Michael Donovan: PacMAT is an acronym that you'll hear quite often in the next 30 minutes. It stands for the Pennsylvania Coordinated Medication Assisted Treatment program, which is administered through the Pennsylvania Department of Health. I have two guests with me today, one being Laura Fassbender, executive advisor in the Office of the Secretary, the Pennsylvania Department of Health; the second being Dr. Max Crowley, Associate Professor of Human Development and Family Studies and the director of the Evidence-to-Impact Collaborative. I wanna thank you both for being with us today. If we wanna just start with some introductions for our listeners, how 'bout—Laura, could you start?

Laura Fassbender: Yeah. Thank you, Mike. I'm glad to be here and get to talk about PacMAT today. As you mentioned, my name is Laura Fassbender. I'm an executive advisor here at the Department of Health, to the Secretary of Health, and in this role, one of the key programs that I have the privilege of working on is the Pennsylvania Coordinated Medication Assisted Treatment program, which is a very unique program here in Pennsylvania that expands access to medication-assisted treatment for opioid use disorder and helps us to get providers throughout the commonwealth trained and comfortable with prescribing lifesaving MAT. Thank you for having me.

Michael Donovan: Excellent. Thank you. Max?

Max Crowley: Thank you, Michael. I'm the Director of the Evidence-to-Impact Collaborative, and my role here at Penn State is I'm both a professor—or associate professor in human development and family studies, as Michael mentioned, but I also oversee a variety of different studies and programs that we operate here out of the EIC, the Evidence-to-Impact Collaborative. Many of those include a focus particularly on substance misuse and, as of late, how we address the ongoing opioid epidemic in this country.

Michael Donovan: Excellent. Again, thank you both for being here today—well, remotely, in this modern life we live. My first question to just kinda start things off for our listeners, Laura, could you describe the genesis, some of the structure, and overall goals of PacMAT, again, the Pennsylvania Coordinated Medication Assisted Treatment program—really from your perspective, sitting in the Department of Health? I'm really interested in if there are any particular challenges that you've encountered in really getting this kind of gargantuan effort off the ground.

Laura Fassbender: Sure. Thank you, Mike. This program was really the brainchild of our previous Secretary of Health, Dr. Rachel Levine. Dr. Rachel Levine and her number two, our previous executive deputy secretary, Sarah Boateng—the two of them spent about a year I'd say, traveling the state in a Dodge Caravan, listening to providers in the community, people who are living with the substance use disorder, family members of people who have been lost to substance use disorder, and really they did a lot of this on-the-ground conversations about what is the real problem here, and how do we fix it? This was during a time when our opioid crisis in America and in Pennsylvania was absolutely peaking, with thousands of deaths per year, and really not a robust infrastructure to support the amount of prevention and treatment and really recovery efforts that needed to happen.

As Dr. Levine and Sarah were doing that traveling and really listening across the state, what they had heard from providers was that there wasn't enough people who were prescribing medication-assisted treatment, which we know is the gold standard for opioid use disorder, and those who were able to get their DEA waiver and prescribe were not necessarily comfortable enough with treating the addiction that was in patients. Because of that, they really looked around and saw what other states were doing, and so they looked at work in Vermont and Rhode Island and other states and saw the efficacy of hub-and-spoke models, and recognizing that Pennsylvania is an incredibly geographically diverse state, thought this model could be something that worked well in Pennsylvania.

This model really started out as a conversation in that Dodge Caravan and eventually transferred over to a sophisticated napkin, and then magically through the funding and commitment from SAMHSA, the Substance Abuse and Mental Health Administration, we received funding to invest in this program. That investment has really been a federal and state and private partnership, and through that, we've been able to issue grant dollars to health systems across the state who are already treating patients for their high blood pressure or for their routine pregnancy care and their migraines, and we asked those patients to really start treating the whole person. We explained this concept that we're not asking you to take on a new population of people. We're asking you to treat the addiction that your current patient is dealing with as well.

We asked that addiction and opioid use disorder be treated the way that any other disease is, and we have found that through that type of messaging, we're able to break down barriers and stigma, and

we have successfully been able to train and recruit and expand the network significantly over the years. We've experienced tremendous success in the program with getting patients connected to medication-assisted treatment and providers comfortably prescribing.

