we will need a legislative change
22 in order to comply with the new reporting
23 requirements as the Federal statute removed the
24 word illegal from the requirements for reporting,
25 so that it's really any substance use. And it's a

1 notification that has to be made to Pennsylvania's
2 child welfare system and data on reporting.
3 So I think that as we've heard from the
4 previous testifiers that really it is a complex
5 issue that requires not just the response of one
6 particular system, but really a community approach
7 in making sure that we're delivering services to
8 children and families and keeping them intact
9 whenever possible and then removing children, as
10 Secretary Dallas said, when that's necessary. But
11 what we've really been doing, I think, more
12 recently is that we've had the benefit of applying
13 for a Federal response to a policy academy, where
14 we could receive technical assistance. We were one
15 of 10 states that was selected to attend the policy
16 academy, and we were permitted to take a team of
17 eight members to the policy academy.
18 And when we did that, we really looked
19 at who was providing services to the infants and
20 their mothers and/or families. So we had
21 advocates, child advocates. We had pediatricians.
22 We had the hospital association. We had staff from
23 the Commonwealth, being the Department of Health,
24 drug and alcohol programs, and then Department of
25 Human Services.

1 And really, what I think we got to the
2 point of recognizing, which we all probably knew
3 before we went, that it is a complex issue that
4 can't be solved by one system alone; that it really
5 requires that collective partnership. We often
6 talk about it takes a community to make sure that
7 children are safe, but that really is key.
8 And really, during the policy academy,
9 we had the benefit of hearing from other states.
10 And the one thing that we heard from other states
11 is that they're having many similar challenges, as
12 we are in Pennsylvania, that they're having
13 epidemics, as well, and that it requires a
14 collective and collaborative response to moving
15 them forward.
16 Our team really sat and talked, in that
17 we came up with a commitment to having a
18 single-policy agenda that would really drive our
19 work forward, but that it's focused in primary
20 prevention. So then how do we ensure that women
21 who are using substances don't become pregnant?
22 And so focusing our efforts on ensuring that we're
23 looking at really, I think that prevention
24 perspective, and are there evidence-based
25 strategies that can be used to do that.

1 And then the second piece is really then
2 looking at substance use screening. And when we're
3 talking about substance use screening, we're not
4 talking about urinalysis or tests. It's really
5 engaging in the conversations, as the previous
6 testifier talked about, to understand, are there
7 any symptoms and/or concerns with substance use for
8 that mother who now -- or new about-to-be mother --
9 so in that prenatal period. So really looking at
10 not just the prenatal period, as well.
11 And part of what we're looking at doing
12 then is, as we identify and have those screening
13 tools that are really asking and engaging in those
14 questions, developing protocols for the safe plans
15 of care as required. Part of what we heard, as
16 well, is that it's not one system who's responsible
17 for driving a safe plan of care, that really it
18 requires that collective group in the community.
19 And then that we would be looking at and tracking
20 our outcomes. And that's just not tracking
21 outcomes for children who are served by the child
22 welfare system, but that's really tracking infants
23 who are identified as being exposed to substance.
24 And as we begin to talk about our action
25 plan, it really, I think, comes in three particular

1 areas. And our focus is looking at kind of three
2 different populations that we had defined. One,
3 it's individuals who are using legal substances and
4 they're not necessarily addicted to the substance
5 use, and they're not having a substance use
6 disorder. We're looking at then those individuals
7 who have a substance use disorder, but are
8 receiving medication-assisted treatment and are
9 active in their treatment and are engaged. And
10 then a population that are misusing either
11 prescription drugs or legal drugs, and they're not
12 actively engaged in treatment.
13 And part of what we learned is that
14 there may be a particular individual or group of
15 individuals who would drive then the safe plan of
16 care. So for the first two populations that we
17 talked about, some of the information that we
18 really learned is that could be the healthcare
19 field. It could be substance use disorder
20 providers. It could be community programs that
21 would assist in driving that safe plan of care, but
22 really then, perhaps the child welfare system would
23 drive the safe plan of care for that third group of
24 individuals who is not receiving substance use
25 disorder.

1 It doesn't mean that we wouldn't be part
2 of conversations or that we wouldn't be engaged in
3 that work, but maybe it's not necessarily driven.
4 I think, Representative Watson, you talked about
5 the burdens that our staff are experiencing as a
6 result of our recent task force amendment, so it's
7 really, I think, looking at and saying, we
8 recognize it takes more than one agency,
9 individual, or group of individuals, and how do we
10 make sure that we're providing the best and most
11 comprehensive services to individuals?
12 Our staff are not substance use disorder
13 clinicians. They're not physicians who are able to
14 treat the physical health needs that the children
15 may have as a result of the exposure, or if they're
16 withdrawing from the substances that their parent
17 mother was using. Our staff aren't necessarily the
18 experts in being able to provide those.
19 So how do we make sure that we have that
20 cadre of evidence-based programs that exist locally
21 in our communities that include home visitation.
22 It may include center-based care, but really making
23 sure that we have that wider way available across
24 our populations. And part of what we identified
25 is, through the technical assistance, that there's

1 really some best practices that are really grounded
2 in, I think, some of the things that we've been
3 talking about: early identification; the screening;
4 that we have to make sure that there's appropriate
5 treatment for pregnant women; and that we have to
6 ensure that we have policies and procedures that
7 are really supporting the work going forward; that
8 we do need to make sure that we have protocols in
9 place about the notification to the child welfare
10 system; that there should likely be memorandums of
11 agreement and/or understanding across our systems
12 to ensure that we're all operating from the same
13 page and moving our work forward; and that it's
14 probably not just going to be one plan of care
15 that's followed throughout the course; that those
16 plans have to be flexible; that they need to be
17 revised and changed as we go forward and learn more
18 each and every day.
19 And part of what we're really beginning
20 to do, I think, is looking at what are the
21 screening tools that we need available? And so
22 we're partnering with the Department of Health in
23 making sure that we have identified what are the
24 tools that are available to be used during the
25 screening of infants and moms, that we could

1 provide that information to our healthcare
2 providers. We're really then looking at what are
3 the elements of a safe plan of care, who should
4 drive it, when they should drive it. And then that
5 we're really focused on that data collection and
6 monitoring going forward.
7 So I don't know that we will ever have
8 all of the answers as we come to talk with you, but
9 I assure you that we're really moving forward and
10 making this a priority in the work that we're
11 doing. One of the things that we've been doing
12 aside from our stakeholder team, we're really
13 looking to expand the group of individuals because
14 we were limited in the number of team members that
15 we could take to the policy academy. We're really
16 looking to expand that to include other system
17 partners. And we've begun to identify those
18 additional partners that should come to the table
19 to help us really form the policies and procedures
20 about which we're about to move forward.
21 Thank you.
22 MAJORITY CHAIRWOMAN WATSON: Thank you.
23 Questions?
24 Representative Toohil has a question.
25 REPRESENTATIVE TOOHIL: Thank you,

1 Madam Chair.
2 Hello to you both, Mr. Secretary, and
3 Cathy Utz.
4 DEPUTY SECRETARY UTZ: Hello.
5 SECRETARY DALLAS: Good morning.
6 REPRESENTATIVE TOOHIL: Good morning.
7 I wanted to ask, is there -- we don't
8 have the number in your testimony, but is there a
9 way to pull the number for 2015 and 2016 of babies
10 that are born -- I know NAS, like, I guess we have
11 to further define that term -- but babies that were
12 born and tested positive for drugs?
13 Because then I think the number of
14 babies that are born and test positive for drugs,
15 then sometimes there's a call to Children and
16 Youth. Sometimes the hospital makes that
17 determination. You know, if they're comfortable
18 with the mother, maybe it's prescription pain
19 killers. I don't know what the situation. There
20 are so many various situations.
21 So the number of babies born with drugs
22 in their system, and then there would be a
23 different number of what the hospital would tag as
24 a child that's presenting withdrawal symptoms and
25 maybe is medicated, like if they keep the baby for

