From: Sally Gibson
To: King, Summer (SAMHSA/OPPI)
Cc: Clark, Spencer (SAMHSA/CSAT/DPT)
Subject: SOR Program Data Collections and Performance Measurement
Date: Friday, October 19, 2018 11:52:06 AM

Summer

Good morning. I wanted to send this email to give you requested feedback on Data Collections and Performance Measurement from email dated 10-17-18.

Overall comments from staff:

The client instrument is very long, and many elements could be pulled from the EHR or chart. It seems clunky and duplicative until you get to the questions that actually are client facing. For that section, my question would really be one of workflow. We are going to face similar challenges to what we are with ISAPs: our staff's capacity ***and*** client compliance.

It would certainly be more cumbersome and time consuming. In order to do it, we would need more staff to handle the increased workload.

This is basically the same evaluation protocol for other SAMHSA grants, except we have dedicated evaluation staff for those grants, covered by those grants, to collect these data. Does this come with any financial support to cover evaluation time? Depending on the client number/caseload, this could be at least a 0.5-1.0 FTE, especially after the case load gets established.

To get at some of what was asked below, for feedback, the burden of data collection is relatively significant (again, depending on the client numbers). This is in no small part due to the fact that it's a relatively long interview (30-60 minutes), and it's a longitudinal design, (potentially) even after discharge - and this client population isn't known for their follow-through. Essentially, we could (would need to?) dedicate a lot of time to tracking procedures if we wanted to ensure a higher response rate (which SAMHSA is always looking for).

As far as the utility of the data, I like the NOMs (overall – it's not perfect), and I like it for monitoring outcomes, QI, etc. So, it's pretty good data, if you can get it.

Ways to make this easier would include phone interviews and pulling as much info from the EHR as possible. Also, not getting the 3- and 6- month follow-ups after discharge… I think doing anything they can to reduce the data being collected would also be helpful, especially at follow-up and discharge intervals…

If we have to collect these, I think we're going to need to talk about hiring additional staff, and incentives would help…

I think that overall, staff feel that this will add significant additional workload and will require additional staff and that some of the information is already being gathered so it is a duplication of what is already being done. It would be nice to see if we can find a way gather the data in a more streamlined way without duplication.

Thanks
Sally

From: Clark, Spencer (SAMHSA/CSAT/DPT) <Spencer.Clark@samhsa.hhs.gov>
Sent: Wednesday, October 17, 2018 4:44 PM
To: lauren.siembab@ct.gov; Michael.parks@maine.gov; Tom.Connors@maine.gov; Katherine.Coutu@maine.gov; Allison.bauer@state.ma.us; amy.sorensen-alawad@state.ma.us; Nicole.m.schmitt@state.ma.us; Jennifer.miller@state.ma.us; Hannah.Lipper@state.ma.us; Abby.Shockley@dhhs.nh.gov; Donald.Hunter@dhhs.nh.gov; Cynthia.Thomas@vermont.gov; Megan.Mitchell@vermont.gov; Mariah.Ogden@vermont.gov; sgoldsby@daodas.sc.gov; dwalker@daodas.sc.gov; ckraeff@daodas.sc.gov; bpowell@daodas.sc.gov; rbraneck@daodas.sc.gov; taryn.sloss@tn.gov; linda.mccorkle@tn.gov; Anthony.jackson@tn.gov; richard.sherman@illinois.gov; terry.cook@fssa.in.gov; Rebecca.Buhner@fssa.IN.gov; Jeremy.Heyer@fssa.IN.gov; Cassandra.Anderson2@fssa.IN.gov; Mark.Loggins@fssa.IN.gov; Kelly.Welker@fssa.IN.gov; ScottL11@michigan.gov; BullardS@michigan.gov; SmithA8@michigan.gov; dave.rompa@state.mn.us; faye.bernstein@state.mn.us; Ellen.Augspurger@mha.ohio.gov; Sanford.Starr@mha.ohio.gov; joyce.allen@wisconsin.gov; Jason.Harris@dhs.wisconsin.gov; Scott.stokes@dhs.wisconsin.gov; tcroom@odmhsas.org; monica.wilke-brown@idph.iowa.gov; Sharon.Kearse@ks.gov; Gowdy, Rick <Rick.Gowdy@dmh.mo.gov>; rachel.winograd@mimh.edu; philip.horn@mimh.edu; tamara.gavin@nebraska.gov; Marlies.Perez@dhcs.ca.gov; tfsunia@dhss.as; herbert.sablan@gmail.com; bvictor@fsmhealth.fm; athena.duenas@gbhwc.guam.gov; temengil.ej@gmail.com
Subject: Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW

Dear STR and SOR Project Directors and Staff:

This is in follow-up to my correspondence to you of last week, indicating the publication of a Federal Registry Notice (FRN) containing the proposed reporting guidelines for the SOR and TOR Grant initiatives.

Please find attached below the proposed SOR information plans and reporting instruments that were referenced in the recent posting of the Federal Register for your review and comment.

I cannot emphasize too greatly how important it is for you to carefully review and comment on these reporting tools, and provide whatever recommendations that you have regarding implementation issues.

I am hopeful that with your feedback we can enter into a meaningful dialogue to maximize the usefulness of this reporting, and minimize any unnecessary reporting burden.

Send comments to Summer King, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland 20857, *OR* email a copy to *summer.king@samhsa.hhs.gov*.

Written comments should be received by December 3, 2018.

I would appreciate your copying me on any feedback that you provide in this process so that I can be fully prepared to participate in this dialogue.

