

# PERFORMANCE AUDIT REPORT

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## Opioid Treatment Audits

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July 2017



Commonwealth of Pennsylvania  
Department of the Auditor General

Eugene A. DePasquale • Auditor General

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EUGENE A. DePASQUALE  
AUDITOR GENERAL

July 7, 2017

The Honorable Tom Wolf  
Governor  
Commonwealth of Pennsylvania  
Harrisburg, PA 17120

Dear Governor Wolf:

Enclosed are our performance audits of the Department of Corrections (DOC), the Department of Human Services (DHS), and the Department of Drug and Alcohol Programs (DDAP). We audited these agencies within the context of the opioid epidemic that is currently the scourge of far too many Pennsylvanians.

We conducted our audits under authority granted by Sections 402 and 403 of The Fiscal Code, 72 P.S. §§ 402 and 403, and in accordance with applicable generally accepted government auditing standards, as issued by the Comptroller General of the United States. Those standards require that we plan and perform our audits to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

We conducted our performance audits of the agencies concurrently. For reporting purposes, we are combining the three audits into this one audit report contained herein. Our audit objective was the same for each agency, which was as follows:

- Determine the extent to which the Department of Corrections, the Department of Human Services, and the Department of Drug and Alcohol Programs are monitoring and measuring the effectiveness of opioid-related drug treatment initiatives.

Our audit period was January 1, 2013, through April 30, 2017, unless otherwise indicated, with updates through the report date. We offer a total of six findings and 21 recommendations encompassing all three agencies. Each agency has agreed with their respective finding(s). Additionally, we also present an *Opioid-Related Drug Treatment Environment* section, which discusses the many issues and problems surrounding the opioid epidemic. We

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believe the findings and recommendations we present will help the commonwealth battle the opioid epidemic.

In closing, I want to thank Secretary Wetzel, Secretary Dallas, and Acting Secretary Smith for their cooperation and assistance during the audits. We will follow up at the appropriate time to determine whether and to what extent all recommendations have been implemented.

Sincerely,

A handwritten signature in black ink, appearing to read "Eugene A. DePasquale". The signature is fluid and cursive, with a long horizontal stroke at the end.

Eugene A. DePasquale  
Auditor General

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#### Executive Summary

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Pennsylvania is currently facing a health epidemic—opioid addiction. No one is immune to this epidemic, and it has already caused merciless pain and sorrow to many Pennsylvania citizens and families. While the scourge of drug addiction is painful to those afflicted and their families, opioid addiction also spurs increases in crime and is very costly in the workplace. There are no easy answers in combatting this epidemic, so it is important to make sure that tax dollars spent to prevent and treat this epidemic are spent wisely and effectively. Further, ongoing legislative negotiations in Washington D.C. regarding the future of Medicaid and the Patient Protection and Affordable Care Act could be an obstacle in battling this epidemic.

With these issues in mind, we conducted not one, but three similarly focused performance audits. While we technically conducted three independent audits, our results are presented here, within this one combined performance audit report. The agencies we audited included the Department of Drug and Alcohol Programs, the Department of Human Services, and the Department of Corrections. Our audit objective was the same for each agency (see also *Appendix A – Objective, Scope, and Methodology*):

- Determine the extent to which the Department of Drug and Alcohol Programs, the Department of Human Services, and the Department of Corrections are monitoring and measuring the effectiveness of opioid-related drug treatment initiatives.

Our findings, conclusions, and recommendations are presented in the sections that follow. Each agency’s findings are presented within its own audit section. Additionally, we have included an *Opioid-related Drug Treatment Environment* section to the audit report. In this section, we do not present findings, but instead discuss some of the challenges in monitoring drug treatment effectiveness, as well as additional views about the accessibility to available drug treatment initiatives for opioid addiction. With respect to the agencies we audited, we found the following:

#### Department of Drug and Alcohol Programs (DDAP)

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*Finding One – DDAP cannot measure the effectiveness of opioid-related drug treatment initiatives. Instead, it monitors drug treatment providers for compliance with regulatory standards.*

- ❖ As discussed in the *Opioid-related Environment*, it is very difficult to measure drug treatment effectiveness because every individual is different and there is no “cure all solution” that works for all substance abuse disorders. Consequently, DDAP does not measure drug treatment effectiveness. DDAP and other stakeholders, however, should develop a method to measure effectiveness of treatment over time, including time periods after participants have left treatment and re-entered the community. While DDAP does

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not measure drug treatment effectiveness, it does monitor drug treatment providers for compliance with laws and regulations. This monitoring is useful as a quality measure (e.g., a treatment provider's ability to meet regulatory standards), but accessing this information is cumbersome and not easily understood by most "lay" persons. DDAP agreed with the finding.

*Finding Two – Chronic understaffing and underfunding at DDAP creates additional challenges in combating the opioid epidemic.*

- ❖ DDAP is a relatively new commonwealth agency and it has been challenged by a lack of staffing and a lack of funding. DDAP's licensing function has been especially hard-hit by shortages in staffing, and yet, DDAP expects an influx of new facilities opening to help deal with the opioid epidemic. In terms of staffing shortages, we identified a number of areas that are impacting licensing staff, such as pay disparities and limited promotion opportunities. Related to staffing constraints, we identified areas where DDAP would like to provide more monitoring related to issues influencing opioid treatment, but DDAP cannot perform these additional duties because it is constrained by its lack of capacity. DDAP agreed with the finding.

*Finding Three – The law creating DDAP did not specify that DDAP could collect licensing fees, nor has DDAP issued regulations that would institute a license fee on drug and alcohol treatment providers.*

- ❖ DDAP was created in 2012 by Act 50 of 2010. While this legislation was instrumental in creating DDAP as a stand-alone cabinet level agency, it did not give DDAP the ability to impose a fee for the licenses it issues to drug treatment providers. As a result, DDAP is missing the opportunity of a potential revenue source to help fund one of its primary operations. Although much of DDAP's funding is from federal and not state dollars, additional state revenue obtained through a licensing fee would greatly aid DDAP in its efforts to curtail the opioid epidemic. DDAP agreed with the finding.

### Department of Human Services (DHS)

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*Finding One – Centers of Excellence (COE) infrastructure for collecting information on outcomes is in place, but there are no apparent plans for DHS to ensure the accuracy of the data used to monitor COE's effectiveness.*

- ❖ A new initiative in the commonwealth's efforts to combat the opioid epidemic are Centers of Excellence (COE). These facilities seek to connect those Pennsylvanians who are struggling with opioid addiction with the necessary behavioral and medical treatment supports. COEs provide a service called a "warm handoff." Through this process, COE staff work with service providers to ensure that those who want help with their substance



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abuse problem actually get help. Although the initiative is still in the initial development phase, COEs will help to ensure that individuals do not “fall between the cracks” and miss the opportunity to get the medical and behavioral health treatment that they need to battle opioid addiction. While DHS has established initial measures for evaluating the effectiveness of the program, we found that DHS could further improve on its COE monitoring by conducting procedures which would ensure that the data collected is accurate and complete. DHS agreed with the finding.

#### Department of Corrections (DOC)

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*Finding One – Only one of seven DOC Alcohol and Other Drug (AOD) Treatment Programs is monitored for effectiveness and that monitoring is limited to recidivism.*

- ❖ DOC only monitors one of its Alcohol and Other Drug Treatment Programs on a regular and routine basis. Other AOD programs have been monitored (i.e., reviewed), but these reviews were conducted infrequently. We encourage DOC to develop regular periodic program evaluations of all its AOD programs and to work with other partner agencies like the Pennsylvania Board of Probation and Parole to access data that could be used to further evaluate each AOD’s effectiveness. DOC agreed with the finding.

*Finding Two – DOC’s Medication Assisted Treatment (MAT) program lacks an ongoing formal monitoring process to measure its effectiveness.*

- ❖ DOC’s medication assisted treatment program, which is based on Vivitrol<sup>®</sup>, a promising drug that has been shown to block cravings and the ability to get “high” from opioids, would benefit from additional program monitoring. This monitoring should target the effectiveness of the drug beyond just recidivism rates. DOC agreed with the finding.

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#### Opioid-Related Drug Treatment Environment

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Our objective for this audit was to determine the extent to which the Department of Corrections, the Department of Drug and Alcohol Programs, and the Department of Human Services are monitoring and measuring the effectiveness of opioid-related drug treatment initiatives. While the audit objective was the same, each of these agencies approaches the issue of opioid treatment differently. By the same token, the opioid epidemic presents a number of difficulties that have transcended all state agencies.

This report includes information about the opioid-related drug treatment environment to provide a summary of what treatment services exist. Within this section, we address some of the overlying issues encountered in conducting our work. These issues are not findings but instead are discussions surrounding the problems of monitoring the effectiveness of drug treatment, specifically in Pennsylvania, as well as additional views about the accessibility to available drug treatment initiatives for opioid addiction.

#### Contextual Factors in Evaluating Drug Treatment

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At the onset of the audit, we learned that three factors would complicate our ability to respond to the audit objective. These factors include the following:

- I. The varying definitions of drug treatment “effectiveness.”
- II. The fact that no specific drug treatment is the “right” treatment.
- III. Tracking effectiveness among drug treatment participants is very difficult.

##### **I. The definition of “effectiveness.”**

Due to the varying definitions of effectiveness, as well as the different definitions provided by those entities measuring effectiveness, it was determined that a consistently used definition of drug treatment effectiveness does not extend across the agencies reviewed during this audit. As such, finding a definitive answer to which treatment method is “most effective” was not a simple task.

**Department of Corrections.** The Department of Corrections is conducting a special pilot project that offers the opportunity for individuals with opioid addictions re-entering the community to receive an injection of Vivitrol® every 28 days.<sup>1</sup> Individuals volunteering to participate in the

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<sup>1</sup> Vivitrol® is a non-narcotic, non-addictive medication that blocks the opiate receptors in the brain and reduces cravings. See also the section that follows on medication-assisted treatment availability and the section pertaining to the Department of Corrections.

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pilot receive the first injection within one week of institutional release and receive up to 11 additional monthly injections in the community following release, contingent upon a community-based medical doctor's continued prescription. The main goals of the Vivitrol® pilot are to keep individuals from relapsing into substance abuse and re-engaging with the criminal justice system. An effective program in this context would mean low recidivism rates among those participating in the pilot when compared to those not participating in the pilot, as well as lower rates of relapse.

**Department of Drug and Alcohol Programs (DDAP).** DDAP's measures of effectiveness do not apply to the efficacy of treatment methods. Rather, DDAP measures effectiveness of its 47 administrative units, called Single County Authorities (SCAs), by looking at timeliness of SCA service. DDAP efficiency metrics for reviewing SCAs include the following:

- 1) No more than 5 percent of individuals shall wait longer than 7 days for a level of care assessment.
- 2) No more than 7 percent of individuals shall wait longer than 14 days to be admitted into the recommended level of care. (Individual requiring detoxification must be admitted within 24 hours of identifying the need for this level of care.)<sup>2</sup>

DDAP does not provide services directly; rather, it allocates state and federal funds to SCAs based on population statistics, competitive awards, and other factors. SCAs are then responsible for contracting with licensed Drug and Alcohol Treatment Providers, as well as with non-treatment providers, which can meet the needs of individuals seeking addiction treatment. SCAs themselves provide screening, assessment and case coordination.

Unrelated to treatment of the individual, DDAP is also required to perform an annual on-site inspection of all Pennsylvania-licensed drug and alcohol treatment facilities that seek renewal of their yearly issued license.<sup>3</sup> During these inspections, DDAP Licensing Specialists are only determining whether facilities are complying with licensing standards, not reviewing the quality of care or effectiveness (or "success" of treatment).<sup>4</sup>

**Department of Human Services (DHS).** DHS measures the effectiveness of opioid drug treatment in terms of the effectiveness of its newly established Centers of Excellence (COE). Rather than just treating addiction, COEs are expected to treat the entire person through team-

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<sup>2</sup> <<http://www.ddap.pa.gov/Manuals/Treatment%20Manual.pdf>>, Section 8.00, p8.00.1 (accessed May 29, 2017).

<sup>3</sup> <<http://www.pacode.com/secure/data/028/chapter709/subchapBtoc.html>>, 28 Pa. Code § 709.11(b) (accessed May 29, 2017).

<sup>4</sup> Interview with representatives from DDAP's Bureau of Quality Assurance for Prevention and Treatment, November 21, 2016.

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based treatment, with the explicit goal of integrating behavioral health, primary care and, when appropriate, evidence-based medication assisted treatment.<sup>5</sup>

Effectiveness is measured along established metrics for quality, care management, and specific outcomes for COEs. DHS' ultimate goal is to provide all Pennsylvanians with treatment that addresses not only their substance use disorder, but also the underlying physical and behavioral health issues that are at the root of their addiction. DHS established a data collection tool and information will be collected every six months from participants, which will allow DHS to track changes over time. Unfortunately, data was unavailable for review during the audit due to the newness of the program.

#### **II. No specific treatment is the “right” treatment.**

Adding to the difficulty of determining which treatment is the most effective is the fact that treatment modality success varies widely between individuals. Further, the same treatment modality can fail for one person multiple times before it is finally effective. Consequently, the “effectiveness” of the treatment program is greatly influenced by the individual’s readiness to be treated and how that individual responds to particular methods of treatment. As a result, evaluating the effectiveness of a treatment modality solely using the number of people who achieved outcomes as a percentage of the number of people who started the treatment would likely lead to a deceptive conclusion. The major reason is that it would fail to take into account the complexity of the disease of addiction.

To the above point, it must also be recognized that each life phase presents unique vulnerabilities for risky substance use and the onset of the disease of addiction.<sup>6</sup> Recognizing these differences as well as the basic risk factors for each phase is critical to reducing risky substance use and addiction.<sup>7</sup> Further, the lack of a standard definition about addiction complicates measurement. Terms used to describe different levels of involvement with addictive substances— experimentation, use, misuse, excessive use, abuse, dependence and addiction—lack precision, obscuring important differences in the nature and severity of the illness.<sup>8</sup> In turn, the ability to intervene and treat the disease is complicated by this lack of precision in addiction-related terminology.<sup>9</sup> In other words, while an individual cannot be “a little pregnant”—i.e., either you are or are not—the disease of addiction is not so clearly defined.

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<sup>5</sup> <<https://www.governor.pa.gov/to-fight-opioid-epidemic-wolf-administration-implements-25-additional-centers-of-excellence-locations/>> (accessed May 29, 2017).

<sup>6</sup> The National Center on Addiction and Substance Abuse at Columbia University, “Addiction Medicine: Closing the Gap between Science and Practice,” June 2012, page 10.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

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Even the word “treatment” lacks precision with regard to addiction, since historically it has been used to refer to a host of interventions, many of which are not based in the clinical and scientific evidence as are treatments for other diseases.<sup>10</sup> Many of the treatment experts that we interviewed explained that there simply is no one best or effective treatment—that it is important to have many different treatment options available. For example, an 18 year old who just tried pills for the first time does not need the same treatment intervention as an individual with a 20-year heroin habit. As stated by one expert, effective treatment means that “you have to meet people where they are, and then use the tools at your disposal to help them.”<sup>11</sup>

### III. Tracking effectiveness is difficult.

In order to track the effectiveness of treatment programs, there also has to be a reliable way to follow up with individuals who have completed treatment to determine the status of their recovery. An essential element of addiction recovery is that the individual change their environment so that they are no longer exposed to the people and situations that trigger and/or encourage the use of the substance. According to an SCA Administrator we interviewed, such changes may involve moving, changing their phone number, or disassociating with certain friends or family members – changes that also make it difficult to track people in recovery and maintain data to measure effectiveness.

Anecdotally, some experts told us that the people that can be tracked are often people who are successfully maintaining sobriety, making objective measurement of treatment effectiveness impossible due to this self-selecting sample bias. Stated simply, people who are doing well are more likely to want to discuss their recovery than people who are not.

Aside from the difficulty of contacting individuals for follow-up, another challenge is that while individuals must be identified for tracking purposes, such identification must be done without using any personally identifiable information that would breach patient confidentiality.

Additionally, it is possible to track people who participate in state or federally funded programs, but there is no way of tracking people who participate in programs that are licensed, but not funded, by the state. For example, we are unable to determine how many people paid for treatment with private insurance or private pay.

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<sup>10</sup> Ibid, page 7.

<sup>11</sup> Interview with representative of the Drug and Alcohol Service Providers Organization of Pennsylvania, March 22, 2017.

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#### Outlier Issues and Factors

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In the sections that follow, we list a number of outlier issues and factors related to drug treatment initiatives available in Pennsylvania. These issues were obtained from our research and/or interviews with experts in the field of substance abuse addiction and treatment, and include the following:

- I. Access to Medication Assisted Treatment (MAT).
- II. Public availability of information about substance abuse and treatment.
- III. Federal initiatives related to the opioid epidemic.

#### I. Access to Medication Assisted Treatment (MAT)

Opioid addiction is a disease that can be treated and managed effectively within the medical profession using an array of evidence-based pharmaceutical and psychosocial approaches.<sup>12</sup> Despite the complexity of treating severe opioid addiction, many experts expressed optimism about MAT, which is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.<sup>13</sup> A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.<sup>14</sup> However, at this time, there are only three medications that have been approved by the U.S. Food and Drug Administration for use in treating opioid addiction, and access to these treatments can be difficult to find. The drugs used with MAT are as follows:

- 1) ***Buprenorphine***. This drug reduces or eliminates opioid withdrawal symptoms, including drug cravings. Buprenorphine works by activating and blocking opioid receptors in the brain. It is available for sublingual (under-the-tongue) administration both in a stand-alone formulation (under brand name Subutex®) and in combination with another agent called naloxone. The naloxone in the combined formulation (marketed as Suboxone®) is included to deter diversion or abuse of the medication by causing a withdrawal reaction

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<sup>12</sup> The National Center on Addiction and Substance Abuse at Columbia University, “Addiction Medicine: Closing the Gap between Science and Practice,” June 2012, page 9.

<sup>13</sup> <<http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview>> (accessed May 29, 2017).

<sup>14</sup> Ibid.

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if it is intravenously injected.<sup>15</sup> Physicians with special certification may provide office-based buprenorphine treatment for detoxification and/or maintenance therapy.<sup>16</sup>

- 2) **Methadone.** This drug prevents withdrawal symptoms and reduces craving in opioid-addicted individuals by activating opioid receptors in the brain. It has a long history of use in treatment of opioid dependence in adults and is available in specially licensed methadone treatment programs. In select cases, opioid-dependent adolescents between the ages of 16 and 18 may be eligible for methadone treatment, provided they have two documented failed treatments of opioid detoxification or drug-free treatment and have a written consent for methadone signed by a parent or legal guardian.<sup>17</sup>
- 3) **Naltrexone.** This drug is approved for the prevention of relapse in adult patients following complete detoxification from opioids. It acts by blocking the brain's opioid receptors, preventing opioid drugs from acting on them and thus blocking the high the user would normally feel and/or causing withdrawal if recent opioid use has occurred. It can be taken orally in tablets or as a once-monthly injection given in a doctor's office (a preparation called Vivitrol®).<sup>18</sup> It is not an opioid, so it is preferable to some people who wish to use MAT, but do not want to use opioid-related medications.<sup>19</sup>

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<sup>15</sup> Subramaniam, G.A.; Warden, D.; Minhajuddin, A.; Fishman, M.J.; Stitzer, M.L.; Adinoff, B.; Trivedi, M.; Weiss, R.; Potter, J.; Poole, S.A.; and Woody, G.E. Predictors of abstinence: National Institute on Drug Abuse multisite buprenorphine/naloxone treatment trial in opioid-dependent youth. *Journal of the American Academy of Child and Adolescent Psychiatry* 50(11):1120–1128, 2011. Cited in Informational Bulletin for Medication Assisted Treatment for Substance Use Disorders, released July 11, 2014,

[https://www.samhsa.gov/sites/default/files/topics/behavioral\\_health/medication-assisted-treatment-joint-bulletin.pdf](https://www.samhsa.gov/sites/default/files/topics/behavioral_health/medication-assisted-treatment-joint-bulletin.pdf) >, page 4 (accessed May 29, 2017).

<sup>16</sup> Substance Abuse and Mental Health Services Administration. Physician Waiver Qualifications. Available at: <<https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/qualify-for-physician-waiver>> (accessed May 29, 2017).

<sup>17</sup> Marsch, L.A. Treatment of adolescents. In Strain, E.C.; and Stitzer, M.L. (eds.) *The Treatment of Opioid Dependence*. Baltimore, MD: Johns Hopkins University Press, pages. 497–507, 2005. Cited in Informational Bulletin for Medication Assisted Treatment for Substance Use Disorders, released July 11, 2014, <[https://www.samhsa.gov/sites/default/files/topics/behavioral\\_health/medication-assisted-treatment-joint-bulletin.pdf](https://www.samhsa.gov/sites/default/files/topics/behavioral_health/medication-assisted-treatment-joint-bulletin.pdf)>, page 3 (accessed May 29, 2017).

<sup>18</sup> Fishman, M.J.; Winstanley, E.L.; Curran, E.; Garrett, S.; and Subramaniam, G. Treatment of opioid dependence in adolescents and young adults with extended release naltrexone: Preliminary case-series and feasibility. *Addiction* 105(9):1669–1676, 2010. Cited in Informational Bulletin for Medication Assisted Treatment for Substance Use Disorders, released July 11, 2014, <[https://www.samhsa.gov/sites/default/files/topics/behavioral\\_health/medication-assisted-treatment-joint-bulletin.pdf](https://www.samhsa.gov/sites/default/files/topics/behavioral_health/medication-assisted-treatment-joint-bulletin.pdf)>, page 4 (accessed May 29, 2017).

<sup>19</sup> <<https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/evidence-based-approaches-to-treating-adolescent-substance-use-disorders/addiction-medications>> (accessed May 29, 2017).

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As explained below, MAT services are not available in several counties, which leaves many opioid-addicted Pennsylvanians underserved. As we previously mentioned, DDAP does not provide treatment services, but rather contracts with SCAs, who in turn establish contracts with treatment providers. Along these lines, according to interviews with DDAP staff, each SCA is required to contract with at least one methadone provider. However, while all 47 SCAs must contract with a methadone provider, the 47 SCAs singly or jointly encompass all 67 counties.<sup>20</sup> Obviously, this occurrence creates some boundary issues for those seeking access to treatment. For example, specific to MAT treatments, consider the points that follow:

- There are 33 counties—nearly half of all Pennsylvania counties—without a methadone provider geographically located within the county lines.
- Of these 33 methadone-lacking counties, 11 counties contain one buprenorphine provider and two other counties contain a Vivitrol provider.
- Consequently, 20 counties do not have any DDAP-licensed MAT providers located within the geographic boundaries of the county. Further, of these twenty counties, only three have a Centers of Excellence—the DHS initiative to help get people needing drug treatment into treatment—within the county.

The map that follows highlights the 20 Pennsylvania counties where there are no licensed MAT providers. By way of further reference, the map also depicts the number of overdose deaths per 100,000 people in 2015—as well as the number of physicians, who have been approved to prescribe buprenorphine in each of those counties.<sup>21,22</sup> As this map shows, there are areas in Pennsylvania where the death by overdose rate is high, but MAT is not as accessible as it could be. The DHS COEs are also shown on the map.

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<sup>20</sup> It should be noted that SCAs are not required to contract with all providers geographically located within their boundary area, so just because a provider is located with the county and is licensed does not mean that the provider is contracted with the SCA.

<sup>21</sup> <[https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field\\_bup\\_physician\\_us\\_state\\_value=PA](https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field_bup_physician_us_state_value=PA)> (accessed March 15, 2017). Note: “Approval” indicates that physicians have met the requirements for the US Drug Enforcement Agency to provide a waiver from requiring that the physicians register as opioid treatment programs to be able to prescribe buprenorphine to patients for treatment of opioid dependence.

<sup>22</sup> See US Drug Enforcement Agency Intelligence Report, (U) Analysis of Drug-Related Overdose Deaths in Pennsylvania, 2015, DEA-PHL-DIR-009-16, July 2016.

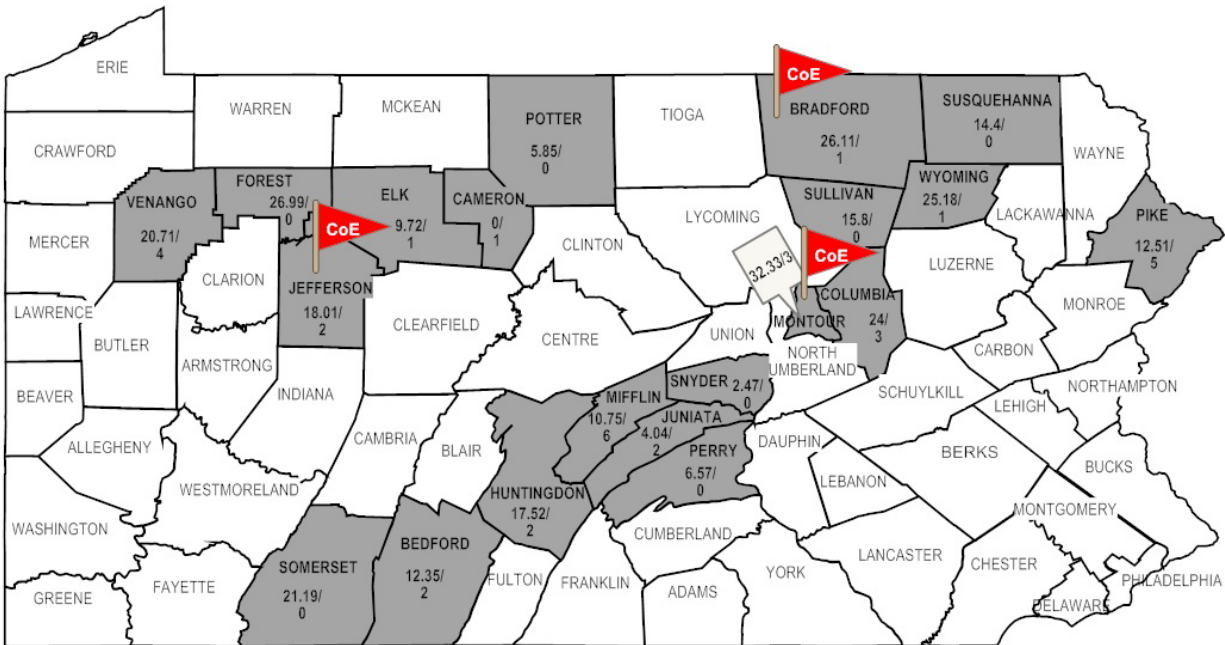
<[https://www.dea.gov/divisions/phi/2016/phi071216\\_attach.pdf](https://www.dea.gov/divisions/phi/2016/phi071216_attach.pdf)>, page 5 (accessed May 29, 2017).



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### Counties Lacking Licensed MAT Providers



Notes: Shaded counties lack licensed MAT facilities. The first number indicates the 2015 opioid death rate per 100,000 residents. The second number indicates the number of DEA-licensed buprenorphine physicians within that county, as of March 14, 2017. Red flags indicate locations where a DHS Center of Excellence is located within the county lacking a MAT provider. There are 42 other Centers of Excellence.

Source: Developed by Department of the Auditor General staff from information obtained from the Department of Drug and Alcohol Programs, US Drug Enforcement Agency, and the US Substance Abuse and Mental Health Services Administration. This information is presented for background purposes only and is from the best available sources.

Beyond the implications of this map for access to MAT providers, our research indicates certain areas of the commonwealth where MAT treatment is limited because only methadone is available (i.e., there is no access to other MAT treatments). These counties include:

- Cambria
- Lawrence
- Crawford
- Clearfield
- Lebanon

Therefore, the lack of other MAT choices in these counties leaves their populations underserved by all possible effective treatments. As reported in by the US Surgeon General in the “Report on

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Addiction,” well-supported scientific evidence shows that medication can be effective in treating serious substance use disorders, but these medications are under-used. The primary reason they are under-used is because there is an insufficient number of existing treatment programs or practicing physicians to offer these medications.<sup>23</sup> Our research showed similar findings.<sup>24</sup>

#### II. Public availability of information about substance abuse and treatment.

Many people that we interviewed acknowledged that getting the right information in the hands of the right people is an issue with which the treatment community continuously struggles. There are a few reasons this issue exists, including:

1. **Need to know basis.** Most people generally have no reason to be informed about opioid addiction treatment—or what information is important about treatment—until they or someone they care about is in crisis. At that moment, making well-informed decisions about getting the best treatment can be difficult because there is an urgency to simply get any treatment. Consequently, family members (or individuals struggling with addiction) can be rushed into making treatment decisions without a proper and thorough vetting of the planned treatment.
2. **Medical training.** Until recently, medical schools have not made opioid addiction and addiction issues a part of the medical school curriculum. As a result, many practicing physicians lack basic education about, or understanding of, addiction, addictive behaviors, or how to treat people with addictions.<sup>25</sup> Further, some have argued that with all of the recent publicity around opioid addiction, emphasis must be given to the genesis of how many addictions start—prescription pain killers. For example, below is a map from the Centers of Disease Control published in the *Wall Street Journal* on April 2, 2017, that shows that in some states physicians wrote more painkiller prescriptions than there are people in those states.