1 further treatment. So if we could get that number,
2 there would be a different amount and then like
3 what results in a placement.
4 Is that too hard to track or --
5 DEPUTY SECRETARY UTZ: So I think you
6 raised, actually, one of the conversations that
7 we've been having in our small group. And that
8 goes back to that in Pennsylvania, we don't have a
9 requirement around universal screening. And I
10 think there's much debate, that we may hear from
11 other testifiers later, about whether there should
12 be or shouldn't be. But I think part of what we're
13 really looking at, Representative Toohil, is
14 identifying and making sure that there are
15 consistent policies in how we are able to identify
16 children who are exposed to substances.
17 I think that there's information that's
18 tracked by the Department of Health, in looking at
19 children who -- and I'm not an expert in this
20 field, so I may misspeak and somebody else can
21 probably correct me then -- but the Department of
22 Health does collect data on children who are
23 identified as NAS and/or FASD, so fetal alcohol
24 spectrum disorder.
25 We're also looking about how we do some

1 of the data matches. So for children who are
2 served and are receiving medical assistance, for
3 example, in the Department of Human Services, we do
4 have some of that data. And we've begun to really
5 unpack and look at some of that data, the data that
6 we have in OCYF. But we're looking again, as I
7 mentioned, with our system partners, across the
8 board, is really looking at, for those children
9 that are reported to the child welfare system,
10 here's the information that we have.
11 So it is one of the areas that we're
12 really tackling. How do we make sure that we have
13 an understanding of the challenge and the issue
14 before us, but I think part of that goes back to,
15 as you said, clearly defining what we're talking
16 about. When we talk about CAPTA, part of the
17 conversation that we were having with our work
18 group is that the Federal government does not
19 define the individuals that have to be reported.
20 They leave that to the State. They say that it's
21 substance use, but they don't define that.
22 So that is one of the first things that
23 we're tackling with our group, is defining what's
24 the population that we would receive notice in the
25 child welfare system. And so I think your question

1 really underscores that it's a collective approach,
2 that we need our other system partners to be there
3 to really help us, I think, identify the scope of
4 the issue.
5 REPRESENTATIVE TOOHIL: Okay. I think
6 you hit the nail right on the head because if we're
7 looking at the 799 children that were having
8 parental substance abuse under the age of one, it
9 would be really great to know how many of them were
10 drug-dependent infants that were born --
11 DEPUTY SECRETARY UTZ: Yeah. So --
12 REPRESENTATIVE TOOHIL: -- and then how
13 many are slipping, perhaps through the cracks.
14 Like if a mother delivers at the hospital, and
15 she's from a well-known family in the community and
16 they're very well-respected, nobody is going to
17 test that baby and find that, hey, that mom is
18 actually abusing prescription pain killers.
19 And then just, I think for us to further
20 expand and define that. And then I think you get
21 an old school doctor that's like, that's just a
22 fussy baby, and ignores it when those parents maybe
23 could be told, keep the baby in a dark room, not as
24 much noise, when there are all these things you
25 could possibly do. And then, I mean, 799 children

1 is not too many more to add for early intervention
2 services under drug dependence. And it would be
3 great to track and target those children, so they
4 wouldn't be as at risk, maybe, later on.
5 Thank you.
6 DEPUTY SECRETARY UTZ: Uh-huh.
7 MAJORITY CHAIRWOMAN WATSON: Thank you
8 both very much.
9 Representative Nesbit, I believe, has a
10 question. And then we, sadly, are going to move on
11 because as both gentlemen on either side of me go,
12 20 minutes late, 20 minutes late. So in any event,
13 we'll try to catch up.
14 Representative Nesbit.
15 REPRESENTATIVE NESBIT: Thank you,
16 Representative. I'll try to keep it brief.
17 So is it defined that if the baby is
18 born drug-dependent, is that automatically an open
19 case, or is that a mandatory reporting?
20 Could you just explain that a little
21 further for me?
22 DEPUTY SECRETARY UTZ: Sure. So the
23 Federal requirement is that there is notice done,
24 and that's notice, to the child welfare system if
25 the child is born affected by or suffering from

1 prenatal substance use and then fetal alcohol
2 spectrum disorder. So it's not necessarily just a
3 dependence, and it's a wide range, but their
4 guidance doesn't necessarily talk about the type of
5 substances or -- it just says substances in
6 general.
7 There's -- you know, some of the
8 information even goes to potentially suggesting
9 that tobacco be one of the things. So that when
10 we're actually looking at and identifying what's
11 the appropriate avenue for someone, how do we make
12 sure that we're doing the appropriate
13 identification, and it's been that it's a notice.
14 It's not a requirement that the child welfare
15 system then get involved. It's not an automatic
16 removal, but it's a notice that then triggers the
17 development of a safe plan of care.
18 REPRESENTATIVE NESBIT: Thank you.
19 MAJORITY CHAIRWOMAN WATSON:
20 Mr. Secretary, thank you very much. Hope you are
21 feeling well soon.
22 Madam Under Secretary, thank you for
23 being here.
24 SECRETARY DALLAS: Best wishes on a
25 recovery for you, too, Madam Chair.

1 MAJORITY CHAIRWOMAN WATSON: I know.
2 We're the halt and the lame, but we're going to get
3 there.
4 Thank you, sir.
5 At this time, we would welcome another
6 esteemed panel of medical professionals. These
7 folks come from the eastern region of the
8 Commonwealth. Crozer-Keystone Health System has,
9 for the past several years, been doing great work
10 in the fight against the opioid abuse epidemic,
11 that includes best practices treating
12 substance-exposed infants and their mothers, which
13 of course was our focus today.
14 First, I'd like to thank Crozer-Keystone
15 Health System CEO, Patrick Gavin, for facilitating
16 the panel. Mr. Gavin is here in attendance today.
17 Thank you very much, sir.
18 And now, I'd like to welcome the
19 specific panel, Dr. Thomas Bader, Chief Medical
20 Officer of Crozer-Keystone; Dr. Christopher
21 Stenberg, Chairman of the Department of Pediatrics;
22 and Dr. Kevin Caputo, Chairman of Psychiatry and
23 Physician Director of the Specialty Care Division.
24 Did I get all of that right?
25 DR. BADER: Yes. Thank you.

1 MAJORITY CHAIRWOMAN WATSON: I just
2 wanted to make sure.
3 And gentlemen, I welcome each of you.
4 Thank you for the drive this morning in the fog and
5 the rain, because I came the same way. And you may
6 begin your testimony when you are ready.
7 We look forward to hearing from you.
8 DR. BADER: Great. Thank you very much,
9 Madam Chairwoman. Thank you for the opportunity to
10 share our experience and describe our program.
11 I'm Dr. Tom Bader, the Chair of
12 Obstetrics and Gynecology, and the Chief Medical
13 Officer for the Health System. And I'm joined by
14 Dr. Kevin Caputo, the Chair of Psychiatry; and Dr.
15 Chris Stenberg, the Chair of Pediatrics.
16 As we've all discussed this morning,
17 we're well aware of the extent of the opiate
18 epidemic in our country and in our State. And
19 studies have shown an eightfold increase in
20 maternal opiate use from 2000 to the present, which
21 has resulted in a fivefold increase in infants who
22 exhibit signs of opiate and other drug withdrawal.
23 As we talked about, a majority of these infants
24 exposed to maternal methadone will develop Neonatal
25 Abstinence Syndrome, or NAS.

