"What Are State Governments Doing to Combat the Opioid Use Epidemic?"

Testimony to:

The Senate Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

The Honorable Roy Blunt, Chairman
The Honorable Patty Murray, Ranking Member

136 Dirksen Senate Office Building

Submitted By:

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Thursday, February 28, 2019
136 Dirksen Senate Office Building

Chairman Blunt, Ranking Member Murray, and members of the Subcommittee, my name is Mark Stringer, and I serve as Director of Missouri's Department of Mental Health. I also serve as the Chair of the Public Policy Committee of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Thank you for the opportunity to testify before the Subcommittee today to discuss actions Missouri is taking to address the opioid crisis. In particular, thank you for the opportunity to share with the Committee the importance of the State Targeted Response to the Opioid Crisis Grants (STR) and the State Opioid Response Grants (SOR) – grants managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) at the federal level and State alcohol and drug agencies at the State level.

Critical Role of the SSA

Critical Role of the Single State Agency (SSA) for Substance Use: The state agency plays a critical role in overseeing and implementing the publicly funded prevention, treatment, and recovery service system. All state substance use agencies develop a comprehensive plan for service delivery and capture data describing the services provided. It is important that federal grant opportunities be coordinated and leveraged with the federal block grants to assure effective and efficient use of resources.

An important focus of state directors across the country is the promotion of effective, high quality services. In Missouri, for example, we use our contracts as a mechanism to promote the use of evidence-based practices. In addition, we utilize onsite "fidelity reviews" in order to assess the extent to which providers are employing best practices in the right way. We also engage in on-site certification surveys or recognize national accreditation to ensure that providers are adhering to standards of care set by the Department of Mental Health. These standards apply to a number of areas related to service delivery, from staffing requirements (number of staff, qualifications of staff, continuing education required, etc.) to important rules governing the facilities within which services are delivered.

State directors focus on another important task: collecting and using data to improve service delivery. In Missouri, we obtain data in a number of categories, including abstinence from the use of alcohol, abstinence from the use of drugs, impact of services on housing, impact of services on employment, connectedness to community, and others. The Division tracks other measures such as the number of children returned to their parents' custody and the number of individuals receiving recovery services. A great deal of prevention data comes from the Missouri Student Survey, which provides information at the county and local levels, with a sample size of nearly 200,000 students.

State substance use agencies represent a key source of technical assistance to the workforce in each state. In Missouri, we partner with the University of Missouri St. Louis, Missouri Institute of Mental Health (UMSL-MIMH) to run our statewide opioid grants, as well as a number of other initiatives, including our Spring Institute that provides training to thousands of staff and administrators in the behavioral health field. We work with the state provider association to plan, coordinate, and present trainings on evidence-based practices. My staff at the department also regularly work directly with providers, offering technical assistance and training in a variety of areas.

Missouri Crisis

Scope of the Substance Use Disorder Problem in Missouri: It is worth stepping back for a moment to first examine the impact of all substance use disorders in the state before focusing on the unique issues related to prescription drug misuse and heroin. Overall, it is estimated that 379,000 Missourians have a substance use disorder. Of these, 17,000 are between the ages of 12 and 17 years old.

We know that approximately 8,600 parolees and 27,200 probationers in the state need substance use disorder treatment (Missouri Department of Corrections, 2017). Close to 28,400 Missouri veterans have a substance use disorder (Missouri Department of Public Safety, 2017) and 8,300 pregnant women struggle with drug or alcohol use (Missouri Department of Health and Senior Services, 2016).

In Fiscal Year (FY) 2018, about 47,820 Missourians received treatment for substance use disorders through the publicly funded system. The majority are individuals who lack resources to pay for treatment. Nearly one-half (45 percent) are referred through the criminal justice system. Alcohol is the most common substance problem presented at treatment admission (31 percent) followed by methamphetamine (21 percent), marijuana (21 percent), heroin (15 percent), and other drugs (12 percent). The state has been affected by methamphetamine use predominantly in the rural areas and heroin use in Eastern Missouri, including metropolitan St. Louis. Intravenous (IV) drug use is problematic statewide due to methamphetamine and heroin use.