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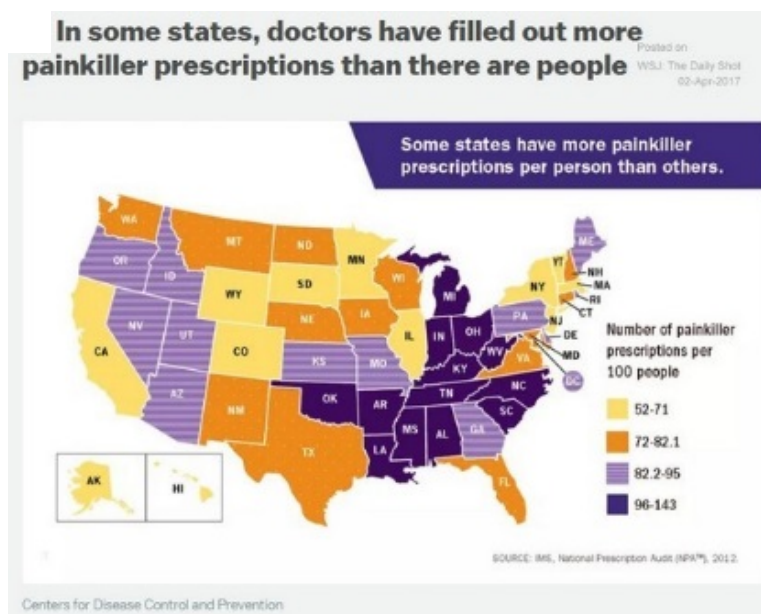
<sup>23</sup> U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016, page 4-2.

<sup>24</sup> DDAP noted that a new initiative, the Pennsylvania Coordinated Medication Assisted Treatment (PacMAT), will address these gaps in service area. A request for proposal to implement PacMAT is expected to be released in July 2017.

<sup>25</sup> The National Center on Addiction and Substance Abuse at Columbia University, “Addiction Medicine: Closing the Gap between Science and Practice,” June 2012, page 13.

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Source: Adapted from the Wall Street Journal, April 2, 2017.

Pennsylvania has taken a step forward on this issue. On November 2, 2016, the Pennsylvania General Assembly passed Act 124 of 2016 (effective January 3, 2017), which directs licensing boards to require individuals applying for an initial license or certification to complete at least 2 hours of education in pain management or identification of addiction and at least 2 hours of education in prescribing and dispensing practices for opioids.<sup>26</sup> For anyone applying for the renewal of a license where the license certifies or authorizes the holder to be an opioid dispenser or prescriber, the license board must require at least 2 hours of continuing education in the areas stated above.<sup>27</sup> Further, in 2016, the Pennsylvania Physician General created a task force which developed, reviewed and approved core competencies for education on opioids and addiction which will be incorporated into the educational process at all Pennsylvania medical schools.<sup>28</sup>

- 3. The stigma surrounding opioid addiction has caused people who have participated in treatment or lost people to addiction to keep silent about their experiences.** Despite the increasing awareness of addiction, to this day, drug addiction is still viewed as a lifestyle choice and not a disease. For that reason, people who have been through treatment, or who have had family who have been touched by addiction, are often less inclined to discuss their experiences. As a result, those needing assistance often fail to obtain first-hand accounts about effective treatments.

<sup>26</sup> Act 124 amended “Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act” (Act 191 of 2014, effective June 30, 2015).

<sup>27</sup> 35 P.S. § 872.9a(a)(2).

<sup>28</sup> <<https://www.ncbi.nlm.nih.gov/pubmed/28339890/>> (accessed May 29, 2017).

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4. **Internet search is not a reliable way to get help.** Although DDAP,<sup>29</sup> DHS<sup>30</sup> and the Governor's Office<sup>31</sup> all provide information and links on their websites for help with an opioid addiction, depending on the search engines used and terms used, the results can produce confusing or misleading information. Even when doing our own searches, we found that if we did not use the word "opioid," we did not find the Pennsylvania government sites. If we searched using the words "heroin addiction" and a county, we did find some Single County Authority sites, but not before we had to look through a number of aggregator websites containing lists of facilities and paid advertisements for individual rehabilitation facilities.
5. **Information about treatment program/facility regulatory compliance is difficult to find and may not reflect the current status.** As we will discuss in the Department of Drug and Alcohol Programs section, DDAP has a drug and alcohol treatment facility license renewal process, which reviews each facility's compliance with regulatory requirements. This process results in a list of citations and plans of correction, which are publicly available for each facility from a link on DDAP's home page. This information can speak to each facility's adherence to regulatory requirements at the time of the inspection, but at the time that the report is viewed, the condition cited may have been corrected by the actions taken as a part of the Plan of Correction. Past inspections can be viewed to determine if there are ongoing issues. But again, these are regulatory issues, not quality or effectiveness issues.
6. **There is no information available about treatment facility quality.** During our research, we found that there is no rating information that lists the kind of services or attributes of treatment facilities. Further, there is no objective way to compare one treatment facility to another, so that someone searching for help can make a determination about what the best option for an individual might be. This serious deficit leaves at-risk citizens and families vulnerable to those among us who may be acting with less than honorable intentions when seeking to provide increasingly necessary addiction treatment services.
7. **PA Get Help Now Hotline.** On November 10, 2016, DDAP implemented a toll-free hotline that is available 24/7 throughout the Commonwealth to help those suffering from addiction find immediate help.<sup>32</sup> When an individual calls the hotline requesting help, he or she will talk to a person who can provide assistance, including a screening for emergent care, and a direct "warm transfer" to a treatment provider. From our research, it appeared that there was monitoring and measuring of the hotline, but we did not

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<sup>29</sup><<https://apps.ddap.pa.gov/gethelpnow/>> (accessed May 29, 2017).

<sup>30</sup><<http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence/index.htm>> (accessed May 29, 2017).

<sup>31</sup><<http://www.pa.gov/collections/opioid-epidemic/>> (accessed May 29, 2017).

<sup>32</sup><<http://www.ddap.pa.gov/layouts/mobile/dispform.aspx?List=03fbb038-cd01-43fa-89b6-8b3e999ac080&View=9557135f-6d62-4e91-904a-171f936ef57a&ID=88>> (accessed May 29, 2017).

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formally audit the hotline program because it was outside the scope of the objective of this audit and was implemented too recently to have auditable results.

### III. Federal opioid-related programs

Listed below are two federal programs that were beyond the scope of this audit, but which may help to curtail Pennsylvania's opioid crisis.

***Certified Community Behavioral Health Centers (CCBHC).*** CCBHC's were created through Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA),<sup>33</sup> which established a demonstration program based on the Excellence in Mental Health Act. CCBHCs are a type of treatment provider intended to improve the behavioral health of citizens by offering community-based mental health and substance use disorder services, advancing the integration of behavioral health and physical health care, assimilating and utilizing evidence based practices on a more consistent basis, and promoting improved access to high quality care.<sup>34</sup> They are required to provide nine different services, including physical health screening, 24 hour crisis and emergency intervention services, outpatient mental health and substance use disorder services. Four services must be offered by the CCBHC themselves, and five may be offered by either the CCBHC or a contracted Designated Collaboration Organization (DCO). The CCBHC's themselves are required to be MAT providers.<sup>35</sup> Pennsylvania is one of eight states chosen to test the CCBHC concept, and in July of 2017 will begin to implement CCBHCs in 10 counties. There are three critical elements to CCBHCs that make them different from Centers of Excellence and Single County Authorities – their required scope of services, their payment structure, and their reporting requirements. Because CCBHC are federal test programs, their reporting requirements are extensive and include comparisons between operating expenses of the CCBHC and similar providers.

***21<sup>st</sup> Century Cures.*** On December 13, 2016, President Obama signed the 21<sup>st</sup> Century Cures Act that included \$1 billion over two years for the Secretary of US Department of Health and Human Services (HHS) to award grants to States to amplify their efforts to combat the opioid epidemic.<sup>36</sup> The funds are to be used to “supplement activities pertaining to opioids undertaken by the State agency responsible for administering the substance abuse prevention and treatment block grant,” such as:<sup>37</sup>

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<sup>33</sup> Public Law 113-93 113<sup>th</sup> Congress.

<sup>34</sup> <<https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/>> (accessed May 29, 2017).

<sup>35</sup> Ibid.

<sup>36</sup> <<https://asam.org/magazine/read/article/2016/12/07/the-21st-century-cures-act---highlights-for-asam-members>> (accessed May 29, 2017).

<sup>37</sup> Ibid.

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- Improving prescription drug monitoring programs (PDMPs).
- Implementing and evaluating prevention activities.
- Training for health care providers on safe opioid prescribing, pain management, recognizing substance use disorders, referral to treatment, and overdose prevention.
- Supporting access to health care services.
- Other public health-related activities.

DDAP worked with the US Substance Abuse and Mental Health Administration (SAMHSA) to get the grant application approved. The grant requires a needs assessment to determine where the state should focus efforts to expand/enhance treatment for the under- or un-insured populations, including the offering of MAT services. Some funds are also allotted for recovery support services and prevention activities. According to DDAP representatives, Pennsylvania's application has been approved and Pennsylvania will receive \$26.5 million per year for two years to combat the opioid epidemic.

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## DDAP Introduction and Background

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### Introduction

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Our audit had one objective—to determine the extent to which the Department of Drug and Alcohol Programs, the Department of Human Services, and the Department of Corrections measure and monitor the effectiveness of opioid treatment programs in Pennsylvania; as discussed in more detail in *Appendix A – Objectives, Scope, and Methodology*. This section of the report discusses our findings and conclusions specific to the Department of Drug and Alcohol Programs (DDAP).

We conducted our work under authority of Sections 402 and 403 of The Fiscal Code<sup>38</sup> and in accordance with applicable *Government Auditing Standards* issued by the Comptroller General of the United States.<sup>39</sup>

In the sections that follow, we provide additional background information about the Department of Drug and Alcohol Programs with the information providing a context for our audit findings and conclusions.

### DDAP Background Information

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#### Statutory History

In 1972, the Pennsylvania General Assembly established a health, education and rehabilitation program for the prevention and treatment of drug and alcohol abuse through the enactment of the Pennsylvania Drug and Alcohol Abuse Control Act.<sup>40</sup> This law established the Governor’s Council on Drug and Alcohol Abuse, which was to be chaired by the Governor. The Council was subsequently reorganized through Reorganization Plan No. 4 of 1981,<sup>41</sup> which transferred its responsibilities and its administrative authority to the Department of Health (DOH). The Council was designated as the advisory body to the DOH on issues surrounding drug and alcohol use and abuse.

In 1985, Act 119<sup>42</sup> amended the Pennsylvania Drug and Alcohol Abuse Control Act, changing the name of the Council and designating the Secretary of Health or his designee as chairperson.<sup>43</sup>

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<sup>38</sup> 72 P.S. §§ 402, 403.

<sup>39</sup> *Government Auditing Standards*, December 2011 revision, issued by the Comptroller General of the United States, United States Government Accountability Office, Washington D.C.

<sup>40</sup> 71 P.S. § 1690.101 *et seq.*, Act 63 of 1972, as amended.

<sup>41</sup> 71 P.S. § 751-31.

<sup>42</sup> 71 P.S. § 1690.103, last amended by Act 119 of 1985, effective Jan. 1, 1986.

<sup>43</sup> *Ibid.*



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Until 2010, the responsibilities outlined in the Pennsylvania Drug and Alcohol Abuse Control Act (mentioned above) were conducted by the Department of Health through its Bureau of Drug and Alcohol Programs (BDAP) within the Office of Health Promotion and Disease Prevention.

In 2010, Act 50<sup>44</sup> created a stand-alone administrative agency called the Department of Drug and Alcohol Programs<sup>45</sup> (DDAP). In January 2012, the former Governor nominated a Secretary answerable directly to him. All duties of the former BDAP were shifted to the newly created Department and Secretary to establish a management plan for the new agency, which was officially established in July 2012.<sup>46,47</sup>

#### **DDAP Duties**

The Department of Drug and Alcohol Program's mission is to engage, coordinate, and lead the Commonwealth of Pennsylvania's effort to prevent and reduce drug, alcohol and gambling addiction and abuse; and to promote recovery, thereby reducing the human and economic impact of the disease.<sup>48</sup>

DDAP's duties, as summarized below from Act 50 of 2010,<sup>49</sup> support its mission. This act requires DDAP to develop a State Plan for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependence problems. A State Plan is a plan for how the state intends to approach selected issues in a thoughtful, deliberate manner. DDAP's main duties include, but are not limited to, the following:

- Coordination of efforts of all state agencies in the control, prevention, intervention, treatment, rehabilitation, research, education and training aspects....so as to avoid duplications and inconsistencies in the efforts of the agencies.
- Development of model drug and alcohol abuse and dependence control plans for local government including how community resources and existing federal and commonwealth legislation may be utilized.
- Assistance and consultation including grants and contracts to local governments, public and private agencies, institutions and organizations and individuals with respect to the

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<sup>44</sup> Act 50 of 2010 added Article XXIII-A (relating to Powers and Duties of the Department of Drug and Alcohol Programs) to the Administrative Code of 1929, see 71 P.S. § 613.1 (Adm. Code § 2301-A), effective July 1, 2011.

<sup>45</sup> 71 P.S. §§ 61, 66, and 613.1. (Adm. Code §§ 201, 206, and 2301-A).

<sup>46</sup> Ibid.

<sup>47</sup> As of April 12, 2017, the Governor's Executive Budget for FY 2017-2018 sought a consolidation of four agencies, including DDAP, the Department of Health, the Department of Human Services, and the Department of Aging, into a Department of Health and Human Services.

<sup>48</sup> <<http://www.ddap.pa.gov/Pages/About.aspx>> (accessed May 29, 2017).

<sup>49</sup> 71 P.S. § 613.1 (Adm. Code § 2301-A).



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prevention and treatment of drug and alcohol abuse and dependence, including coordination of programs among them.

- Cooperation with organized medicine to disseminate medical guidelines for the use of drugs and controlled substances in medical practice.
- Establishment of training and educational programs and materials about drug and alcohol dependence to be used by the following:
  - Professional and non-professional personnel
  - Elementary and secondary school children as well as parent-teachers' associations
  - Media
  - Law enforcement officials
- Providing standards for the approval by the relevant State agency for all private and public treatment and rehabilitative facilities.
- Review the administration and operation of programs, including the effectiveness of such programs in meeting the purposes for which they are established and operated, and make annual reports of the findings.
- To gather and publish statistics pertaining to drug and alcohol abuse and dependence and determine regulations, specifying uniform statistics to be obtained, records to be maintained and reports to be submitted.
- To require all appropriate State and local departments, agencies, institutions and others engaged in implementing the State plan to submit as often as necessary, but no less often than annually, reports detailing the activities and effects of the implementation and recommending appropriate amendments to the State plan.<sup>50</sup>

#### **DDAP Organizational Structure**

DDAP is one of the smaller agencies of state government. Currently, it is composed of just an Acting Secretary, a Deputy Secretary, and three bureaus with a total approved staff complement of 79. The three bureaus are as follows:

***The Bureau of Treatment, Prevention and Intervention.*** This bureau provides county authorities, providers, and communities throughout the commonwealth with the tools they need to effectively prevent and treat drug and alcohol problems, as well as problem gambling.<sup>51</sup> Within this bureau, there are two divisions:

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<sup>50</sup> Ibid.

<sup>51</sup> <<http://www.ddap.pa.gov/Pages/BTPI.aspx>> (accessed May 29, 2017).

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- **Treatment Division**

Responsible for program planning and development of standards, policies, guidelines, service descriptions, and outcome data for the clinical functions of case management and treatment systems for drug and alcohol issues and problem gambling.<sup>52</sup>

- **Prevention and Intervention Division**

Provides for the development, oversight, and management of substance abuse prevention services statewide, and strives to increase the effectiveness of implemented services through evidence-based programs and state-approved, effective programs and strategies.<sup>53</sup>

***Bureau of Quality Assurance for Prevention and Treatment.*** This bureau ensures that drug and alcohol programs throughout the commonwealth meet or exceed high quality standards and licensure requirements.<sup>54</sup> This bureau includes two divisions:

- **Accountability And Program Improvement Division**

Oversees Methadone Death & Incident Review (MDAIR)-related activities and investigates complaints at licensed drug and alcohol treatment facilities.<sup>55</sup>

- **Program Licensure Division**

Safeguards the public by assuring that facilities providing drug and alcohol treatment services meet minimum standards of care based on published regulations.<sup>56</sup> DDAP has regulatory responsibility through its licensure authority over both public and private drug and alcohol abuse treatment facilities.<sup>57</sup>

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<sup>52</sup> Ibid.

<sup>53</sup> Ibid.

<sup>54</sup> <<http://www.ddap.pa.gov/Pages/BAQPT.aspx>> (accessed May 29, 2017).

<sup>55</sup> [Ibid.](#)

<sup>56</sup> Ibid.

<sup>57</sup> 28 Pa. Code §§ 701.1-715.3.; the authority of the Department to license drug and alcohol treatment activities is established under the powers and duties contained in Articles IX and X of the Human Services Code (62 P.S. §§ 901-922, 1001-1031, and 1051-1059) as transferred to the Department by Reorganization Plan No. 2 of 1977 (71 P.S. § 751-25) and No. 4 of 1981 (71 P.S. § 751-31).

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*The Bureau of Administration and Program Support.* This bureau supports DDAP programs, including fiscal management, training, data collection and analysis, information technology, administrative and clerical services.<sup>58</sup> Its divisions include:

- **Budget and Grants Management Division**

Maintains the internal departmental budget, as well as the administration of grants, including the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant.<sup>59</sup> DDAP allocates Block Grant funds to counties, who may use the funds to provide or arrange for treatment and treatment-related services to individuals with substance use disorders. The funds may also be used for prevention and intervention services. The SAPT Block Grant Application is available on WebBGAS.<sup>60</sup>

- **Administrative and Support Services Division**

Provides overall administrative support including human resource services and office services, and manages clerical support for the Department. Collects, analyzes and disseminates data on drug and alcohol programs to provide policymakers with up-to-date information and to meet federal data reporting requirements. The division also maintains the DDAP website and several other systems designed to enhance communications and operations for county authorities statewide. Through its training component, the division also coordinates multiple training initiatives, including a web-based application that allows drug and alcohol and other human services professionals to register for trainings offered throughout the commonwealth.<sup>61</sup>

### **DDAP Operations and Funding**

DDAP receives funding from a variety of state and federal sources and is designated the Single State Authority (SSA) to plan for and allocate the funds. DDAP allocates funding to forty-seven administrative units called Single County Authorities (SCAs). SCAs are awarded grants based on population statistics, needs assessments, and competitive awards. Additional funds can also be generated via county funds, fees, private sources, third party insurance coverage, etc.<sup>62</sup>

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<sup>58</sup> <<http://www.ddap.pa.gov/Pages/BAPS.aspx>> (accessed May 29, 2017).

<sup>59</sup> The Substance Abuse Prevention and Treatment Block Grant program provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity to prevent and treat substance abuse. <<https://www.samhsa.gov/grants/block-grants/sabg>> (accessed April 13, 2017).

<sup>60</sup> WebGAS (Web Block Grant Application System) is the federal government Block Grant System maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). State mental health authorities and single state agencies (like DDAP) can submit applications through this electronic application system, and the applications is publicly accessible. To view the Pennsylvania application, log in as "citizenpa" and use "citizen" as the password.

<sup>61</sup> <<http://www.ddap.pa.gov/Pages/BAPS.aspx>> (accessed May 29, 2017).

<sup>62</sup> Commonwealth of Pennsylvania Department of Drug and Alcohol Programs Uniform Application Federal Fiscal Year 2016, Substance Abuse Prevention and Treatment Block Grant Application and Report, page 16.

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The SCAs expend federal and state funds issued by DDAP according to requirements in the grant agreements that they sign with DDAP. SCAs may subcontract for services with providers as long as they comply with the rules and regulations of the Department. The grant language includes pass-down of grant requirements, administrative and fiscal requirements, the implementation of any federal or state regulatory requirements, as well as specific protocols prescribed by DDAP related to the provision of prevention, intervention, treatment and treatment-related, to include case management and recovery support services. DDAP's Bureau of Administration and Program Support monitors the areas for compliance at the SCA and SCA subcontractor level.<sup>63</sup>

Listed in the table below are the various DDAP funding sources used in support of opioid addiction treatment, although not used exclusively for opioid addiction treatment. Descriptions and information about each appropriation<sup>64</sup> were provided by DDAP and immediately follow the table.

Appropriation	Fiscal Year 2013-2014	Fiscal Year 2014-2015	Fiscal Year 2015-2016	Total
11-029 (state funds)	\$40,392,000	\$40,392,000	\$42,931,000	\$123,715,000
20-382 (state funds)	\$ 3,000,000	\$ 3,000,000	\$ 3,000,000	\$ 9,000,000
70-963 (federal funds)	\$47,938,614	\$47,944,136	\$48,684,614	\$247,430,000
70-964 (federal funds) (1)	\$ 1,332,579	\$ 1,776,772	\$ 1,776,772	\$ 4,886,123
70-964 (federal funds) (2)	\$ 533,864	\$ 1,211,169	\$ 3,011,169	\$ 4,756,202
70-965 (federal funds)	\$ 5,624,000	-	-	\$ 5,624,000
Total	\$98,821,057	\$94,324,077	\$99,403,555	\$292,548,689

Source: Developed by Department of the Auditor General staff from information provided by DDAP staff.

#### ▪ Appropriation 11-029 (state funds)

All SCAs receive an allocation from the General Assistance appropriation. These funds may be used to provide or arrange for treatment and treatment-related services to individuals with substance use disorders. The funds may also be used for administration, prevention, and intervention services.

For the first time in FY 2015-16, DDAP distributed \$3,500,000 of the annual total 11-029 appropriation funding among the 47 SCAs specifically for the purpose of addressing the opioid overdose epidemic. DDAP required the funds to be directed primarily to long-term rehabilitation, medication assisted treatment, and case management (particularly to facilitate a seamless transition from the emergency department to treatment). SCAs were required to

<sup>63</sup> Ibid., pages 16-17.

<sup>64</sup> <http://www.ddap.pa.gov/Manuals/Fiscal%20Manual.pdf> (accessed May 7, 2017). An "appropriation" is a statutory authorization granted by the state legislature to an agency, allowing it to incur obligations and make expenditures for specific purposes within a specific period of time and generally for a maximum dollar amount.

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submit budget narratives to DDAP indicating how the SCA planned to use the funds. Due to the budget impasse in 2015-2016, the \$3,500,000 was not able to be released until December 2015. Because of the late release of funds combined with the time required to fully execute contracts, some SCAs experienced difficulty in expending the full amount of their award during the months that remained in the fiscal year which ended June 30 2016. DDAP intends to continue to make this \$3,500,000 available annually for distribution among the 47 SCAs contingent upon receipt and approval of annual budget narratives containing plans for how the funds will be spent.

- **Appropriation 20-382 (state funds)**

All SCAs receive an allocation from the Assessment & Residential Treatment Fund, which can only be used for drug and alcohol addiction assessments, including drug and alcohol addiction assessment associated or related to compulsive and problem gambling, and for the related addiction treatment, in nonhospital residential detoxification facilities, nonhospital residential rehabilitation facilities and halfway houses licensed by DDAP.

- **Appropriation 70-963 (federal funds)**

All SCAs receive an allocation from the Substance Abuse Prevention & Treatment Block Grant, which may be used to provide or arrange for treatment and treatment-related services to individuals with substance use disorders. The funds may also be used for prevention and intervention services.

- **Appropriation 70-964 (federal funds) (1) SPF-PFS & (2) CABHI (explained below)**

This appropriation was created to track encumbrances and expenditures against limited term federal contracts and grants, as well as federally-funded special projects. The federal Strategic Prevention Framework Partnerships for Success (SPF-PFS) grant is designed to address two of the nation's top substance abuse prevention priorities: 1) underage drinking among persons aged 12 to 20 and 2) prescription drug misuse and abuse among persons aged 12 to 25.

The federal Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant provide an accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services; permanent supportive housing; peer supports; peer navigators; and other critical services to persons who experience chronic homelessness with substance use disorders or co-occurring substance use and mental disorders.

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- **Appropriation 70-965 (federal funds)**

The Access to Recovery Initiative was a pilot program designed to promote implementation of a voucher program for substance abuse clinical treatment and recovery support services. It was available only in FY 2013-2014.

#### **Role of the Single County Authorities (SCA)**

Since the inception of the Governor's Council of Drug and Alcohol Abuse in 1972, the belief has been that the needs of local communities cannot be best determined at the state level. Therefore, the state has contracted with and funded SCAs to administratively plan and fund drug and alcohol prevention, intervention, treatment and treatment-related services in their communities. SCAs serve as administrative entities for a service area that includes one or more counties. Currently there are 47 SCAs serving the 67 counties in the commonwealth.<sup>65</sup>

It is the SCAs' responsibility to determine the needs of their service area and then provide needed services to individuals with addictions or contract with providers to deliver the appropriate services.<sup>66</sup> The services must cover all possible needs, from prevention to treatment aftercare. DDAP requires SCAs to implement care coordination services to ensure that patients receive proper placement within the service spectrum. SCAs are responsible for conducting needs assessments and then creating strategic plans that address identified needs.<sup>67</sup>

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<sup>65</sup>Commonwealth of Pennsylvania, Department of Drug and Alcohol Programs Uniform Application Federal Fiscal Year 2016, Substance Abuse Prevention and Treatment Block Grant Application and Report, page 19.

<sup>66</sup> Ibid.

<sup>67</sup> Ibid.

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**Finding 1 – DDAP cannot measure the effectiveness of opioid-related drug treatment initiatives. Instead, it monitors drug treatment providers for compliance with regulatory standards.**

#### Measuring Effectiveness

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The problems related to measuring the effectiveness of opioid-related drug treatment initiatives are discussed in *Section One – Opioid-Related Environment*. In summary, it is nearly impossible for the Department of Drug and Alcohol programs (DDAP) to measure effectiveness when methods to determine effectiveness have not been developed due to the many variables impacting on what constitutes “effective” treatment. These variables include:

- The varying definitions of “effectiveness.”
- The fact that no specific drug treatment is the “right” treatment.
- Tracking effectiveness among drug treatment participants is very difficult.

Going forward, developing methods to measure effectiveness of opioid-related drug treatment initiatives is imperative in order to monitor drug treatment effectiveness.

#### Monitoring Effectiveness

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While DDAP does not measure the effectiveness of opioid-related drug treatment initiatives, it does monitor drug treatment providers for compliance with regulatory standards. In this capacity, DDAP licenses providers and conducts annual licensing inspections to ensure the facilities are meeting state standards. Consequently, through the licensing process, DDAP is able to monitor providers, but only to the extent that those providers are meeting state regulations, not in terms of measuring the effectiveness of treatment provided. DDAP posts licensing information to its website, but it does not do so in a way that allows the public to identify “quality” treatment providers (i.e., those that are meeting state regulatory standards) easily.

Separate from licensing, DDAP contracts with Single County Authorities (SCAs), that in turn contract with drug treatment providers to supply services ranging from case management to long-term residential treatment for people with opioid addictions. DDAP monitors SCAs, who in turn monitor the service providers with whom they contract, but again, only for compliance with regulatory and contract requirements, not to measure the effectiveness of opioid treatment.

DDAP also has significant understaffing issues in divisions that perform compliance monitoring. These issues are further discussed in *Finding Two*. The two divisions primarily involved in monitoring are as follows:

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#### 1. Division of Program Licensure /Inspections

DDAP licenses drug and alcohol treatment providers in Pennsylvania.<sup>68</sup> Providers submit the required application and supporting documentation to DDAP for review. Staff from the Division of Program Licensure review application materials, and when the application is complete, a DDAP license is issued to the provider. Licenses expire one year from the date of issuance. Staff from DDAP's Division of Program Licensure also inspect the operation and administration of all licensed providers.

DDAP inspections follow a standard checklist and evaluate the extent to which the provider complies with state regulations. DDAP staff conduct inspections on an annual basis and in response to complaints as necessary. None of DDAP's inspections are related to the ability of the provider to provide "effective" substance abuse treatment.

#### 2. County Program Oversight/Single County Authority Monitoring

DDAP's "Treatment Manual" provides SCAs and service providers with information to assist in implementing the necessary requirements for the provision of drug and alcohol treatment, treatment-related services, and case-management services.<sup>69</sup> The County Program Oversight Section monitors for compliance with the grant agreement between the SCAs and DDAP, which includes DDAP's Treatment Manual. "Service providers" are the organizations contracted by SCAs to provide drug and alcohol addiction treatment, screening, assessment, care coordination, and case management services to the population within each SCA's respective geographic area. SCAs typically do not provide treatment services, except in more rural counties where it is difficult to find treatment providers to perform certain services, such as inpatient treatment.