1 Crozer-Chester Medical Center is in a
2 location in southern Delaware County, where the
3 opioid epidemic is prevalent, abuse rampant,
4 resources limited, and where pregnant women are one
5 of the most underserved populations in the area.
6 The number of registered methadone clients in
7 treatment in Delaware County is 400, but there are
8 many more who seek methadone treatment outside of
9 the county. And there's also a very large
10 untreated population that abuses heroin, oxycodone,
11 Fentanyl, and other substance. And this population
12 is currently not engaged in treatment. And again,
13 some of these people who aren't receiving treatment
14 are pregnant.
15 Opiate treatment services to pregnant
16 women are limited and do not meet the needs beyond
17 what we have through the methadone clinic. Other
18 areas of concern are pregnant substance abusers,
19 who are using or misusing medications other than
20 opiates, such as alcohol or Benzodiazepines,
21 psychiatric patients prescribed antidepressants,
22 for example, the SSRIs like Zoloft, and other
23 medications that require monitoring.
24 Obstetricians, like myself and
25 Dr. England, should take the lead in education of

1 women of childbearing age by increasing patient
2 knowledge about prescription and nonprescription
3 drug use during pregnancy and its impact; routine
4 screening -- and again, the screening beyond just
5 urine screening -- but screening of all pregnant
6 woman for the use of prescription medications and
7 nonprescription drugs, including alcohol, opiates,
8 other analgesics, and some antidepressants as well
9 as tobacco use; and finally, assisting in providing
10 coordinated care that manages pregnancy, but also
11 treats the whole woman and prepares her and her
12 family for the care of the newborn exposed in
13 utero.
14 To accomplish this, we need to educate
15 our colleagues. This involves the development of a
16 core curriculum for obstetrical providers and
17 making it easier for those providers to refer
18 patients for the care that they need. It's also
19 important that providers recognize that the
20 challenge of substance and drug use in pregnancy
21 affects all socioeconomic demographics. And now,
22 Dr. Caputo will describe the substance abuse
23 programs that we have in place to assist this needy
24 population.
25 DR. CAPUTO: Thank you. Thank you for

1 having me here today.
2 Crozer-Chester has been a leader in the
3 area of substance abuse treatment for over 40
4 years. We offer a full continuum of care for
5 addictions that include not only access to care,
6 initial evaluation, and placement in treatments,
7 all the way through in-patient detoxification and
8 rehabilitation. We are a Governor Wolf-designated
9 opioid Center of Excellence, as well.
10 We, as Dr. Bader had said, accept
11 everyone. We do not discriminate based on gender,
12 payer, ethnicity, or medical comorbidity. But most
13 importantly, we're one of the few organizations
14 that treat pregnant women for all levels of care in
15 substance abuse. And we work closely with our
16 pediatric and obstetric colleagues in the care of
17 those patients.
18 The model of treatment we use in our
19 substance abuse program is based on team work. We
20 frequently, in behavioral health, are the
21 coordinators and owners of health care for patients
22 with substance abuse, most notably, opiates. We
23 collaborate with many social services, as well,
24 medical providers, legal services, CYS, just to
25 name a few.

1 It is for us, in behavioral health, a
2 natural extension to spearhead and collaborate in
3 the care of the addicted pregnant woman. It is
4 through extensive work with these professionals
5 that we have developed the Perinatal Center of
6 Excellence. Funding has been provided for this
7 through a State grant with our local Medicaid
8 provider to develop the program.
9 The Perinatal Center of Excellence in
10 Chester, in Crozer-Chester is a holistic perinatal
11 center care program that focuses on substance
12 abusers. Pregnant woman who screen positive will
13 be referred to a nurse navigator, who is trained in
14 obstetrics and in the care of pediatric patients.
15 The nurse navigator will coordinate care and help
16 develop a comprehensive written multidisciplinary
17 maternal and neonatal care plan that includes many
18 elements, but of particular note, are preparing the
19 woman for her baby's hospital stay and the
20 management of NAS in the outpatient arena; the role
21 of CYS; the rule of home-visiting nursing services;
22 next pregnancy prevention or planning counseling;
23 and welfare, child care, and case management
24 services.
25 Other members of the team, when we

1 borrow this from behavioral health, are perinatal
2 intensive case managers, who are people with boots
3 on the grounds, out in the street with cars
4 bringing pregnant women to appointments, to make
5 sure that they comply with their medical
6 appointments, with their substance abuse treatment,
7 and with the social service needs that are entailed
8 in a pregnancy.
9 And a certified recovery specialist.
10 Certified recovery specialists are very big in
11 psychiatry nowadays. They are people that have
12 gone through something, and they can share their
13 experiences. So we will have on the team a woman
14 who has a NAS baby, who has navigated the social,
15 medical, legal system so she can share her
16 experiences with the pregnant woman. Team members
17 will work closely with the psychiatrist and
18 pediatricians to assure that the health of the
19 mother is maintained, but more importantly, the
20 development of the child.
21 We'll look at measuring outcomes. The
22 baseline outcome that we want to look at is
23 education of 100 percent of the providers that are
24 treating these pregnant women. We also want to
25 look at, actually, the health status of the baby at

1 ages six months, one year, and two years. So we're
2 perinatal, but we're also postnatal. So we want to
3 make sure that the child is not left behind.
4 Thank you for allowing me to discuss the
5 role of the pregnant woman and her NAS baby and the
6 vulnerability that these children endure. I'm
7 going to turn it over to Dr. Stenberg, who can talk
8 more about this vulnerable patient population.
9 Thank you.
10 DR. STENBERG: Thank you. Thank you,
11 Chairs Watson and Conklin for having us here today.
12 Crozer-Chester Medical Center is one of
13 the largest providers of NAS care for infants in
14 southeast Pennsylvania, second only probably to
15 Jefferson, in terms of the number of babies we take
16 care of every year, which for us ranges to about 80
17 diagnosed babies.
18 I refer everybody for comments about
19 women and pregnancy, what we know is that women who
20 are on maintenance therapy have earlier and more
21 compliant prenatal care. They have improved
22 maternal nutrition and weight gain, and notably,
23 have less children who end up in the foster care
24 system. And they have an improved enrollment and
25 treatment in recovery programs afterwards.

1 At Crozer-Chester, we identify babies by
2 either prenatal diagnosis, which we prefer, or by
3 symptom scoring for the newborn babies or babies
4 that we identify as having potential NAS are held
5 for five days to make sure that they don't go
6 through withdrawal necessitating medication.
7 In those five days, though, those babies
8 often have other treatments given to them. We have
9 highly-trained nurses who now deal with taking care
10 of babies with NAS. We moved our babies from our
11 neonatal intensive care unit out into our general
12 pediatric unit, so they can have more single rooms,
13 and frankly, an environment, which NICU nurses, by
14 and large, don't like taking care of NAS babies.
15 They prefer to be managing the premature
16 28-weekers. These babies are very difficult to
17 treat.
18 We have a very protocolized treatment
19 system that we follow with what's called cluster
20 care. Nobody is allowed, even the physicians, are
21 allowed to interfere with the babies, except at the
22 three hourly-scheduled time periods for when the
23 babies are fed; changed; and if they are on
24 medication, given medication. With that, we have
25 decreased our length of stay for NAS babies from

1 when, five or six years ago, a routine stay was
2 four, maybe six weeks. Now, our routine length of
3 stay is below 20 days.
4 We see babies both with methadone and
5 with Suboxone or Subutex exposures. And please be
6 aware, there is a good supply of street Subutex
7 available in most of Pennsylvania at the moment.
8 We call those our street pharmaceutical vendors.
9 On discharge, ongoing services are
10 needed for the mother and infant diet. Infants, at
11 discharge, are not completely without symptoms.
12 They still have subacute symptoms, such as poor
13 feeding and difficulty sleeping. Early and ongoing
14 bonding can reduce risks, and we know this from our
15 own work. Mothers who are highly involved during
16 the treatment phase -- we encourage them to be with
17 the babies 24 hours -- mothers that are highly
18 involved, those babies wean faster, and we think,
19 have a better outcome.
20 Post-discharge is a very vulnerable
21 time, both for the mother to relapse, and maternal
22 oversedation is a major problem, potential problem,
23 after postpartum because often women, during
24 pregnancy, require increased doses of actually the
25 substances they're on, if they're in program

1 because of the volume of distribution. So they
2 become -- they have higher fluid volume. The risk
3 of another subsequent drug exposed pregnancy is
4 much higher, obviously, than the rest of the
5 population.
6 We have babies who leave us who go into
7 adoptions, foster care, and home with their
8 parents. Unfortunately, the rate of infant death
9 is much higher in this population than for all
10 other children. I would refer you to the Reuters
11 investigation that came out last year -- sorry, a
12 year and a half ago now -- called Helpless and
13 Hooked. It's well worth looking at.
14 They identified in their investigation
15 110 post-discharge NAS infant deaths throughout the
16 country between 2010 and 2015. And 75 percent of
17 these events, unlike any other childhood deaths due
18 to accident or neglect, the mother was actually the
19 indicated person being responsible for the death.
20 And most often, that was due to unintentional
21 smothering of the infant.
22 Of the 326 infants that we've treated in
23 Crozer in less than the last five years, we're
24 aware of five deaths in our population. That's a
25 rate of 1.5 percent death rate. That's seven times