With that being said, this did not come without challenges. I would say that our key challenges are really focused into two buckets. One with stigma—which still exists—but we have made progress, but more — needs to be done—and the other with public health infrastructure and the lack of funding and a carve out for behavioral health and really trying to navigate how to find sustainability in the billing models and payments for the program. We have found some innovative solutions around both of those. We've really worked to raise awareness and education about addiction and opioid use disorder and the benefits of MAT, and we also have learned a lot about investments and ways to continue to support this important initiative. We know that it is actually a life-saving initiative, but really a cost-saving initiative as well.

There have been challenges, but overall, it's been a program that we are universally proud of and has worked really well. The main mission and the vision of the program is simple. Really, the mission is to expand access to medication-assisted treatment through a hub-and-spoke model throughout Pennsylvania, and we have done that, and we continue to expand that. The vision, which we have still work to do here, but as a state, where regardless of where you live, you have access to high-quality, evidence-based medication-assisted treatment for opioid use disorder.

We've sought out to make strides towards that vision, as I said, through a hub-and-spoke model. At the center of the hub is a centralized addiction specialist-led team that really is the center and the expert of the program. Then they recruit spoke sites, and they provide direct support, technical assistance, guidance, leadership to their spokes. Then those hub members and those expert addiction medicine providers or clinicians—they're able to help the smaller spoke sites, which is really a benefit to how Pennsylvania is geographically, to get the treatment into the community and into the providers' offices that they're already going to.

These physicians—perhaps at a large health stem or at a large hub—they're able to consult with these smaller practice physicians on new patients or complex patients, able to help with case management. If there's significant needs among a patient, the

patient can go between the hub and the spoke site. Then really, they work together collaboratively to collect data and develop metrics to track their success along the way and then adapt as they go. The spokes—we started out the program by defining them as primary care practices who provide the medication-assisted treatment in their community while being supported by the hub. That support is really a key backbone of the program.

The spokes are also responsible for coordinating patient counseling and managing that whole-person care, the overall health of the patient. We're not asking to set up another methadone clinic—which of course, there is value in that, but we're really asking to integrate this treatment into primary care service lines.

As I said, the spoke, we began defining that as a primary care site, but over time, that has evolved beyond traditional lines of primary care into places like pain management specialists, urgent care management specialists, urgent care providers, emergency departments, drug treatment courts, mental health providers, community organizations. And we're really excited about that. We've seen that, and we believe that part of the success of the program is really attributed to the flexibility that's been allowed among sites and among the different programs throughout the state. We've been able to see this type of creative integration, and that has worked really well so far.

Michael Donovan: Thank you so much, Laura. That's really remarkable and comprehensive rundown of the structure, goals of a really complex program that's helping so many people in Pennsylvania, in really a dynamic and changing environment. Part of that changing environment led you all at the Department of Health to really try to think about how to measure and study this program. I'd like to bring Dr. Crowley in here to talk a little bit about the technical assistance project that the Evidence-to-Impact Collaborative started on last year. Max, could you just kind of introduce to us what the technical assistance project related to PacMAT looked like and some of the process and details from your vantage point in the academy and some of the approach, some of the scientific aims?

Max Crowley: Thank you, Michael, and thank you, Laura. It was very nice to hear, once again, your description of all of the genesis as well as the good work of PacMAT. We came to PacMAT—as many academic researchers often do, where we were not overly familiar, actually, with the PacMAT model at first. We'd heard good things about it from providers in the state, and we'd certainly heard it

spoken about in a variety of different settings across PA government, but at the time, we really didn't understand a depth as well as the reach that the model had already taken root in Pennsylvania. We had the opportunity to come from it from an independent viewpoint.

In particular, along with my co-leads Joel Segel, an assistant professor of health policy here at Penn State University Park, as well as Glenn Sterner, an assistant professor at Penn State Abington—we were able to bring a diverse perspective and diverse background. Joel's background is in health policy, mine is in human development and public finance, Glenn's is in criminology, to understand the opioid epidemic in really all of its different forms requires sort of this interdisciplinary view and the bringing of different theories and methodologies, and we really got to express that with the PacMAT work. We were so excited about the partnership with the Department of Health. They were so supportive of the work from the get-go.

Diving into what our technical assistance project entailed was really characterizing and understanding what PacMAT looked like on the ground, and so really—as Laura alluded—in terms of the story of how PacMAT came to be—it evolved through this really formative work that the Secretary and her colleagues were doing and then was sketched out on a napkin, as all good ideas start out as. We had the opportunity of working with the Department of Health to really elucidate and operationalize what the model looked like in the real world. It's amazing to see how close these idealized, original ideas of what the model could be and then how it actually was being implemented, and there was such a tight connection and it really speaks to the investment of time and energy from leadership as well as the buy-in that was able to be achieved through industry and other folks—stakeholders around the state.