Prescription Drug Use, Heroin, and Illicit Fentanyl: More than 52,000 Missourians meet clinical criteria for opioid use disorder (OUD). The epicenter of Missouri's overdose crisis spans the eastern region, including both urban St. Louis City and County and rural surrounding counties. The highest rates of overdose deaths in Missouri are in urban, predominantly African-American communities that are underserved and stricken by poverty.

Missouri had 951 opioid overdose deaths in 2017 – meaning we are losing nearly three people a day. And despite our tremendous efforts, preliminary death numbers from 2018 are looking even higher. The largest driver continues to be illicitly-made fentanyl, which has infiltrated our heroin supply and effectively resulted in an acute poisoning crisis, particularly in the eastern side of our state in and around St. Louis. We are also starting to see fentanyl in the methamphetamine supply. In the St. Louis region, which accounts for about 70% of opioid overdose deaths in the state each year, upwards of 90% of these deaths involve fentanyl.

Financial Burden: In 2018, analysis by the Missouri Hospital Association found the economic burden of the opioid crisis was approximately $12.6 billion each year. These costs are linked to premature death, hospital and emergency room visits, lost productivity, vehicle crashes, and more.

Benefits of Prevention, Treatment, and Recovery: A primary message for this Committee is that services to prevent, treat, and maintain recovery from substance use disorders help millions in Missouri and across the country. These services literally save lives. ***We have made dramatic improvements in prevention activities, treatment service delivery, and recovery support services in the last two years, largely because of the generous federal funds we have received,***

combined with the urgency we all feel to put an end to this overdose crisis. As I will describe shortly, our evidence-based treatment efforts have shown incredible growth and improvement, resulting in nothing less than a system transformation in Missouri.

Introduction to Grant Efforts

Missouri received two large grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the opioid crisis— the State Targeted Response (STR) grant of $10M for two years (FY 2017-2018) and the State Opioid Response (SOR) grant of over $18M for two years (FY 2018-2019). As a State Department, we have become even more rigorous in our prioritization of evidence based models of care for prevention, treatment, and recovery. This includes our transformative approach to opioid use disorder (OUD) – what we call the "Medication First" Model of treatment. The key tenets of this model include:

- People with OUD receive pharmacotherapy as quickly as possible, prior to lengthy assessments or treatment planning sessions;
- Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
- Individualized psychosocial services are offered but not required as a condition of pharmacotherapy;
- Addiction medications are discontinued only if it is worsening the patient's condition.

In addition to the STR and SOR grants, we have pursued and secured multiple other grants to address the overdose crisis. We used a Prescription Drug and Opiate Addiction (PDOA) grant to expand access to medication assisted treatment (MAT) in our hardest hit areas and it afforded us the opportunity to begin work on the Medication First model. We also utilize the Prescription Drug/Opioid Overdose grant to expand overdose education and naloxone to emergency responders and social service agents out in the field. We are committed to leveraging and coordinating all dollars and grants – local, state, and federal – to make sure all money is spent as efficiently and effectively as possible.

Consistent with SAMHSA's target domains, the goals of the Missouri Opioid STR/SOR project included:

1. Increase student-focused opioid use and overdose prevention initiatives and programs;
2. Increase access to evidence-based MAT for uninsured and underinsured individuals with OUD through provider training, direct service delivery, health care integration, and improved transitions of care;
3. Increase the number of individuals with OUD who receive recovery support services; and,
4. Enhance sustainability through policy and practice changes as well as demonstrated clinical and cost effectiveness of grant-supported protocols.

For more information about our STR and SOR efforts, visit our website: www.MissouriOpioidSTR.org

Stakeholders and Collaborations

Planning and Coordination with Other State Agencies, Providers, Stakeholders: In Missouri, we understand that substance use disorders impact every aspect of our society. No one is immune from developing this disease, and resources must be used wisely to impact this community crisis. As a result, our agency directs a tremendous amount of energy building relationships and working collaboratively with stakeholders in order to ensure a coordinated, effective, and efficient approach to addressing substance use disorders in general, and the opioid epidemic in particular.