The Treatment Manual describes staffing, training, record keeping, and reporting requirements, as well as treatment priority populations and resources and information that must be available to SCA/provider clients. Monitoring is conducted annually through a combination of desk reviews of materials submitted to the DDAP Project Officer and on-site visits. DDAP staff complete both a programmatic and administrative review of SCAs including reviews of fiscal compliance and expenditure appropriateness. DDAP staff also look at case management functionality in the assessment and management of clients and adherence to confidentiality requirements. However, DDAP does not monitor the effectiveness of treatment services.

With respect to SCAs, these organizations monitor the providers with whom they contract for services. SCA monitoring involves a compliance check with both the

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<sup>68</sup> 28 Pa. Code § 709.3 . <<http://www.pacode.com/secure/data/028/chapter709/subchapAtoc.html>>, (accessed May 5, 2017).

<sup>69</sup> <<http://www.ddap.pa.gov/Manuals/Forms/AllItems.aspx>>, Department of Drug and Alcohol Programs Treatment Manual, July 1, 2015 – June 30, 2020, Revised January 2016, page 1.00.1 (accessed May 5, 2017).



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Treatment Manual and the provider contract, but beyond these reviews, the SCA does not monitor the effectiveness of provided treatment services.<sup>70</sup>

#### **Limited Information Available Regarding “Quality”**

While information related to effectiveness is not available, DDAP does provide limited information about quality from inspection results posted to DDAP’s website. In this context, “quality” would be the extent to which the provider meets (or did not meet) state regulations during its annual licensing inspection and/or during DDAP’s investigation of a complaint.

Once staff from the Program Licensure Division have completed their inspection, the results are listed on a standard DDAP form known as a “2567.” If a facility was cited for failure to comply with a state regulation(s), the 2567 includes information about the noted deficiency. Providers have 15 working days to submit a “Plan of Correction” for any deficiencies noted during the inspection.<sup>71</sup>

DDAP posts the results of inspections and complaint investigations on its website. Once the Plan of Correction is received and approved by DDAP, it may be accessed from [DDAP’s Home Page](#) under the [Drug & Alcohol Facility Inspection Results](#) link.<sup>72</sup> Under this link, one can search for providers by county or by facility. DDAP inspection reports are listed by date and include deficiencies and Plans of Correction.

DDAP does not rank cited deficiencies by severity. According to DDAP management, because citations are not one-size-fits-all, DDAP reviews each facility independently. Sometimes, a single violation is so egregious (e.g., jeopardizing client safety) that DDAP places a facility on a provisional license, and other times it is a combination of citations that causes the facility to be placed on a provisional license. As a result, DDAP management stated that it can be difficult to determine the pervasiveness and seriousness of the deficiency. Therefore, assigning measures of severity in an objective and consistent manner would be difficult.

By way of comparison, when the Department of Health (DOH) posts information to its web site about nursing home inspections, it includes a “severity designation” for each deficiency. DOH ranks deficiencies as follows: *minimal citation-no harm*; *minimal harm*; *actual harm*; or *serious harm*. These designations allow the viewer to make more informed decisions about the quality of services that are offered by the operator.

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<sup>70</sup> Commonwealth of Pennsylvania Department of Drug and Alcohol Uniform Application Federal Fiscal Year 2016, Substance Abuse Prevention and Treatment Block Grant Application and Report, page 106.

<sup>71</sup> 28 Pa. Code § 709.16b.<<http://www.pacode.com/secure/data/028/chapter709/subchapBtoc.html>> (accessed May 5, 2017).

<sup>72</sup> Although the information is posted to DDAP’s website that website is actually contained within the Department of Health’s information technology platform. Subsequently, the data presented to the public appears as if it is from the Department of Health.

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#### Recommendations for Finding 1

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We recommend that DDAP:

1. Work with the Department of Human Services, DOH, lawmakers, advocates, treatment participant representatives, and other relevant stakeholders to develop a method to measure the effectiveness of treatment over time, including time periods after participants have left treatment and re-entered the community.
2. Monitor the effectiveness of treatment programs on a regular and consistent basis using the newly developed method.
3. Develop a method to share information about the quality and effectiveness of treatment programs that is easy to access and is available to the public.
4. Consider developing a “severity designation” for licensing deficiencies it posts on its website.

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#### **Finding 2 – Chronic understaffing and underfunding at DDAP creates additional challenges in combating the opioid epidemic.**

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#### **Department of Drug and Alcohol Programs (DDAP) Understaffing**

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We found that chronic understaffing has restricted some business units within DDAP from being able to perform sufficiently. This understaffing creates challenges for DDAP and the Commonwealth as it battles the worsening opioid epidemic.

#### **Program Licensure Division**

For DDAP, the functions of the Division of Drug & Alcohol Program Licensure, such as performing annual licensing inspections, are specialized, labor-intensive, and time-consuming activities that require professional expertise. In addition, the division provides technical assistance to the treatment facilities as necessary. The inspection process involves pre-inspection submission of paperwork from the facilities (which is reviewed by Licensing Specialists), on-site staff interviews, review of personnel files, review of patient files, physical plant inspections, and completion of licensing paperwork. Depending on the size of the provider and its facilities, as well as the number of deficiencies found, an inspection may take a day or up to a month to complete.

Licensing specialists receive their schedules two to three months in advance and contact licensees to arrange visits. DDAP tries to schedule facilities for inspection three months prior to the expiration of the license, so that the provider has time to implement a plan of correction, if necessary. Prior to the expiration of the current license, DDAP notifies the provider of the date for the annual on-site inspection for renewal of the license.<sup>73</sup>

DDAP has been trying to fill four vacancies in the Program Licensure Division. DDAP staff stated that filling these positions is difficult for many reasons including, but not limited to, the following:

1. **Pay disparities.** Licensing Specialists require a bachelor's degree and are classified as a pay grade 7.<sup>74</sup> DDAP officials said that it takes about a year to train a new hire as a licensing specialist; however, once specialists are trained, they are then eligible to apply for licensing positions in other agencies (like the Department of Human Services or the Department of Health) where similar positions are classified as a pay grade 8. We were

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<sup>73</sup> 28 Pa. Code § 709.11 . <<http://www.pacode.com/secure/data/028/chapter709/chap709toc.html>> (accessed May 8, 2017).

<sup>74</sup> <[http://classweb.state.pa.us/Specs/38010.asp?JOB\\_CD=38010&PAY\\_SCL\\_GRP=07&PAY\\_SCL\\_TYP=ST&BG\\_UNIT=G4&JOB\\_TYP\\_SVC=C&EBA\\_LAST\\_UPDATE=3/21/1994&EBA\\_NO=592&EBA\\_ITEM\\_CD=17](http://classweb.state.pa.us/Specs/38010.asp?JOB_CD=38010&PAY_SCL_GRP=07&PAY_SCL_TYP=ST&BG_UNIT=G4&JOB_TYP_SVC=C&EBA_LAST_UPDATE=3/21/1994&EBA_NO=592&EBA_ITEM_CD=17)> (accessed May 8, 2017).

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informed that the Civil Service Commission audited the positioning for reclassification but denied moving the licensing classification to a pay grade 8.

- Promotion opportunities are rare.** Because DDAP is a small agency, there are few promotion opportunities. According to DDAP officials, there are only four supervisor positions, none of which has experienced much turnover. Further, a Licensing Specialist Supervisor is classified as pay grade 8, which as mentioned above, contributes to greater incentive to leave DDAP.

Without DDAP's licensing function adequately staffed, it will be unable to ensure that drug and alcohol treatment facilities meet the necessary regulatory standards. According to recent testimony by DDAP's Acting Secretary to the Senate Appropriation Committee, because of an increase in the capacity of drug and alcohol treatment programs (i.e., the number of programs), loss of staff, and the recruitment issues that they experience within the licensing division, DDAP is dangerously close to not being able to fulfill the responsibility to meet their annual licensing requirements.<sup>75</sup> At the time of the hearing, DDAP was using supervisors to complete required licensing activities, and according to the data we received, appear to be completing all monitoring activities on time.<sup>76</sup> DDAP management estimated that to support all licensing activities adequately, and projecting for the increase in the number of licensed facilities in the coming years; DDAP would require 22 licensing specialists, yet it only has 13 licensing specialists as of May 2017.

As of November 2016, there were 776 licensed drug and alcohol treatment facilities, and there were just 11 licensing specialist positions filled as of May 8, 2017.<sup>77</sup> Assuming that all 11 are fully trained, each person would have to complete 70 facility inspections per year within the annual timeframe.<sup>78</sup> This projection does not take into account that some facility inspections are done in groups and take weeks to complete or that new facilities continue to be added to address the ever-growing opioid crisis.

One ramification to the problem of chronic understaffing is that if DDAP fails to license facilities, insurers could deny insurance payments to those facilities. If this were to happen, those in treatment could be financially responsible for all uncovered treatments and/or, providers would be unable to provide services to treatment participants already in their care, placing recovery at risk.

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<sup>75</sup> Senate Appropriation Committee Hearing for the Pennsylvania 2017-2018 Budget, Health-Related Agencies, March 8, 2017, Acting-Secretary Jennifer Smith remarks at timestamp 3:03:10.

<sup>76</sup> We received data from DDAP that contained dates of all annual monitoring activities completed and when the licenses were due to expire for all facilities. Analysis completed on the data itself indicated that all reviews were completed on time. Although we did not verify the accuracy and completeness of the data, we believe the source to be reliable for the purposes of this audit.

<sup>77</sup> <[http://classweb.state.pa.us/payexp.asp?JOB\\_CD=38010](http://classweb.state.pa.us/payexp.asp?JOB_CD=38010)> (accessed May 8, 2017).

<sup>78</sup> We were informed that one additional licensing specialist may resign. If so, that would leave the licensing division with 10 trained licensing specialists, which increases the number that each specialists must complete to 78.

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#### County Program Oversight Section

As was discussed in Finding 1, the County Program Oversight Section monitors Single County Authorities (SCAs) for compliance with DDAP's Treatment Manual, but does not monitor for treatment effectiveness. According to our interviewees, before the County Program Oversight function was transferred to DDAP from the Department of Health, 12 staff performed the SCA compliance monitoring oversight activities. When the function transferred, only five positions—a section director and four project officers—moved to carry out the same amount of work. Only three Project Officer positions were filled at the time of our interview. Additionally, interviewees reported that they previously had a budget analyst that reviewed SCA budgets, expenditure reports, and budget revisions. This work is now performed by the Project Officers, who each manage 12-15 SCAs.

Interviews we had with DDAP staff indicated that they are not able to do more program oversight than what they currently do, and due to staff limitations, they have cut back on some monitoring activities. For example, in the past, if the SCA contracted with an agency to provide case management, during monitoring visits to the SCA, DDAP staff would visit the contracted provider. However, DDAP staff are unable to provide that service and must now rely on the SCA to monitor the provider. The result is that DDAP is relying on its own contract provider to deliver similar oversight of those entities' contracted providers. This condition is not ideal for DDAP having a stronger monitoring position with respect to drug treatment provider compliance.

The County Program Oversight staff would like to be able to perform quality and effectiveness monitoring beyond what is required for compliance. For instance, staff noted to us that they would like to visit SCAs on a regular basis and do thorough reviews of completed patient assessments to ensure that the assessments are completed correctly and that the individual is placed in the level of care that is reflected in the clinical paper work. DDAP staff cannot do this now due to inadequate staffing.

#### Treatment Division

The Treatment Division is staffed with a Division Director plus two staff members. Although the work demands are being met, the issue within this division is that staff are unable to do more to determine the effectiveness of programs, or to put additional needed programs in place. For instance, according to DDAP representatives, the Pennsylvania Latino population is underserved. Currently, Spanish-speaking individuals requiring treatment have no way to interact with SCAs to connect with treatment providers, putting this population at higher risk due to a language barrier and the DDAP staff shortage. DDAP has been working on a program to hire Spanish-speaking staff in locations with large Latino populations.

The Treatment Division is also trying to get a survey of detoxification facilities completed to determine capacity and need. These facilities are reportedly full six out of seven days per week,

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and publicly funded clients take longer to place. During interviews, we learned that one of the providers reported getting 200 calls per day from people seeking beds for detox patients. Effective detoxification includes not only the medical stabilization of the patient and the safe and humane withdrawal from drugs, including alcohol, but also entry into treatment. Successfully linking detoxification with substance abuse treatment reduces the “revolving door” phenomenon of repeated withdrawals, saves money in the medium and long run, and delivers the sound and humane level of care patients need.<sup>79</sup> Studies show that detoxification and its linkage to the appropriate levels of treatment lead to increased recovery and decreased use of detoxification and treatment services in the future.<sup>80</sup>

DDAP staff also noted that grant management duties are a pressing need. DDAP staff observed that they frequently identify grants for which the department would be eligible, but find themselves unable to make application because of time and duty constraints. Being unable to complete grant applications places the department and individuals in the Commonwealth needing treatment at a disadvantage. The issue is not that DDAP cannot free up staff in the short term to complete applications, the bigger issue is that they do not have enough staff to manage the grants once they receive the funding. When an organization receives a grant, there are grant requirements such as tracking, auditing, reporting, and specific conditions that must be met for each grant to be maintained. Grant management is a full time job for a staff member, and DDAP does not have a grant manager in its approved complement. Grants are a potential source of critically needed funding for DDAP that could also cover the required additional labor costs.

#### **Accountability and Program Improvement Division**

The Accountability and Program Improvement Division is staffed with one staff person plus a recently hired supervisor and is responsible for responding to all complaints that cannot be referred to the Program Licensure Division. At the time of the audit, due to division staffing shortages, division staff were tasked with reviewing complex complaints and those complaints that required immediate attention.

In addition, this division is responsible for the Methadone Death and Incident Review (MDAIR) activities. MDAIR is a group of legislative-mandated activities that include collecting data on methadone-related deaths and incidents and providing a brief description of each, and making sure that aggregate statistics are posted to DDAP’s website. The division is also responsible for preparing an annual report on MDAIR activities that is distributed to the Chairman and Minority Chairman of the Senate and House Judiciary Committees, the House Public Health and Welfare Committee, the House Human Services Committee.

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<sup>79</sup> Kertesz S G, Horton N J, Friedmann P D, Saitz R, Samet J H. “Slowing the revolving door: Stabilization programs reduce homeless persons' substance use after detoxification.” *Journal of Substance Abuse Treatment*. 2003; 24(3). Pages 197–207. <<https://www.deepdyve.com/lp/elsevier/slowing-the-revolving-door-stabilization-programs-reduce-homeless-BFOp0pLK0v>> (accessed May 29, 2017).

<sup>80</sup> <<https://www.ncbi.nlm.nih.gov/books/NBK64119/>> (accessed May 8, 2017).

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#### DDAP Funding

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When DDAP was created in 2010, the House Committee on Appropriations estimated that the cost of creating the new department would be \$2.1 million annually, and would include a staff increase of 22 positions. However, when the Department was officially transferred in July 2012, the department received just \$466,000 in state funds for General Government Operations and added three staff positions: the Secretary, the Deputy Secretary and an administrative secretary.<sup>81</sup>

In reviewing DDAP's state appropriations since 2012, the department has never been funded at the initial estimated \$2.1 million.<sup>82</sup> In fact, the closest the agency has ever come to \$2.1 million was in fiscal year 2015-16, when it received \$1,869,000; however, this amount included \$750,000 that had been previously targeted to the Department of Military and Veterans Affairs for treatment of veterans with post-traumatic stress disorder and substance use disorders. DDAP could not use the funds in that fiscal year due to the late passage of the budget, so the funds were appropriated again in FY2016-2017 and designated as funds for a non-recurring project. This money was placed in the General Government Operations line item but was designated for a specific program.

#### General Government Operations Appropriations Funding History

We spoke to DDAP staff about how the General Government Operations (GGO) appropriation is used. They explained that GGO is used mostly for department personnel and operating costs that are not covered by federal or targeted grant funding. As discussed in the DDAP introduction and background section of this report, the majority of DDAP's funding comes from federal sources. For instance, the federal Substance Abuse and Prevention Treatment Block Grant is used to fund 69 of its current 79 positions<sup>83</sup>, the Compulsive and Problem Gambling Treatment Fund, which are state funds, is used to fund three positions. However, as previously discussed, DDAP can only monitor for regulatory and contract compliance with these funds, and not additional measuring and monitoring of the effectiveness of drug treatment initiatives. The GGO appropriation is used to fund the seven remaining positions. Operating costs include expenses like professional membership dues and other expenses not directly related to specific programs. Personnel expenses are generally salary and benefits for staff not directly billable to a specific program.

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<sup>81</sup> <<http://publicsource.org/agency-battling-drug-crisis-has-big-job-little-state-money/>> (accessed April 9, 2017).

<sup>82</sup> These dollar amounts do not include the funding discussed in the table presented in the introduction and background.

<sup>83</sup> Approximately \$5.7 million of the federal Substance Abuse and Prevention Treatment Block Grant was expended for DDAP personnel costs during state fiscal year end June 30, 2016.

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#### **Additional funding needed to expand DDAP’s regulatory review of certain MAT-prescribing physicians.**

The opioid epidemic is placing unforeseen demands on the agency’s resources. One area where additional funding could benefit DDAP is for monitoring of physicians who are currently prescribing buprenorphine, a drug used in Medication-Assisted Treatment programs.<sup>84</sup> Buprenorphine has been used successfully to treat certain patients with an opioid use disorder; however, one potential downside to prescribing this drug is that—like any prescribed medication—the drug can be diverted, i.e., the drug is prescribed to a patient, but then the patient sells or trades the drug on the streets.<sup>85</sup>

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) tracks the number of physicians who are authorized to provide buprenorphine treatment for opioid dependency.<sup>86,87</sup> According to DDAP, 2,127 (1,109 published and 1,018 non-published) physicians in Pennsylvania are authorized to treat opioid dependency with buprenorphine.<sup>88</sup> The federal Drug Enforcement Agency also licenses these physicians to prescribe controlled substances. Monitoring these physicians and their prescription writing practices is important because of the high potential for diversion among their patients. One way to monitor these physicians would be through additional licensing of their treatment practices through DDAP.

We asked DDAP management whether adequate regulatory oversight was in place at the state level for physicians who are authorized to prescribe buprenorphine. DDAP management said that it could further license these doctors under its current regulatory authority, but it was not currently doing so. This licensing would enable DDAP to monitor these physicians’ treatment practices to ensure that these are legitimate facilities and not “pill mills.”<sup>89</sup> Additionally, coupled with the Department of Health’s (DOH) Prescription Drug Monitoring program, additional tools are available to help detect the possible illegal diversion of prescription drugs.<sup>90</sup>

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<sup>84</sup> Buprenorphine is sold as Subutex. When it is combined with naloxone (sold as Narcan), it is sold as Suboxone.

<sup>85</sup> One of the most troubling instances of this type of illegal trading occurred in November 2016, when a suspect allegedly traded five Suboxone pills for a handgun. That handgun was later involved in the execution-style killing of a Pennsylvania State Trooper. See Pennlive, “Stolen Gun Traded for Drugs Used to Kill Trooper Weaver,” January 3, 2017.

<sup>86</sup> SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

<sup>87</sup> <<https://www.samhsa.gov/about-us>> (accessed May 8, 2017).

<sup>88</sup> These numbers are from DDAP as of June 30, 2017.

<sup>89</sup> Pill mills are facilities that operate under questionable ethical standards. Typically these facilities prescribe pain medications on a cash-only basis and ask few questions of patients. Although they exist nationwide, most pill mills are located in Texas and Florida due to the states’ looser restrictions on prescription drug monitoring. See <https://www.addiction.com/a-z/pill-mills/> (accessed May 29, 2017).

<sup>90</sup> Under Act 191 of 2014 Pennsylvania created a prescription drug monitoring program that is designed to be used as a tool to increase the quality of patient care by giving prescribers and dispensers access to a patient’s controlled substance prescription medication history. This information is to aid medical professionals to potential dangers for purposes of making treatment determinations; and to aid regulatory and law enforcement agencies in the detection



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DDAP management explained that the decision to not enforce the licensing requirement was originally made by DOH, and it was continued when DDAP split from DOH in 2012. DDAP staff noted that the policy was decided well before the growth of buprenorphine prescribers as it exists today, and it is not within their purview to comment on a policy decision that was issued or decided in a prior administration while the department was a bureau within DOH. Going forward, DDAP staff stated they have recognized that more oversight may be necessary, especially since it has recently become clear to them that the federal government is relying on states to monitor some of these physicians.

Given that DDAP is already constrained by staffing and funding limitations, it is highly unlikely that DDAP would be able to add additional licensing and regulatory responsibilities with its existing resources. Nonetheless, the issue of buprenorphine prescribing physicians being under regulated in the Commonwealth is an issue worthy of additional scrutiny, as buprenorphine, while a helpful part of a treatment program, can also be abused. Some states are taking action on this issue. For example, West Virginia can impose up to a \$20,000 fine on prescribers who write fraudulent or excessive prescriptions for medication-assisted treatments.

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### Recommendations for Finding 2

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We recommend that DDAP:

1. Work with the Governor and the General Assembly to procure additional funding to be used to enhance the department's efforts in fighting the opioid epidemic.
2. Work with the State Civil Service Commission to reevaluate the job classification and pay grade status of DDAP's Licensing Specialist position. By creating a more competitive position, DDAP should then be able to attract and retain employees in its licensing areas.
3. Consider revising regulations that would allow for licensing renewal on a longer-term basis, such as every two or three years, depending on certain factors such as length of time in operation, length of time without citations, etc., or with shorter, interim licensing reporting requirements that could be followed up on randomly.
4. Within the next six months, begin discussions with the Department of Health to develop regulations that would ensure that Pennsylvania physicians who have been

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and prevention of fraud, drug abuse, and the criminal diversion of controlled substances. *See* <<http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/GeneralInfo.aspx#.WRTIHTD-4>> (accessed May 29, 2017).

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authorized to prescribe buprenorphine-related medications are treating patients with opioid addictions in a safe, well-controlled environment.

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**Finding 3 – The law creating DDAP did not specify that DDAP could collect licensing fees, nor has DDAP issued regulations that would institute a license fee on drug and alcohol treatment providers.**

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In 2010,<sup>91</sup> the Pennsylvania General Assembly provided for the establishment of a cabinet-level agency in the Administrative Code of 1929 (Code) under the jurisdiction of the governor called the Department of Drug and Alcohol Programs (DDAP).<sup>92</sup> The department, which is focused on alcohol and drug prevention, intervention, and treatment services, was fully operational by July 2012.

Article XXIII-A of the Code<sup>93</sup> lists all of the powers and duties of DDAP. Section 2301-A(9) of the Code<sup>94</sup> contains the department's authority to issue regulations necessary to carry out all of the provisions provided for in statute. One significant weakness with the statute and DDAP's regulations<sup>95</sup> is that DDAP is unable to impose fees to cover its costs related to licensing and inspecting drug and alcohol treatment providers.

According to DDAP staff, because the agency has no explicit statutory authority to impose a licensing fee, DDAP licenses are issued free of charge. As a result, DDAP is missing the opportunity of a potential revenue source to help fund one of its primary operations. Although much of DDAP's funding is obtained from federal sources, additional state revenue (obtained through a licensing fee) would greatly benefit DDAP. For example, additional staff could be hired to aid in licensing efforts, and/or DDAP could develop programming that could help in measuring and monitoring treatment effectiveness.

Our research of states with similar population and opioid crisis profiles shows that about half of those states charge licensing fees either on an individual practitioner or on a facility basis. As shown below, facility fees vary widely, from \$15 (Delaware) to \$5,000 (Nevada).

#### States That Charge Licensing Fees for Treatment Facilities/Providers

State	Example of annual fees charged	Entity to which fees apply	Additional Notes
Louisiana	\$300/\$300 Application/ Renewal fees	Practitioner	Fees charged: Application fee, Renewal of credential fee (every two years),

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<sup>91</sup> Act 50 of 2010.

<sup>92</sup> Such services were previously provided by the Department of Health.

<sup>93</sup> See Section 2301-A of the Code, 71 P.S. § 613.1.

<sup>94</sup> 71 P.S. § 613.1(9).

<sup>95</sup> 28 Pa. Code § 701.1 *et seq.*, effective October 18, 2014.

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			certification by reciprocity fee, late renewal fee, reinstatement fee. <sup>96</sup>
Maryland	\$700	Facility	Fees charged: Application and recertification fee for each site for programs providing Opioid Maintenance Therapy. Providers pay per site. <sup>97</sup>
Connecticut	\$190	Practitioner	Fee charged: licensure for individual practitioners. <sup>98</sup>
Michigan	\$500	Program/ Individual/ Facility	Fee charged: Any program/individual that offers services designed to prevent and/or treat substance abuse. <sup>99</sup>
Arizona	\$250/\$350/ \$175/\$100	Practitioner	Fees charged: Substance Abuse Technician License; Application Fee; Renewal Fee/Reduced fee for additional license; Late Fee. <sup>100,101</sup>
Missouri	\$30	Facility	Fees charged: Business Application for Missouri Controlled Substance Registration for Narcotic Treatment Program. <sup>102</sup>
Nevada	\$5,046/ \$2,523	Facility	Fee charged: License to operate a facility for treatment with narcotics – initial/renewal. <sup>103</sup>
Massachusetts	\$150/ \$300/ \$75	Practitioner Facility Facility	Fees charged: Application Fee for practitioner for each license application. Additional fees for each satellite office/medication unit <sup>104,105,106</sup>

<sup>96</sup> <[http://la-adra.org/images/Docs/GuidelinesPolicies/LAC\\_as\\_of\\_May\\_2014\\_revision.pdf](http://la-adra.org/images/Docs/GuidelinesPolicies/LAC_as_of_May_2014_revision.pdf)> (accessed May 9, 2017).

<sup>97</sup> <<http://health.maryland.gov/ohcq/SA/Pages/home.aspx>>, then <[Click here for the COMAR 10.63 application](#)>, click cancel when the dialog box appears to see the licensing application in a MS Word document. The second paragraph states “each program site requires a separate application.” (websites accessed May 9, 2017).

<sup>98</sup> <<http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389230>> (accessed May 10, 2017).

<sup>99</sup> <<http://www.michigan.gov/statelicenserearch/0,4671,7-180-24786-81658--,00.html>> (accessed May 10, 2017).

<sup>100</sup> <<http://www.azbbhe.us/pdfs/Applications/LSAT%20App%20110116%20FINAL%20FILLABLE.pdf>>, page 13 (accessed May 10, 2017).

<sup>101</sup> <<http://www.azbbhe.us/pdfs/Renewal%20application%20122916%20fillable.pdf>> (accessed May 10, 2017).

<sup>102</sup> <<http://health.mo.gov/safety/bnnd/pdf/580-3013.pdf>>, page 5 (accessed May 10, 2017).

<sup>103</sup> <<http://www.leg.state.nv.us/nac/nac-449.html#NAC449Sec01229>> (accessed May 10, 2017).

<sup>104</sup> <<http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/drug-control/mcsr/forms/practioner-registration/faq-of-practitioner-registration-information.html>> (accessed May 10, 2017).

<sup>105</sup> <<http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/app-clinics.pdf>> (accessed May 10, 2017).

<sup>106</sup> <<http://www.mass.gov/eohhs/docs/dph/regs/105cmr164.pdf>>, page 23 (accessed May 10, 2017).

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Tennessee	\$810 – 1 category/ \$1,620 – more than 4 categories Beds/ 2-3 - \$200/ 4-10 - \$280/ 11-15 - \$410/ 16-50 - \$810/ 50+ - \$1,220	Facility	Requires an application-processing fee based on the number of distinct, non-residential categories to be operated at each non-residential site; and on the total number of service recipient beds to be operated at each distinct, residential facility site. <sup>107,108</sup>
Oklahoma	\$140	Practitioner	Fees charged: Practitioner Certification. <sup>109</sup>
Delaware	\$15	Facility	Application processing fee per facility. <sup>110</sup>
Utah	\$900-\$1,400/ \$300-\$1,400	Facility	Fees charged: Facility initial fees (range varies depending on category of service) Facility renewal fees (range varies depending on category of service). <sup>111</sup>
Kentucky	\$155/\$80	Facility	Fees charged: Initial facility application fee/Facility renewal application fee. <sup>112</sup>

Source: Developed by Department of the Auditor General staff. This information is presented for background purposes only and is from the best available sources (each state's drug and alcohol licensing website).

Regardless of the amount of the licensure fee, it is clear that states with overdose death rates similar to Pennsylvania's rate have established a fee-based system.<sup>113</sup> The total amount of revenue generated from licensing fees could vary depending on the model utilized. In Pennsylvania, there are 776 licensed drug and alcohol facilities as of November 2016. In the simplest of models, an annual facility license fee of \$1,300 would generate approximately \$1 million per year for Pennsylvania. Additional funding is critical to allow DDAP to add staff and programming to monitor and measure the effectiveness of opioid-related drug treatment initiatives.

