H. 885 – ADAP Amendment
Department of Health Testimony to House Human Services 5.1.14

Good Morning and thank you for the opportunity to provide input on a provision in the budget to move the treatment related services currently in the Alcohol and Drug Abuse Program at VDH to the DVHA.

At the outset I would say that this provision came at the eleventh hour in the Senate and frankly was a surprise. It was passed by the Senate committee without hearing substantive testimony from stakeholders, including the Department of Health, Department of Vermont Health Access, ADAP, and service providers. This morning is our first opportunity to provide any testimony. This is a distressing lack of the customary process.

As you know, the Governor is committed to addressing the opiate public health crisis that confronts Vermont and the nation in a comprehensive manner. That means working intensively on multiple levels in the community throughout the spectrum of prevention, early intervention, harm reduction, treatment and recovery. I have been lucky to have foundational elements of each housed in VDH. With this structure in place we are integrated in order to coordinate these efforts. We are on the right path and making progress. Dividing ADAP into two distinct pieces would be operationally challenging, programmatically disruptive, and resource intensive. The Division would have to stop its work and instead plan for moving both people and functions - including program staff, administrative assistance, and IT.

The goal of VDH, DVHA and other AHS partners is an integrated approach to. Currently resources to process ADAP grants and manage Federal Block and discretionary grant income are part of the VDH Business Office structure. This function is connected to our Federal reporting requirements as the Single State Authority and is different from anything that DVHA currently administers. Disconnecting these pieces would be quite disruptive to the VDH infrastructure, as well as burdensome to the DVHA structure. There are also unique Federal reporting requirements such as the Substance Abuse Prevention and Treatment Block grant.

In short, this proposal would disrupt an integrated approach to addressing addiction and would fragment the critical work that is being done to combat the current opiate crisis.

Central to our efforts to address the opiate public health crisis is the Care Alliance for Opioid Treatment, what used to be called the “Hub and Spoke.” The goal of the Alliance is evidence-based treatment on demand. Our progress is a testament to a successful partnership between DVHA and VDH. VDH provides the oversight and management for the specialty treatment like methadone in the Hubs and DVHA (Blueprint) provides the same in the spokes many of which are in primary care practices. This partnership has been working well based on the strengths of each department- DVHA does the analytics and fiscal management, VDH the program

management. To be frank, this is not easy work but it is immensely satisfying to note our progress.

The treatment managed by ADAP is specialty treatment in substance abuse such as methadone and care by co-occurring capable Preferred Substance Abuse Providers licensed by VDH. All of this care must be fully integrated and coordinated with other AHS departments (DOC, DCF and DMH). ADAP leads the Agency's efforts to coordinate substance abuse treatment. Most of this treatment is paid for by Medicaid, supplemented by the Federal Substance Abuse Prevention and Treatment Block Grant to provide for the uninsured.

There are no savings associated with moving ADAP. In fact the disruption and complexity of such a move would bring both financial and programmatic costs and unclear benefits.

Critically, ADAP, MCH, EH, ID/EP are all public health programs. ADAP and the *other* public health divisions of the Department of Health work together on a daily basis to improve Vermonters' health. Together, they comprise an important piece of Vermont's public health enterprise.

The ability of VDH to provide comprehensive leadership and specialized knowledge to address the community impact of substance abuse is a function that took years to develop. Moving pieces of ADAP as we are implementing the community and clinical work will undermine the team and certainly reduce our overall effectiveness and delay new initiatives such as SBIRT.

Clearly it is the prerogative of the legislature to determine the structure of state government. I trust that a decision of this magnitude would involve stakeholder input and thoughtful consideration. This proposed move is the wrong decision at the wrong time but would welcome any further discussion regarding the issue next year.

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