Specific Partnerships:

State Departments and Boards:

- Department of Health and Senior Services
- Department of Social Services
- Department of Corrections
- Departments of Natural Resources and Conservation
- Department of Public Safety
- Missouri Board of Pharmacy

Professional Organizations, Associations, and Coalitions:

- Missouri Coalition for Community Behavioral Healthcare
- Missouri Hospital Association
- Missouri Primary Care Association
- Missouri Pharmacy Association
- Missouri Association of Osteopathic Physicians and Surgeons
- The St. Louis Regional Health Commission
- Missouri Coalition of Recovery Support Providers

Local Governments:

- Dozens of city and county health departments
- Sheriffs' departments
- City and county courts, treatment courts, and jails

Hospitals, Healthcare Systems, Provider Networks:

- Cox, Mercy, Barnes Jewish, SSM Hospital systems
- Federally Qualified Health Centers (FQHCs)
- Community Mental Health Centers
- Certified Community Behavioral Health Clinics
- Rural Health Clinics

Faith-based and Social Service Institutions and Agencies:

- Multiple churches, places of worship
- Homeless shelters
- Domestic violence shelters
- Transitional living facilities
- Food pantries

Domains of Collaboration:

Prevention Collaborations:

- *Partners in Prevention* is Missouri's higher education substance use consortium dedicated to creating healthy and safe college campuses. The coalition is comprised of 21 public and private college and university campuses across the state. Campus judicial officials, law enforcement, and campus prevention professionals are encouraged to take part in both their local coalition efforts and the statewide Partners in Prevention coalition.
- *National Council on Alcoholism and Drug Abuse* (local prevention organization)
- *Community Partnership of the Ozarks* (local prevention organization)
- *Boys and Girls Clubs of America* (10 clubhouses statewide)

Treatment Collaborations:

- Close partnership with the *Missouri Coalition for Community Behavioral Healthcare*
- *Missouri Primary Care Association* and FQHCs
- *Missouri Hospital Association* and hospital/healthcare networks

Law Enforcement and Corrections Collaborations:

- Teams have provided training and naloxone to over 50 police departments and 38 of 44 state park rangers
- Partnered with city and county jails and drug treatment courts
- Partnered with State and Federal probation and parole divisions for overdose training and education on evidence-based treatment and recovery practices

Recovery-focused Collaborations:

- Partnered with the *Missouri Coalition of Recovery Support Providers* and recovery housing providers throughout the state to establish and improve accreditation processes for recovery housing entities
- Collaborated with community recovery leaders to activate four Recovery Community Centers in high-need areas of the state
- Partnered with the *Missouri Credentialing Board* to launch a comprehensive Certified Peer Specialist training program to grow our peer workforce

Universities and Academic Collaborations:

- Partner with the University of Missouri St. Louis *Missouri Institute of Mental Health* to help administer, implement, and evaluate STR and SOR
- Work with the University of Missouri--Columbia's *Missouri Telehealth Network* to launch two opioid-focused ECHO programs (Pain Management and Opioid Use Disorder Treatment)
- Contract with *Washington University* in St. Louis to enhance and disseminate a mobile app for pregnant and postpartum women with OUD
- Contract with faculty from the *St. Louis College of Pharmacy and Southern Illinois University of Edwardsville* to lead pharmacy-based naloxone and treatment training and education
- Partner with faculty from the *University of Central Missouri* to develop, run, and evaluate a family support network through a Recovery Community program

Missouri Outcomes of Federal Opioid Funding

We are extremely grateful for the resources that Congress has provided states, as well as all the time and energy placed on loosening the grip this crisis has on our whole nation.

We have spent these dollars on what we believe must be prioritized in this current public health emergency: increasing access to life-saving services, including naloxone for overdose reversal and maintenance medical treatment for opioid use disorder. Our efforts focus on three broader, sequential goals: **survival, stabilization, and thriving**. This broadly represents our efforts in three areas: prevention, treatment, and recovery.