<sup>107</sup> <[https://www.tn.gov/assets/entities/behavioral-health/licensure/attachments/Licensure\\_INITIAL\\_APP\\_Web.pdf](https://www.tn.gov/assets/entities/behavioral-health/licensure/attachments/Licensure_INITIAL_APP_Web.pdf)>, page 5 (accessed May 10, 2017).

<sup>108</sup> <[http://www.tn.gov/assets/entities/behavioral-health/attachments/Licensure\\_Proceedures\\_Fee\\_Schedule.pdf](http://www.tn.gov/assets/entities/behavioral-health/attachments/Licensure_Proceedures_Fee_Schedule.pdf)>, page 3 (accessed May 10, 2017).

<sup>109</sup> <[http://www.okdrugcounselors.org/download.php/5/Form\\_201\\_App.pdf](http://www.okdrugcounselors.org/download.php/5/Form_201_App.pdf)> (accessed May 10, 2017).

<sup>110</sup> <<http://www.dhss.delaware.gov/dhss/dsamh/files/adstannew.pdf#search=substance%20abuse%20treatment%20licenses>>, page 5 (accessed May 10, 2017).

<sup>111</sup> <<http://hslic.utah.gov/docs/LicenseApplicationJan2017.pdf>> (accessed May 10, 2017).

<sup>112</sup> <<http://www.lrc.ky.gov/kar/908/001/370.htm>> (accessed May 10, 2017).

<sup>113</sup> Regarding other states' comparative opioid death profiles, we used information obtained from the U.S. Centers for Disease Control and Prevention, Overdose Deaths.

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#### Fines for regulatory violations

Similarly, DDAP is unable to levy fines for licensing regulation violations. Having the ability to levy fines against providers who commit egregious licensing violations would provide a disincentive to those providers to establish practices that put citizens at risk and give DDAP another tool to encourage providers to comply with regulations more quickly, thus ensuring the safety of patients.<sup>114</sup>

Another area where DDAP could collect fines is with respect to operators who do not have a license. We reviewed available data from selected states and found examples of fees for failure to obtain an applicable operating license (see exhibit that follows). Currently, DDAP issues a “cease and desist” order to operators it identifies who lack proper licensing from DDAP. They then work with their legal department to obtain relief if efforts to either license the operator or get their agreement to cease operations fail. However, the ability to levy a fine would provide additional pressure for operators to ensure they are properly licensed.

In a related matter, although Pennsylvania has opted at this time to not enforce the regulations that would require office-based buprenorphine-prescribing physicians to be licensed through DDAP (see Finding 2), having the ability to levy fines against these physicians found abusing prescribing privileges would provide a disincentive to those providers to establish practices that put citizens at risk. Similarly, having an ability to financially penalize these operators for failure to comply with DDAP’s licensing requirement may impart a greater incentive for compliance.

As shown in the exhibit that follows, a number of states do allow for a penalty/fine structure for those entities that fail to comply with their state’s respective regulations. These fines may apply to the entity or the practitioner within the facility.

#### States That Charge Licensing Penalties

State	Example of penalties charged	Entities	Additional Notes
New Jersey	Civil penalty – \$25/day – first occurrence <sup>115</sup>  \$50/day – any subsequent	Facility	The New Jersey Administrative Code §10:161B-2.14(a)(1) authorizes Department of Human Services, Division of Mental Health & Addiction Services to impose the enforcement remedy of a civil monetary penalty against unlicensed substance use disorder treatment centers. <sup>117</sup>

<sup>114</sup> While DDAP does not have an ability to fine licensees, it can place them on a provisional license status. Under current practice, DDAP management places egregious violators on a provisional license status. We were informed by DDAP that this is an infrequent occurrence. In fact, only four provisional licenses have ever been issued. See [28 Pa. Code § 709.13](#), <<http://www.pacode.com/secure/data/028/chapter709/s709.13.html>>, (accessed May 17, 2017).

<sup>115</sup> <<http://www.lexisnexis.com/hottopics/njcode/layout.htm>>, The New Jersey Administrative Code §10:161B-2.17(a)(1) (accessed May 9, 2017).

<sup>117</sup> Ibid. The New Jersey Administrative Code §10:161B-2.14(a)(1).

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	occurrence from date of initiation of services <sup>116</sup>		
New York	Criminal penalty – If the Commissioner has reason to believe an actor <sup>118</sup> knowingly fails to comply with applicable provisions of the New York Hygiene Law, that actor shall be guilty of a misdemeanor. <sup>119</sup>	Facility or Practitioner	In New York, the Commissioner of Alcoholism & Substance Abuse Services issues operating certificates to facilities that offer non-residential and/or residential treatment for persons suffering from chemical abuse or dependence. Any facility/entity holding itself out to the public in a manner which indicates, directly or indirectly, the availability of treatment, programs, or services for persons suffering from chemical abuse or dependence that knowingly fails to comply with the provisions of §32.05 of the New York Hygiene Law [providing services without the required operating certificate] shall be guilty of a misdemeanor as defined in the penal law. <sup>120</sup>
Maryland	Civil penalty, not more than \$1000 for each offense	Person responsible for facility	§19-2504 – Title 19 (a) Prohibition – a person may not advertise, represent, or imply to the public that recovery residence is a certified recovery residence unless the recovery residence has obtained a certificate of compliance under this subtitle; (b) Civil penalty (1) a person who violated subsection (a) of this section is subject to a civil penalty imposed by the Department of Health and Mental Hygiene ( <b>DHMH</b> ) not to exceed \$1,000 for each offense; (2) in setting the amount of the civil penalty under paragraph (1) of this subsection, <b>DHMH</b> shall consider the nature, number, and seriousness of the violations, the ability of the certified recovery residence to pay the penalty, and any other factors <b>DHMH</b> determines are relevant. <sup>121</sup>
Delaware	Criminal penalty – Class A misdemeanor for	Facility	Title 16 – Chapter 22 – §2209 <sup>122</sup> , – Violation of licensing requirement; injunction - Any organization that maintains, manages or operates, or aids or abets another in maintaining, managing

<sup>116</sup> Ibid.

<sup>118</sup> Individual, partnership, association, corporation, limited liability company/partnership, public or private, or any part thereof.

<sup>119</sup> <[https://www.lawserver.com/law/state/new-york/ny-laws/ny\\_mental\\_hygiene\\_law\\_32-05](https://www.lawserver.com/law/state/new-york/ny-laws/ny_mental_hygiene_law_32-05)> (accessed May 9, 2017).

<sup>120</sup> Ibid.

<sup>121</sup> <<https://www.lexisnexis.com/hottopics/mdcode/layout.htm>>, Annotated Code of Maryland, Health – General, Title 19. Health Care Facilities – Subtitle 25. Recovery Residences §19-2502, §19-2504 (accessed May 9, 2017).

<sup>122</sup> <<http://www.delcode.delaware.gov/title16/c022/index.shtml>>, Delaware Code, Title 16, §2209 (accessed May 9, 2017).

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	<p>knowingly maintaining, managing operating or abetting in operating without a license</p> <p>Civil penalty –</p> <p>State can be awarded costs of prosecution including reasonable amount for attorney’s fees</p>		<p>or operating, a facility knowingly without a valid license or outside of a facility’s proper designation is guilty of a class A misdemeanor and subject to the penalties as set out in Chapter 42 of Title 11.<sup>123</sup></p>
West Virginia	<p>Civil penalty – Not to exceed \$10,000 if programs director misrepresents actions taken to correct a violation</p> <p>Concurrently operating a licensed and unlicensed MAT program – fine not to exceed \$5,000 per day.</p> <p>Failing to apply for new license upon change in ownership of a licensed MAT program – fine not to exceed \$5,000 per day.</p> <p>Physician who operate, own or manage unlicensed or unregistered MAT</p>	Facility or Practitioner	<p>For MAT programs...Any person, partnership, association or corporation which establishes, conducts, manages or operates a medication-assisted treatment program without first obtaining a license or registration as herein provided, or who violates any provisions of this article or any rule lawfully promulgated pursuant to this article, shall be assessed a civil penalty by the secretary in accordance with this subsection. Each day of continuing violation after conviction shall be considered a separate violation<sup>125</sup></p>

<sup>123</sup> <<http://delcode.delaware.gov/title11/c042>>. Title 11 – Criminal & Criminal Procedure – Criminal Procedure Generally – Chapter 42. Classification of Offenses; Sentences – §4202 Classification of misdemeanors (a) Misdemeanors are classified for the purpose of sentence into 2 categories (1) Class A misdemeanors; and (2) Class B misdemeanors (accessed May 9, 2017).

<sup>125</sup> Ibid.



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	programs, not more than \$20,000. <sup>124</sup>		
California	Civil penalty – \$200 per day from the date the facility received notice that they were operating in violation of licensing law/operating without a license. <sup>126</sup>		Except for facilities operated by a State agency, no person, firm, partnership, association, corporation, county, city, public agency or other governmental entity shall hold out, advertise, or represent by any means that it is operating, establishing, managing, conducting, or maintaining a facility which provides 24-hour nonmedical, residential, alcoholism or drug abuse recovery or treatment services to adults without first obtaining a current, valid license from the Department. <sup>127</sup>

Source: Developed by Department of the Auditor General staff. This information is presented for background purposes only and is from the best available sources (review of respective state's regulations).

In summary, if DDAP had a means to charge fees licensing fees as well as a means to issue fines/penalties for violators as is done in many other states, it would provide an incentive for provider compliance and provide an additional revenue stream that DDAP could use to further battle the Commonwealth's opioid epidemic.

### Recommendations for Finding 3

We recommend that DDAP:

1. Work closely with the General Assembly to pass legislation allowing for a licensing fee schedule for drug and alcohol treatment providers.
2. Work closely with the General Assembly to pass legislation allowing for a penalty fee schedule for providers who do not comply with DDAP regulations.

<sup>124</sup> <[http://www.legis.state.wv.us/Bill\\_Text\\_HTML/2016\\_SESSIONS/RS/bills/SB454%20SUB%20ENR.pdf](http://www.legis.state.wv.us/Bill_Text_HTML/2016_SESSIONS/RS/bills/SB454%20SUB%20ENR.pdf)>, page 28 (accessed May 9, 2017).

<sup>126</sup> <[https://govt.westlaw.com/calregs/Document/I41DC94D0D45411DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/I41DC94D0D45411DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))>, Barclays Official California Code of Regulations, Title 9, Division 4. Department of Alcohol and Drug Programs, Chapter 5. Licensure of Residential Alcoholism or Drug Abuse Recovery or Treatment Facilities, Subchapter 2. Licensing Process, Article 6. Enforcement (accessed May 9, 2017).

<sup>127</sup> <[https://govt.westlaw.com/calregs/Document/I38125340D45411DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/I38125340D45411DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))> (accessed May 9, 2017).

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3. Use the additional funds collected from licensing fees and penalties to develop and increase DDAP's ability to effectively monitor and measure opioid-related drug treatments.

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## DHS Introduction and Background

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### Introduction

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As discussed in *Appendix A – Objectives, Scope, and Methodology*, our audit had one objective—to determine the extent to which the Department of Drug and Alcohol Programs (DDAP), the Department of Human Services, and the Department of Corrections measure and monitor the effectiveness of opioid treatment programs in Pennsylvania. This section of the report discusses our findings and conclusions specific to the Department of Human Services (DHS).

We conducted our work under authority of Sections 402 and 403 of The Fiscal Code<sup>128</sup> and in accordance with applicable *Government Auditing Standards* issued by the Comptroller General of the United States.<sup>129</sup>

In the sections that follow, we provide additional background information about DHS and its role in creating newly established Centers of Excellence to help curtail the opioid epidemic. This information provides a context for our audit findings and conclusions.

### DHS Background Information

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#### Centers of Excellence Statutory History

On July 13, 2016, Governor Wolf signed a bill<sup>130</sup> to supplement and complete the state’s fiscal year (FY) 2016-17 budget. The bill allocated \$20.4 million in new funding for the Department of Human Services (DHS) to expand opioid treatment services. DHS was to use the funding to establish twenty Opioid Use Disorder<sup>131</sup> Centers of Excellence (COE) to coordinate and integrate behavioral and physical health services, similar to the patient-centered medical home model.<sup>132</sup>

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<sup>128</sup> 72 P.S. §§ 402-403.

<sup>129</sup> *Government Auditing Standards*, December 2011 revision, issued by the Comptroller General of the United States, United States Government Accountability Office, Washington D.C.

<sup>130</sup> House Bill 1198, latest Printer No. 3731, as reported from the Committee of the Conference, amending the Tax Reform Code of 1971, now Act 84 of 2016, 2015-2016 legislative session.

<sup>131</sup> <<http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf>> (accessed May 3, 2017). Also see Appendix B for information about OUD.

<sup>132</sup> <<http://www.aafp.org/practice-management/transformation/pcmh.html>> (accessed April 5, 2017).

According to the American Academy of Family Physicians, the patient-centered medical home model seeks to improve the quality, effectiveness, and efficiency of the care they deliver while responding to each patient’s unique needs and preferences. They do this through a physician-led practice with a whole-person orientation providing integrated and coordinated care with a focus on quality and safety. These practices commit to enhancing patients’ access to care.

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According to a DHS COE executive team member interviewed for an article on the COE, the goal of the COEs is to connect people with addictions to treatment and, most importantly, surround them with a team of people to help them stay in recovery long term. The COE executive team member further explained that the COE teams will further guide patients to treatment for any medical and mental health issues that are contributing to their addiction and steer patients to organizations that can assist with housing and employment. In addition, he claims that the COEs will increase access to certain medications used to combat opioid addiction,<sup>133</sup> also known as Opioid Use Disorder (OUD).

The \$20.4 million allocated in the FY 2016-2017 budget included \$10 million in behavioral health funding and \$5 million in medical assistance funding for a total of \$15 million of state funding. In addition, this funding would allow DHS to draw down \$5.4 million in federal funding for an overall total of \$20.4 million for the COEs.<sup>134</sup>

On October 1, 2016, twenty COEs were launched using the \$10 million in behavioral health funding with the expectation of treating 4,500 people.<sup>135</sup> After working with actuaries to analyze the impact of adding medication-assisted treatment to Medicaid managed care rates and subsequently negotiating 2017 rates with managed care organizations, DHS determined that they could implement 25 additional COEs with the \$5 million in state Medicaid funds and \$5.4 million in federal funds. The additional COEs are expected to serve at least 5,600 additional individuals.<sup>136</sup> The additional 25 COEs were implemented on January 1, 2017.

#### **Centers of Excellence Purpose and Structure**

Through the establishment of COEs, DHS intends to get Pennsylvanians struggling with opioid addiction into treatment to address not only their substance use disorder, but also the underlying physical and behavioral health issues that are at the root of their addiction. COEs will treat the entire person through team-based treatment, with the explicit goal of integrating behavioral health and primary care and, when appropriate, evidence-based medication-assisted treatment. As shown in the figure, below DHS will use a “hub and spoke” model of treatment, using the COE as the hub.

Each selected COE was required to be a Medicaid service provider and either a DDAP-licensed drug and alcohol treatment provider or a physical health provider that could offer Medication

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<sup>133</sup> <[http://www.pennlive.com/news/2016/12/heroin\\_painkillers\\_centers\\_pen.html](http://www.pennlive.com/news/2016/12/heroin_painkillers_centers_pen.html)>, posted on December 20, 2016 (accessed April 5, 2017).

<sup>134</sup> <<https://www.governor.pa.gov/to-fight-opioid-epidemic-wolf-administration-implements-25-additional-centers-of-excellence-locations/>>, posted on August 29, 2016 (accessed April 5, 2017).

<sup>135</sup> <<http://www.post-gazette.com/news/state/2016/07/19/Gov-Wolf-visits-Center-for-Excellence-opioid-treatment-facility/stories/201607190048>>, posted on July 19, 2016 (accessed May 3, 2017).

<sup>136</sup> <<https://www.governor.pa.gov/to-fight-opioid-epidemic-wolf-administration-implements-25-additional-centers-of-excellence-locations/>>, posted on August 29, 2016 (accessed April 5, 2017).

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Assisted Treatment (MAT)<sup>137</sup> or other treatment services.<sup>138</sup> The COE operates within the existing provider and can treat patients using host provider services, if the patient assessment reflects those needs. If not, the COE staff use the relationships that have been established within the community (which are the spokes in the model) to perform “warm hand-offs”<sup>139</sup> to the appropriate service providers.

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<sup>137</sup> According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Medication-assisted treatment (MAT) is the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose. There are currently three FDA-approved MAT medications for treatment of opioid dependency: methadone, buprenorphine and naltrexone. <<https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat>> (accessed May 29, 2017).

<sup>138</sup> <<https://www.haponline.org/Newsroom/News/ID/1651/DHS-to-Fund-50-Centers-to-Fight-Opioid-Abuse-Seeks-Applications>>, posted on April 11, 2016 (accessed May 1, 2017).

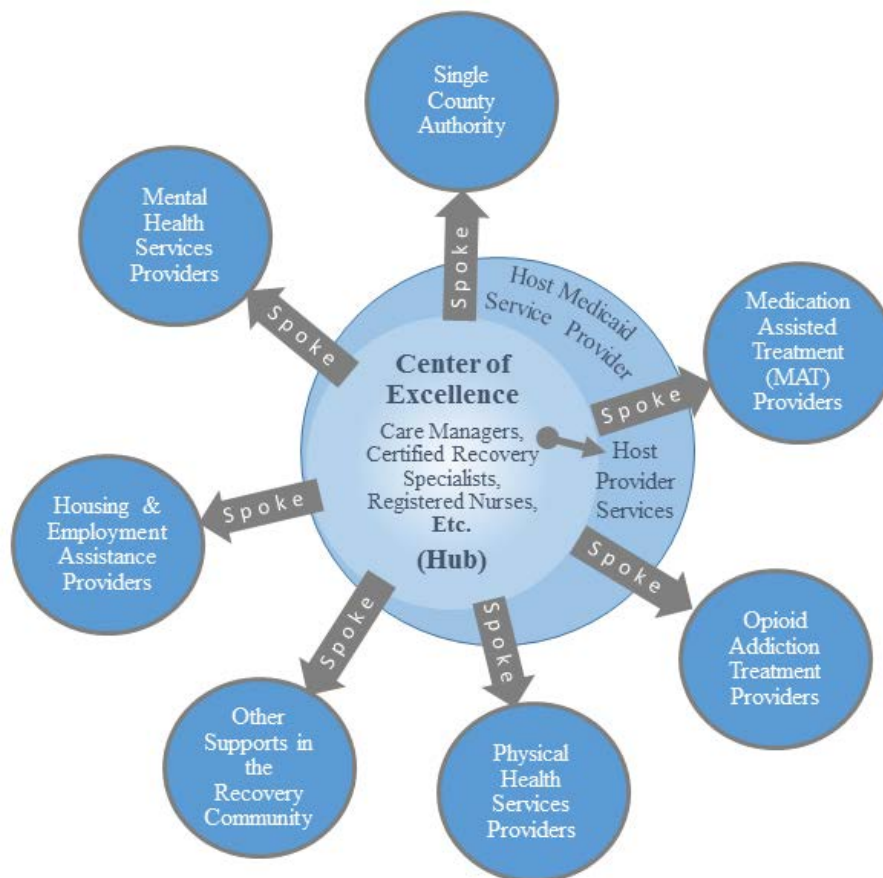
<sup>139</sup> A “warm hand-off” is a process where the patient is personally introduced to a contact at the service provider to which they are being referred. The referring contact provides information about the patient, with the patient’s consent, so that the new service provider can speak with the patient knowledgeable about their case and their needs. The intervention is based on the belief that, if the patient has a connection to someone at the new provider, they will already be engaged with the provider and be more likely to attend their appointments.

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#### COE Hub and Spoke Model



*Source: Developed by Department of the Auditor General staff from information obtained from the Department of Human Services website.*

According to DHS staff, the COEs provide care management services and establishes relationships with treatment providers and providers of other types of supports, such as employment and housing assistance services. The goal of the COEs is to address individual treatment and non-treatment needs to help individuals remain engaged in treatment and progress throughout the recovery process.<sup>140</sup> We observed that a key difference between COEs and most treatment programs is that the COE care manager can track outcomes over time because they remain in steady contact with the person outside of the treatment environment, whereas most treatment programs do not. COEs have a set of recovery outcome measures, the results of which

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<sup>140</sup> Opioid Use Disorder-Centers of Excellence, Centers of Excellence Requirements, A.1.a.i., December 28, 2016, page 2.

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will be collected for every individual every six months. In addition, COEs have a set of encounter metrics in place to measure program use and effectiveness that will be collected on a monthly basis.

#### **DHS Administration of Centers of Excellence**

DHS has been tasked with implementing COEs, including soliciting bids, awarding contracts, and monitoring the program's outcomes and effectiveness.

Organizationally, COE administration falls under several different business units within DHS:

- The Special Assistant for Centers of Excellence, who has overall responsibility for operations, reports directly to the Secretary of DHS.
- An interoffice work group that manages the overall COE program policy decisions at a high level includes the:
  - Secretary's Office
  - Office of Mental Health and Substance Abuse Services (OMHSAS)
  - Office of Medical Assistance Programs (OMAP)
  - DHS Office of Chief Counsel
  - DHS Policy and Budget

OMHSAS and OMAP allocate the funding for COEs through their respective HealthChoices Medicaid Managed Care contracts to Medicaid enrolled behavioral health or physical health providers. In addition, OMHSAS also allocates funding to Single County Authorities for contracts with the behavioral health providers that contract as COEs. From a data analysis and reporting perspective, data analysts within OMHSAS and OMAP will be analyzing the data collected from spreadsheets that have been developed to measure both quantitative program usage and timeliness metrics as well as qualitative quality-of-life metrics.<sup>141</sup> They will be reviewing the data to ensure its integrity and to ensure providers are meeting the requirements of the Centers of Excellence. They will also analyze claims data. Program leadership will ultimately use data to determine whether improvements were made in getting people into treatment, keeping them engaged in the treatment continuum for greater lengths of time, providing integrated mental and physical health care and expanding access to medication assisted treatment. Analysts will aggregate the data and prepare an analysis and report for the Secretary, who will use the data to measure the program's success. DHS intends to release results in some public form after they have collected a sufficient amount of data.

COEs differ from Single County Authorities (see the DDAP section of this report) that are associated with DDAP. According to DHS, although COEs are intended to address the opioid addiction crisis, they are organizationally located in DHS rather than DDAP because, despite the similarities, COEs are intended to treat behavioral and physical health aspects of the individual

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<sup>141</sup> These metrics are discussed in more detail in the Finding 1.

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whereas the DDAP focus is on behavioral health. The table below shows the difference between these entities.

Entity	Single County Authority (SCA)	Center of Excellence (COE)
<b>Agency</b>	DDAP	DHS
<b>Program Description</b>	SCA determines eligibility for service funding, assesses need for treatment or other services, and makes referrals to appropriate programs to match treatment and/or service needs. SCAs provide referrals to SCA-contracted service providers, including Medication-Assisted Treatment (MAT) providers. SCAs do refer to physical health providers for conditions requiring medical treatment or oversight as necessary, such as pregnancy or diabetes, etc., but their focus is on addiction treatment services.	Rather than treating only the addiction, DHS COEs treat the entire person through team-based treatment, with the explicit goal of integrating behavioral health and physical health primary care and, when appropriate, providing evidence-based medication-assisted treatment. The COEs are a mix of behavioral and physical health providers, ensuring access to all levels of care and FDA-approved medication assisted treatment.
<b>Funding for Treatment</b>	Pennsylvania's Medical Assistance Program, either through a managed care organization or the traditional fee-for-service system, pays for many of these services for eligible individuals. People who use services, but are not on Medical Assistance and are without access to other insurance, are assessed for their ability to pay for services by the SCA and may receive money from the SCA. Those needing further assistance may be referred to a local County Assistance Office (CAO) or the local Social Security Administration (SSA) Office.	State funds and federal Medicaid matching funds
<b>Customers</b>	PA citizens requiring addiction treatment	Medicaid-eligible PA citizens requiring addiction treatment*
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Assessment</li> <li>2. Case Management</li> <li>3. Referral to Treatment</li> <li>4. Warm Handoff</li> <li>5. Provide Treatment in some rural locations</li> </ol>	<ol style="list-style-type: none"> <li>1. Assessment</li> <li>2. Care Coordination</li> <li>3. Certified Recovery Specialists</li> <li>4. Referrals to treatment</li> <li>5. Warm Handoff</li> <li>6. Treatment, when appropriate**</li> </ol>
<b>State role</b>	Oversight Monitoring Data Collection and Evaluation Technical Support Funding	Oversight Monitoring Data Collection and Evaluation Technical Support Funding

\* At this time, COEs serve primarily people who are Medicaid eligible. If an individual is not already on Medicaid, the care manager works with the appropriate resource to enroll the individual in Medicaid or identify other funding streams to pay for treatment.

\*\*Funding does not pay for treatment, only for staff and basic program infrastructure, but every COE is housed inside an existing treatment provider that can treat with Medicaid dollars when the individual patient assessment indicates that treatment for the level of care available from that provider is required.

Source: Developed by Department of the Auditor General staff from information provided by the Department of Drug and Alcohol Programs and the Department of Human Services.



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While COEs and SCAs are situated in two different cabinet-level departments (DHS and DDAP respectively), COEs are required to convene and facilitate recurring meetings with key stakeholders, including SCAs, behavioral and physical health managed care organizations, treatment providers (that are not already designated as COEs), hospitals and health systems, and other appropriate treatment referral/access sources in its county to review the following:

- Review existing OUD-related services.<sup>142</sup>
- Identify opportunities to collaborate and bridge treatment and recovery support gaps.
- Develop strategies to implement a cooperative network of behavioral and physical health services for recipients of COE support services in collaboration with behavioral and physical health managed care organizations.<sup>143</sup>

COEs are also required to participate in a learning network that will include OUD treatment operational implementation and complex case-based learning.<sup>144</sup> These requirements are especially important as Commonwealth agencies move forward with implementation of many varied, but interrelated, efforts to address the opioid epidemic to avoid duplication of effort, share information about successful treatments, share new and promising methodologies, and identify new threats to people with opioid addictions in the community.

#### **Center Of Excellence Locations**

In March of 2016, Governor Wolf announced that he had included \$34 million in his proposed 2016-17 budget to combat the opioid crisis. This funding was designated for the creation of Centers of Excellence, for individuals with Substance Use Disorder (SUD).<sup>145</sup> On April 11, 2016, DHS posted the COE application to its DHS website. DHS also publicized the application through a press release and sent out an announcement to a DHS email list consisting of DHS stakeholders, including providers, who had indicated interest in receiving announcements and other information from DHS.<sup>146</sup> Any organization who expressed interest received a cover letter outlining the pertinent dates and an application.<sup>147</sup> Applications were due May 6, 2016. An

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<sup>142</sup> See Appendix B for information about OUD.

<sup>143</sup> Opioid Use Disorder-Centers of Excellence, Centers of Excellence Requirements, A.1.a.i., December 28, 2016, page 4.

<sup>144</sup> Ibid.

<sup>145</sup> <[http://www.media.pa.gov/Pages/DHS\\_details.aspx?newsid=194](http://www.media.pa.gov/Pages/DHS_details.aspx?newsid=194)>, posted on March 10, 2016 (accessed May 3, 2017). According to DHS, because the intent was to treat people with opioid-related Substance-Use Disorders, and there was a specific DSM-5 diagnosis for OUD, the term was changed to reflect the more precise intent of the COEs.

<sup>146</sup> DHS created a number of email update services for people interested in receiving information from the department. These services enable the department to relay important information to subscribers in a fast, efficient manner. To be added to a list, individuals can access the DHS website and request to be added to a list to receive updates related to specific topics.

<sup>147</sup> <[http://dhs.pa.gov/cs/groups/webcontent/documents/document/c\\_225592.pdf](http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_225592.pdf)> (accessed May 1, 2017).