The technical assistance project is probably best characterized as a mixed methods project. That's a term we often use in research settings to talk about both the qualitative—the narrative information, holistic information that you can learn about a phenomenon or in this case, the PacMAT model, as well as a quantitative work, where we actually did data analysis, both working with data that the Department of Health really opened their books to us to look inside and kick the tires of the PacMAT model, as well as bringing objective data from other sources, both from other public sources as well as from actually industry. This was a really exciting work because it allowed us to think both

holistically about the underlying narrative and approach the work qualitatively, as well as quantify what we were seeing on the ground.

All of this happening in a highly interdisciplinary context with the singular goal of how do we address sort of the opioid epidemic—and Laura spoke so nicely about the intent and the goals as it relates to access, and that was a huge focus of our work, was we wanted to characterize what PacMAT was, but we also wanted to understand, was it achieving that sort of really important proximal goal of how do we support and provide access to high-quality medication-assisted treatment, which has time and time again, through a number of different clinical trials, demonstrated its value.

It's really about getting—supporting providers to get this—these treatments into place and then supporting the patient population to be able to receive them. As you can see, there were many different components to the work, and it involved speaking with key stakeholders, both inside government and out, as well as a variety of exciting opportunities—at least for us in academia—around looking at the quantitative data.

Briefly, 'cause I think we'll get the opportunity to get into this in other parts of the conversation today, what we found was that the model was—as I mentioned before—uncharacteristically being systematically implemented over a variety of settings and stakeholders in a really consistent manner. You don't see that every day, especially from organically grown efforts that states often bring online, which are about responding to the needs in front of them often, but what we found was that the model was really systematically being implemented. I think much of that is attributable to the Secretary and her background as not only a clinician, but also a scientist. It was nice to come behind someone who clearly had been thinking about not just today, but the future of this work.

What we found in particular was not only that it was being implemented consistently in the same way, to meet patients' needs and the needs of the providers—but the providers themselves were really enthusiastic about what PacMAT was offering them. In particular, as Michael mentioned before and, Laura, you discussed—the coordination is so key. How do we coordinate and build that capacity locally within communities, but also making sure that there is the supervision to ensure that high-quality care is happening?

Once again, we were pleasantly surprised through our interviews to see this positive take. The Department of Health was not involved in who we talked to. They basically just opened the doors, and so we talked to lots of folks. We did also find opportunities for growth for the model. As I think everyone knows, the opioid epidemic continues across this country and has been worsened by COVID, and so there are many opportunities—in terms of, of course, resources, which are always scarce, but also in terms of the excitement that existing providers who are using the PacMAT model had for new PacMAT users to come on board, because they really characterize themselves community of practice in their adoption of that work.

Again, we were able to capture this holistic perspective, but in addition to that, some of our quantitative work also revealed more objectively what it was actually happening on the ground. What we were excited to see is the amount of access that was being provided was really tremendous. Hundreds of new doctors being supported and waivered through ASAM and some of the other key investments that the state was making, but also then patients—numerous patients, particularly in areas of the state that had otherwise really not had access being able to receive the PacMAT model, and this occurring every month—thousands of new patients—which is really important and really—particularly serving Pennsylvania which has a large rural population where access to care can be so difficult.

Further, I mentioned that we had the opportunity to use different industry data that was totally separate from government in that work, and in particular, through a data partnership with IQVIA, previously Quintiles, we were able to look at local pharmaceutical prescriptions—the filling of those prescriptions and particularly as it related to the types of prescriptions that are needed to deliver MAT in a high-quality fashion. What we saw was that, indeed, that in the areas where PacMAT was operating versus the areas where it wasn't, we were seeing the lifesaving supports through these drugs being offered to patients at a higher rate. That was really nice to see because this was totally separate from anything that the state had collected. This was totally industry data that we were able to mine and again, having that objective triangulation is hugely important.