PREVENTION (SURVIVAL)

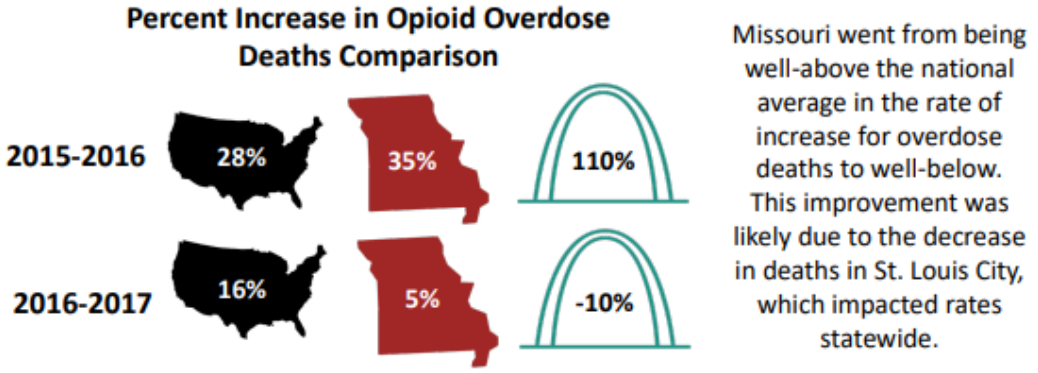
Survival Snapshot: Our focus has been on preventing the development and consequences of addiction by training youth to avoid drug misuse, training providers how best to treat chronic pain, and saturating high-risk communities with naloxone, the opioid overdose antidote.

- Trained over 10,000 youth how to avoid prescription drug misuse
- Trained nearly 450 predominantly rural medical providers how to manage chronic pain safely and effectively
- Trained nearly 15,000 individuals in opioid overdose education and the use of Narcan/naloxone.
- Distributed nearly 60,000 doses of naloxone
- Collected 2,230 reports of lives saved through the Overdose Field Report system we created with these grants.

Addressing Overdose: Through the STR/SOR and PDO grant projects combined, 14,340 individuals have been trained in overdose education and naloxone distribution, 17,827 boxes of naloxone have been distributed, and OUD treatment has been initiated for 4,072 individuals.

Through STR/SOR, OEND trainings have been provided to 6,155 individuals including criminal justice staff and justice-involved persons, pharmacy management and frontline technicians, recovery housing providers, and recovery support group members. Eight thousand seven hundred nineteen (2-dose) naloxone kits have been distributed through STR (in addition to 3,100 intra-muscular naloxone provided by Direct Relief, a humanitarian aid organization that provides free naloxone to non-profit entities.) Through MO-HOPE, OEND trainings have been provided to 8,185 individuals including emergency responders, treatment and medical providers and other social service agency staff. Seven thousand six hundred thirty three (2-dose) naloxone kits have been distributed (in addition to 3,499 intra-muscular naloxone provided by Direct Relief.) Community Pharmacy Naloxone Expansion: Over 1,169 pharmacists and pharmacy students across the state have participated in an overdose and naloxone information training. Criminal Justice Overdose Prevention Program – Mo' Heroes: 1,314 individuals, both staff and criminal-justice involved individuals, have received OEND training.

Notably, prior to the start of these grants, MO was **well above** the national average for rate of increase in opioid overdose deaths (35% increase in MO vs. a 28% increase nationally); after, we were **well below** the average rate of increase (5% increase in MO vs. a 16% increase nationally) See below figure:



Addressing Opiate Prescribing: The Missouri Telehealth Network (MTN) conducts numerous Extension for Community Healthcare Outcomes (ECHO) projects. For STR/SOR, MTN created an ECHO on Chronic Pain Management for primary care providers. The ECHO team has conducted 33 sessions, reaching 136 unique providers. The most recent session took place on December 20, 2018, with seven more sessions planned over the rest of the grant year.

Preventing Use/Misuse: Though the focus of our spending has been on helping those already in the throes of addiction and at greatest risk of death, we have also dedicated robust efforts towards prevention initiatives. We've provided school-based training and education about prescription drug misuse to over 11,000 students, and have partnered with the Boys and Girls Clubs of America to implement novel prevention programs in their clubhouses so we can reach youth who are likely at highest risk of developing addiction later in life.

TREATMENT (STABILIZATION)

Stabilization Snapshot: Our focus has been on improving access to medical treatment for OUD by providing rigorous multidisciplinary training and consultation, connecting overdose survivors to community treatment, and delivering effective, evidence-based treatment services to thousands of Missourians struggling with opioid addiction.