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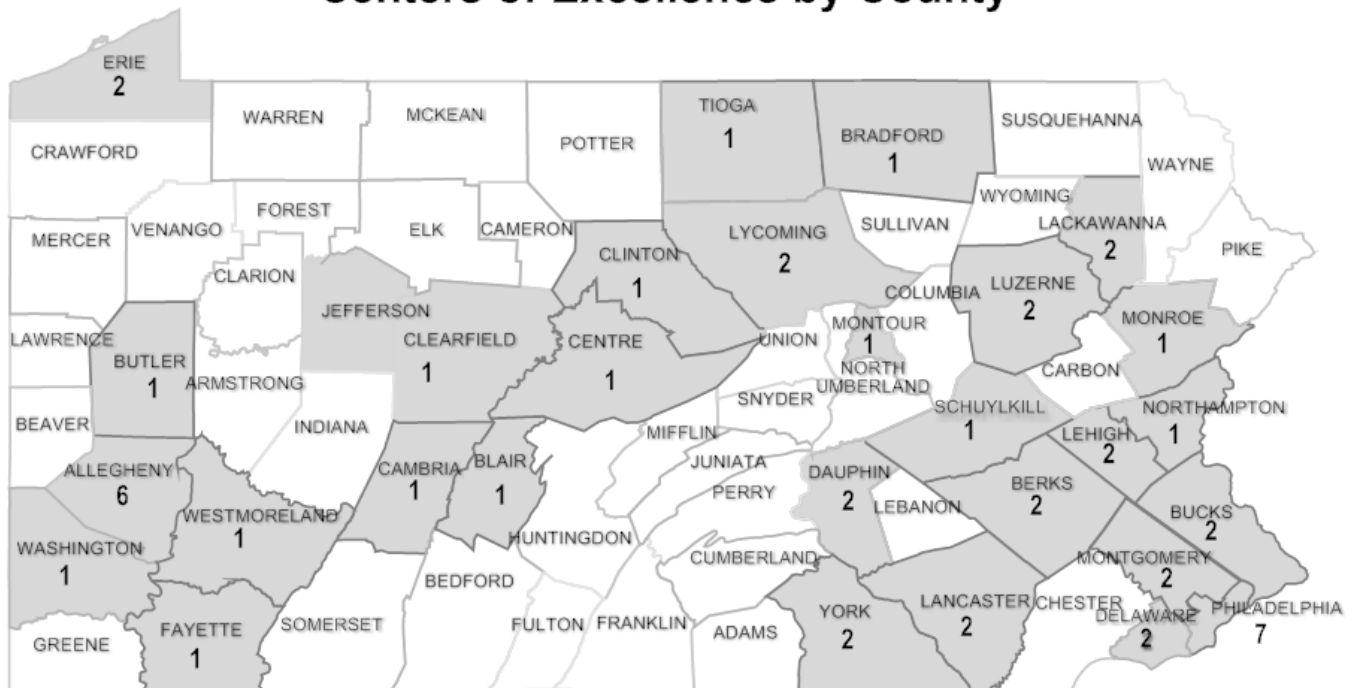
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initial selection of candidates was completed by May 20, 2016, based on the strength of the application in addition to input from the counties, behavioral health Managed Care Organizations, and physical health Managed Care Organizations.

The DHS selection team chose the finalists and submitted them for approval by the DHS Secretary on June 24, 2016. Selections were made from applications received from 116 organizations statewide. According to the DHS selection team, organizations were chosen based on the needs of the area that they would serve. Other factors included the following: the population, the opioid overdose death rate, the number of available treatment providers, the capability of the organization to meet the need, stakeholder input, and status of the applying organizations as Medicaid providers.

The map and table below show the number of COEs distributed by county. Although 45 COE organizations were selected, there are 51 COE locations because some COEs have more than one location.

### Centers of Excellence by County



Source: Developed by Department of the Auditor General staff from information obtained from the DHS website.

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#### Center of Excellence Providers<sup>148</sup>

	Name	County
1	AIDS Care Group/ Sharon Hill Medical	Delaware
2	Alliance Medical Services	Cambria
3	Butler Memorial Hospital	Butler
4	CASA of Livingston County Inc./Trinity	Bradford
5	Clearfield-Jefferson Drug and Alcohol Commission	Clearfield/Jefferson
6	Clinical Outcomes Group Inc.	Schuylkill
7	Community Health & Dental Care Inc.	Montgomery
8	Crossroads Counseling Inc.	Centre
	Crossroads Counseling Inc.	Clinton
	Crossroads Counseling Inc.	Lycoming
	Crossroads Counseling Inc.	Tioga
9	Crozer-Chester Medical Center - Community Hospital	Delaware
10	Esper Treatment Center	Erie
11	Family First Health Corporation	York
12	Family Service Association of Bucks County	Bucks
13	Gateway Rehabilitation Center	Allegheny
14	Geisinger Clinic / GIM Danville	Montour
15	Habit OPCO Dunmore Comprehensive Treatment Center	Lackawanna
16	Hamilton Health Center	Dauphin
17	Highlands Hospital	Fayette
18	Lancaster General Hospital	Lancaster
19	Magee-Womens Hospital of UPMC	Allegheny
20	Maternal Addiction Treatment, Education and Research (MATER)	Philadelphia
21	Mon Valley Community Health Services Inc.	Westmoreland
22	Mt. Pocono Medical	Monroe
23	Narcotic Addiction Rehab Program of Thomas Jefferson University	Philadelphia
24	Neighborhood Health Centers of the Lehigh Valley	Lehigh/Northampton
25	New Directions Treatment Services	Berks
26	Pathways to Housing PA	Philadelphia
27	Penn Foundation Inc.	Bucks
28	Penn Presbyterian Medical Center	Philadelphia
29	Pennsylvania Care LLC DBA Miners Medical	Luzerne
30	Pennsylvania Counseling Services - Allison Hill	Dauphin

<sup>148</sup> <<http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence/index.htm>> (accessed April 5, 2017).

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	Pennsylvania Counseling Services - York Psychiatric	York
31	Public Health Management Corporation	Philadelphia
32	Pyramid Healthcare Inc.	Blair
33	Reading Hospital and Health System (RH and RHS)	Berks
34	Resources for Human Development Inc./Montgomery Cty Methadone Ctr	Montgomery
35	Tadiso Incorporated	Allegheny
36	Temple University - Of The Commonwealth System of Higher Education	Philadelphia
37	The CARE Center Inc.	Washington
38	The Wright Center Medical Group	Lackawanna
39	Total Wellness Center LLC. Clean Slate	Erie
	Total Wellness Center LLC. Clean Slate	Luzerne
	Total Wellness Center LLC. Clean Slate	Lycoming
40	Treatment Trends Inc.	Lehigh
41	TW Ponessa & Associates Counseling Services Inc.	Lancaster
42	University of Pittsburgh Physicians: General Internal Medicine Clinic - Oakland	Allegheny
43	Wedge Medical Center	Philadelphia
44	West Penn Allegheny Health System	Allegheny
45	WPIC of UPMCPS	Allegheny

*Source: Developed by Department of the Auditor General staff from information obtained from the DHS website.*

#### **Who is employed by a Center Of Excellence and what do they do?**

Within each COE, a Community-Based Care Management (CBCM) team will consist of licensed and unlicensed professionals such as licensed nurses, licensed social workers, certified recovery specialists, and other professionals to provide recovery-focused care and supports.<sup>149</sup> Each COE is located within a treatment provider that can provide opioid addiction treatment services to patients whose level of care assessments indicate the need for one of its services. However, the Center's purpose is to provide the patient links to treatment and treatment programs as well as non-treatment supports that will create an individualized community of care by making the resources available that will give him or her the best chance at getting treatment and staying in recovery. To that end, the inclusion of the certified recovery specialist in a COE is a key element in the approach to managing the opioid crisis. Recovery specialists use their personal experiences with addiction to support others in recovery from a substance use disorder.<sup>150</sup> They serve as role models, mentors, advocates, and motivators to recovering individuals in order to help prevent relapse and promote long-term recovery, and by demonstrating that recovery is

<sup>149</sup> Opioid Use Disorder-Centers of Excellence, Center of Excellence Requirements, Section A.1.a.ii., December 28, 2016, page 2.

<sup>150</sup> <<https://www.overdosefreepa.pitt.edu/pa-dhs-centers-of-excellence/>> (accessed April 7, 2017).

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possible.<sup>151</sup> This service is expected to reduce relapse and result in less lost recovery time when relapses do occur.

The care management team is focused on initiation of appropriate treatment and supports the individual in continued treatment. Initiation is defined as a face-to-face level of care evaluation in which the care manager uses a standard statewide evaluation questionnaire to determine what particular services the individual requires and at what intensity.

Engagement in this context is defined as at least one face-to-face contact within 30 days of the face-to-face level of care evaluation. Further engagement is defined as a face-to-face activity at least once every 30 days up to day 365, i.e., 12 encounters in a year.

The care management team works within their local community to accept warm hand-offs of individuals with OUD from local emergency departments, state and county corrections facilities, and from primary care providers. It will also work with inpatient and outpatient residential drug and alcohol providers to assure individuals living with OUD transition from that level of care to the COE for ongoing engagement in treatment. The CBCM team will motivate and encourage individuals with OUD to stay engaged in both physical health and mental health treatments. Team members will facilitate recovery by helping individuals find stable housing and employment and helping them reestablish family/community relationships.<sup>152</sup>

By engaging the individual in the community and with their families, using a hands-on approach with a CRS and maintaining contact over time, it is hoped that more people can enter into treatment and stay in recovery from OUD.

#### **What funding does each Center Of Excellence receive and how is it used?**

Each COE was designated to receive an allocation of \$500,000 in two installments. The initial installment of \$330,000 was distributed to begin operations based on when their agreements were signed, and the second of \$170,000 will be distributed after six months of operation, contingent on the COE establishing the case management team and delivering services and supports and tracking and reporting outcomes to DHS as specified in the agreements each COE signed.<sup>153</sup> None of the second payments have yet been made. Progress will be assessed, including review of expenditures report, at the end of the fiscal year to determine whether COEs will receive the second payment of \$170,000.

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<sup>151</sup> <<http://www.councilsepa.org/assets/Documents/Admin/Certified-Recovery-Specialist-montco.pdf>> (accessed April 7, 2017).

<sup>152</sup> <[http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c\\_227004.pdf](http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_227004.pdf)> (accessed May 3, 2017).

<sup>153</sup> Opioid Use Disorder-Centers of Excellence, Centers of Excellence Requirements, A.1.a.i., December 28, 2016, page 1.

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Funding is used as follows:

1. Salary and benefits of the care management staff, manager or supervisor of the care management team as well as other employees<sup>154</sup> of the COE, i.e., data entry, reporting, etc.
2. Up to \$25,000 for minor computer equipment and software purchases and mobile devices (or reimbursement for use of personal devices).
3. Travel-related costs (e.g., reimbursement for mileage for the CBCM team).
4. \$15,000 for expenses related to participation in the Learning Community.<sup>155</sup>
5. Up to \$15,000 for operating expenses, which may include expenses for rent, utilities, taxes, insurance, supplies, printing/copying and telephone.<sup>156</sup>

Funding may not be used for any of the following items:

1. Treatment services and other client-related support services that are covered under the Medical Assistance program (i.e., services included on the Medical Assistance programs Fee Schedule or covered under a contract or an agreement between the provider and a physical or behavioral health managed care organization, as well as services that are covered under the individual's private insurance), given that the CBCM team's activities must not overlap or be redundant of already existing reimbursed care management services.
2. Vehicles.
3. Computer system purchases including electronic health record software.
4. Brick and mortar or other capital costs or fixed assets (e.g., new building, renovations).<sup>157</sup>

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<sup>154</sup> If the manager, supervisor, or other staff are not full time, pro-rata portions of salary and benefits commensurate with the amount of time devoted to the COE are allowable expenses.

<sup>155</sup> A learning community is defined as a group of like-minded people with a durable and ongoing commitment to cooperation and information sharing to achieve their individual goals. Pennsylvania's learning community is The Learning Network - a formal statewide and regional learning community that will be facilitated by third parties outside of DHS.

<sup>156</sup> Opioid Use Disorder-Centers of Excellence, Centers of Excellence Requirements, A.1.a.i., December 28, 2016, page 5.

<sup>157</sup> Ibid., page 6.

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#### **Finding 1 – Centers of Excellence (COE) infrastructure for collecting information on outcomes is in place, but there are no apparent plans for DHS to ensure accuracy of the data used to monitor COE’s effectiveness.**

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As discussed in the introduction and background section, the Department of Human Services (DHS) has created a network of Centers of Excellence (COE) as a means to assist those addicted to opioids with obtaining treatment and staying in recovery. Through increased access to treatment for those struggling with Opioid Use Disorder (OUD), ideally Pennsylvania will be able to help address its opioid epidemic<sup>158</sup>.

DHS’ goal with COEs is to ensure that those with an OUD receive treatment for the underlying physical and behavioral health issues that are at the root of their addiction. Rather than just treating the addiction, COEs will treat the entire person through a team-based treatment, with the explicit goal of integrating behavioral health and primary care and, when appropriate, using evidence-based medication-assisted treatment.<sup>159</sup>

Because COEs are a new initiative to combat the opioid epidemic, it will be imperative for DHS to evaluate and monitor the program’s ongoing effectiveness from its inception. Without proper program measurement, DHS will be unable to determine if the COEs are having a meaningful impact on the opioid epidemic. To this point, DHS has established sets of both quantitative and qualitative program measures to evaluate COE performance. With regard to quantitative measures, the metrics DHS intends to use are as follow:

#### **Quantitative Metrics Reflecting COE Quality**

1. Percentage of individuals who receive an initial contact within one business day of referral
2. Number of individuals newly admitted into Substance Use Disorder<sup>160</sup> treatment
  - a. Average number of days between the Date of Initial Contact with the COE and the Level of Care Evaluation
  - b. Average number of days from the Date of the Level of Care Evaluation and the Date of Treatment Admission

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<sup>158</sup> <[http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c\\_230391.pdf](http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_230391.pdf)> (accessed May 5, 2017).

<sup>159</sup> <<https://www.governor.pa.gov/to-fight-opioid-epidemic-wolf-administration-implements-25-additional-centers-of-excellence-locations/>>, posted August 29, 2016 (accessed May 5, 2017).

<sup>160</sup> <<https://www.samhsa.gov/disorders/substance-use>>, posted October 27, 2016 (accessed May 5, 2017). The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to Substance Use Disorders (SUD), which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. The most common SUDs are Opioid Use Disorder (OUD), Alcohol Use Disorder (AUD), Tobacco Use Disorder, Cannabis Use Disorder, Stimulant Use Disorder, and Hallucinogen Use Disorder.

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3. Number of individuals engaged in treatment per month<sup>161</sup>
  - a. Number of individuals engaged in month 1
  - b. Number of individuals engaged in month 2
  - c. Number of individuals engaged in month 3
  - d. Number of individuals engaged in month 4
  - e. Number of individuals engaged in month 5
  - f. Number of individuals engaged in month 6
  - g. Number of individuals engaged in month 7
  - h. Number of individuals engaged in month 8
  - i. Number of individuals engaged in month 9
  - j. Number of individuals engaged in month 10
  - k. Number of individuals engaged in month 11
  - l. Number of individuals engaged in month 12
  
4. Individuals referred and treated for mental health conditions
  - a. Percentage of individuals treated and referred for mental health conditions
  - b. Number of individuals with a mental health treatment
  - c. Number of individuals referred for a mental health condition
  
5. Individuals referred and treated for drug and alcohol (D & A) counseling
  - a. Percentage of individuals treated and referred for D & A counseling
  - b. Number of individuals receiving D & A counseling
  - c. Number of referrals to D & A counseling
  
6. Individuals referred and treated for pain management
  - a. Percentage of individuals referred for comprehensive pain management treatment
  - b. Number of individuals treated for pain management
  - c. Number of individuals referred for pain management treatment

#### Care Manager Metrics

7. Average case load number
8. Number of inactive status members

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<sup>161</sup> DHS management intends to measure how many people stay engaged with treatment and for how long. This metric will be determined by tracking the frequency of face-to-face treatment engagements with a licensed professional/facility in 30-day intervals. Using aggregate data, DHS will be able to determine over time if there is a treatment engagement length at which time the patient is more vulnerable/more likely to leave treatment (e.g., their first month, second month, third month, etc.). DHS management will then be able to adjust the program accordingly.



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#### COE Client Opioid Use Metrics

9. Aggregate number of individuals testing positive for benzodiazepines
10. Aggregate number of individuals testing positive for illicit opioids

With respect to qualitative measures, which are focused on the patient's quality of life, DHS will require COEs to use an "Outcomes Tool" questionnaire to measure aspects of the patient's quality of life and movement toward recovery. The questionnaire will be administered to each individual within 30 days of the initial COE treatment admission date and re-administered face-to-face every six months. Patients will rate their experiences along a scale in response to the following statements:

- I deal more effectively with daily problems.
- I feel better about myself.
- I am better able to control my life.
- I am better able to deal with crisis.
- I am getting along better with my family.
- I do better in social situations.
- I do better in school or work (if applicable).
- I do better with my leisure time (that is I get more out of leisure time).
- My housing situation has improved.
- My symptoms are not bothering me as much.
- I have become more independent.
- I have become more effective in getting what I need.
- I can deal better with people and situations that used to be a problem for me.
- I am better able to get physical health care.
- My employment situation has improved.

The questionnaire information will be collected for each participant in an electronic spreadsheet maintained by each COE, which is submitted monthly by the COE to DHS along with the quantitative data mentioned earlier.

The first COE submission of all data collected since Phase 1 implementation (October 1, 2016) was provided to DHS during the week of February 17, 2017 for all COEs. We asked to review the data; however, DHS officials indicated that the data they received was in the early stages of review and not yet finalized. Because it was only four months, and for some only one month of data, the data collected lacked sufficient outcomes data, which is only collected from participants at the six month mark. Consequently, because the timing of our audit occurred during the roll-out of the new COE process, we were unable to analyze the data to provide analysis for this audit.

Going forward, DHS data staff will extract the information and analyze it, which will allow DHS to track program effectiveness over time. However, through interviews of the DHS COE team,

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we found that although DHS has data evaluation tools and processes in place, the team had not considered including a step to verify the accuracy and completeness of the data by tracing the data back to source documents. As a result, no such step is included in the process at this time.

Reviewing the data for accuracy and completeness is a necessary step because without this assurance the results of the analysis may be flawed or misleading. Further, this step is especially important because the distribution of funds is to be contingent on the COE establishing the case management team, delivering services and supports, and tracking and reporting outcomes as specified in the DHS agreements signed by each provider chosen to be a COE.

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### **Recommendations for Finding 1**

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We recommend that DHS:

1. Develop a process to quarterly, or at least semi-annually, verify the accuracy and completeness of the data provided by the Centers of Excellence.
2. Going forward, regularly and adequately evaluate and monitor the effectiveness of COE performance, including ensuring that outcome metrics support an effective evaluation of the program.
3. Maintain frequent and open communications with all stakeholder groups to ensure coordination of all statewide efforts and initiatives addressing the opioid crisis.

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## DOC Introduction and Background

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### Introduction

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Our audit had one objective—to determine the extent to which the Department of Drug and Alcohol Programs, the Department of Human Services, and the Department of Corrections measure and monitor the effectiveness of opioid treatment programs in Pennsylvania; as discussed in more detail in *Appendix A – Objectives, Scope, and Methodology*. This section of the report discusses our findings and conclusions specific to the Department of Corrections (DOC).

We conducted our audit under the authority of Sections 402 and 403 of The Fiscal Code<sup>162</sup> and in accordance with applicable *Government Auditing Standards* issued by the Comptroller General of the United States.<sup>163</sup>

In the sections that follow, we provide additional background information about the Department of Corrections with the information providing a context for our audit findings and conclusions.

### DOC Background Information

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#### History

In 1790, the Pennsylvania General Assembly passed an act which added a penitentiary block to Philadelphia’s Walnut Street Jail, and birthed the “penitentiary concept.” Between 1790 and 1921, prisons were constructed throughout Pennsylvania, but there was no centralization or uniformity of administration, because prisons were operated independently and each controlled by its own board of trustees. This presented some difficulties when it came time to determine what state aid and appropriations the prisons should receive, so there were various attempts made to provide some common structure that ultimately did not succeed. In 1921, the legislature passed an act that created the Department of Public Welfare and centralized control of “State institutions”...“including all penal, reformatory and correctional institutions...” along with hospitals and other charitable institutions under one agency. There was no change to the nature of the control of the institutions themselves, which were still governed by boards of trustees.<sup>164</sup> In early 1953, following riots that occurred at prisons in Pittsburgh and Rockview, a special

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<sup>162</sup> 72 P.S. §§ 402, 403.

<sup>163</sup> *Government Auditing Standards*, December 2011 revision, issued by the Comptroller General of the United States, United States Government Accountability Office, Washington D.C.

<sup>164</sup> Barnes, Harry E, PhD, *The Evolution of Penology in Pennsylvania: A Study in American Social History*, The Bobbs-Merrill Company, Indianapolis, 1927, pages 194-200.

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committee was convened to investigate prison problems and to develop recommendations to improve the correctional system and reduce unrest.<sup>165</sup>

The special committee suggested the establishment of one agency whose sole purpose would be to manage the state prison system. To that end, Act 408 of 1953 created the Bureau of Corrections within the Pennsylvania Department of Justice.<sup>166</sup>

In 1980, constitutional changes resulted in an elected state attorney general, and the disbanding of the Justice Department. At that time, the Bureau of Corrections changed hands from the former Pennsylvania Department of Justice to the newly created Office of General Counsel to the Governor.<sup>167</sup>

Act 245 of 1984<sup>168</sup> created the modern day version of the Department of Corrections as a stand-alone, cabinet-level agency. Today, the department has a budget of approximately \$2.5 billion and oversees 25 state correctional institutions (SCI), 1 motivational boot camp, 14 community corrections centers, nearly 40 contract facilities, a training academy, approximately 15,000 employees and nearly 50,000 inmates.<sup>169</sup>

DOC's mission is to reduce criminal behavior by providing individualized treatment and education to offenders, resulting in successful community reintegration through accountability and positive change.<sup>170</sup>

#### **DOC Organizational Structure Related to Alcohol and Other Drug Abuse Treatment**

Although many bureaus within DOC may be involved with aiding individuals with substance abuse disorder, the bureaus most directly involved include the Bureau of Research, Planning, and Statistics, which reports directly to the Secretary, and the Bureau of Treatment Services, which reports to the Executive Deputy Secretary. These bureaus are discussed further below.

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<sup>165</sup> <<http://www.cor.pa.gov/About%20Us/Documents/Overview.pdf>> (accessed May 17, 2017).

<sup>166</sup> P.L. 1428, July 29, 1953, pages 1428-1429.

<sup>167</sup> <<http://www.cor.pa.gov/About%20Us/Documents/Overview.pdf>> (accessed May 17, 2017).

<sup>168</sup> 71 P.S. § 310-1. By way of further background, the pre-existing powers and duties of the Bureau of Corrections under Act 408 of 1953 were pursuant to Section 1 which added Section 911 to the Administrative Code of 1929. Act 245 of 1984 expressly repealed Section 911 and transferred all the powers and duties of the Bureau of Corrections to the Department of Corrections by adding Section 901-B to the Administrative Code of 1929, codified at 71 P.S. § 310-1. <<http://www.cor.pa.gov/About%20Us/Documents/Overview.pdf>> (accessed May 17, 2017).

<sup>169</sup> Ibid.

<sup>170</sup> <<http://www.cor.pa.gov/About%20Us/Pages/Mission-Statement.aspx#.WRSAmNnD ug>> (accessed May 11, 2017).

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#### *Bureau of Planning, Research and Statistics*

The Bureau of Planning, Research, and Statistics is responsible for directing the ongoing planning, research, statistics and grant activities of DOC. More specifically, the Bureau is responsible for:<sup>171</sup>

- Preparing various planning and research reports based on databases maintained by the Department of Corrections.
- Implementing standards, guidelines and procedures for state research and data analysis activities.
- Identifying and defining correctional planning and research problems.
- Preparing research models appropriate to the problem.
- Developing instrumentation and procedures for data measurement.
- Collecting and analyzing corrections-related data.
- Submitting recommendations for departmental research and evaluation priorities.

With respect to our audit objective, we focused on the activities undertaken by this bureau related to measuring and monitoring the effectiveness of the DOC treatment programs (and specifically opioid-related treatment programs). This office is also significant because it manages all aspects of research initiatives for the SCI system, from approvals to measurement and monitoring.

#### *Bureau of Treatment Services*

The Bureau of Treatment Services administers Alcohol and Other Drug (AOD) treatment programs (see section that follows). This bureau has two divisions which are responsible for directing, monitoring, and assisting SCIs in the assessment of needs and the delivery of treatment programs and other related services. The bureau director reports to the Executive Deputy Secretary, and the bureau provides services related to substance use disorders, inmate risk and needs assessments and diagnosis. Programs and services offered through the bureau include the following:

- Religion and family services
- Volunteers
- Casework and counseling services
- Alcohol and other drug treatment services
- Inmate classification and risk/needs assessment
- Diagnostic and classification process
- Pardons services
- Inmate Activities

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<sup>171</sup> <<http://www.cor.pa.gov/About%20Us/Statistics/Pages/default.aspx>> (accessed May 15, 2017).

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- Non-AOD Treatment Programs (e.g., Thinking for a Change, Violence Prevention, Batterer’s Intervention, Gender-specific programs)

Programs that address alcohol and other drug addiction, sex offenses, violence prevention, criminal thinking, domestic violence and victim awareness are standard in all institutions.<sup>172</sup> Drug and Alcohol Treatment Specialist Managers and Supervisors manage these services at each SCI.

#### **Background Information on DOC’s Substance Abuse Treatment**

According to DOC’s Bureau of Research, Planning, and Statistics, 64 percent of the individuals entering the correctional system are identified as having Substance Use Disorders (SUD).

With such a high percentage of individuals in the system with a SUD, DOC operates in-house substance abuse programs, called Alcohol and Other Disorders (AOD) treatment programs. These programs seek to help individuals with addictions learn to live without the substance(s) to which they are addicted. Through these programs, DOC hopes to assist individuals with the highest need for treatment and who pose the greatest risk for re-offending.<sup>173</sup>

DOC has adapted a structured substance abuse treatment model, known as the Pennsylvania Substance Abuse Treatment (PASAT) model. The PASAT model is based on the principles of effective correctional programming, and it incorporates elements of change theory, motivational enhancement theory, cognitive-behavioral therapy, and social learning theories. The overall objective of the PASAT model is to target reductions in AOD abuse, criminal behavior, anti-social attitudes, and recidivism<sup>174</sup> among the inmate population.<sup>175</sup>

#### ***Qualifying for Treatment***

As mentioned previously, DOC assesses individuals upon intake to the correctional system. Part of this process involves use of a “Risk Screen Tool” (RST)<sup>176</sup> to detect the individual’s propensity (or risk) to re-offend. Individuals also undergo the Texas Christian University (TCU) Drug Screen to indicate the severity of any identified substance abuse problems. Those who score moderate or high on the RST survey and the TCU drug screen are eligible to receive

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<sup>172</sup> <[http://www.cor.pa.gov/About%20Us/General%20Information/Pages/default.aspx#.WRnpvNnD\\_uj](http://www.cor.pa.gov/About%20Us/General%20Information/Pages/default.aspx#.WRnpvNnD_uj)> accessed May 17, 2017).

<sup>173</sup> <<http://www.cor.pa.gov/About%20Us/Documents/DOC%20Policies/07.04.01%20AOD%20Treatment%20Programs.pdf>>, page 1-1 (accessed May 18, 2017).

<sup>174</sup> A measurement of the rate at which offenders commit other crimes, either by arrest or conviction baselines, after being released from incarceration. <<http://legal-dictionary.thefreedictionary.com/Recidivism>> (accessed May 22, 2017).

<sup>175</sup> Ibid.

<sup>176</sup> Rex Hildebrand, “Risk Screen Tool (RST)”, memo, April 27, 2009, addressed to Superintendents.

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Outpatient Program and Therapeutic Community treatment services. Those who score low on the RST and TCU drug screen do not participate in AOD treatment programs during their incarceration, but can participate in various “self-help programs.” All AOD treatment is voluntary.

#### DOC Treatment Programs and Availability

The exhibit that follows includes information regarding the availability of AOD treatment programs by SCI. Further descriptive information regarding the specifics of the AOD treatment program follows the exhibit.

#### AOD Treatment Program Locations

	Type of AOD Program						
	Therapeutic Community	Co-Occurring Therapeutic Community	Hispanic Therapeutic Community	Outpatient	Co-Occurring Outpatient	State Intermediate Punishment- *Indicates overflow site <sup>177</sup>	Medication Assisted Treatment - Vivitrol®
<i>Program Length</i>	<i>4 Months</i>	<i>6 Months</i>	<i>4 Months</i>	<i>41 sessions</i>	<i>47 sessions</i>	<i>4 Months</i>	<i>1 Month<sup>178</sup></i>
<b>SCI</b>							
Albion		X		X	X		
Benner	X			X	X		
Cambridge Springs	X			X	X	*	X
Camp Hill	X			X	X		
Chester	X		X			*	X
Coal Center	X			X	X		
Dallas	X			X	X		X
Fayette	X			X	X		
Forest	X			X	X		
Frackville				X	X		
Graterford	X			X	X		X
Greene	X			X	X		

<sup>177</sup> The State Intermediate Program’s (SIP) primary location is the Quehanna Motivational Boot Camp. When program participation is high, therapeutic communities at SCI Chester, SCI Muncy and SCI Cambridge Springs are equipped to administer SIP so that no interruption of program services occur.

<sup>178</sup> Participants receive one injection before they re-enter the community and then they receive the remainder of the treatments under the supervision of community treatment providers.