Michael Donovan: That's an excellent rundown on a very complex project, utilizing a variety of different datasets and sources. It goes to show the value of diversity in the research team as well, from an interdisciplinary

orientation. I wanna zoom out a little bit here, and my next question is for you, Laura. Obviously, the Department of Health has a wide menu of services and challenges in front of them as we sit here in the midst of a global pandemic. could you orient us to how PacMAT really is situated in the commonwealth's grand strategy for substance abuse prevention and treatment and the larger ecosystem there, as well as the Wolf administration writ large in terms of their policy agenda and imperatives. From our work with this project, we certainly know that the Department of Drug and Alcohol programs and the Department of Human Services play significant and different roles, as well as the federal government, From intergovernmental perspective and kind of a horizontal perspective, could you give us a little orientation there?

Laura Fassbender: So, the opioid crisis is—and needs to be—an all-hands-on-deck approach. There's really no other way to respond to such a colossal epidemic than to have all hands-on deck. We've learned through a public health framework about the social determinants of health, in that if we want to improve public health outcomes, we can do all the public health work that we want—education—but it also has larger implications on society and on communities. Because of that, the governor recognized this, and he signed a 60-day disaster declaration in January of 2018. The purpose of this disaster declaration was to bolster resources to combat the crisis.

Since then, it's now 2021, that disaster declaration has continued to be renewed every two months, and it still really is a critical component of our response. Through that declaration, it promulgated the Opioid Command Center, and so if you are not familiar with the Opioid Command Center, it has been a tremendous effort in Pennsylvania. It is a group of people from 17 different state agencies and stakeholders from the community who meet every Monday to discuss opioid-related data, programmatic updates, tools to address the crisis, any challenges and barriers, and then during that time, we all really put our heads together and figured out how can we overcome these challenges.

And so, we've bucketed the response to the opioid crisis into three key categories, which is prevention, rescue, and treatment. Of course, PacMAT falls into that treatment bucket, which is absolutely critical, but we know that those prevention efforts are absolutely key to make sure that we save people from ever dealing with an opioid crisis or eventually needing to use this lifesaving MAT.

In the prevention vein, there is a number of initiatives that the Wolf administration has led, and those all continue to propel forward. Some of those include prescribing guidelines. We have, at this point, well over 10—I think maybe 13 prescribing guidelines for different types of scenarios and medicine, so prescribing guidelines for sickle-cell disease or how to prescribe an opioid to somebody who does have opioid use disorder, pain management guidelines for people with opioid use disorder. That type of education has been a really key pillar of our response. We've also worked to integrate addiction medicine and medication-assisted treatment prescribing practices into the medical school curriculum.

Then another absolutely foundational prevention effort has been the prescription drug monitoring program. We call that the PDMP, and we saw—from the implementation of the PDMP to when it was in full swing and years down the line—from that initial change, tremendous success because we were able to show other providers if a patient was receiving a medication from multiple facilities—if they were doctor shopping or if they clearly needed help—we were able to demonstrate that to providers. Then if there are providers there who weren't prescribing opioids judiciously, we were able to know who those providers were. Through that effort, we've had tremendous success from preventing opioid use disorder from happening in the first place. Those efforts continue on. Most of these efforts are still very active, and there are a number of other prevention efforts, but those are some of our key elements that all tie in with the program as well.

That second bucket I mentioned was rescue, and so we've done a lot of work to increase access to naloxone. Naloxone is the medication that you can provide when somebody is having an overdose or a suspected overdose, and essentially brings back life to the individual, and it is a very easy tool to use. We've really made it our mission in this administration to make Naloxone as widely-available as possible, so through this administration, we've had police become equipped with naloxone, park rangers become equipped with naloxone, schools become equipped with naloxone, and then the general public really having naloxone available to them. That has been through the Secretary of Health and now the Physician General's standing order to naloxone. We know that has really been another pillar to our response.

In the treatment vein, what we're talking about today, PacMAT, has really been a key effort, but PacMAT is not the only effort in the administration's response to this crisis. We've had a number of other efforts. We have launched addiction medicine fellowships to

get young professionals into the addiction medicine field. We've also had MAT summits where we've trained hundreds of providers at once so that they have their DEA waiver to prescribe MAT. We also have a really robust network of centers of excellence throughout the state who are doing the same type of treatment and making medication-assisted treatment more accessible in our communities.

Michael Donovan: Certainly seems to be a Herculean effort across all levels of government and very much a priority of the Wolf administration. It's especially pressing as we experience this epidemic within a pandemic, of course that is really making conditions so much worse for so many people. One thought about the PacMAT program overall is the conception of it as a potential model for implementation elsewhere. We've thought about this before, we've talked about it, and it's really a testament to the investment that's been put into it already in its design. I wanna talk about some of the features of the program as well as some of the demographics or attributes of Pennsylvania, really, that either strengthen or weaken the proposition of features of this program or a similar program being implemented in other states or even on the national level. What features are beneficial to encouraging broader adoption? Are there areas that might need to be modified?