1 the national post-neonatal mortality rate, which is
2 around about two per thousand live births. Also
3 ongoing, there was some initial thought that
4 neonatal opiate exposure was not going to be
5 related to long term sequela in terms of long-term
6 education.
7 Unfortunately, a major study just
8 published in Pediatrics put some serious concern on
9 that. There was an article published from
10 Australia following 2,234 children who were born in
11 if the State of New South Wales between 2000 and
12 2006 with NAS as their diagnosis. They compared
13 them to a matched control group and with the
14 general population of children who are born in New
15 South Wales in that time. They looked at their
16 results in literacy and numeracy testing. These
17 were State-sponsored tests at grades, three, five,
18 and seven.
19 The mean test scores for children with
20 NAS were significantly lower in grade three. And
21 unfortunately, this deficit became progressive. By
22 grade seven, the children who had NAS as a
23 diagnosis were performing less than their
24 case-matched grade-five comparators.
25 The conclusion of the study is that NAS

1 is now strongly associated with not only poor but
2 deteriorating school performance. Parental
3 education may decrease the risk of this failure.
4 And the authors in this study, as I'm sure you've
5 heard today, strongly recommend that children with
6 NAS in their families must be identified early and
7 provided with the support to minimize the
8 consequences of this disease.
9 Thank you.
10 MAJORITY CHAIRWOMAN WATSON: Doctors, we
11 thank you.
12 In spite of running a little late, I'm
13 going for a question. Just hold on there.
14 Representative Rothman, you had a
15 question; please.
16 REPRESENTATIVE ROTHMAN: Dr. Stenberg,
17 you mentioned Suboxone and Zoloft, which are drugs
18 that are given to people in treatment to get them
19 off heroin, correct?
20 DR. STENBERG: Yeah --
21 REPRESENTATIVE ROTHMAN: Or opiates.
22 DR. STENBERG: -- to control addiction.
23 Zoloft, though, is an SSRI. So it's an
24 antidepressant, as Dr. Caputo spoke of.
25 REPRESENTATIVE ROTHMAN: Have there been

1 studies of the effects of those drugs on the
2 infants and on the babies?
3 DR. STENBERG: Most of the studies
4 rolling out look at either babies -- sorry, infants
5 of mothers who are treated either with Suboxone or
6 methadone or were just identified some other way.
7 So we have a large population of pregnant women who
8 are on methadone. There are probably somewhere
9 between four to 6,000 women of childbearing age, in
10 Delaware County alone, who are receiving
11 prescription painkillers.
12 REPRESENTATIVE ROTHMAN: Legally?
13 DR. STENBERG: Legally.
14 REPRESENTATIVE ROTHMAN: And so there
15 hasn't been -- have there been conclusive tests on
16 the effect it's having on the unborn child?
17 DR. STENBERG: No, the studies -- I
18 mean, this is the first study that's come out in
19 Australia, which is showing some long-term effect.
20 This study is -- this is an international problem:
21 Australia, Canada, the United States.
22 DR. CAPUTO: I can just speak about
23 Zoloft because that's in my neck of the woods.
24 Zoloft is a very common antidepressant. It's a
25 very short-acting antidepressant. It doesn't do

1 long-standing damage. There's just a small
2 withdrawal syndrome when babies are born with
3 Zoloft in utero. Overwhelmingly, there's
4 convincing evidence that using it in pregnancy is
5 very safe and very effective and does not have
6 long-lasting effects on the fetus or the child.
7 DR. BADER: And I think just to clarify,
8 whether it's methadone or Suboxone or whether it's
9 Fentanyl or whether it's heroin, they all have
10 potential effects in the newborn.
11 MAJORITY CHAIRWOMAN WATSON: Thank you.
12 And one more. I'm going to sneak one
13 more in.
14 DR. STENBERG: Sure.
15 MAJORITY CHAIRMAN WATSON:
16 Representative DeLissio.
17 REPRESENTATIVE DeLISSIO: Thank you,
18 Madam Chair.
19 Quick question. Of the mothers that go
20 through these programs, are any of them repeat
21 folks?
22 Do they subsequently get pregnant again
23 and are still in and addicted state?
24 And if they are, what does that data
25 look --

1 DR. STENBERG: Yeah. We see repeat
2 families. Actually, we see families, as well, with
3 sisters who are, you know, chronic users of opioid
4 medication. Being a repeat person isn't
5 necessarily a bad thing if your symptoms are
6 controlled and you're in program. It's the
7 uncontrolled and out-of-program people that we
8 really try to build a strong catchment system
9 around to provide that wraparound care.
10 REPRESENTATIVE DeLISSIO: Well, help me
11 understand this a minute. So I get that if you're
12 a repeat person and you're in the program, it's
13 better than being not in the program --
14 DR. STENBERG: Yeah.
15 REPRESENTATIVE DeLISSIO: -- but,
16 ideally, we don't want people to repeat those same
17 mistakes in terms of addiction. This is what I'm
18 thinking. I --
19 DR. STENBERG: So addiction is a
20 disease. It's very complicated. Many people will
21 stay on maintenance therapy. Dr. Caputo could tell
22 further --
23 DR. CAPUTO: So methadone for some
24 people is a lifelong treatment. Subutex, Suboxone,
25 typically, is not a lifelong treatment.

1 Unfortunately, some patients are so sick that they
2 need it for lifetime. The advice would be, you
3 know, pregnancy counseling. Do you want to have a
4 baby that's going to be addicted and go through
5 NAS? That's really where the education lies.
6 REPRESENTATIVE DeLISSIO: And that's
7 exactly what I was about to say. So to what degree
8 is that type of education, counseling, and the
9 ability to plan better for pregnancies or plan
10 better to not have pregnancies, birth control, is
11 that part of the program?
12 DR. CAPUTO: Well, hopefully, when our
13 Perinatal Center of Excellence gets
14 fully-developed, that is part of the discussion
15 that one has with the woman after the baby is born,
16 yes.
17 DR. STENBERG: Can I just add one other
18 thing?
19 That's a really important part. And we
20 do talk about that in our family therapy now,
21 although we -- until the program is fully rounded
22 out, we don't have the home visiting.
23 The other thing to know is that
24 shorter-acting opioids, though, actually decrease
25 fertility. So there is a major risk when women go

1 from short-acting opioids into treatment, that the
2 people who are providing treatment need to be
3 talking about contraception at that time because
4 the fertility goes up when you go onto the
5 maintenance therapies, the long-lasting therapies
6 like methadone or even Suboxone.
7 REPRESENTATIVE DeLISSIO: Okay. I
8 appreciate that.
9 Thank you, Madam Chair.
10 MAJORITY CHAIRWOMAN WATSON: Thank you.
11 Gentlemen, thank you very much. I know
12 that you have to get back traveling east. We
13 appreciate your time and your expertise, and I
14 suspect you will hear from us again on things that
15 we need to know.
16 Thank you very much.
17 While we're doing the changing of the
18 guard, I should add that we've had members come and
19 go. Those of you that attend hearings know that
20 that happens because there were five committees
21 meeting at the same time this morning, but we have
22 been joined by Representative Hahn,
23 Representative Kirkland, Representative Lowery
24 Brown, and our last questioner,
25 Representative DeLissio. So we are grateful for

1 that, but when you see people in and out, don't
2 take it personally that they weren't interested.
3 All right. I think we're ready then.
4 Dr. Karla Nickolas-Swatski, a
5 pediatrician, practices in Bryn Mawr. And you're
6 testifying on behalf of the Pennsylvania Chapter of
7 the American Academy of Pediatrics, something I'm
8 very familiar with because the past president, Dr.
9 Dr. Kressly --
10 DR. NICKOLAS-SWATSKI: How so?
11 MAJORITY CHAIRWOMAN WATSON: -- her
12 offices is three doors down from my district
13 office. So we will meet in the parking lot and
14 hold meetings, where I see her on the way out and
15 we talk. And we love the fact that she's in our
16 building because then we get to see children and
17 babies, and it's very cool.
18 DR. NICKOLAS-SWATSKI: I understand very
19 well.
20 MAJORITY CHAIRWOMAN WATSON: So in any
21 event, I'm very familiar with the American Academy
22 of Pediatrics.
23 Dr. Swatski, good morning. Thank you
24 for being here. And please, have at it. Go right
25 ahead.