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Houtzdale	X	X		X	X		X
Huntingdon	X			X	X		
Laurel Highlands	X			X	X		X
Mahanoy	X			X	X		X
Mercer	X			X	X		X
Muncy	X	X		X	X	*	X
Pine Grove	X			X	X		
Pittsburgh <sup>179</sup>							
Quehanna Motivational Boot Camp				X	X	X	X
Retreat		X		X	X		X
Rockview	X			X	X		
Smithfield	X			X	X		
Somerset	X			X	X		
Waymart	X			X	X		X
<b>TOTALS</b>	<b>21</b>	<b>4</b>	<b>1</b>	<b>24</b>	<b>24</b>	<b>1</b>	<b>12</b>

*Source: Developed by Department of the Auditor General staff from information provided by DOC staff.*

### Therapeutic Community

Therapeutic Communities (TC) are residential AOD treatment programs where an individual is housed in a separate unit in the facility. The TC model views addiction as a disorder of the whole person, reflecting problems in conduct, attitudes, values, moods, and emotional management. The primary therapeutic agent in the TC is the whole environment, best defined as “community-as-healer.” The process depends upon a solid structure that provides a surrogate family and community, with distinct values and morals. Key to the process is direct, honest and immediate feedback to the individual from the other people in the community in a way that provides social order.

To be eligible for a TC, an individual must be Moderate to High Risk for reoffending and have a TCU score of 6 to 9, which indicates a high level of severity. TC program duration is four months. It has three phases that include:

- Phase I – Orientation – Educational Therapy Groups and Introduction to Self-Help
- Phase II – Primary Treatment – Cognitive Based Therapy Groups: Problem Solving, Skill Building (including relapse prevention)

<sup>179</sup> All SCI Pittsburgh Therapeutic Communities were closed and beds and patients relocated to other facilities when DOC announced the closing of SCI Pittsburgh in January of 2017.



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- Phase III – Re-Entry – Aftercare groups, continued group therapy, reintegration into general population<sup>180</sup>

#### Co-Occurring Therapeutic Communities

Similar to TCs, Co-Occurring TCs are housed in separate units and have the same community-as-healer philosophy, but the eligibility for participation differs. To be eligible to participate in a Co-Occurring TC, the individual must have a mental health diagnosis in addition to a Moderate to High Risk for reoffending and have a TCU Score of 6 to 9. Co-Occurring TCs have six-month rather than four-month durations due to the additional co-occurring Disorders Program by Dartmouth University and Hazelden Publishing Company. This model includes trauma, gender responsiveness, living skills, etc.

#### Hispanic Therapeutic Community

The Hispanic TC is available only at SCI Chester. Only Hispanic Bi-Lingual and Spanish Speaking individuals are eligible to participate in this particular TC. In addition, as with the other TCs, individuals must be a Moderate to High Risk for reoffending and have a TCU Score of 6 to 9. The Hispanic TC program materials and language at SCI Chester are conducted entirely in Spanish.<sup>181</sup> SCI Chester is a medium-security prison dedicated to inmates with a documented substance abuse history and has four TCs in addition to the Hispanic TC.<sup>182</sup>

#### Outpatient Treatment Program

The Outpatient Treatment Program (OTP) is available in all facilities except SCI Chester. “Outpatient” in the prison setting means that individuals attend scheduled sessions during the day, but return to their cell in general population and to other regularly scheduled activities when not participating in AOD Outpatient programming. To qualify for OTP, one must be Moderate to High Risk for reoffending and have a TCU Score of 3 to 5, which indicates a moderate level of severity. OTP includes 1.5 hour group sessions three times a week for 41 sessions. These programs typically last about five months. Sessions include Cognitive Based Therapies (CBT) Addictions Concepts, CBT Relapse Prevention, Commitment to Change, and Introduction to Self Help Groups.

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<sup>180</sup> Department of Corrections, Alcohol and Other Drugs Treatment Programs, Policy DC-7.4.1, Issued December 19, 2005, Effective January 19, 2006, Section 6 – Treatment Techniques and Components, Attachment 6-A Therapeutic Community Programs Operations Manual, pages 1-10.

<sup>181</sup> <[http://www.cor.pa.gov/Facilities/StatePrisons/Pages/Chester.aspx#.WR9ECtnD\\_IU](http://www.cor.pa.gov/Facilities/StatePrisons/Pages/Chester.aspx#.WR9ECtnD_IU)> (accessed May 19, 2017).

<sup>182</sup> <[http://www.cor.pa.gov/Facilities/StatePrisons/Pages/Chester.aspx#.WSG9UtnD\\_IU](http://www.cor.pa.gov/Facilities/StatePrisons/Pages/Chester.aspx#.WSG9UtnD_IU)> (accessed May 21, 2017).

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#### Co-Occurring Outpatient Treatment Program

The Co-Occurring Outpatient Treatment Program is available in all facilities except SCI Chester. These programs are limited to those individuals who have a mental health diagnosis in addition to a Moderate to High Risk for reoffending and have a TCU Score of 3 to 5.

Co-Occurring Outpatient programming includes one-hour group sessions three times a week for 47 sessions. Sessions include Integrated Combined Therapy, Medication Management, CBT, and Family Education and Skills through the Dartmouth University Co-Occurring Disorders Program. These programs also last for about five months.

#### State Intermediate Punishment (SIP) Program

The SIP program<sup>183</sup> was created in response to concerns about the link between substance abuse and crime in that many persons commit crimes while under the influence of alcohol and/or other drugs. The SIP program was designed as a sentencing alternative, with the goal of enhancing public safety through a period of incarceration while at the same time reducing recidivism through intensive substance abuse treatment.<sup>184</sup> Act 112 of 2004, which created the SIP program, was signed into law on November 19, 2004 and became effective on May 18, 2005.<sup>185</sup> Act 122 of 2012<sup>186</sup> expanded and modified SIP eligibility requirements.<sup>187</sup>

The SIP program consists of four phases, lasts a total of 24 months, and is the only DOC Treatment Program that has monitoring and measurement required by statute.<sup>188</sup>

- Phase 1 involves confinement in a SCI for a period of no less than seven months. Currently, all male SIP participants are sent to either the Quehanna Boot Camp or SCI Chester and female SIP participants are sent to either the Quehanna Boot Camp or SCI Cambridge Springs for participation in the SIP program.
- Phase 2 involves a minimum of two months in a community-based TC treatment program.
- Phase 3 involves a minimum of six months of outpatient addiction treatment. During this period, the participant may be housed in a community corrections center or placed in an approved transitional residence.

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<sup>183</sup> 61 Pa.C.S. § 4101 *et seq.*

<sup>184</sup> 61 Pa.C.S. § 4105.

<sup>185</sup> Act 33 of 2009, effective October 13, 2009, codified the program provisions within Title 61 (Prisons and Parole).

<sup>186</sup> 61 Pa.C.S. § 4104.

<sup>187</sup> <[http://www.cor.pa.gov/Facilities/StatePrisons/Pages/Chester.aspx#.WSG9UtnD\\_IU](http://www.cor.pa.gov/Facilities/StatePrisons/Pages/Chester.aspx#.WSG9UtnD_IU)> (accessed May 21, 2017).

<sup>188</sup> In accordance with Act 112 of 2004 (now codified at 61 Pa.C.S. § 4107), which created the State Intermediate Punishment (SIP) Program, DOC is required to provide the Judiciary Committee of the Senate and the Judiciary Committee of the House of Representatives with an evaluation of the program by no later than February 1 in even-numbered years with the Pennsylvania Commission on Sentencing. *See* <<http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2004&sessInd=0&act=112>> (accessed May 21, 2017).

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- Phase 4 consists of a DOC supervised reintegration into the community for the balance of the 24 months of the program.<sup>189</sup>

#### Medication Assisted Treatment

DOC makes Medication Assisted Treatment (MAT) available to individuals re-entering their communities through its Vivitrol® program. Three medications have been approved by the FDA for treatment of opioid addiction (also known as Opioid Use Disorder – OUD): methadone, buprenorphine and naltrexone<sup>190</sup> (sold as Vivitrol®). Naltrexone is the only FDA approved medication for treatment of opioid addiction/OUD that is not a narcotic, and it is the only one that is long acting. DOC partnered with the manufacturer of Vivitrol® to pilot a MAT program so that re-entrants into communities could approach the challenges of reintegration without the added stress of facing cravings from fighting their addictions as well.

Vivitrol® requires an injection every 28 days, which blocks opiate receptors in the brain and reduces opioid drug cravings. DOC is aware that the use of MAT helps with cravings, and may therefore enable inmates to get greater benefit from their program participation (because they are not pre-occupied by those cravings), the Department is moving in the direction of MAT maintenance for the duration of one's incarceration.

The Vivitrol® Program was started with a Second Chance Act grant and was initiated at SCI Muncy, and then expanded to SCI Chester, SCI Mahanoy, SCI Pittsburgh and SCI Graterford. The initial grant was for 175 re-entrants to receive Vivitrol®.

Individuals wishing to take part in the Vivitrol® Program are identified by social workers who meet with re-entrants during Residential and Outpatient Treatment groups, Parole Committees, etc. at each participating facility.

Eligible individuals receive their first injection within one week before they are released and then receive up to 11 injections in the community. They must participate in some form of treatment in the community, with Outpatient Treatment services being the minimum level of services allowed.

To be eligible an individual:

- Must volunteer to participate.
- Can be low, moderate, or high risk.
- Must have an opiate or alcohol addiction.

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<sup>189</sup> <<http://www.cor.pa.gov/About%20Us/Statistics/Documents/Reports/2017%20SIP%20Annual%20Final.pdf>>, page 2 (accessed May 16, 2017).

<sup>190</sup> <<https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat>> (accessed May 18, 2017).

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- Must have 2-12 months until their minimum release date (Timeframe may be shorter as long as detoxification and medical testing requirements are met).
- Must have no liver failure, liver problems, or acute hepatitis.
- Must be released to a participating county.<sup>191</sup>

Re-entrants must undergo extensive medical testing and assessments to verify their eligibility, and they must review and sign acknowledgement and consent forms<sup>192</sup> to ensure that they understand the nature of the program and the medication. As stated previously, the re-entrant receives the first injection at the facility. The social worker at the SCI, who is critical to the enrollment and re-entry process, schedules the follow-up treatment appointment and the next injection to ensure continuity of care.

When in the community, the re-entrant meets with their Parole Officer and reviews the Vivitrol® Project. They take a battery of assessments through their community provider to make sure that they are receiving the necessary care and continue the injections through coordination with their medical and treatment providers.

DOC has been conducting an ongoing study of participants in pilot SCIs to determine the effectiveness of Vivitrol® in reducing recidivism and relapse in individuals re-entering communities after being incarcerated. However, after reviewing results of pilot participants indicating positive program results, the pilot has been discontinued and participants are no longer being enrolled (see Finding 2 for further discussion).

### **Other Types of AOD Treatment Programs**

Beyond the treatment programs offered above, DOC also offers other types of AOD treatment programs including self-help programs, a peer assistant program, and AOD recovery units.

#### ***Self Help Programs***

As mentioned previously, these programs are open to all inmates with substance abuse needs, regardless of risk level or program participation status. Self-Help Programs are offered at all facilities at least once a day. Either a peer assistant (a fellow inmate as explained further below) or a volunteer from the local recovery community leads the programs. The exhibit that follows discusses the programs offered. With the exception of “Gamblers Anonymous,” all of the self-help programs are available at each SCI.

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<sup>191</sup> Vivitrol® is not available in all counties, DOC has established mobile Vivitrol® units to be able to provide injections to individuals at their locations rather than individuals having to travel to the provider site. Re-entrants wishing to enroll in the Vivitrol® program can only be released to counties where a continuation of the injections is available.

<sup>192</sup> Individuals who want to participate in the Vivitrol® program must sign and date the Vivitrol® Information Acknowledgement Form and the Consent to Receive Vivitrol® forms.

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#### Other AOD Treatment Programs – Self Help Programs

Program	Focus
Alcoholics Anonymous (AA)	12-Step Program focused on alcoholism. “Alcoholics Anonymous is an international fellowship of men and women who have had a drinking problem. It is nonprofessional, self-supporting, multiracial, apolitical, and available almost everywhere. There are no age or education requirements. Membership is open to anyone who wants to do something about his or her drinking problem.” <a href="http://www.aa.org/">http://www.aa.org/</a>
Narcotics Anonymous (NA)	12-Step-based program for individuals with addictions. “Narcotics Anonymous offers recovery to addicts around the world. We focus on the disease of addiction rather than any particular drug. Our message is broad enough to attract addicts from any social class or nationality. When new members come to meetings, our sole interest is in their desire for freedom from active addiction and how we can be of help.” <a href="https://www.na.org/?ID=IsNAForMe-content">https://www.na.org/?ID=IsNAForMe-content</a>
Al-Anon	12-Step “support group for friends and families of problem drinkers.” <a href="http://al-anon.org/">http://al-anon.org/</a>
Double Trouble in Recovery (DTR)	12-Step Program for individuals with a mental health diagnosis in addition to substance abuse - “Double Trouble in Recovery (DTR) is a twelve-step fellowship of men and women who share their experience, strength, and hope with each other so that they may solve their common problems and help others to recover from their particular addiction(s) and mental disorder(s).” <a href="https://www.hazelden.org/HAZ_MEDIA/3818_doubletroubleinrecovery.pdf">https://www.hazelden.org/HAZ_MEDIA/3818_doubletroubleinrecovery.pdf</a>
Gamblers Anonymous (GA) (only 3 facilities at this time)	12-Step Program – “GAMBLERS ANONYMOUS is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from a gambling problem.” <a href="http://www.gamblersanonymous.org/ga/">http://www.gamblersanonymous.org/ga/</a>
SMART (Self-Management and Recovery Training) –	Non-spiritual approach to recovery that parallels the 12-Step approach – “SMART Recovery is the leading self-empowering addiction recovery support group. Our participants learn tools for addiction recovery based on the latest scientific research and participate in a world-wide community which includes free, self-empowering, science-based mutual help groups.” <a href="http://www.smartrecovery.org/">http://www.smartrecovery.org/</a>

Source: Developed by Department of the Auditor General staff from information obtained from Department of Corrections staff and websites of the listed self-help programs.

#### Peer Assistant Program

The Peer Assistant (PA) Program was launched in 2014. The purpose of the PA Program is to train a select number of individuals from the inmate population to serve as PAs to AOD-abusing inmates. This program equips the PA with skills to facilitate some of the group sessions and the Self-Help groups. The following are some of the criteria that qualify an individual to be a PA:

- Misconduct free for a minimum of one year.
- No misconducts for assaultive behavior in the last two years.
- Recommended by the management team on their housing unit.

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- Resident of the facility for at least three months.
- Understands Self-Help Groups.
- At least six months of regular Self-Help Group attendance.

If they are selected, they are trained and monitored by the Drug and Alcohol Treatment Specialist team.

#### *AOD Recovery Units*

AOD Recovery Units are a group of individuals housed together prior to, during, or after AOD treatment services on one unit based upon their documented need for AOD services including aftercare services. The primary responsibility of the Recovery Unit is to involve the residents in addressing addiction issues and the recovery process. The residents at the Recovery Unit are considered knowledgeable about recovery and self-help programs. Residents and staff reinforce pro-social values and coping skills and assist the residents in establishing goals for participation in the recovery and aftercare program. Self-help meetings occur at the Recovery Unit on a daily basis with the support of PAs. Recovery Unit activities focus on providing the information and treatment necessary for residents who are in need of intense treatment and TC participation. The Recovery Unit staff monitor daily AOD activities at the unit, and DATS provide technical assistance in running AOD programs at the unit including self-help meetings. This is a voluntary program focused on recovery-centered programs.<sup>193</sup>

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<sup>193</sup> Department of Corrections, Alcohol and Other Drugs Treatment Programs, Policy DC-7.4.1, Issued December 19, 2005, Effective January 19, 2006, page 64.

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**Finding 1 – Only one of seven DOC Alcohol and Other Drug (AOD) Treatment Programs is monitored for effectiveness and that monitoring is limited to recidivism.**

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#### **How does DOC monitor and measure the effectiveness of opioid-related drug treatment initiatives?**

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The Department of Correction’s (DOC) mission is to “reduce criminal behavior by providing individualized treatment and education to offenders, resulting in successful community reintegration through accountability and positive change.”<sup>194</sup> Stated differently, DOC’s primary concern is in rehabilitating the offender, so that he/she does not reenter the criminal justice system (i.e., does not commit additional crimes after release), also known as recidivism.

As discussed in the *Introduction and Background* section, the DOC offers a number of treatment programs to aid individuals in overcoming substance abuse disorders. DOC refers to these programs as Alcohol and Other Drug (AOD) treatment programs. With the exception of the Vivitrol program (discussed in Finding 2), AOD programs are not specific to any type of drug, but rather substance abuse in general.

Consistent with DOC’s mission, a key objective of any AOD program is to help the individual overcome his/her addiction; thus, increasing the likelihood that they will be able to live free from substance use once released. If an individual is able to overcome his/her addiction, by extension, it is expected that he/she will then be less likely to recidivate. This fact is an important distinction, because it impacts how DOC views effective treatment.

Accordingly, with respect to our audit objective and how DOC monitors and measures the effectiveness of opioid-related drug treatment initiatives, DOC’s focus is primarily on reducing recidivism rates and not just addressing opioid addiction. Therefore, it is possible that an individual will complete a DOC AOD program, be reintegrated into the community and live a sober lifestyle; however, if he/she commits another crime (even unrelated to alcohol or drugs) then within DOC’s perspective, the AOD program was not effective for that individual. Conversely, the same individual could relapse with their addiction, but so long as he/she meets the conditions of his/her parole and does not commit additional crimes, then the AOD program was effective.

Looking beyond the nuances of how DOC monitors and measures effectiveness, despite DOC’s mission to reduce recidivism through rehabilitation, only one AOD treatment program—the State Intermediate Punishment (SIP) program<sup>195</sup>—has a monitoring component related to measuring

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<sup>194</sup> <[http://www.cor.pa.gov/About%20Us/Pages/Mission-Statement.aspx#.WS16o9TD- 4](http://www.cor.pa.gov/About%20Us/Pages/Mission-Statement.aspx#.WS16o9TD-4)> (accessed May 26, 2017).

<sup>195</sup> 61 Pa.C.S. § 4101 *et seq.*

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the effectiveness of the treatment provided.<sup>196</sup> This monitoring is related specifically to recidivism. Specifically, DOC is required to provide a program performance report to the Judiciary Committees of both chambers of the Pennsylvania General Assembly by no later than February 1 in odd-numbered years and the Pennsylvania Commission on Sentencing is to provide its report in even-numbered years.<sup>197</sup> This report includes information on the following:

1. The number of offenders evaluated for the drug offender treatment program.<sup>198</sup>
2. The number of offenders sentenced to the drug offender treatment program.
3. The number of offenders sentenced to a state correctional institution who may have been eligible for the drug offender treatment program.
4. The number of offenders successfully completing the drug offender treatment program.
5. The six-month, one-year, three-year and five-year recidivism rates for offenders who have completed the drug offender treatment program and for a comparison group of offenders who were not placed in the drug offender treatment program.
6. Any changes the department or the commission believes will make the drug offender treatment program more effective.<sup>199</sup>

Beyond the SIP program's statutorily required program measures relating to recidivism, DOC does not monitor the effectiveness of any other AOD treatment programs in terms of reducing recidivism.<sup>200</sup> DOC management noted that due to difficulties in obtaining data on outcomes after release and competing organizational priorities within DOC, they have not been able to establish these routine program measures.

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<sup>196</sup> As provided for in the "Findings and purpose" section of Act 33 of 2009 (see 61 Pa.C.S. § 4102(6)), which created the SIP program, SIP's purpose is "to create a program that punishes persons who commit crimes, but also provides treatment that offers the opportunity for those persons to address their drug or alcohol addiction or abuse and thereby reduce the incidents of recidivism and enhance public safety." The original act was Act 112 of 2004, which is now repealed. See <<http://www.legis.state.pa.us/WU01/LI/LI/CT/HTM/61/00.041..HTM>> (accessed May 24, 2017).

<sup>197</sup> 61 Pa.C.S § 4107(b).

<sup>198</sup> Drug offender treatment program means the State Intermediate Punishment program. It should be noted that the SIP program is not a specific type of drug treatment program, rather SIP participants are placed into existing DOC AOD programs (therapeutic communities and outpatient programs) designed for SIP participants. Further, the SIP program is not specific to any type of substance abuse addiction. Because the SIP program is not a specific type of drug treatment initiative, nor is it specific to opioid addiction, we did not review the program beyond the monitoring requirements outlined in Act 33 of 2009. We did review DOC's most recent performance report (February 2017) and found it conformed to the above requirements.

<sup>199</sup> 61 Pa.C.S. § 4107(b). See <<http://www.legis.state.pa.us/WU01/LI/LI/CT/HTM/61/00.041..HTM>> (accessed May 24, 2017).

<sup>200</sup> DOC staff did; however, provide a listing of evidence-based evaluations that had been conducted in the past by outside research universities.



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Best management practices suggest that periodic program evaluations are necessary to ensure that program outcomes are meeting management’s expectations.<sup>201</sup> Accordingly, DOC should be conducting routine and systematic data collection about each of the AOD treatment programs it offers. The collected data could then be used in conjunction with periodic program evaluation reviews, similar to the annual program reports required of the SIP program.

Without these periodic reviews, DOC may not be strategically focusing its efforts to its mission and thus, may end up wasting taxpayer resources on ineffective AOD treatment programs. In light of the ongoing opioid epidemic facing the Commonwealth, DOC must ensure that its AOD treatment programs are effective in aiding the rehabilitation of offenders and reducing recidivism.

### **DOC needs to use other existing data sources, rather than just recidivism data, as a means of monitoring effectiveness.**

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In the discussion above, we noted that only one of DOC’s AOD treatment programs—the SIP program—has a monitoring component. At a minimum, it is important for DOC to conduct periodic program evaluations of all of its AOD treatment programs to ensure the programs are effective in helping to reduce recidivism, which is DOC’s primary mission.

While reducing recidivism is crucial, as discussed previously, Substance Use Disorder (SUD) in general—and Opioid Use Disorder (OUD), specifically—are difficult diseases to treat. As outlined by the National Institute of Health (NIH), among criminal justice populations, one of the key principles of drug abuse treatment is to tailor services to fit the needs of the individual.<sup>202</sup> To that end, we believe DOC should use existing data sources to evaluate the effectiveness of its AOD treatment programs beyond just recidivism. The resulting evaluations would then allow DOC to better tailor its treatment programming to the needs of its population; thereby ensuring that the treatment provided is leading to better outcomes.

For example, some individuals released from SCIs enter into the Commonwealth’s probation and parole system (Pennsylvania Board of Probation and Parole – PBPP), where they are monitored for compliance with the Pennsylvania Code governing conditions of parole. One of these conditions is to “abstain from the unlawful possession or sale of narcotics and dangerous drugs

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<sup>201</sup> Program evaluation is defined as, “the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development.” See U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. Introduction to program evaluation for public health programs: A self-study guide. Atlanta, GA: Centers for Disease Control and Prevention, 2011.

<sup>202</sup> National Institutes of Health, “Principles of Drug Abuse Treatment for Criminal Justice Populations - A Research-Based Guide.” See <<https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/how-effective-drug-abuse-treatment-criminal-justice>> (accessed May 25, 2017).

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and abstain from the use of controlled substances within the meaning of The Controlled Substance, Drug, Device and Cosmetic Act (35 P. S. §§ 780-101—780-144) without a valid prescription.”<sup>203</sup> Ensuring compliance with that condition is typically completed through regular drug screens that are a condition of the individual’s probation or parole.<sup>204</sup> Accessing the results of this data (e.g., are parolees remaining clean of drugs once released back to the community) would provide some insight as to the ongoing effectiveness of DOC’s AOD treatment programs in each facility related to recidivism and relapse. Further, using and evaluating the results from this data would give DOC staff additional information to tailor available drug treatment services to the needs of its populations, as suggested by the NIH.

DOC management recognized that this type of additional program evaluation for its AOD treatment programs is needed. They indicated that prior to December 2016, they lacked an appropriate agreement with the PBPP by which they could obtain the needed data. Management from the Bureau of Planning, Research, and Statistics indicated a “memorandum of understanding” is now in place between DOC and PBPP, which allows DOC to obtain the necessary data sets to complete its evaluation. DOC staff were unable to provide an exact date when the evaluations would be completed, but they noted that it would begin with its Therapeutic Communities AOD treatment program, as that program was ranked high on the priority list of projects by DOC senior management.

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### Recommendations for Finding 1

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We recommend that DOC:

1. Conduct periodic program evaluations of all AOD treatment programs, similar to that which is conducted of the SIP program, to ensure that the programs are effective in helping to reduce recidivism.
2. Continue to work with the PBPP to collect data on parolees, including, at a minimum, drug screening results at various intervals after release.
3. Using data obtained from the PBPP, develop program evaluation methodology to determine the effectiveness of AOD treatment programs (and by treatment program at each SCI, where applicable).
4. Based on the results of the AOD treatment program evaluations, develop drug treatment programs which are most helpful in combating opioid-related addiction.

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<sup>203</sup> 37 Pa. Code § 63.4(5)(i). See <<http://www.pacode.com/secure/data/037/chapter63/chap63toc.html>> (accessed May 25, 2017).

<sup>204</sup> <<http://www.pbpp.pa.gov/Information/Documents/Publications/What%20Offenders%20and%20Their%20Families%20Need%20To%20Know%20December%202016.pdf>>, page 8 (accessed June 6, 2017).

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#### **Finding 2 – DOC’s Medication Assisted Treatment (MAT) program lacks an ongoing formal monitoring process to measure its effectiveness.**

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To audit DOC’s Vivitrol® Program, we interviewed the MAT Statewide Coordinator, the Director of the Bureau of Treatment Programs, the Director of the Bureau of Planning, Research, and Statistics, and reviewed documentation related to the program including studies, information distributed to participants, information published about the program, and clinical information about Vivitrol®.

#### **What is Vivitrol®?**

Vivitrol® (Naltrexone for extended release injectable suspension) is a type of Medication Assisted Treatment (MAT), which was approved by the Federal Drug Administration in 2010 to aid in combatting opioid addiction.<sup>205</sup> Vivitrol® is effective in combatting opioid use disorder because when it is administered to those suffering from addiction, it reduces their drug cravings and—should they actually take an opioid—blocks their ability to get “high.” Vivitrol® can also be used to treat Alcohol Use Disorder (AUD), but because our audit objective is to determine effectiveness of opioid-related treatment programs, we will be addressing Vivitrol® as it relates to treatment for Opioid Use Disorder.

Vivitrol® requires an injection every 28 days. Further, because it is injected monthly, it removes the daily need for patients to motivate themselves to stick to a treatment regimen—a formidable task, especially in the face of multiple triggers of craving and relapse.<sup>206</sup> This latter aspect is especially important to criminal justice populations first returning to their communities, as this is a vulnerable period associated with a high risk for relapse, overdose, or re-arrest. Therefore, giving high-risk re-entrants an injectable drug like Vivitrol® may significantly increase their successful reentry to society.

#### **Vivitrol® Pilot**

To the above points, as the director of the Vivitrol® Program explained, DOC established a pilot MAT program so that re-entrants into communities could approach the challenges of reintegration without the added stress of facing cravings from fighting their addictions. The program initially began with certain qualifying female re-entrants at SCI Muncy—which is a women’s facility—in February of 2012. Penn State University researchers, who worked with DOC on the program’s initial start-up, evaluated the initiative and then recommended that DOC consider expanding the pilot to men’s institutions.

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<sup>205</sup> <<https://www.drugabuse.gov/about-nida/directors-page/messages-director/2010/10/important-treatment-advances-addiction-to-heroin-other-opiates>> (accessed May 26, 2017).

<sup>206</sup> Ibid.

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As a result, in July 2015, the Vivitrol® Program was maintained at SCI Muncy and the pilot expanded to SCI Chester, SCI Graterford, SCI Mahanoy, and SCI Pittsburgh.

In addition to these initial Vivitrol® Program sites being designated as pilot sites, a research project was initiated to monitor and measure the effects of the DOC Vivitrol® pilot on recidivism and drug use among re-entrants. DOC designed a randomized control trial study in which 48 volunteers over the course of the study were placed in a control group and did not receive Vivitrol®. A total of 49 individuals did receive Vivitrol® over the same time period. The control group outcomes were compared to those of individuals who had been given Vivitrol® injections. DOC management reviewed the data that had been collected to date in March of 2017. After determining that the data showed that use of Vivitrol® resulted in success in preventing relapse in pilot participants, DOC decided to discontinue the study. Now that the study has concluded, there is no other formal continued monitoring of the Vivitrol® Program's effectiveness.

Note that although DOC concluded the pilot and study at the original sites, eligible participants are still being identified and enrolled in the Vivitrol® Program at those SCIs.