Max Crowley: Michael, that's a really great question. The PacMAT model is well-positioned for it sort of being exported, if you will, to other states. Pennsylvania is such a great place for testing and evaluating different types of coordinated and behavioral supports that engage communities because it is so diverse in many ways with its two large urban areas anchoring both sides of the states and then its large rural populations in central Pennsylvania. The opportunities, in particular, surround the role and flexibility of the PacMAT model to engage in a variety of settings with a variety of providers and then reach out and reach in, if you will, to different communities is what we saw.

In particular, through Glenn Sterner's social network analysis that he conducted of the hub-and-spoke models, what we saw is those that were able to develop increasingly dense networks where they had many spokes, and they developed them in the sustainable fashion—those seemed to be the ones that had the most reach and most touch across the state, and so supporting the maturity of those hubs and spokes seems really important. Further, something that I think Laura can speak to is the trust that we heard from the providers through our stakeholder interviews that they were partners on this work as well as the partnerships that many of the

providers expressed around being able to work with their colleagues at other providers, really a culture of collaboration and communities of practice as opposed to competition. I think those were key, but Laura may have more to add here.

Laura Fassbender: Yeah, Max. I agree completely with your thoughts there. I think the most unique thing about the program is the collaboration that it has built. We have 11 health systems—who are all truly competitors—across the state, in one room, and all sharing their secrets about the success of the program, the pitfalls of their programs, and really in this open conversation because once everyone starts talking, that's where the power is, really. That's when you learn about the shared challenges or a challenge that someone else in the room has already gone through six months ago, and then you can apply that same strategy or talk to the same person to learn how they got through it or who helped them get through it. That has been an absolutely key component of the success.

I think unfortunately, we've had the realization that there is enough patients to go around here, so we're not competing for a specialty service to be providing. We're all united behind one mission, and there is plenty of patients—unfortunately and tragically—to go around. I think that somewhat removes the barriers to collaboration there because we know that this is a universal issue, and just how we've said that it required all hands-on deck, from a state agency perspective, it really relied on all hands-on deck from the health system perspective. That's exactly what we've gotten. We have very open conversations in that group, and they have been so helpful, and it's really unique to hear from month to month the programs share the updates and then oftentimes, it's just a dialog back and forth between the programs, hearing about ways to overcome that challenge. I think that has been a key success of the program and something that's unique to the program.

I also think what allowed the program to be adoptable by so many different sites—and as Max said, replicable—is really allowing the sites to craft their own path. We handed over, essentially, the dollars and told the sites we're here to support you, but this is your work to lead and to be the expert in your community. We found that transferring over that decision-making about how the program on the ground would operate, to the programs, was tremendously valuable. It ultimately resulted in a system-wide change within their large health systems. That has been a key success of the program, and I think without the flexibility that we enabled them to

have and the ability to innovate on their own, we would not have been in the place that we are today.

Michael Donovan: Fascinating, and really key to collaboration is institutional knowledge as well. I think about all the various players, public and private, in industry, academic, that have been a piece of this. I wanna think about what changing and transition means for programs like these. We all know that, of course, Dr. Levine will be—pending senate approval—our new Assistant Secretary of the Department of Health and Human Services in the Biden administration, which is very exciting. Really proud of Pennsylvania and Pennsylvania's very proud of her. That does lead to questions about what does the future hold for some of her legacy here in the Commonwealth, if you think of PacMAT as a signature program?

Laura, you had thoughts on what transitions to new roles mean for programs, and how do we really seek to reduce some of the inefficiencies that are related to the loss of institutional knowledge as those in public service—having been in it myself before, there's a lot of rotation and change. I don't know if you had any thoughts on that and thoughts about the future of PacMAT.

Laura Fassbender: Well, I like to say—and maybe it's for my piece—that we all will continue to be working with Secretary Levine or Assistant Secretary of Health and Human Services Levine just from a further ways away, because we will really still be working on public health together. That being said, there still is a commitment—a strong commitment here—from the Department of Health and from the Wolf administration to continue to invest in the PacMAT program and expand it beyond what it is right now.