1 DR. NICKOLAS-SWATSKI: Thank you so
2 much. It is an honor to speak at this hearing
3 today. As you said, I'm here on behalf of the
4 Pennsylvania Chapter of the American Academy of
5 Pediatrics and its 2,200 member pediatricians who
6 are dedicated to promoting the health and
7 well-being of children in the Commonwealth, to
8 share the Academy's support for HB 235, which
9 creates the Opioid Abuse Child Impact Task Force.
10 We were pleased that the House of Representatives
11 passed this important legislation unanimously
12 earlier this month, and we will work with you as
13 needed to facilitate the passage in the Senate.
14 We all know that opioid abuse has
15 reached epidemic proportions across the country,
16 and Pennsylvania is no exception. We commend
17 the General Assembly for expeditiously responding
18 with multiple legislative proposals to address this
19 crisis. We also praise Chairwoman Watson for her
20 efforts and encourage the General Assembly to
21 continue working with Governor Wolf and his
22 administration to reverse the tide of opioid
23 addiction.
24 As opioid use among pregnant women has
25 increased, the rate of infants in the United States

1 experiencing opioid withdrawal has increased
2 proportionally. Newborn opioid withdrawal symptoms
3 are noted in over half of the babies born to
4 mothers addicted to, or treated with, opioids while
5 pregnant.
6 In 2000, the incidence of newborn opioid
7 withdrawal, called Neonatal Abstinence Syndrome,
8 was approximately one in 670 hospital births, but
9 by 2012, the incidence climbed to one in every 165
10 hospital births. Pediatricians who care for
11 newborns believe that the current ratio is even
12 higher.
13 The effect on the newborn can be
14 profound. Symptoms and signs may develop within
15 days of birth and include excessive or continuous
16 high-pitched crying, sleep disturbances, tremors,
17 muscle rigidity, seizures, elevated temperature,
18 distressed breathing, vomiting, diarrhea, and
19 excessive weight loss. Babies experiencing
20 withdrawal have symptoms that typically last two to
21 four weeks. And associated healthcare costs are
22 estimated to be $1.5 billion.
23 Under HB 235, an Opioid Abuse Child
24 Impact Task Force will be created and charged with:
25 1. Identifying strategies for prevention

1 of substance-exposed infants;
2 2. Making Recommendations to improve
3 outcomes for pregnant women and parenting women
4 recovering from addiction;
5 3. Promoting health and safety of these
6 children who are at risk for abuse and neglect and
7 placement in foster care because of parental
8 substance abuse; and
9 4. Ensuring Pennsylvania compliance with
10 the Federal Law CAPTA, The Child Abuse Prevention
11 and Treatment Act.
12 Compliance with CAPTA comes in
13 identifying exposed infants and developing a
14 multidisciplinary plan of safe care. These goals
15 are synergistic with the American Academy of
16 Pediatrics' Policy Statement published in the March
17 2017 issue of Pediatrics, which I have given to
18 you. That policy, entitled A Public Health
19 Response To Opioid Use In Pregnancy recommends a
20 multifaceted approach to maternal substance use in
21 pregnancy. We would offer this policy as a
22 template for the Task Force to follow as it
23 considers making recommendations.
24 The overarching premise of this policy
25 statement is to approach this crisis from a public

1 health rather than a punitive perspective. Several
2 states have taken the approach of prosecuting and
3 incarcerating pregnant women with substance use
4 disorders. Not only is this unnecessary, this
5 approach has demonstrated no proven benefits for
6 maternal or infant health.
7 Further, it may lead to avoidance of
8 prenatal care and a decreased willingness to engage
9 in substance use disorder treatment programs. The
10 AA's statement on opioid use in pregnancy outlines
11 aspects of a public health response that include:
12 a focus on preventing unintended pregnancies and
13 improving access to contraception; universal
14 screening for alcohol and other drug use in women
15 of childbearing age; knowledge of and informed
16 consent for maternal drug testing and reporting
17 practices; improved access to comprehensive
18 obstetric care, including opioid replacement
19 therapy; gender-specific substance use programs;
20 and improved funding for social services and child
21 welfare systems.
22 The Pennsylvania AAP was pleased to see
23 that the legislation requires the task force to
24 include expertise in both pediatric and obstetric
25 medicine. And we stand ready to play our part in

1 combatting this crisis through participation in the
2 task force and by serving as a resource to its
3 members, the General Assembly, and the
4 Commonwealth. The PA-AAP is dedicated to efforts
5 to improve children's health and well-being and
6 looks forward to having one of its members as a
7 representative on the Task Force.
8 Dr. David Turkewitz, a past president of
9 the Academy, provided testimony to the Task Force
10 on Child Protection in 2012, and he currently
11 serves as an appointee to the Children's Advocacy
12 Center Advisory Committee, established by
13 Act 28. Given his clinical and advocacy
14 backgrounds as well as experience working with the
15 legislature, Dr. Turkewitz would be an outstanding
16 contributor to the Opioid Abuse Child Impact Task
17 Force. Thank you for your time and your
18 consideration of Dr. Turkewitz, as well as other
19 pediatric colleagues.
20 Thank you.
21 MAJORITY CHAIRWOMAN WATSON: Thank you
22 very much, Dr. Swatski.
23 And just to be perfectly clear --
24 appreciate you talking about a specific
25 individual -- HB 235, passed by the Senate, signed

1 by the Governor, and becomes law, it will be up to
2 that group to do that. Because I've had people
3 come to me and say, listen, I'd like to be on it;
4 can you do that? And it's like, no, we don't have
5 a say as such, but I think that they're certainly
6 talking to the Governor and who is appointed and
7 how many.
8 The mechanics are in the bill as to who
9 appoints whom, and that will be important. And the
10 idea is, quite frankly, in writing it, I wanted the
11 best and the brightest. And I wanted you all for
12 free, that we didn't pay for anything. But we got
13 you to feel it was your civic duty and volunteer
14 your time, just like we got you to come here today.
15 That's how we get things done when you have a tight
16 budget.
17 So I do thank you for that. And I thank
18 you for saying that the Pennsylvania Chapter of the
19 American Academy of Pediatrics is always at the
20 forefront wanting to help with children and wanting
21 to help the General Assembly. Thank you very much.
22 DR. NICKOLAS-SWATSKI: You are very
23 welcome.
24 MAJORITY CHAIRWOMAN WATSON: Our next
25 testifier also testified at our first hearing on

1 this issue that was held back in September.
2 Rosemarie Halt is the Director of Health Policy and
3 Practice for the Maternity Care Coalition, which is
4 based in Philadelphia. Since 1980, the Maternity
5 Care Coalition has been improving the lives of
6 young children and their families by working to
7 improve maternal and child health and well-being
8 through the collaborative efforts of individuals,
9 families, providers, and communities in
10 southeastern Pennsylvania. It serves roughly 5,000
11 families per year.
12 So we welcome you back, Ms. Halt, and
13 please begin your testimony.
14 MS. HALT: Thank you so much,
15 Chairwoman. My testimony has been submitted. So
16 in the interest of time, I'm going to highlight
17 some parts of this for you.
18 Okay. In the past three decades, since
19 MCC began, there have been major shifts in
20 substance abuse, including the devastating cocaine
21 epidemics of the late '80s and '90s,
22 methamphetamines in the early 2000s, and now the
23 opioid epidemic. We have learned some valuable
24 lessons, having working with these communities in
25 those times. One is that trust is earned in the

1 community; multidisciplinary approach is needed to
2 be successful; and most of all, that we have to
3 remember that children come in families, and we
4 have to address the entire family.
5 There were a couple points here today
6 that there were facts being asked, so I just want
7 to highlight some of those. In 2015, there were
8 2,691 newborns hospitalized in Pennsylvania for
9 substance-related problems, with 82 percent of the
10 newborns born dependent on opioids that their
11 mother took.
12 Eighty percent of pregnancies to women
13 having substance abuse disorders are unintended and
14 50 percent unintended pregnancies in the general
15 population, so that's a key area that we really
16 have to focus on. I also want to highlight that 92
17 percent of the women in Philadelphia prisons are
18 mothers. Yeah, you have to keep that in mind
19 because many of those women are incarcerated
20 because of a connection to illicit drugs.
21 On average, MCC sees about 30 pregnant
22 women in the prison any month, and we help them
23 through those services in the prison and help with
24 the delivery. One out of every four Pennsylvania
25 families suffers from drug or alcohol abuse. Okay.