We did not review the data for the Vivitrol® Program or the Vivitrol® study for this audit. Because of the relative newness of the program, the number of individuals participating in the Program was not large enough and had not been in the community long enough for us to be able to obtain a large enough sample for testing.

#### **Further Expansion of Vivitrol®**

While the pilot and study were ongoing, DOC decided that because of its lack of addictive properties and clinical documentation of the medication's ability to help sustain recovery, the Vivitrol® Program would be further expanded throughout DOC. The SCIs where individuals have access to the Vivitrol® Program are as follows:<sup>207</sup>

- SCI Cambridge Springs
- SCI Chester
- SCI Dallas
- SCI Graterford
- SCI Houtzdale
- SCI Laurel Highlands
- SCI Mahanoy
- SCI Mercer
- SCI Muncy<sup>208</sup>

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<sup>207</sup> SCI Pittsburgh is now closed.

<sup>208</sup> SCI Chester, SCI Graterford, SCI Mahanoy, and SCI Muncy were pilot locations. When added to the expanded locations, there are 12 total locations.

## Performance Audit Report

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- Quehanna Motivational Bootcamp
- SCI Retreat
- SCI Waymart

MAT Program management hopes to be able to expand the Vivitrol® Program system-wide as funding for social work staff and opportunities to join with complementary efforts become available.

Through May 24, 2017, according to DOC management, 255 individuals had received Vivitrol® injections prior to their release to community programs.

#### **Paying for Vivitrol**

One complication of the Vivitrol® Program is that the medication is costly.<sup>209</sup> This factor is significant, because although most re-entrants qualify for Medicaid, those that do not are funded through a \$150,000 federal grant that DOC receives to cover these costs. Vivitrol's® manufacturer provides the first injection to eligible re-entrants inside their respective SCI at no cost to DOC. Before release back into society, DOC social workers work with each re-entrant to enroll them in Medicaid. To date, Medicaid has been the main source of funding for the Vivitrol® program. If, for some reason, the re-entrant is ineligible for Medicaid or cannot get private insurance, DOC covers these costs. If, in the future, these federal grant funds are not available, the cost of the medication may become an issue to the program's continuation.

#### **Limitation of the Vivitrol Program**

One limitation of the Vivitrol® Program is that re-entrants are not required to receive all 11 Vivitrol® injections, nor does agreeing to participate in the program obligate them to report to anyone, if they opt to stop receiving injections. In fact, the consent form that re-entrants sign before enrolling in the program informs them that should they opt to stop receiving (also known as “revoke consent”) Vivitrol® injections, it will not impact their parole status. Obviously, if re-entrants stop taking their medication, they are at a potentially greater risk for relapse, and consequently, incarceration should they engage in criminal activity related to their opioid addiction.

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<sup>209</sup> Prescription medication pricing is not regulated, and as of June 6, 2017, there is no generic version of injectable naltrexone available. According to Good Rx, a website that shows the range of prices of prescription drugs at local pharmacies depending on the users zip code, most patients in Pennsylvania could expect to pay between \$1,347 and \$1,414 (with a coupon) on June 6, 2017.

<[https://www.goodrx.com/vivitrol?hide\\_online\\_pharmacies=true&show\\_pet\\_friendly\\_pharmacies=false](https://www.goodrx.com/vivitrol?hide_online_pharmacies=true&show_pet_friendly_pharmacies=false)> (accessed June 6, 2017).

Most Vivitrol® Program participants are covered by Medicaid. According to the Department of Human Services, MA Fee For Service pays \$1,353 to the dispensing provider and after rebates are collected, the net cost to the FFS MA program is \$726.

## **Performance Audit Report**

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Further, participants may revoke consent at any time and simply walk-away from the program. Community-based providers, from whom DOC has arranged for re-entrants to receive their follow-up injections, do not report participation status to DOC. As a result, although DOC knows who received Vivitrol® prior to their release, and DOC informs each re-entrant's parole agent of their involvement in the program, once a re-entrant starts the community treatment program, DOC's monitoring stops.

Recently, DOC's MAT program director has been working with DHS to develop a method to use Medicaid claims data to track the number of injections program participants received per community provider used by DOC. In this manner, DOC is hoping to be able to determine how many average injections program participants received before re-entrants left the program.

#### **Monitoring and Measurement of Vivitrol® Program**

With the discontinuation of the Vivitrol® study, there is no longer a formal evaluation of DOC's principle medication assisted treatment program in terms of recidivism (i.e., committing additional crimes and returning to prison) and preventing relapse among re-entrants. With the high expense of Vivitrol® medication and funding of the program dependent on continued Medicaid funding and federal grants, it is critical to evaluate the program effectiveness.

Moreover, we caution that while Vivitrol® has the propensity to aid the Commonwealth greatly in fighting the opioid epidemic, there is no single, cure-all solution. Simply put, much more research is needed so that DOC can understand how to best structure the program to provide the most benefit to re-entrants and to the Commonwealth as we continue to face both mounting opioid and budget crises.

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### **Recommendations for Finding 2**

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We recommend that DOC:

1. Work with the Department of Human Services Office of Medical Assistance Programs, PA Board of Probation and Parole, and the DOC Bureau of Planning, Research, and Statistics to develop a methodology, using combined data, which would monitor and measure the effectiveness of the Vivitrol® Program.
2. Using data obtained and the program evaluation methodology developed, determine the effectiveness of the Vivitrol® program.
3. Share the results of the program evaluations with DOC treatment program staff, so that it can best tailor drug treatment programs that are most helpful in reducing the opioid epidemic.

## **Performance Audit Report**

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#### **Agencies' Responses and Auditors' Conclusions**

We provided draft copies of our audit findings and related recommendations to the Department of Drug and Alcohol Programs, the Department of Human Services, and the Department of Corrections for their review. On the pages that follow, we included their responses in their entirety. Following the agencies' responses is our auditors' conclusions.

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### Audit Response from the Department of Drug and Alcohol Programs



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

June 30, 2017

Eugene A. DePasquale, Auditor General  
c/o Scott D. King, CPA, Assistant Director  
Commonwealth of Pennsylvania  
Department of the Auditor General  
Bureau of Performance Audits  
302 Finance Building  
Harrisburg, PA 17120-0018

Re: DDAP Performance Audit

Dear Mr. King,

We are in receipt of your draft findings and recommendations that pertain to your performance audit of the Department of Drug and Alcohol Programs (DDAP).

Below is our response to the draft findings and related recommendations:

**Finding 1: DDAP cannot measure the effectiveness of the opioid-related drug treatment initiatives.**

DDAP Response: DDAP agrees with this finding.

Department of the Auditor General (AG) Recommendation 1: Work with the Department of Human Services (DHS), Department of Health (DOH), lawmakers, advocates, treatment participant representatives, and other relevant stakeholder groups to develop a method to measure the effectiveness of treatment over time, including time periods after participants have left treatment and re-entered the community.

DDAP Response: DDAP believes that our new treatment data system, WITS, which has yet to be fully implemented, has the potential to assist in future endeavors to measure the effectiveness of treatment over time. Please note that without changes to the current state confidentiality law related to drug and alcohol information, DDAP will only ever be able to gauge the effectiveness of treatment on an aggregate, deidentified basis.

AG Recommendation 2: Monitor the effectiveness of treatment programs on a regular and consistent basis using the newly developed method.

DDAP Response: When the new treatment data system is fully implemented, DDAP will work to monitor the effectiveness of treatment programs as the law and the data system allows.



## Performance Audit Report

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AG Recommendation 3: Develop a method to share information about the quality and effectiveness of treatment programs that is easy to access and is available to the public.

DDAP Response: DDAP does provide limited information about quality from inspection results posted to DDAP's website. We will work to expand on that information.

AG Recommendation 4: Consider developing a "severity designation" for licensing deficiencies it posts on its website.

DDAP Response: DDAP will consider the possibility of including a severity designation of licensing deficiencies it posts on its website as we work to expand on the information currently posted. We will look to the information provided on the DOH website, namely how they include a severity designation for each deficiency as they relate to nursing homes licensed by the DOH, as an example of how this could be accomplished.

**Finding 2: Chronic understaffing and underfunding at DDAP creates additional challenges in combating the opioid epidemic.**

DDAP Response: DDAP agrees with this finding.

AG Recommendation 1: Work with the Governor and the General Assembly to procure additional funding to be used to enhance the department's efforts in fighting the opioid epidemic.

DDAP response: It is of vital importance to DDAP that Governor Wolf's proposed 2017-2018 be enacted. Included in the Governor's proposed budget is \$26.5 million from the federal 21<sup>st</sup> Century CURES Act, for which DDAP serves as the fiscal agent. We believe that the Governor's proposed unification of DDAP with three other agencies to create the Department of Health and Human Services will address the gaps in resources that DDAP currently faces, and will further maximize the department's ability to distribute the CURES Act funds and coordinate with DHS and DOH to implement activities that further the commonwealth's efforts to address the heroin and opioid epidemic.

AG Recommendation 2: Work with the State Civil Service Commission to reevaluate the job classification and pay grade status of DDAP's licensing specialist position. By creating a more competitive position, DDAP should then be able to attract and retain employees in its licensing areas.

DDAP Response: DDAP is not averse to exploring this possibility with the State Civil Service Commission as we work to expand our complement, but budget constraints must be kept in mind. If the current classification and pay grade status are deemed appropriate, DDAP would pursue revising the minimum education and training (MET) requirements to allow a larger number of applicants to qualify for these positions. Our licensing specialist position has attracted qualified personnel, we simply are not receiving an adequate volume of candidates who meet the METs. DDAP is working to fill vacant positions as budgets allow, and is cognizant of the need to pursue Spanish-speaking candidates. In the interim, we will explore state contracts in place with vendors who can provide translation services as needed.

## Performance Audit Report

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AG Recommendation 3: Consider revising regulations that would allow for licensing renewal on a longer-term basis, such as every two to three years, depending on certain factors such as length of time in operation, length of time without citations, etc., or with shorter, interim licensing reporting requirements that could be followed up on randomly.

DDAP Response: DDAP has drafted and is moving forward with a proposed regulation to extend the current annual licensure timeframe from one year to up to two years for drug and alcohol facilities that qualify for such an extension.

AG Recommendation 4: Within the next six months, begin discussions with the Department of Health to develop regulations that would ensure that Pennsylvania physicians who have been authorized to prescribe buprenorphine-related medications are treating patients with opioid addictions in a safe, well-controlled environment.

DDAP Response: DDAP has been working with the Governor's Office to determine how to best monitor physicians authorized to prescribe buprenorphine, as well as other forms of Medication Assisted Treatment (MAT). In the near future, DDAP and the Governor's Office will convene a stakeholder workgroup to look at developing a framework for regulations related to all MAT providers. The workgroup will be charged with making recommendations related to quality standards, looking at how other states regulate MAT providers/prescribers, and making recommendations for a regulatory framework that includes an appropriate fee structure in order to ensure quality and incentivize providers/prescribers to participate.

**Finding 3: The law creating DDAP did not specify that DDAP could collect licensing fees, nor has DDAP issued regulations that would institute a license fee on drug and alcohol treatment providers.**

DDAP Response: DDAP agrees with this finding.

AG Recommendation 1: Work closely with the General Assembly to pass legislation allowing for a licensing fee schedule for drug and alcohol treatment providers.

AG Recommendation 2: Work closely with the General Assembly to pass legislation allowing for a penalty fee schedule for providers who do not comply with DDAP regulations.

DDAP Response: DDAP believes that application and noncompliance fees could generate a funding stream that DDAP could use to hire additional staff to assist with combatting the opioid epidemic. The department will work closely with the Governor's Office and the General Assembly to develop application and noncompliance fee schedules for drug and alcohol treatment providers.

AG Recommendation 3: Use the additional funds collected from licensing fees and penalties to develop and increase DDAP's ability to effectively monitor and measure opioid-related drug treatments.

DDAP Response: In addition to using application and noncompliance fees to hire additional staff to assist with the opioid epidemic, DDAP would look to use any additional funding to enhance existing programs and collaborate with other state agencies to implement new, evidence-based programming to continue addressing the heroin and opioid epidemic.

## Performance Audit Report

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I hope that this letter assures you that DDAP is working to improve in the outlined areas and is appreciative of your review of and guidance to DDAP. In addition, I hope that our corrections/suggestions are received in the same spirit in which they were provided. Namely, that accurate information is the most valuable tool in fighting the heroin and opioid epidemic. Please do not hesitate to contact me, if you have any question or concerns.

Sincerely,



Jennifer S. Smith, Acting Secretary  
Department of Drug and Alcohol Programs

cc: Ms. Tawny Mummah, Chief Counsel  
Ms. Kimberly Coleman

# Performance Audit Report

## Opioid Treatment Audits

### Audit Response from the Department of Human Services



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HUMAN SERVICES

JUL 05 2017

The Honorable Eugene A. DePasquale  
Auditor General  
Department of the Auditor General  
229 Finance Building  
Harrisburg, Pennsylvania 17120

Dear Auditor General DePasquale:

I am writing in response to your letter of June 16, 2017 which provided the draft performance audit of the Pennsylvania Department of Human Services related to the opioid drug epidemic. We appreciate the opportunity to respond to the finding in the draft audit report.

Below is our response to the draft finding and related recommendations:

**Finding 1:** Centers of Excellence (COE) infrastructure for collecting information on outcomes is in place, but there are no apparent plans for DHS to ensure accuracy of the data used to monitor COE's effectiveness.

**DHS Response:** DHS agrees with this draft finding.

**Department of the Auditor General (AG) Recommendation 1:** Develop a process to quarterly, or at least semi-annually, verify the accuracy and completeness of the data provided by the Centers of Excellence.

**DHS Response:** DHS will review the data elements submitted by the COEs and compare with claims submitted through the enterprise data warehouse. The claims-based analysis will allow DHS to verify that the COE reports for engagement in treatment are reflected in a billable opioid use disorder (OUD) or mental health service by the COE or other treatment providers.

**AG Recommendation 2:** Going forward, regularly and adequately evaluate and monitor the effectiveness of COE performance, including ensuring that outcome metrics support an effective evaluation of the program.

**DHS Response:** DHS will evaluate and monitor the effectiveness of COE performance through both qualitative and quantitative measures. Critical measures for COE effectiveness include the timely initiation of services and continued engagement in services. DHS will be able to compare the performance of the COE on these measures

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The Honorable Eugene A. DePasquale -2-

JUL 05 2017

to the overall performance of other providers enrolled in the Medical Assistance program. A second aspect of evaluation will include the ability to measure change in consumer reports of quality of life and movement toward recovery. These measures are gathered every six months through face-to-face interviews utilizing an outcome tool required by participating providers.

**AG Recommendation 3:** Maintain frequent and open communications with all stakeholder groups to ensure coordination of all statewide efforts and initiatives addressing the opioid crisis.

**DHS Response:** DHS participated in numerous stakeholder meetings on a regular basis providing an important avenue for stakeholder input and engagement. The opioid crisis and the planning and operations of the COEs have been and will continue to be a regular part of these discussions. These meetings include the Medical Assistance Advisory Committee, the DHS Office of Mental Health and Substance Abuse Services Planning Council, the Rehabilitation and Community Providers Association, the Pennsylvania Association of County Administrators of Mental Health and Developmental Services, and the Pennsylvania Association of County Drug and Alcohol Administrators. The DHS website also provides a forum for broader updates to be shared with stakeholders.

DHS is committed to ensuring data submitted by the COEs is accurate, as this will be critical to the evaluation of each COE, as well as provide information to further improve OUD treatment for Pennsylvanians.

Thank you for opportunity to respond to this draft report. Please contact Mr. David R. Bryan, Manager, Audit Resolution Section, Bureau of Financial Operations, at 717-783-7217, or via email at [davbryan@pa.gov](mailto:davbryan@pa.gov), if you have any questions regarding this matter.

Sincerely,



Theodore Dallas  
Secretary

c: Mr. David Bryan

# Performance Audit Report

## Opioid Treatment Audits

### Audit Response from the Department of Corrections



June 29, 2017

The Honorable Eugene DePasquale  
Auditor General  
Office of the Auditor General  
Harrisburg, PA 17120-0018

Dear Auditor General DePasquale:

This correspondence will serve as the written response from the Department of Corrections ("Department") to the Department of the Auditor General's ("AG") draft findings and recommendations report ("Report") related to its performance audit to determine the extent to which the Department is monitoring and measuring the effectiveness of opioid-related drug treatment initiatives.

Our nation is in the midst of an unprecedented opioid epidemic. Fighting the opioid epidemic is a top priority for the Wolf Administration. Providing treatment, is a critical component of fighting the epidemic, is a top priority for the Department. Furthermore, the Department's treatment programs are of the utmost importance to our criminal justice system's effort to reduce recidivism. I tremendously appreciate the time and work that you and your staff expended in this review. Thank you for efforts in this regard.

An audit committee, appointed in accordance with Management Directive 325.10, reviewed and evaluated the Report. The review committee included the Department's Director of the Bureau of Treatment Services ("BTS"), Chief of Treatment for BTS, Medication-assisted Treatment ("MAT") Coordinator for BTS, Drug and Alcohol Program Manager for BTS and the Director of Planning, Research and Statistics. The following are the Department's responses to the finding and recommendations outlined in the Report:

**Audit Finding #1: Only one of seven DOC Alcohol and Other Drug (AOD) Treatment Programs is monitored for effectiveness and that monitoring is limited to recidivism.**

**Response:** The Report states that only the State Intermediate Punishment ("SIP") program has a monitoring component, required by statute and is limited to measuring recidivism, and that the Department does not regularly monitor the effectiveness of any other AOD treatment programs. While the Department agrees with the Finding that such programs are not formally monitored and evaluated on a *scheduled, reoccurring or regular* basis, it is not accurate to say that the Department does not evaluate the other programs.

There have been various evaluations of the seven AOD program types. The documentation related to these evaluations was provided during the course of the



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audit. Therefore, the Department requests that the Draft Report be amended to note that:

- The AOD treatment programs the DOC employs are, in fact, evidence-based and have demonstrated success rates based upon independent research not conducted by the Department.
- The Department has conducted several evaluations of Therapeutic Communities ("TC") and Outpatient treatment, which include the following:
  - In 2015-16, Faye S. Taxman, Ph.D., Center for Advancing Correctional Excellence, George Mason University, applied the Risk Needs Responsivity ("RNR") Simulation Tool to the DOC's Substance Use Disorder treatment programs for evaluation purposes. The RNR tool matches the Department's resources to the needs of the inmate population. Following the evaluation, the Department made several changes including eliminating redundancy between treatment programs and improving AOD treatment staff training. There are new curriculum-based trainings, as well as a modification of the existing TC Experiential Training;
  - A 5-site TC evaluation conducted by Temple University;
  - The SCI-Chester TC experiment conducted by Temple University;
  - A study of TC quality and resources by George Mason University;
  - An internal unpublished evaluation of the optimal length of TCs (the "differential TC study"); and
  - A recently initiated study with Penn State and other university collaborators called the "TC-PINS" (Prison Inmate Network) study, which is being conducted at SCI-Chester. This is a project that analyzes the social network in a therapeutic community.
- The Department had an evaluation conducted by Penn State of its Co-Occurring Disorders curriculum and treatment.
- The Department recently completed enrollment in a Vivitrol study.
- Individuals who complete recommended AOD treatment programs in the SCIs are administered a **Client Satisfaction Survey**, and, thus, provide staff with a personal evaluation of the facilitator, the curriculum, and the overall experience of participating in the group.

In addition, each facilitator is evaluated by his/her Supervisor/Manager on a quarterly basis using a **Program Evaluation Tool** to guide the evaluation. This is done in order to ensure fidelity to the treatment model and standard curriculum, and to enhance clinical supervision of the treatment staff.

The Department strives to continually better its evidence-based programs for improved outcomes and has always reviewed and evaluated such programs for effectiveness. However, the Department agrees that a routine program evaluation cycle should be established as best-practice. Therefore, the Department concurs with AG's finding and the recommendations and responds to each recommendation as follows:

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**Recommendation #1** – Conduct periodic program evaluations of all AOD treatment programs, similar to that which is conducted of the SIP program, to ensure that the programs are effective in helping to reduce recidivism.

The Department concurs that a routine, scheduled program evaluation cycle for all programs would be a best-practice to achieve the best outcomes and intends to work on a policy-driven solution to address this concern.

**Recommendation #2** –Continue to work with PBPP to collect data on parolees including, at a minimum drug screening results at various intervals after release.

The Department concurs with this recommendation and the Department and PBPP intend to continue to work closely in this regard.

**Recommendation #3** – Using data obtained from PBPP, develop program evaluation methodology to determine the effectiveness of AOD treatment programs (and by treatment program at each SCI, where applicable).

The Department concurs with this recommendation and the Department and PBPP intend to continue to work closely in this regard.

**Recommendation #4** – Based on results of the AOD treatment program evaluations, develop drug treatment programs which are most helpful in combatting opioid-related addiction.

The Department concurs with this recommendation and will continue to implement evidence-based programs and discontinue ineffective programs where appropriate. The Report acknowledges two difficulties in meeting this recommendation: 1) obtaining data on outcomes after release; and 2) competing organizational priorities within DOC. In addition to these two constraints, the Department notes that there are at least two additional significant constraints: 1) staff/resources needed to address all of the Department's evaluation priorities in this area; and 2) methodological difficulties in developing adequate comparison groups necessary to compare program results.

**Audit Finding #2: DOC's Medication Assisted Treatment (MAT) program lacks an ongoing formal monitoring process to measure its effectiveness.**

**Response:** The Department agrees with the Finding that such programs are not formally monitored and evaluated on a *scheduled, reoccurring or regular* basis. However, the Department notes that community-based providers part of the initiative, do, in fact, continue to report on participation. Tracking worksheets are submitted monthly by the providers to the Bureau of Planning, Research and Statistics.



## Performance Audit Report

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**Recommendation #1** – Work with the Department of Human Services Office of Medical Assistance Programs, PA Board of Probation and Parole, and the DOC Bureau of Planning, Research, and Statistics to develop a methodology using combined data, which would monitor and measure the effectiveness of the Vivitrol® Program.

The Department agrees with this recommendation and the Department, DHS, and PBPP intend to continue to work closely in this regard. The Department is already working with DHS and PBPP to receive Medicaid claims data because Medicaid is the main resource to obtain the medication. Although the Department has taken steps to establish cooperative agreements with PBPP that will help to address these concerns, the Department notes that pending legislation to consolidate PBPP with the Department (SB 522 and SB 523), would further facilitate effectuating this recommendation. The consolidation is expected to result in cost savings and increased efficiencies in the operation of our state prisons and parole services.

**Recommendation #2** –Using data obtained and the program evaluation methodology developed, determine the effectiveness of the Vivitrol® Program.

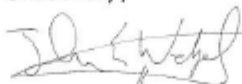
The Department concurs with this recommendation and the Department intends to evaluate the program in this regard.

**Recommendation #3** – Share the results of the program evaluations with DOC treatment program staff, so that it can best tailor drug treatment programs that are most helpful in reducing the opioid epidemic.

The Department concurs with this recommendation and the Department intends to share its data in this regard.

Again, the Department wishes to sincerely express its appreciation to the Auditor General’s staff regarding this review. Please do not hesitate to contact my office if you have any questions or concerns with regard to this response. Again, thank you for the effort that your office put into this audit report.

Sincerely,



John E. Wetzel  
Secretary of Corrections

cc: Shirley R. Moore Smeal, Executive Deputy Secretary  
Audit Review Committee  
File

## Performance Audit Report

### Opioid Treatment Audits

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#### Auditors' Conclusions

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##### DDAP

DDAP management agreed with the audit findings and recommendations. In addition to their agreement, DDAP management also provided us with additional clarifications/suggestions to the audit report, which were editorial in nature and/or provided a more recent update to the information we presented. We agreed with these clarifications, and we have modified the audit where necessary. None of these clarifications changed our findings or recommendations.

##### DHS

DHS management agreed with the finding and recommendations.

##### DOC

DOC management agreed with the findings and recommendations, but noted that outside research groups had conducted evidence-based evaluations of some of its Alcohol and Other Drug (AOD) treatment programs. We added a footnote to include this fact in the final report. DOC management agreed that these reviews were not conducted on a scheduled, reoccurring or regular basis. Our findings and recommendations pertain to DOC performing more periodic reviews of its AOD programs, which should include using data from the Pennsylvania Board of Probation and Parole, of which DOC management is in agreement.

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#### Appendix A – Objective, Scope, and Methodology

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The Department of the Auditor General conducted these performance audits in order to provide an independent assessment of how the Department of Drug and Alcohol Programs (DDAP), the Department of Human Services (DHS), and the Department of Corrections (DOC) are monitoring the success of opioid-related drug treatment services. While each audit is technically independent from the others, to avoid duplication in reporting, we are presenting our Objective, Scope, and Methodology collectively.

We conducted these audits in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States.<sup>210</sup> Those standards require that we plan and perform each audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

#### Objective

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Our performance audit objective was identical for each agency:

Determine the extent to which the Department of Corrections, the Department of Human Services, and the Department of Drug and Alcohol Programs are monitoring and measuring the effectiveness of opioid-related drug treatment initiatives.

#### Scope

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For each agency, our audit presents information for the period January 1, 2013, through April 30, 2017, unless otherwise noted, with updates through the report date.

Each respective agency's management is responsible for establishing and maintaining effective internal controls to provide reasonable assurance that they are in compliance with applicable laws, regulations, contracts, grant agreements, and administrative policies and procedures.

In conducting our audits, we did not consider any internal controls to be significant within the context of the audit objective.

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<sup>210</sup> *Government Auditing Standards*, December 2011 revision, issued by the Comptroller General of the United States, United States Government Accountability Office, Washington D.C.

## Performance Audit Report

### Opioid Treatment Audits

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#### Methodology

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The methodology for each agency audit is listed below. Additionally, we have included methodology that is nonspecific to any one agency, but was used to develop background information about the opioid epidemic.

##### *Department of Drug and Alcohol Programs*

- Reviewed relevant statutory history related to DDAP, including among others, Act 119 of 1985 and Act 50 of 2010.
- Reviewed relevant DDAP state and federal funding sources.
- Interviewed various DDAP staff involved in drug and alcohol treatment licensing and monitoring of drug treatment facilities.
- Interviewed staff from selected Single County Authorities about their respective role in monitoring and measuring drug treatment effectiveness.
- Reviewed DDAP's web site for information regarding drug treatment effectiveness and monitoring efforts conducted by DDAP.
- Reviewed DDAP's licensing efforts, including staff scheduling, inspection reviews, and internal procedures.
- Reviewed the job description for a DDAP Licensing Specialist.
- Obtained and reviewed the Acting Secretary's testimony to the Senate Appropriations Committee for the 2017-18 Executive Budget.
- Researched and compared licensing fees for drug and alcohol treatment provider licenses in selected other states.
- Researched and compared selected other states' fines and penalties for drug and alcohol provider violations.
- Reviewed information from the Federal Substance Abuse and Mental Health Services Administration on the availability of buprenorphine treatment in Pennsylvania.

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#### *Department of Human Services*

- Reviewed relevant statutory authorizations (Act 84 of 2016) that provided the initial funding for Centers of Excellence.
- Reviewed DHS' web site for information specific to Centers of Excellence.
- Interviewed applicable DHS program staff regarding the establishment and monitoring of Centers of Excellence.
- Reviewed and compared functional descriptions between Single County Authorities and Centers of Excellence.
- Reviewed permissible and non-permissible spending categories for Centers of Excellence.
- Reviewed proposed quantitative and qualitative program measures for Centers of Excellence performance.
- Reviewed the procedures for data collection and verification for data collected from Centers of Excellence.

#### *Department of Corrections*

- Reviewed historical perspectives on the DOC's origins.
- Obtained and reviewed information regarding various Bureaus within DOC that are involved with substance abuse treatment.
- Obtained and reviewed Medication Assisted Treatment (MAT) initiatives within DOC.
- Obtained and reviewed information pertaining to various non-MAT substance abuse treatment initiatives.
- Interviewed various program staff with knowledge of DOC's substance abuse treatment initiatives regarding how the treatment programs are monitored.
- Obtained and reviewed program performance reports for DOC's Statewide Intermediate Punishment Program.

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- Obtained and reviewed comparative information from the National Institutes of Health regarding substance abuse treatment among criminal populations.

#### *Nonspecific agency methodology*

- Interviewed the Pennsylvania Physician General about the commonwealth's opioid epidemic, including the origins of the epidemic, and emerging commonwealth initiatives for combatting the epidemic.
- Met with representatives from the Pennsylvania Drug and Alcohol Service Providers Association about the opioid epidemic and substance abuse treatment challenges.
- Met with representatives from several substance abuse treatment providers about the difficulty and challenges in treating opioid addiction.
- Met with a district attorney regarding the opioid epidemic.
- Attended an "Opioid and the Law" legal forum, which covered the commonwealth's growing opioid crisis.
- Met with a physician and operator of a Pennsylvania-based suboxone clinic.
- Obtained and reviewed a report prepared by the US Surgeon General on Alcohol, Drugs, and Health.