- Trained over 4,000 medical and behavioral healthcare providers on best practices for OUD treatment.
- Reached over 2,000 overdose survivors in emergency departments to connect them with treatment and other services.
- Provided evidence-based medical treatment to over 4,000 individuals under our new Medication First treatment model.

The following improvements have been realized when comparing treatment prior to STR and SOR grants: **1)** better access to medications for OUD, **2)** faster access to those medications, **3)** improved treatment retention at 1, 3, and 6 months, and **4)** 26% lower average monthly cost of treatment.

Sustainable Treatment

Intervention Post-Overdose: Through Opioid STR/SOR funding, Missouri has expanded the Engaging Patients in Care Coordination (EPICC) project and was able to secure state funding to replicate the model statewide. Patients routinely present to emergency departments seeking help with opioid withdrawal and – all too often – needing emergency resuscitation for opioid overdose. Emergency Department (ED) physicians are uniquely positioned to change the life trajectory of patients who present due to opioid overdose and can serve as a link for at-risk patients into treatment and recovery support services. Utilizing evidenced-based, FDA-approved medicines (e.g. buprenorphine) in the ED improve patient engagement and connection to opioid use disorder treatment services, and ultimately reduce patient mortality. The EPICC project expedites access to MAT and improves the coordination of care between emergency departments and community-based settings. Recovery coaches meet patients post-overdose in the emergency department and connect patients to SUD treatment agencies. This peer outreach has been provided to more than 2,200 individuals since May 2017.

Medical Treatment Providers: A key concern when utilizing time-limited grant dollars is sustainability of efforts. Missouri realized that trainings in key areas represented core sustainability in use of naloxone (identified above) addiction medications. Unfortunately, access to evidence-based addiction medications is limited by a lack of knowledge by medical professionals and exacerbated by the need for prescribers to obtain a DEA waiver in order to offer the gold standard of care in the initial treatment of OUD: buprenorphine. Prescribing and managing this medication requires eight hours of training for physicians and 24 hours of training for mid-level practitioners (advance practice nurses and physician assistants). Missouri worked hard to outreach to prescribers already working in behavioral health, but also primary care providers working in Federally Qualified Health Centers and emergency department physicians. We have also provided technical assistance directly to FQHCs to promote the treatment of OUD

within the primary care health system. Under these grants, Missouri has thus far secured waiver training for nearly 150 professionals and most of them have successfully obtained the waiver needed to prescribe buprenorphine products.

We have also recognized the need for ongoing training and clinical support for prescribers, so an ECHO specific to the management of OUD was developed by the Missouri Telehealth Network (MTN). The MTN has also launched a Project ECHO on OUD Treatment. The OUD ECHO team has conducted 22 sessions, reaching over 179 unique providers. The second round of OUD ECHO is set to begin in April.

Medical Treatment Model: Maintenance pharmacotherapy with buprenorphine or methadone can reduce fatal opioid overdose rates by 50-70%, reduce illicit drug use, and increase treatment retention. However, in traditional treatment programs for addiction, the vast majority of patients are offered no ongoing medical treatment. Those who do receive medical care often face intensive psychosocial service requirements that make treatment both burdensome and costly. Though we wholeheartedly believe all clients should be offered a full menu of psychosocial support services such as counseling, family therapy, job training, case management, and more, we also believe medication should not be withheld as a condition of mandatory participation in these services. In Missouri we set forth with renewed focus to promote individualized psychosocial treatment rather than arbitrary requirements, ensuring each client gets exactly what he or she needs – nothing more, nothing less.

Through STR, we finalized and disseminated a treatment model we refer to as "Medication First." The name and principles of Medication First are borrowed from the Housing First approach to homelessness. The National Alliance to End Homelessness explains: "Housing First is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed." This approach prioritizes client choice in both housing selection and service participation. Our Medication First model similarly prioritizes rapid and sustained access to a lifesaving resource – medication for opioid use disorder – as a central tenet of treatment.