1 So there are significant things to think about, the
2 context of what children are living in.
3 Today, I just want to share some
4 two-generational and cross-system solutions that
5 MCC has developed in response to the opioid
6 epidemic, the deadliest drug epidemic in US
7 history. And I just want to say that I'm actually
8 a registered pharmacist, and I have a master's in
9 public health. And I've been looking at this train
10 wreck developing for 15 years.
11 When I started as a pharmacist, the
12 potency of prescription opioids was 20 percent less
13 than it is today. We have significantly increased
14 the number, as noted earlier in the testimony, and
15 the potency of these medications.
16 So we're right now working with two
17 Centers of Excellence in Philadelphia, the Temple
18 University and Wedge Medical Center and the
19 University of Pennsylvania's University Health
20 Systems. Our role, as community health workers,
21 which we refer to as advocates, we support clients
22 through home visitation; accompaniment to
23 appointment; connections to a wide range of
24 services; social and economic support housing; WIC;
25 and most of all, which is often neglected is

1 transportation because many women can't find
2 transportation to their appointments.
3 And key to this is the developing of a
4 family service plan, defying client goals and
5 priorities and helping them in the current
6 situation as well as beginning to think of the
7 long-range plan for themselves and their children.
8 And its important collaboration between the medical
9 team, the treatment program, and the advocate are
10 key in helping the client meet the many challenges
11 in the road to recovery.
12 Another important program that we're
13 working with is Keystone First. So we have
14 developed an innovative intervention with Keystone
15 First, and that is a targeted program using the
16 models from our other interventions. And it
17 focuses on ensuring that the babies go from the
18 NICU to a safe living environment, where their
19 health needs are addressed, along with the mom's.
20 The advocate stays with the mom until
21 the baby is considered living in a stable
22 environment until at least one month of age. At
23 this point, MCC hopes to transition a family into
24 other programs, such as Early Head Start or
25 evidence-based visiting programs. The key is to

1 ensure that the mother has support she needs to
2 take care of her infant during this very vulnerable
3 period.
4 We use a strength-based home visitor
5 model, which is explained in here, so I'm not going
6 to go into that too much. Another program that
7 we're working with, and we just submitted a grant
8 for this, is working with Jefferson University's
9 MATER Program, which is an addiction recovery
10 program for pregnant women. And so we're using our
11 Parenting Collaborative model, which is a
12 group-based parenting education program that is
13 committed to reducing child abuse and maltreatment.
14 The program is specialized for populations, such as
15 incarcerated women, families in shelters, and
16 parents transitioning from drug treatment programs.
17 The program provides a DHS-approved certificate
18 upon successful completion, which is very important
19 to these women because they often want to be able
20 to keep their children, and they need the
21 certificate to do so.
22 Through this collaboration with
23 Jefferson, we were able to submit a grant because
24 we looked at the dramatically increasing rates of
25 opioid addiction in pregnant women, and so

1 together, we submitted the grant to the Substance
2 Abuse and Mental Health Services Administration.
3 And if we get the grant, it would fill the enormous
4 need for services in special populations of women
5 requiring transitional support from residential
6 treatment programs. So they're pregnant, they
7 delivered, they're in medication-assisted treatment
8 programs. And so this would reaffirm their role as
9 mother while protecting the infant and other
10 children in the family.
11 Similar to our other home visiting
12 programs, MCC will begin services while
13 the mother is in treatment and continue through the
14 critical time of reentry into the community. And
15 that's when many women often fail. We also will
16 support MATER in recruitment of pregnant women with
17 opioid dependency from our other programs,
18 including the Riverside Correctional Facility.
19 So an important part of this, and it's
20 not often funded, is staff training. Because our
21 staff, just like everyone else, has to learn how to
22 help families. And so we've been providing
23 community health workers with unique programs that
24 require critical components of staff training. And
25 we do that by internal and external expertise, and

1 we particularly focus on trauma-informed care.
2 We also are partnering with Montgomery
3 County, which we service clients in, with their
4 early intervention services to provide joint
5 training for both our staff and their staff. And
6 those trainings have also helped us foster joint
7 solutions in those communities. One of the things
8 that we just found out is that one of the hospitals
9 has notified us, through this kind of group
10 communication, that they've seen a 40-percent
11 increase in NICU in the last year.
12 So that reminds me that the data is
13 critical. We need much more realtime data. Most
14 of us were giving you 2015 data here today. That's
15 -- that doesn't tell us what's happening on the
16 ground. Other states like Tennessee and those have
17 developed very simple solutions using even people
18 going on the computer and doing, you know, online
19 surveys from the hospitals just till they could
20 develop the data system that they need, but we need
21 realtime data.
22 And so time is of the essence. And I
23 just want to share with you, finally, one of the
24 stories from one of our clients. This young woman
25 was referred to our Montgomery County program from

1 her outpatient addiction. She herself had been a
2 victim of sexual abuse, both as a child and an
3 adult. She was nine months pregnant with her third
4 child. She was struggling to maintain her housing
5 and a part-time job. Her children were being
6 followed by child welfare services, and she was
7 trying to attend her required drug treatment
8 program and a parenting program and find child care
9 for her young children.
10 She was worried about delivering at a
11 local hospital because she heard at her parenting
12 group that the nurses did not take kindly to
13 patients on medication-assisted treatment. She was
14 unable to keep many of her prenatal appointments,
15 partly out of shame of her addiction, partly
16 because of transportation issues. She had no one
17 to be her coach during delivery and no trusted
18 adult lined up to take care of her other children
19 when she delivered.
20 MCC staff helped her to navigate these
21 barriers, including offering doula support for her
22 delivery. The baby was delivered, and through
23 coordinated care, had limited medical
24 complications. The mother is working hard on
25 keeping her family together and being the best

1 parent she can be.
2 The work that this Committee has done
3 has highlighted so many of the things that families
4 need. And I appreciate you continuing to keep the
5 focus on mothers and infants. But we need to
6 really focus also on the funding that needs to do
7 this work. There's been a $9 million proposed cut
8 in opioid and the Center of Excellence in the House
9 budget version. And there's significantly little
10 improvement in home visiting and other services
11 that need to be provided, including training for
12 staff. That's a very abbreviated version.
13 MAJORITY CHAIRWOMAN WATSON: Very nice.
14 And we thank you very much for the work that you
15 are doing, for the insight that you provided. And
16 I'm going to, because our time is short and we have
17 to be on the floor at 11:00, so I'm not going to
18 take questions, but if you have questions for
19 Ms. Halt, please give them to Greg; we'll see that
20 they're forwarded correctly.
21 We're going to get a little perspective,
22 kind of a summary, on how analytics can help
23 sharpen the focus on identifying at-risk children
24 and families who are affected by opioid addiction.
25 SAS is a world leader in analytics and data

1 management. We are happy to have with us this
2 morning Mr. Steve Kearney, SAS's Medical Director
3 for State and Local Government.
4 Good morning, Mr. Kearney. It is still
5 morning; we're rolling along. We appreciate you
6 making the trip from North Carolina. If we gave
7 out prizes, you would get the prize for coming the
8 furthest, but it's a tight budget.
9 So indeed, we look forward, though, we
10 are happy to listen to your testimony.
11 Please begin, sir.
12 MR. KEARNEY: Thank you.
13 Good Morning, Chairwoman Watson,
14 Co-Chair Conklin, Mr. Grasa, and the Honorable
15 Committee. I Thank you for allowing me the
16 opportunity to speak today.
17 My name is Steve Kearney. I'm the
18 Medical Lead for the US Government practice at SAS
19 Institute. SAS is the software that is used by
20 every Department of Health and the CDC to actually
21 report the information on Neonatal Abstinence
22 Syndrome. And you will hear, and have heard, many
23 statistics about those surveillance programs and
24 sometimes the lack of a standardization in that
25 program.