#### **Data Reliability**

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For data that we obtain from agencies, and which materially affect the findings, conclusions, or recommendations that we present, *Government Auditing Standards* requires us to assess the completion and accuracy of computer-processed data.<sup>211</sup>

No computer-processed data from either the Department of Drug and Alcohol Programs, the Department of Human Services, or the Department of Corrections was used in presenting the results of these audits. As such, we did not perform data reliability assessments.

Certain other data is used in the audit report to provide a context for our findings, conclusions, and recommendations. Data that we used for these purposes was obtained

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<sup>211</sup> See United States Government Accountability Office, *Assessing the Reliability of Computer Processed Data*, July 2009.

## **Performance Audit Report**

### **Opioid Treatment Audits**

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from the best available sources. *Government Auditing Standards* do not require us to complete a data reliability assessment for data that is used for these purposes.

## Performance Audit Report

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## Appendix B – Additional Information Pertaining to the Opioid Epidemic

### What are opioids?

Opium, opiates, and opioids are all related terms; but today these terms have taken on different meanings and contexts. Generally, these terms refer to alkaloids—plant-based compounds that provide certain physiological effects to the body.<sup>212</sup> Coffee is one type of common alkaloid; however, within the context of this report, we are referring to drugs that have a much more powerful and possibly addictive effect to the body.

Historically, the alkaloid drugs referenced in this report were derived from a variety of the poppy plant (classification: *Papaver somniferum*).<sup>213</sup> For example, *opium*, a word derived from the Greek word for “juice” is the brownish residue observed after the poppy’s juice is extracted from the poppy bud and dried.<sup>214</sup> Opium was widely used (and abused) for centuries in many different cultures. *Opiate*, on the other hand, is the older term classically used in pharmacology to mean a drug derived from opium.<sup>215</sup> Perhaps the most familiar example of an opiate is morphine—the powerful pain medication developed in the early 19<sup>th</sup> century. Interestingly, morphine continues to be the standard by which pain medication potency is measured.<sup>216</sup>

*Opioid*, a more modern term, is used to designate all substances, both natural and synthetic, that bind to opioid receptors in the body.<sup>217</sup> As such, opioids include illegal drugs, such as heroin, but also chemically similar prescription drugs, such as fentanyl, morphine, codeine, oxycodone and various other physician-prescribed medications. These latter drugs are known by common brand names such as OxyContin<sup>®</sup>, Vicodin<sup>®</sup>, and Percocet<sup>®</sup>. There are also numerous street names for opioids, such as “Oxys,” “Percs,” and “Demmys” – to name a few.

Prescription opioids are highly effective in managing short-term acute pain, as well as long term chronic pain (in certain situations).<sup>218</sup> Individuals often take opioids because their pain cannot be managed through over-the-counter medications, like aspirin, acetaminophen, or ibuprofen.

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<sup>212</sup> <<http://medical-dictionary.thefreedictionary.com/alkaloid>> (accessed May 3, 2017).

<sup>213</sup> <<https://www.opioids.com/poppy.html>> (accessed May 3, 2017).

<sup>214</sup> Hemmings, Hugh and Egan, Talmage D. *Pharmacology and Physiology for Anesthesia: Foundations and Clinical Application: Expert Consult - Online and Print. Elsevier Health Sciences, 2013, p. 253.*

<sup>215</sup> Ibid.

<sup>216</sup> See Equianalgesic charts, e.g., <[http://www.emedicinehealth.com/opioid\\_potency\\_comparison/article\\_em.htm](http://www.emedicinehealth.com/opioid_potency_comparison/article_em.htm)> (accessed May 3, 2017).

<sup>217</sup> Ibid.

<sup>218</sup> Within opioid prescribing guidelines established by the Centers for Disease Control and Prevention, chronic pain is defined as lasting greater than 3 months or past the time of normal tissue healing. Long term use of opioids can be dangerous because of the addictive nature of these drugs.



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Opioids are very effective because they chemically interact with specific receptors on nerve cells to block pain and produce a feeling of well-being.<sup>219</sup>

#### What is the problem with opioids?

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Opioid pain relievers are generally safe when taken for a short time and as prescribed by a doctor, but they are frequently misused (taken in a different way or in a greater quantity than prescribed, or taken without a doctor's prescription) because they produce euphoria in addition to pain relief.<sup>220</sup> Regular use—even as prescribed by a doctor—can produce dependence, and when misused or abused, opioid pain relievers can lead to fatal overdose.<sup>221</sup>

A negative property of opioid drugs is their tendency, when used repeatedly over time, to induce *tolerance*.<sup>222</sup> Tolerance occurs when the person no longer responds to the drug as strongly as he or she did at first, thus necessitating a higher dose to achieve the same effect. The establishment of tolerance hinges on the ability of abused opioids (e.g., OxyContin, morphine) to desensitize the brain's own natural opioid system, making it less responsive over time.<sup>223</sup>

Tolerance can have other effects too. For example, people with an opioid addiction may try unintended ways of administering the medication to overcome their tolerance. The Director of the National Institute on Drug Abuse best describes this occurrence:<sup>224</sup>

Opioid medications can produce a sense of well-being or euphoria because these drugs affect brain regions involved in reward. People who abuse opioids may seek to intensify their experience by taking the drug in ways other than those prescribed. For example, extended-release oxycodone is designed to release slowly and steadily into the bloodstream after being taken orally in a pill; this minimizes the euphoric effects. People who abuse pills may crush them to snort or inject which not only increases the euphoria, but also increases the risk for serious medical complications, such as respiratory arrest, coma, and addiction.

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<sup>219</sup> National Institute on Drug Abuse, Drugs of Abuse- Opioids. See <<https://www.drugabuse.gov/drugs-abuse/opioids>> (accessed May 3, 2017).

<sup>220</sup> Ibid.

<sup>221</sup> Ibid.

<sup>222</sup> Williams, J. "Regulation of  $\mu$ -opioid receptors: desensitization, phosphorylation, internalization, and tolerance." *Pharmacology Review*, 65(1):223-54, 2013.

<sup>223</sup> Ibid.

<sup>224</sup> Written testimony presented to the US Senate Caucus on International Narcotics Control by Nora D. Volkow, M.D., Director of the National Institute on Drug Abuse (NIDA) at the National Institutes of Health. May 14, 2014.

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The Diagnostic and Statistical Manual of Mental Disorders fifth edition, DSM-5, combines the Opioid Dependence and the Opioid Abuse diagnoses from previous editions into one disorder, Opioid Use Disorder (OUD). Symptoms of OUD include:

- Taking more opioid drugs than intended.
- Wanting or trying to control opioid drug use without success.
- Spending a lot of time obtaining, taking, or recovering from the effects of opioid drugs.
- Craving opioids.
- Failing to carry out important roles at home, work, or school because of opioid use.
- Continuing to use opioids, despite use of the drug causing relationship or social problems.
- Giving up or reducing other activities because of opioid use.
- Using opioids even when it is physically unsafe.
- Knowing that opioid use is causing a physical or psychological problem, but continuing to take the drug anyway.
- [Tolerance](#) for opioids.
- [Withdrawal symptoms](#) when opioids are not taken.

The diagnosis of Opioid Use Disorder can be applied to someone who uses opioid drugs and has at least two of the above symptoms within a 12-month period.<sup>225</sup>

OUD—or addiction—can have devastating impacts on users and their families. Oftentimes, opioid users are unaware of the addictive nature of these drugs, and subsequently, find themselves in a downward spiral in which they become obsessed with obtaining and taking the drug in order to stay “normal.” The passage below, adapted from an opioid-addicted user’s personal account, typifies the spiraling effects often experienced by opioid addicts.<sup>226</sup>

A ‘friend’ of mine turned me on to oxys. I started with 40 mg tabs, then after a couple of months I bumped up to 60 mgs. I was really addicted by this point and started chewing them to get off quicker so I wouldn’t be sick. Had to have one in the morning when I got up or I’d be sick. Had to have another before noon. Then a couple more in the afternoon and evening. I knew I was hooked because I had to have them to function. I felt horrible without them. Not only physically, but I couldn’t deal with people or life without them. Then I went to 80 mgs and my world came tumbling down. I started stealing from everyone I knew to get my fix.... —**Charleen**

While Charleen’s story of addiction is common, some people with addictions to prescription opioids have turned to another method to meet their opioid need—heroin. Increasingly, when

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<sup>225</sup> <<http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf>> (accessed May 3, 2017).

<sup>226</sup> <<http://www.drugfreeworld.org/drugfacts/prescription/opioids-and-morphine-derivatives-effects.html>> (accessed May 3, 2017).

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prescriptions run out or become too expensive for a prescription opioid abuser, heroin is used, which is less expensive and available on the streets. The heroin that is available on the streets, however, is unsafe because it is often mixed (cut) with other drugs such as fentanyl (a powerful synthetic opioid) that make the drug far more dangerous than the prescription drugs the user is accustomed. As a result, the risk of a deadly overdose is even more likely for the opioid abuser.

To the above point, heroin is now also being cut with an even more powerful drug—carfentanil—a synthetic opioid that is used to sedate large animals, like elephants. By comparison, carfentanil is 10,000 more potent than morphine. This drug is extremely dangerous and has already led to several deaths in Pennsylvania.<sup>227</sup> The Secretary of the Department of Health added the following, "Because carfentanil is a synthetic opioid that is much more potent and deadly than morphine and fentanyl, it could lead to increases in cluster overdoses and deaths; it poses significant threats to those who may be using opioids as well as others who may come into contact with it."<sup>228</sup>

### What created the opioid problem?

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According to the National Institute on Drug Abuse, several factors are likely to have contributed to the severity of the current prescription drug abuse problem. The following factors together have helped create the broad “environmental availability” of prescription medications in general and opioid analgesics in particular:<sup>229</sup>

- (1) Drastic increases in the number of prescriptions written and dispensed for opioid medication.
- (2) Greater social acceptability for using medications for different purposes.
- (3) Aggressive marketing by pharmaceutical companies.

These factors are further supported by a U.S. Surgeon General report that the opioid epidemic has been spurred on, in part, by the over-prescription of opioids to treat the physical pain that many Americans feel.<sup>230</sup>

In support of the above factors, consider the statistics from the U.S. Centers for Disease Control and Prevention (CDC) that follow:<sup>231</sup>

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<sup>227</sup> Two PA overdoses linked to use of elephant sedative; state issues warning,” Allentown Morning Call, January 17, 2017.

<sup>228</sup> Ibid.

<sup>229</sup> Written testimony presented to the US Senate Caucus on International Narcotics Control by Nora D. Volkow, M.D., Director of the National Institute on Drug Abuse at the National Institutes of Health. May 14, 2014.

<sup>230</sup> <<https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>>, page 1-14 (accessed May 11, 2017).

<sup>231</sup> Centers for Disease Control and Prevention, Injury Control and Prevention: Opioid Overdose, Prescribing Data. <<https://www.cdc.gov/drugoverdose/data/prescribing.html>>, accessed on May 11, 2017.

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- Sales of prescription opioids in the U.S. nearly quadrupled from 1999 to 2014, but there has not been an overall change in the amount of pain Americans report.
- During this same time period, prescription opioid overdose deaths increased similarly.
- An estimated 1 out of 5 patients with non-cancer pain or pain-related diagnoses are prescribed opioids in office-based settings.
- From 2007 – 2012, the rate of opioid prescribing has steadily increased among specialists more likely to manage acute and chronic pain. Prescribing rates are highest among pain medicine (49%), surgery (37%), and physical medicine/rehabilitation (36%). However, primary care providers account for about half of opioid pain relievers dispensed.
- Health care providers, including those in primary care settings above, report concern about opioid-related risks of addiction and overdose, as well as insufficient training in pain management. Although prescription opioids can help manage some types of pain, there is not enough evidence that opioids improve chronic pain, function, and quality of life.

### How bad is the opioid epidemic?

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The CDC indicated that opioids—prescription and illicit—are the main driver of drug overdose deaths. Within Pennsylvania, opioids were involved in 81% of the overdose deaths.<sup>232</sup> The opioid epidemic is a national problem, which has hit Pennsylvania with a steady increase in scale. As shown in the table below, for the past three years, Pennsylvania has continued to rise as one of the top 10 states for overdose deaths.

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<sup>232</sup> DEA, *2015 Analysis of Drug-Related Overdose Deaths in Pennsylvania*, page 11.

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#### 2015 Top 10 States for Overdose Deaths, with 2014 and 2013 Rankings

State	2015 Rank	2015 Rate*	2015 Deaths	2014 Rank	2014 Rate*	2014 Deaths	2013 Rank	2013 Rate*	2013 Deaths
West Virginia	1	41.5	725	1	35.5	627	1	32.2	570
New Hampshire	2	34.3	422	3	26.2	334	22	15.1	203
Kentucky	3	29.9	1,273	4	24.7	1,077	2	23.7	1,019
Ohio	4	29.9	3,310	5	24.6	2,744	7	20.8	2,347
Rhode Island	5	28.2	310	6	23.4	247	4	22.4	241
<b>Pennsylvania</b>	<b>6</b>	<b>26.3</b>	<b>3,264</b>	<b>8</b>	<b>21.9</b>	<b>2,732</b>	<b>9</b>	<b>19.4</b>	<b>2,426</b>
Massachusetts	7	25.7	1,724	13	19.0	1,289	18	16.0	1,081
New Mexico	8	25.3	501	2	27.3	547	3	22.6	458
Utah	9	23.4	646	7	22.4	603	5	22.1	594
Tennessee	10	22.2	1,457	11	19.5	1,269	12	18.1	1,187
<b>National Rate</b>		<b>17.8</b>	<b>52,404</b>		<b>16.1</b>	<b>47,505</b>		<b>14.9</b>	<b>43,982</b>

Notes:

\*Death rate per 100,000 residents.

Source: *The US Center for Disease Control Overdose Deaths.*

According to the CDC, nationwide, opioids were involved in 33,091 deaths in 2015, and opioid overdoses have quadrupled since 1999. Overdose deaths have now surpassed automobile accidents as the leading cause of accidental deaths in Pennsylvania.<sup>233</sup>

As shown in the preceding table, the national overdose death rate increased by 19 percent from 2013 to 2015; yet, in Pennsylvania that same rate has increased by a staggering 35 percent.

<sup>233</sup> <<http://www.ddap.pa.gov/overdose/Pages/community%20resources.aspx>> (accessed May 11, 2017).

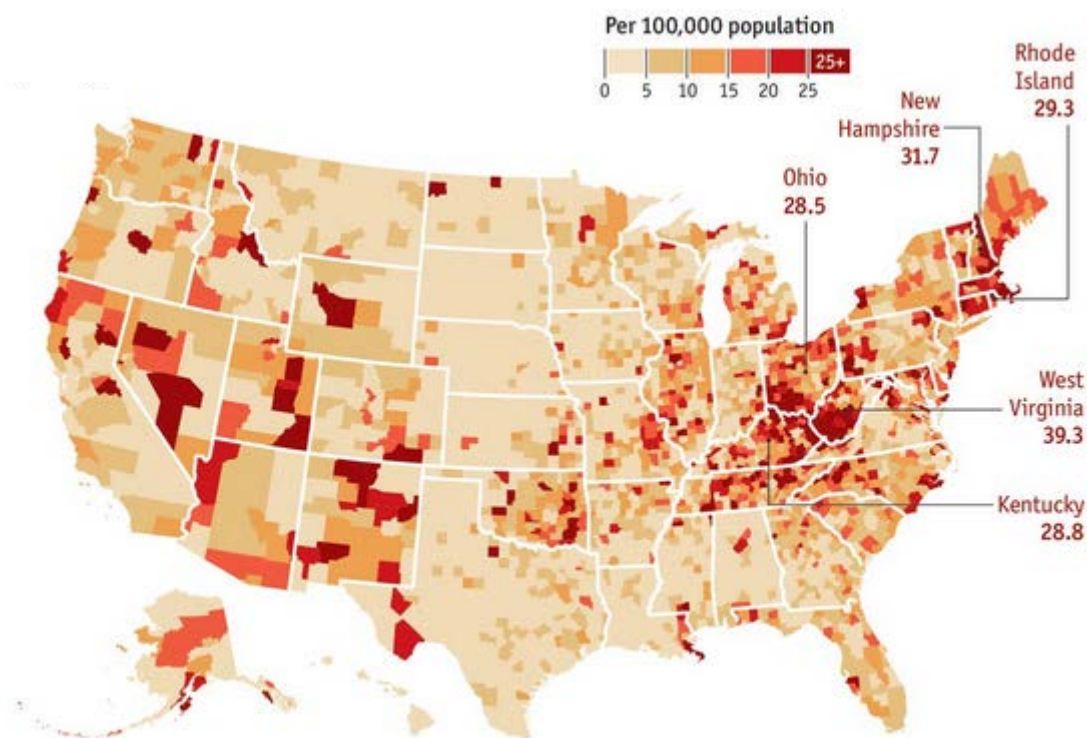
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The map below highlights the overdose death rate by county in the United States during 2015.

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Source: US CDC and the Economist.com.

### What has Pennsylvania done to control the opioid epidemic?

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We interviewed the Pennsylvania Physician General, who has been at the forefront of the effort to control Commonwealth's opioid epidemic. During this meeting, we were informed that Pennsylvania's response to the opioid epidemic can be thought of as falling into three policy-related "buckets" as follow:<sup>234</sup>

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<sup>234</sup> The Pennsylvania Physician General reiterated this concept on February 28, 2017, during the PA House of Representatives, Appropriation Committee Budget Hearings for the Department of Health and Department of Drug and Alcohol Programs.

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#### Pennsylvania's Policy-Related Approaches to Battle the Opioid Epidemic



##### Expanding Education

Pennsylvania is disseminating opioid epidemic educational information to medical schools, professional medical societies, and similar organizations, and instructing their students, faculties, and members how to demonstrate good opioid stewardship. More recently, Act 126 of 2016<sup>235</sup> requires medical colleges and other medical training facilities to develop and implement, beginning August 1, 2017, a safe opioid prescribing curriculum. The curriculum must include: current information related to pain management; alternatives to opioids pain medications; safe prescribing methods; identifying patients who are at risk for addiction; and managing substance abuse as a chronic illness. Through improved education future doctors will learn improved opioid prescribing practices; thus, lessening the potential for patients to become addicted.



##### Rescue

Within the last two years, Pennsylvania has enacted naloxone legislation<sup>236</sup> through Act 139 of 2014– expanding the classes of persons who can administer the medication from first responders to, more recently, members of the general public, including family members or loved ones of a person who may require a dosage of naloxone. Naloxone is a medication that blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. Naloxone is also used to help diagnose whether a person has overdosed on an opioid.<sup>237</sup> Act 139,<sup>238</sup> sometimes referred to “David’s Law”, also allows first responders, good Samaritans and families to administer naloxone to individuals who they believe were suffering an opioid overdose and were at risk of dying. Further, on October 28, 2015, the Physician General signed a standing order that allowed anyone in the Commonwealth to obtain naloxone.<sup>239,240</sup>

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<sup>235</sup> 35 Pa.C.S. § 5102(a).

<sup>236</sup> 35 P.S. § 780-113.8, enacted September 30, 2014, effective December 1, 2014.

<sup>237</sup> <<https://www.drugs.com/naloxone.html>> (accessed May 11, 2017).

<sup>238</sup> 35 P.S. § 780-113.7.

<sup>239</sup> <<https://www.governor.pa.gov/naloxone-standing-order/>> (accessed May 11, 2017).

<sup>240</sup> <<http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/opioids/Documents/Naloxone%20Standing%20Order%20DOH%20Public%20April%202017.pdf>> (accessed May 11, 2017).

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#### Expanding access to treatment

Expansion of treatment programs will help capture more addicted persons who might not otherwise receive attention, diagnosis and treatment. As discussed in the Department of Human Service section of our audit report, Pennsylvania has established Centers of Excellence to help Medicaid-qualified patients into treatment.

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*Source: Developed by Department of the Auditor General staff.*

Other opioid-related legislation that has been enacted in response to the opioid epidemic includes the following:

Act 191 of 2014,<sup>241</sup> known as the Achieving Better Care by Monitoring All Prescriptions Program Act (ABC-MAP), established a prescription drug monitoring program that “collects information on all filled prescription for controlled substances. This information helps health care providers safely prescribe controlled substances and helps patients get the treatment they need.”<sup>242</sup> This program is intended to give prescribers and pharmacists access to patient’s controlled substance prescription history, which will inform the medical professionals of potential risks regarding the treatment of individual patients. The Prescription Drug Monitoring Program also assists law enforcement agencies in the “detection and prevention of fraud, drug abuse and the criminal diversion of controlled substances.”<sup>243</sup>

More recently, on November 2, 2016, Governor Wolf signed legislation intended to further the fight against opioid abuse. These new laws include the following:

- Act 125 of 2016 – This act restricts the amount of opioids physicians can prescribe for minors to seven days.<sup>244</sup>
- Act 124 of 2016 – This act amends Act 191 of 2014 and requires continuing education in pain management, addiction and dispensing for prescribers and dispensers. Further, prescribers must check the state’s prescription database every time they prescribe an opioid or benzodiazepine class drug. In addition, the prescription dispensers

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<sup>241</sup> 35 P.S. § 872.1 *et seq.*, effective June 30, 2015.

<sup>242</sup> <<http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/home.aspx>> (accessed May 11, 2017).

<sup>243</sup> <<http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/GeneralInfo.aspx>> (accessed May 11, 2017).

<sup>244</sup> 35 Pa.C.S. § 52A03, effective upon publication of notice at 47 Pa.B. 671, Feb. 4, 2017.



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must input prescription data to the state's prescription database within 24 hours of dispensing.<sup>245</sup>

- Act 122 of 2016 – Hospital emergency rooms can only write opioid prescriptions for up to seven days and may not write prescriptions for opioid refills.<sup>246</sup>
- Act 123 of 2016 – Law enforcement offices, hospitals, health care facilities and pharmacies can be used as drop off locations for extra or unwanted drugs.<sup>247</sup>

### What treatment options are available for opioid addiction?

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While many drug abuse treatment programs prefer drug-free therapies to help their patients, focusing on counseling and rehabilitation, some programs offer Medically Assisted Treatment (MAT), which use medications (methadone, buprenorphine, naltrexone) in combination with counseling and behavioral therapies, to provide an integrated, person-centered approach to treatment. When treating a substance use disorder (SUD), and specifically opioid dependence, or Opioid Use Disorder (OUD), developing a comprehensive and integrated healthcare approach that combines medication and behavioral therapies can achieve the greatest success and treatment outcome.<sup>248</sup>

Professionals evaluate individuals seeking treatment for SUDs in order to determine the most appropriate level of care. To that end, the American Society of Addiction Medicine (ASAM) developed patient placement criteria to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction.<sup>249</sup>

Today, this criteria has become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are used in over 30 states.<sup>250</sup> Despite this wide usage, until quite recently, Pennsylvania used a separate placement criteria known as Pennsylvania Client Placement Criteria (PCPC) for Adults. These guidelines provided detailed guidance for

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<sup>245</sup> Amended 35 P.S. §§ 872.7 and 872.8 and added-872.9a, effective January 3, 2017. This Act also amended 35 P.S. §§ 872.3 and 872.5.

<sup>246</sup> 35 P.S. § 873.3. This Act added 35 P.S. § 873.1 *et seq.*

<sup>247</sup> 35 P.S. § 6029.206.

<sup>248</sup> <<https://www.samhsa.gov/medication-assisted-treatment/treatment>> (accessed May 11, 2017).

<sup>249</sup> <<http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about>> (accessed May 11, 2017).

<sup>250</sup> *Ibid.*

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special issues and populations that are important to ensuring that individuals receive optimal treatment placement.<sup>251</sup>

On March 9, 2017, the Department of Drug and Alcohol Programs announced that Pennsylvania will begin using the ASAM for determining the appropriate level of care for an individual seeking treatment or already within the treatment system, with full implementation targeted for July of 2018. DDAP indicated that the change was made for the following reasons:<sup>252</sup>

- Adherence to the Centers for Medicare and Medicaid Services rules which require the use of the ASAM to apply for certain waivers.
- The newly acquired treatment data system is already equipped with the ASAM continuum of care which will make the system more usable with fewer revisions.
- The ASAM is currently used for adolescent placement and is required by many insurance companies for adults. There will be more consistency for payers and providers across the system.

After evaluation, treatment for drug addiction typically follows one of the following programs, which are distinguished by their level of care. The level of care is based on the degree and severity of alcohol and other drug use through the development of a comprehensive confidential personal history, including significant medical, social, occupational, educational, and family information. Treatment programs are described as follows:

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#### Drug Addiction Treatment Programs

Care Level	Treatment Program	General Description
1	Outpatient  Intensive Outpatient	Psychotherapy provided for no more than five hours per week where the patient does not live at the facility. Psychotherapy provided for more than five hours, but not more than ten hours per week, and where the patient does not live at the facility.
2	Partial Hospitalization  Halfway Houses	Provides psychiatric and psychological therapies on a regularly scheduled basis. The patient does not live at the facility. This program requires a minimum of three days and ten hours per week.

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<sup>251</sup> <<http://www.ddap.pa.gov/treatment/Pages/PCPC3rdEdition.aspx>> (accessed May 11, 2017).

<sup>252</sup> <<http://www.ddap.pa.gov/Pages/Announcements.aspx>>, Secretary Smith's Announcement Regarding Transition From the PCPC to the ASAM (accessed May 11, 2017).

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		State-licensed professionally staffed programs that provide individuals counseling and employment assistance. Individuals in this program live at the facility, but can hold jobs in the public.
3	<p>Medically Monitored Inpatient Detoxification</p> <p>Medically Monitored Short Term Residential</p> <p>Medically Monitored Long Term Residential</p>	<p>The individual lives at the facility and the facility provides evaluation and detoxification. The detoxification process helps substance abuse dependent patients eliminate drugs from their system. These facilities can provide inpatient services, around-the-clock observation, monitoring and medication.</p> <p>24-hour evaluation, care and treatment for addicts in acute distress. It provides observation, monitoring and treatment for 24 hours. After the 24 hours, the patient may be referred for medical services, detoxification, and assessment.</p> <p>This program attempts to change the lifestyles of individuals who have led lives of chronic drug abuse. The program starts with a 24 hour evaluation, care and treatment before the individual is moved into a lifestyle improvement program.</p>
4	<p>Medically Managed Inpatient Detoxification</p> <p>Medically Managed Inpatient Residential</p>	<p>24-hour evaluation and detoxification by medical personnel. This program offers treatment for those who might have multiple addictions or mental health issues. 24-hour physician care and nursing care must be available at these types of facilities.</p> <p>The patient receives 24-hour medical care including evaluation and treatment. These facilities cater to those with coexisting conditions including biomedical, psychiatric and behavioral issues. These facilities must provide 24 hour nursing care, specialized medical care, intensive medical care and physician care for its patients.</p>

Source: *Pennsylvania's Client Placement Criteria for Adults, Third Edition, 2014.*

With regard to Pennsylvania's capacity to provide substance abuse treatment, the following table lists the number of licensed programs statewide for each level of care along with the total capacity (i.e., the number of individuals who can be treated) by the program.

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#### PA Drug Treatment Capacity by Type of Treatment

Level	No. of Programs Statewide	Program Capacity Statewide
1	733	106,202
2	351	12,346
3	61	1,103
4	27	547
<b>Total</b>	<b>1,172</b>	<b>120,198</b>

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Source: The PA Department of Drug and Alcohol Programs, Division of Licensing.

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#### Appendix C – Distribution List

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This report was distributed to the following Commonwealth officials:

**The Honorable Tom Wolf**  
Governor

**The Honorable Jennifer S. Smith**  
Acting Secretary  
Pennsylvania Department of Drug and  
Alcohol Programs

**The Honorable Ted Dallas**  
Secretary  
Pennsylvania Department of Human  
Services

**The Honorable John E. Wetzel**  
Secretary  
Pennsylvania Department of Corrections

**The Honorable Randy Albright**  
Secretary of the Budget  
Office of the Budget

**The Honorable Joseph M. Torsella**  
State Treasurer  
Pennsylvania Treasury Department

**The Honorable Josh Shapiro**  
Attorney General  
Office of the Attorney General

**The Honorable Sharon P. Minnich**  
Secretary of Administration  
Office of Administration

**The Honorable Gene DiGirolamo**  
Majority Chair  
House Human Services Committee

**The Honorable Angel Cruz**  
Democratic Chair  
House Human Services Committee

**The Honorable Matt Baker**  
Majority Chair  
House Health Committee

**The Honorable Florindo Fabrizio**  
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House Health Committee

**The Honorable Lisa Baker**  
Majority Chair  
Senate Health and Human Services  
Committee

**The Honorable Judy Schwank**  
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Senate Health and Human Services  
Committee

**Mr. Brian Lyman, CPA**  
Director  
Bureau of Audits  
Office of Comptroller Operations

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**Ms. Mary Spila**

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