The Medication First (or low-barrier maintenance pharmacotherapy) approach to the treatment of Opioid Use Disorders (OUD) is based on a broad scientific consensus that the epidemic of fatal accidental poisoning (overdose) is one of the most urgent public health crises in our time. Increasing access to buprenorphine and methadone maintenance is the most effective way to reverse the overdose death rate. Increased treatment access will best be achieved by integrating buprenorphine induction, stabilization, maintenance, and referral throughout specialty addiction programs, as well as primary care clinics and other medical settings throughout the mainstream healthcare system.

Supporting System Change: Understanding how to successfully and efficiently manage a clinic that offers addiction medications, as well as how to provide psychosocial services that complement the use of these medications, also requires training. Changing practices and attitudes were essential to adopting evidence-based treatment that lasts longer than the life of the federal funding.

- **Training and Consultation to Address Provider-Level Knowledge and Attitudinal Barriers:** To address gaps in knowledge about MAT and reduce attitudinal barriers to MAT, we developed a multimodal, multidisciplinary training curriculum called Opioid Crisis Management Training (OCMT) in collaboration with consulting physicians, nurses, counselors, social workers, and people who use drugs and/or are in recovery. The training curriculum includes a content lecture on the role of brain chemistry in opioid addiction, the science of MAT, the role of the counselor in treating OUD, a panel of individuals sharing how MAT has helped them achieve recovery, and profession-specific breakout sessions to promote dialogue and problem-solving about MedFirst implementation. Preliminary evaluation shows OCMTs improve knowledge and attitudes surrounding MAT and serve as an opportunity to connect with providers and encourage utilization of our ongoing training and consultation services.

- **Steps to Address Agency-level Barriers:** To support MedFirst implementation, we assessed program readiness through environmental scans and site visits; held bi-monthly, statewide open "Office Hours" calls to discuss administrative and clinical questions; and provided data-driven, program-specific "Treatment Barometers" comparing data from Pre-STR and STR timeframes. Many state-contracted treatment agencies are in rural areas where transportation and access to waivered prescribers are limited. Thus, to increase access to care and reduce frequency of canceled or "no-show" appointments, STR funds were used to purchase telemedicine equipment and reimburse agencies for client transportation. Additionally, cross-agency collaboration was facilitated to increase prescriber capacity.

- **Process, Policy, and Procedural Changes to Address Structural and Systemic Barriers:** We anticipated several structural and systemic barriers to implementing MedFirst. These included:

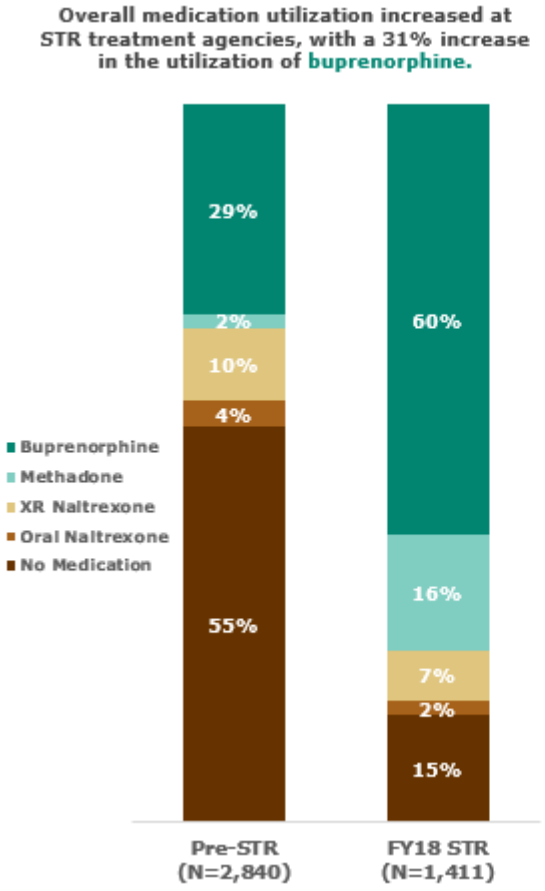
    1) State billing requirements and intake procedures;
    2) buprenorphine prior authorizations and step-down dosing requirements in our Medicaid program;
    3) over-utilization of group services, non-medical detoxification, and residential services;
    4) high administrative burden coupled with low reimbursement rates for medical services; and
    5) a dearth of buprenorphine waivered providers in our state.