1 Prior to joining SAS, I was a Director
2 in the Medical Outcomes Specialist Group at Pfizer,
3 where I worked for 17 years helping states, payers,
4 providers, integrated delivery networks, and
5 really anyone that interacted with health care
6 measure outcomes. Specifically, my teams worked to
7 help develop systems of care that could measure the
8 outcomes and then suggest policies and practices to
9 impact change.
10 Prior to Pfizer, I had a joint
11 appointment at Duke and UNC, where I had a practice
12 with 11 internists at Duke, and then I taught
13 Ambulatory Medicine at UNC and was the assistant
14 director of the Area Health Education Center. This
15 marks my 30th year in health care.
16 I'm honored to speak to you today and
17 really to be part of this impressive group here.
18 My comments are going to actually build on
19 Secretary Dallas' and Deputy Secretary Utz's
20 comments, as well. Obviously, you've heard the
21 statistics from the other presenters. But it's my
22 understanding that I was really invited because of
23 my work in two areas: one, in SAS; and then in
24 Project Lazarus in North Carolina. So I'm going to
25 address comments in those areas. And I'd like to

1 share what we've learned from both in the period of
2 time that I've been there.
3 So like I said, I was with Pfizer prior
4 to SAS. And on that role, I was on the Behavioral
5 Health Subcommittee in North Carolina. And I was
6 also on the Chronic Pain Subcommittee. And In
7 2012, just like Pennsylvania, we had huge
8 challenges in the opioid epidemic. We started
9 building on, with our Chronic Pain Subcommittee, on
10 learnings from a project called Project Lazarus
11 from a small county, called Wilkes County, in North
12 Carolina. And unfortunately, at that time, it had
13 one of the highest overdose rates in the country.
14 Project Lazarus Model is a public health
15 model based on the twin premises that overdose
16 deaths are preventable, and that all communities
17 are responsible for their own health, just as many
18 of you learn from your own constituents. The model
19 is a hub-and-wheel model that includes public
20 awareness, coalition action, and data and
21 evaluation as the center of the model. A key
22 concept of that model is provider education.
23 I was responsible and involved for the
24 provider education for 40 programs that we had
25 across the State of North Caroline, where we

1 trained 2,000 providers on appropriate pain
2 management; one being the best opioid is the one
3 you don't write. And then, I'm really here to
4 share a lot of the key learnings in that space.
5 The biggest challenge that we had is we
6 had all stakeholders in the room. We didn't have a
7 common platform or a common way to share
8 information. There were tremendous numbers of
9 folks there doing really good work. And as Deputy
10 Secretary Utz said, that information was a lot of
11 times in multiple agencies and multiple silos and
12 it was very difficult to share that information.
13 Specifically, then, we started working
14 on a specific platform to try to share that
15 information there in North Carolina. However, in
16 most surveillance programs, there's not a platform
17 like this. When we talk about surveillance, we're
18 truly talking about monitoring. We're talking
19 about monitoring a program versus taking action on
20 a program. So I'd like to share a little insight
21 in that, as well.
22 And then, again, as we present at these
23 committee hearings, unfortunately, I've been to a
24 number of those across the country, as we provide
25 updates, the challenge is that those updates then

1 don't become actionable. And what we've learned is
2 that the platforms that provide those updates, we
3 actually could develop an actionable report or
4 actionable system of care from that same
5 environment. For example, now, as the Medical Lead
6 for SAS, I have the great opportunity to work with
7 all 50 States and the Federal government. And
8 we've talked to them, all 50 States, and the
9 Federal government about what would this look like
10 and how could you share that information.
11 I will tell you that in every instance,
12 it's not technology; it's not the people trying to
13 do the good work. It's that we don't have systems
14 and good policy in place to be able to empower
15 those groups. So for example, the agencies that we
16 have all discussed today, as they look at the
17 different groups that they represent, whether it's
18 public health, whether it's corrections, whether
19 it's caseworkers, the challenge in all of those
20 environments, is they all work individually many
21 times in that environment.
22 So the best way to impact the issue that
23 we have seen is to really go to kind of where the
24 core information is housed, and that's actually in
25 the State. The State actually currently has all of

1 the information for these agencies and can share
2 that information prior to an individual actually
3 presenting with Neonatal Abstinence Syndrome.
4 For example, in the United States in
5 2012 -- again citing very poor data and very old
6 data -- it was $1.2 billion to the medicaid
7 agencies to take care of Neonatal Abstinence
8 Syndrome. However, those same medicaid agencies
9 had the claims information that could have been
10 actionable to send information to all of the
11 networks that we've talked about so far to actually
12 work on prevention and treatment. But
13 unfortunately, the systems were not in place.
14 The same way that we approach heart
15 failure; for example, now, if I have a patient
16 admitted to the hospital for heart failure, then
17 I'm notified. I have a case manager that's
18 notified. We put a prevention protocol in place,
19 and we have a wraparound services, where they will
20 actually go to a cardiac rehab clinic or other
21 things like that afterwards to follow up with those
22 individuals. We don't have anything like this now.
23 We've heard some great examples of what individual
24 agencies and individual practices are doing, but a
25 statewide platform right now, we don't currently

1 have.
2 The other part of that for this
3 Committee is good policy. Whether we're working
4 with the National Governor's Association, we're
5 working with any of the other State and Federal
6 agencies, one of the big challenges in this space
7 is good policy to say, you know, whether it's HIPAA
8 42 CFR, which is the privacy requirements, all of
9 those things, they're opportunities to share
10 information where it's the best interest of the
11 patient -- and specifically when we're talking
12 about children today -- in those spaces and to do
13 it correctly, and we can do it with a good data
14 platform.
15 I'd like to thank you just for listening
16 to my comments. I wanted to keep them very brief
17 so that if we did have a chance for questions -- we
18 work in this space across the country. Someone
19 brought up Tennessee. And so we've been working
20 with Tennessee on what does it look like with
21 realtime data, and how would that impact the care
22 and a system to ingest that information.
23 We're doing the same thing in States
24 like Florida. We're doing it, starting in small
25 counties as an iterative approach. Project Lazarus

1 was started on a small county approach and getting
2 all the stakeholders together and sharing
3 information. And so we're doing that across the
4 country, as well, bringing that information
5 together in a protected way, the same way that I
6 would for any information for any of my patients,
7 being able to share that back to the providers that
8 take care of them, and then let them impact change.
9 I think our biggest challenges that we
10 talk about monitoring programs and surveillance
11 systems is that, unfortunately, I'd be back here
12 next year and we'd be talking about the same
13 numbers, and we haven't put a system of care in
14 place that would actually change that.
15 Thank you.
16 MAJORITY CHAIRWOMAN WATSON: Thank you
17 very much. I appreciate your testimony, and I was
18 -- in my head, I'm going, well, if I get that bill
19 through, I think the task force is going to want to
20 talk to you at some length. So I suspect you will
21 be back in Pennsylvania at some point and hopefully
22 sooner rather than later, but we do thank you for
23 your testimony and your time.
24 MR. KEARNEY: Thank you very much. And
25 I'm happy to serve.