Through working with our Penn State colleagues here, we've learned a tremendous amount—opportunities for growth within the program, but also what has been successful and what would lead it to be more successful. We're excited to apply that knowledge, with Secretary Levine leaving, I don't think this is, in any way, the end of an era. It's just continuing this work in building upon what she has started here. We're excited to continue to support this program. We have received SAMHSA dollars to administer for year three, so we'll continue to invest in the program and expand it beyond what it is now.

We will hope that the dollars will continue to flow in. We think one silver lining of the pandemic may be revealing the importance of having a public health infrastructure to respond to both

pandemics and epidemics and whether it be opioid use disorder or the COVID-19 pandemic, there really is a critical need to invest in public health, to prevent other more serious medical conditions from eventually happening and having a larger impact negatively on society as a whole. I personally remain hopeful that we will continue to have more investment and support in public health in the future, and that will look like supporting programs like PacMAT.

Michael Donovan: Thank you. I really wanna think about how we can find ways to better foster collaboration between government partners like yourself, Laura, and the academic community. Any thoughts come to mind? Any efficiencies we could seek or things we'd redo if we had a redo, if we had a mulligan on this? I don't know. Max, you wanna chime in on that, please?

Max Crowley: Well, we've had the opportunity at the Evidence-to-Impact Collaborative to engage with and partner with a variety of different government organizations at the federal, state, and local level. This project has been a particularly gratifying one and I think that for us, is often an exemplar we point to for the types of relationships we like to have with government partners. Really for us, this was about co-producing evidence—we as the researchers were given free rein to open the books and talk to who we wanted to talk to and at every step of the way, we found the Department really receptive to our feedback, the identification of strengths and weaknesses and opportunities. That's really a joy from a scientific standpoint because we get to have the conversation. It wasn't about trying to frame it in the right way or something like that.

I think that for others looking to work with and enter into these research policy type partnerships—I couldn't more highly recommend it for the sake of the science, but I also can say—from the experience here—that it's possible to have really productive, open, and exciting partnerships such as this.

Laura Fassbender: I echo all of your thoughts, Max. I know here at the Department, the work that we do really relies on research—or it prompts research—but we aren't researchers here, and so we heavily rely or always need to rely on the expertise of academia and really taking your expertise as advisement here to the work that we do. We have done that through this program and I hope that the work and the model and the relationship that we've built through this program can be applied to programs more broadly throughout the Department and the administration. I think it has, in some ways already.

I also would just say that having the conversation is the most important part. I know all of us have different areas of expertise, and whether it be listening to community members or from people who are experiencing addiction, people who are researching the outcomes of addiction, people who are prescribing MAT—it's really just critical to hear what the collective experience is so that we can respond accordingly. I cannot say enough positive remarks about the relationship that we've had, working with the Penn State team here, to really expose ways that the program can grow, but also not just rely on our anecdotal evidence of how the program has been successful, really putting evidence behind it, looking at the pharmacy data, interviewing providers who participate in the program without us there—it's really shown us the program for what it is.

I think doing that is, one, a great way to foster accountability, but really to foster more productivity. I think this has been a great partnership, and I would certainly just encourage people to have the conversation and to reach out and to ensure that we're fostering an environment that there are opportunities to have conversations like these ones.

Michael Donovan: Wonderful. Thank you so much. I do wanna give each of you the opportunity for any closing thoughts, anyone like to chime in?

Laura Fassbender: Thanks, Mike. I would just like to close by expressing my gratitude, really, for the 11 programs, whether currently receiving support from the Department to do this work or if they've already found ways to sustain their programs. This work, I think—I know, truly does save lives, and it is not always easy, but it is always necessary. I'm thankful to all of the providers or community health workers or peer recovery specialists or program managers who participate in PacMAT and then also so grateful for the support of the governor and our previous secretary, Dr. Rachel Levine, for Sarah Boateng, for our new secretary of health, Secretary Beam, just the support that we've received has allowed us to do this. Without that, we wouldn't be having this conversation today, so I'm very thankful for that.

Max Crowley: That's wonderful, and I just wanna say thank you to the state as well as my co-leads, Joel and Glenn. This was a exciting project, doing important work, and so really appreciate the opportunity.

Michael Donovan: Well, thank you both so much for your time today and for a really excellent conversation on a really crucial program that you both

put a lot of work into. With that, we can conclude the conversation with Laura Fassbender, Executive Advisor in the Office of the Secretary at the Pennsylvania Department of Health, as well as Max Crowley, Associate Professor of Human Development and Family Studies and director of the Evidence-to-Impact Collaborative. Thank you.