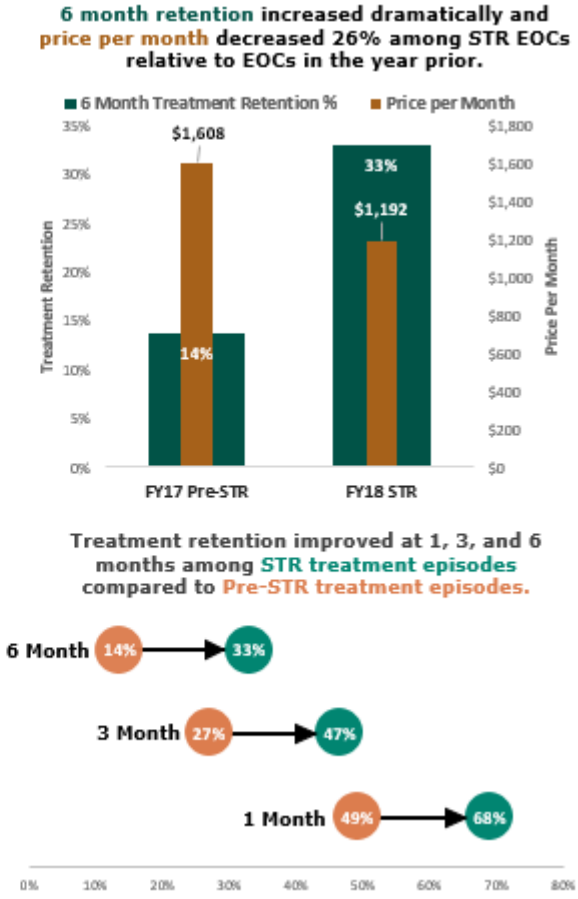
  To address **1)** we altered State billing requirements to allow 30 days for completion of STR client assessments, facilitating faster client access to medical providers. Regarding **2)** through collaboration with the Missouri Medicaid program, prior authorizations for initial buprenorphine prescriptions were removed, as were requirements for step down dosing and tapering plans. (Though uninsured individuals were the target of STR treatment funds, we also worked simultaneously to remove barriers in the Medicaid system.) Over utilization of group services, non-medical detoxification, and residential services **3)** was addressed by removing these from the STR services menu and only

allowing for their reimbursement through existing agency allocations. To begin to remedy **4)**, we increased the provider administrative payments on medical services from 7% to 15% for the STR program. Last, STR leaders addressed Missouri's lack of buprenorphine prescribers **5)** by offering state-sponsored DATA 2000 trainings and a reimbursement to medical providers who obtained their waiver.

These system-level changes, coupled with the provider- and agency-focused efforts, aimed to incentivize best practice and remove as many obstacles to MedFirst implementation as possible.

Our early findings are very promising. As stated above, through STR and SOR, we have treated over 4,200 people with OUD and found they are more likely to: obtain medical treatment; be connected to that medical treatment faster; be retained in treatment at 1, 3, and 6 months; and have lower average monthly costs of treatment than prior to the STR and SOR grants.





RECOVERY (THRIVING)

Thriving Snapshot: Our focus has been on building fulfillment and meaning in peoples' lives while they seek or complete formal treatment programs. We have accomplished this through the establishment of Recovery Community Centers in high-need areas, providing safe recovery housing to individuals in need, and building the workforce of peer specialists.

- Funded four Recovery Community Centers that have served over 14,000 people to help them find jobs, housing, and community connections.
- Provided secure housing to over 700 people who were engaged in treatment but didn't have anywhere safe to live while they did so.
- Trained 338 individuals to become Certified Peer Specialists so they can join the workforce and give back by sharing their lived experience with people who can benefit from what they've been through.

Recovery Community Centers: With support from STR/SOR, Recovery Community Centers (RCCs) have been an integral part of Missouri's work on the opioid epidemic. RCCs are independent, non-profit organizations that help individuals recovering from substance use disorders. They help build recovery capital by providing advocacy training, recovery information, mutual-help or peer-support groups, social activities, and other community-based services. In 2018, Missouri RCCs served over 14,000 people. About 58% of those people were individuals with an Opioid Use Disorder (OUD).