1 MAJORITY CHAIRWOMAN WATSON: All right.
2 And I guess then we have a final
3 testifier who has been a driving force in bringing
4 attention to this facet of the opioid abuse
5 epidemic. She's been one of Pennsylvania's leading
6 advocates for children, has emersed herself in the
7 recent years in the issue of substance-exposed
8 infants and how the crisis has affected children
9 throughout the Commonwealth -- and I want to
10 emphasize throughout; in terms of economics
11 throughout, in terms of geography throughout.
12 When sometimes we like to relegate
13 something -- it's a problem, I watched it on PCN,
14 but it's not in my neighborhood -- and sadly, if
15 nothing else that you take away today, please
16 understand it's in every person's neighborhood, and
17 we have nowhere to go. So, therefore, we need to
18 solve it.
19 A warm welcome then to Cathleen Palm.
20 She is the founder of the Center for Children's
21 Justice. Nice to see you again, and please begin.
22 MS. PALM: Well, thank you so much,
23 Chairwoman Watson, Chairman Conklin, members. I
24 know you have a little detail to get to in terms of
25 the House floor, so I'll be quick. I kind of

1 gently encouraged Greg to put me at the end, so
2 that in case you didn't need me, you could move on
3 about your day.
4 But I do just want to say a couple of
5 things. And to be perfectly blunt, which I -- you
6 know, I am first and foremost a mother of three
7 young kids. And that has opened my eyes
8 dramatically to how quickly life changes and how
9 quickly they grow. And I just want you to know
10 that in 2015 was the first time we asked for a
11 conversation about kids in the opioid crisis in
12 Pennsylvania. I don't say that to kind of like dig
13 at anyone, but to just say we just haven't had a
14 sense of urgency.
15 And so you heard about Steve and the
16 platform and things like that. Before we can get
17 to talking about what the solutions are, we've got
18 to agree that these kids and their moms and their
19 families matter enough to, frankly, do something
20 about it. So the fact, Chairman Watson, people are
21 asking you why you have a task force, look -- task
22 force sounds like bureaucracy; people hate
23 bureaucracy. But I will tell you, we are not in
24 any intentional way, despite best efforts, thinking
25 across health, corrections, economics, human

1 services. We are not thinking intentionally about
2 this population and kids and this impact on them.
3 And we have to be doing something.
4 Most of the kids that are being so
5 dramatically impacted -- one of the things we did,
6 I gave Greg a word cloud because I thought I could
7 send you a gazillion PowerPoints of things we've
8 done, but what we've done in the last two weeks is
9 we went through every single needs-based budget
10 that the counties submitted. So you're deciding
11 how much money you're going to put into child
12 welfare in the next year, so they've submitted
13 their plans to Kathy. Her and her team are working
14 through it. We made a word cloud from that.
15 You're going to see that over and over what those
16 counties are talking about is not just the trifecta
17 of the impact of the CPSL reforms, but also the
18 drug crisis.
19 So before we finalize a budget this
20 session, we should really be looking at those
21 needs-based budget plans, not just Kathy, but also
22 some of you, and saying, so what are counties
23 asking for? What are counties dealing with? Will
24 the money we put on the table actually help them?
25 This is not a pitch for more or less money, but

1 let's put money in the right places.
2 The other thing is the home visiting.
3 But we should be -- you know, we're putting money
4 into home visiting, but do we have any strategies
5 about it? Do we say, these are the outcomes, the
6 metrics we really want to move the needle on?
7 In two to three years, you bring people
8 back here and say, so what do low birth weight
9 babies look like in the Hispanic population? I
10 mean, we really have to start to hold ourselves to
11 be way more accountable. And by ourselves, I mean
12 all of us, to be way more accountable about the
13 safety, the well-being, the health, and all of the
14 things that are important about kids in this State.
15 We talk a lot about public education.
16 We talk a lot about what the education budget looks
17 like. Look, we've got to get kids to live and to
18 thrive before age five, before they step inside a
19 classroom.
20 So if we don't start paying more
21 attention to those first 1,000 days, those first
22 three years of life, then we really are going to
23 keep finding ourselves in sessions like this, where
24 we lament -- Representative Toohil, you know, the
25 bill on postpartum depression. There are so many

1 good things that you're all doing, but there is so
2 little connector tissue.
3 So from our perspective, the concept of
4 a task force is not about having yet another layer
5 of bureaucracy, but finally someone saying with the
6 bully pulpit, we're paying attention. You kids,
7 you really are not off the radar to us.
8 And I think that's one of the things --
9 we are the folks who asked for a task force in
10 support with you, Representative Watson. We are
11 nervous about that, just because we don't like
12 bureaucracy either. But I will tell you, when
13 people told us they didn't want a task force, they
14 said that's because we didn't want to be bogged
15 down by bureaucracy. They wanted solutions. We're
16 two years into this. We're not any closer to
17 solutions.
18 And in the meantime, I really struggle
19 -- and then I'll end here -- I struggle sitting
20 here today listening to all of the testimony, as
21 fine and wonderful as it was, we have a five-month
22 old infant who starved to death and died from
23 dehydration in Cambria County. We had people
24 respond to his parents' home for an overdose a
25 month earlier.

1 His parents then both died in the house
2 from an overdose -- her parents, sorry -- and she
3 then laid. And God knows what she went through,
4 wondering when's somebody coming to change the
5 diaper; when's somebody going to feed me.
6 I don't say that because we should have
7 a punitive approach to this, because the fact of
8 the matter is, addiction is a disease. And these
9 women want healthy babies. They want to live and
10 grow alongside of their kids. But I say -- tell
11 you that story because it shocks me that I sit in
12 my State Capitol, and that today, there's no more
13 sense of urgency for Summer or for Brayden Cummings
14 or for any of these kids who are experiencing
15 unbelievable outcomes on their behalf.
16 So for all of the people who are going
17 to go on the floor today and talk about kids, I'm
18 going to have trouble believing it until we start
19 doing something and really put something behind it.
20 And I mean no disrespect to this Committee because
21 short of you guys, I'm not sure that we'd be having
22 much conversation about kids in this State, and so
23 I thank you.
24 MAJORITY CHAIRWOMAN WATSON: I can
25 assure you -- and we are ready to end this

1 hearing -- but that this Committee takes it
2 seriously.
3 I was like you, that I never believed.
4 I have been here long enough that I thought, you
5 know, task forces and whatever, they do a report,
6 it sits somewhere. It was the Task Force on Child
7 Protection that changed my opinion about them.
8 We got 23 bills out of what they came up
9 with, as I'll call it, their blueprint. And sadly,
10 because of, again, some egregious cases related to
11 child protection, it was time when people would
12 recognizes it, accept it, and move on.
13 This is what I believe we have to do
14 with this. It's not because it's mine. I would
15 have been like most of the people out in the public
16 going, I don't believe in these task forces; it's a
17 bunch of bologna.
18 But I do know, and I've been a part of
19 one or two in my life that have really gotten
20 something done. So I know they can work. The key
21 is then getting the right people in it, setting a
22 short time frame, saying you have to produce
23 something, and we're going to take it from there.
24 So you'd be too embarrassed not to produce
25 something, and getting you to do it for free; very

1 critical. So I think that can happen and do that.
2 And I think this is an integral -- some
3 people said, well, it's kind of really a small part
4 of the issue. No, it's not. I think it's probably
5 the long-term part of the issue that, while I can
6 get adults into recovery and moving on, the
7 problems I was very distressed by hearing the
8 doctor -- and I forgot his name now, but he talked
9 about the Australian study that we may have
10 far-reaching complications from children born
11 opioid-dependent.
12 We thought that if we solved that and
13 helped the family, six, seven, eight, years when
14 they're in school, everything is okay. Now, we're
15 getting studies saying, no, there are problems.
16 That disturbs me.
17 That's my point. And I recognize that
18 it's a disease, and it could recur if you're
19 addicted; I get that. But I've got innocent
20 children who have nothing to do with anything, and
21 we aren't dealing with it. So let's start there
22 and maybe get into prevention, as some of those
23 programs do -- that we don't have a problem, and
24 move people forward and -- as you say, I want
25 children to have the best start they can.

1 And then we'll deal with them when
2 they're in kindergarten and first grade and
3 whatever, but I have got to get them that far. And
4 I'm sorry, it is absolutely awful -- and I think
5 about it frequently -- no child should die in a
6 home where their parents OD and the case worker, or
7 whoever the visitor, wasn't due till the Tuesday or
8 Wednesday, and that child starved to death and
9 became dehydrated at five months.
10 I understand that's one; one is way too
11 many. And God knows if there aren't more than that
12 that we just don't know. We will work on it.
13 Thank you all. I thank all of the
14 testifiers. I thank my Committee people who do a
15 great job and let nothing go, honestly. And I
16 thank you who are in the audience for your
17 attendance and your involvement.
18 This hearing is now adjourned.
19 (Whereupon, the hearing concluded at
20 11:05 a.m.)
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25

1 C E R T I F I C A T E

2

3 I do hereby certify that the foregoing

4 is a true and accurate transcript, to the best of

5 my ability, of a public hearing taken from a

6 videotape recording.

7

8 Tiffany L. Mast

9 Tiffany L. Mast, Reporter

10 Notary Public

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