Our RCCs were open over 9,000 hours, offered 3,569 activities, and distributed over 3,000 Narcan kits. RCCs completed outreach to 3,296 people with OUD. The RCCs served over 8,000 total individuals with OUD in 2018.

Safe and Sober Housing. Through STR/SOR, and the Missouri Coalition of Recovery Support Providers (MCRSP), Missouri has built a network of National Alliance for Recovery Residences (NARR) accredited and medication-friendly recovery housing entities for individuals enrolled in STR/SOR treatment programs. To date, more than 52 houses have been approved to receive STR/SOR funds. Over 700 individuals have received more than 15,000 bed nights to support individuals with OUD as they receive Medication First treatment through STR/SOR contracted treatment site.

Recommendations for Federal Action:

First, I want to applaud a strong SAMHSA under the leadership of Dr. Elinore McCance-Katz. She and her management team have worked hard to ensure that these vital grant funds are distributed quickly and implemented effectively.

In this report, I have outlined what Missouri has been able to accomplish in the areas of prevention, treatment, and recovery specific to opioid use disorders. While we've done so much with the federal opioid dollars, we need to think about a bigger, longer-term investment in these efforts to make a significant impact and make death rates go down.

We are fighting an urgent and very steep uphill battle here – as much as these generous grant dollars have helped, we still have people who cannot get into lifesaving treatment or find affordable recovery housing in our state. We know this becomes a death sentence for many, but we still don't have enough resources to help everyone who needs it.

Broader SUD Focus: Again, while we appreciate the opioid specific resources, we would recommend a transition over time from opioid specific resources to investing funds in the SAPT Block Grant. This allows for flexibility in directing funds to a range of alcohol or drug issues across the continuum – prevention, treatment, and recovery. This approach would benefit all states and territories. An important feature of the SAPT Block Grant is flexibility. Specifically, the program is designed to allow states to target resources according to regional and local circumstances instead of predetermined federal mandates. This is particularly important given the diversity of each state's population, geography, trends in terms of drugs of use/misuse, and financing structure. We know that alcohol use disorders kill as many, or more, individuals per year – but does so more insidiously. We also know that some states or regions are impacted more by methamphetamine, which also causes devastation in families and communities.

Ensure Federal Addiction Initiatives Work through State Substance Use Agencies: State substance use agencies work with stakeholders to craft and implement a statewide, coordinated system of care for substance use disorder treatment, prevention, and recovery. In so doing, state agencies employ a number of tools to ensure public dollars are dedicated to effective programming. These tools include performance and outcome data reporting and management, contract monitoring, corrective action planning, onsite reviews, training, and technical assistance. States also redirect, redistribute, or eliminate support for programs that are not achieving results. In addition, state substance use agencies work to ensure that services are of the highest quality through state or nationally established standards of care. Federal policies that promote working through the state substance use agency ensure that initiatives are coordinated, accountable, effective, and efficient.

Maintain a strong commitment to the Substance Abuse Prevention and Treatment (SAPT) Block Grant without ever losing focus on prevention services: We recommend that Congress maintain robust support for the SAPT Block Grant, an effective and efficient program supporting prevention, treatment, and recovery services. In FY 2018, the SAPT Block Grant provided treatment services for 1.5 million Americans. During the same year, of patients discharged from treatment, 76 percent were abstinent from alcohol and approximately 60 percent were abstinent from illicit drugs.

By statute, states must dedicate at least 20 percent of SAPT Block Grant funding for primary substance use prevention services. This prevention set-aside is by far the largest source of funding for each state agency's prevention budget, representing on average 70 percent of the primary prevention funding that states, U.S. territories, and the District of Columbia coordinate. In 35 states, the prevention set aside represents 50 to 100 percent of the substance use agency's budget.

We appreciate the difficult decisions Congress must face given the current fiscal climate. We believe it is equally important to note that trends in federal appropriations for the SAPT Block Grant have led to a gradual but marked erosion in the program's reach.