Thank you and best regards,

Spencer Clark

Spencer Clark, MSW, LMSW, ACSW,
Public Health Advisor/
Government Project Officer,
Opioid State Targeted Response, State Opioid Response, and MAT-PDOA Grant Initiatives,
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California Department of Health Care Services' Public Comment on Proposed State Opioid Response Program Data Collection and Performance Measurement

Summary

The California Department of Health Care Services ("DHCS") is committed to providing data necessary for the Substance Abuse and Mental Health Services Administration ("SAMHSA") to fulfill the Government Performance and Results Modernization Act of 2010 requirements, as well as ensuring that program goals and objectives of the State Opioid Response ("SOR") grant are met. The Grantee Level Tool SAMHSA has proposed is straightforward, easy to understand, and not overly burdensome.

However, the Client-Level Data Collection Tool ("Client Tool") that SAMHSA proposes is exceptionally complicated and lengthy, which would create an immense burden on providers and cause resources to be shifted away from providing direct patient care. As a result, DHCS recommends that the Office of Management and Budget deny SAMHSA's current request and urge that the Client Tool be revised and abbreviated, such that it continues to collect sufficient data on patient treatment but does not impose excessive burdens on treatment providers.

Extensive Client Tool and Administrative Burden to DHCS

At over forty pages in length, the Client Tool is substantially more complex than the Client Tool currently being utilized by DHCS' subrecipients for the State Targeted Response to the Opioid Crisis ("O-STR") grant. DHCS has been informed by its subrecipients that a material number of patients are unwilling to submit the information requested by the existing Client Tool. It is anticipated that the numbers of patients declining to provide information will increase as a result of the complexity and length of the proposed reporting tool. This could potentially lead to the collection of less accurate data on the sample of patients receiving services as part of the SOR, which would run counter to the objectives of the data collection.

The constraints of the current system prevent DHCS' subrecipients from inputting information electronically, increasing the administrative burden on California. In the current process, only two of DHCS' subrecipients were selected to submit data. These subrecipients submit electronic copies of the forms to DHCS, where DHCS personnel enter the information into the web-based system. DHCS analysts spend approximately fifteen minutes entering data from each respective form. California estimates data entry for the SOR form to increase to a minimum of twenty minutes, adding to the administrative burden.

DHCS recommends the following solutions to remedy the issue: 1) SAMHSA allow DHCS to designate subrecipients and subrecipients of subrecipients to have their own accounts in the SAMHSA Performance Accountability and Reporting System (SPARS) system used to enter Client Tool data. This will create a mechanism for subrecipients to enter data directly into the system as they conduct interviews; 2) abbreviate the form to request slightly less detailed information, as this would reduce the time required for subrecipients to interview patients and increase adherence of the Client Tool data collection requirements; and 3) allow data to be collected for only a sample of the

programs and sites to be funded through the grant. These proposed recommendations fulfill SAMHSA's performance objectives, while also easing administrative burdens and efforts needed by providers to collect relevant data.

Treatment Services Definition

DHCS is concerned that use of the phrase *treatment services* is not adequately defined in the draft regulations and is likely to cause data to be collected inconsistently by subrecipients. DHCS recommends that a full, specific, and well-defined explanation of *treatment services* be provided, so that programs may be consistent in the data that they are collecting. This is necessary for meaningful comparisons to be performed between programs and grantees.

Supporting Statement regarding Confidentiality of Client Data

The supporting statement provided does not provide sufficient assurance that SAMHSA will protect patient data from unauthorized access or release. The specific statement that "SAMHSA cannot ensure complete confidentiality of client data" provided on page four of the document is unlikely to remedy existing client attitudes about providing extensive data that may be received by malicious parties. Many patients may simply choose to decline to provide the information, impacting the veracity of the data.

Follow-up Requirements

The estimation of patients required to submit follow-up information, even after discharging from the program, is unreasonable. This requirement adds to existing burdens on programs and would require programs to shift resources away from direct patient care. DHCS recommends that the 80% follow-up requirement be reduced to an attainable percentage.

Conclusion

DHCS has determined that if the Client Tool is not significantly redesigned, it will create an added burden on treatment providers and is likely to result in information being collected inconsistently among programs and patients. DHCS recommends that SAMHSA consider the simplicity and ease of use of the Grantee Level Tool when revising the Client Tool and consider using the abbreviated tool currently being used for the O-STR projects. Lastly, DHCS requests that any subsequent divisions to either of the reporting tools be resubmitted for further public comment.

From:	Fred Rottnek
To:	King, Summer (SAMHSA/OPPI)
Cc:	Fred Rottnek
Subject:	Comments on proposed reporting guidelines for the SOR and TOR Grant initiatives
Date:	Friday, October 19, 2018 4:42:01 PM

Thank you for allowing us the opportunity to comment on proposed reporting guidelines.
In addition to my information below, I am very involved with the current STR and future SOR programs through a few avenues:

1. I contract with the Missouri STR team for training, in-services, and resource development. (30% of my time)
2. I contract with ARCA as medical director. (another 30% of my time) At ARCA, we provide on-site and telehealth addiction medicine and co-occurring disorder services to 19 agencies at 37 sites around the state. We are on-track to see over 36,000 unduplicated patients in 2018.

When I reviewed these guidelines, a few things jumped out at me.

1. The questions are incredibly relevant to the population we are serving.
2. The reporting requirements as drafted seem to turn a primary service grant (STR being 76% in treatment and recovery support) into some type of hybrid service ***and*** research grant.
3. The reporting requirements as drafted would be so onerous to our staff and patients, that they would functional serve as a barrier to treatment.

While I am no expert in research design, I propose a way to gather a statistically significant number of the proposed questions which minimizing reporting data for the bulk of clients treated.
For example, could the full reporting drafted here be mandated for a fraction of patients treated? Say 10-25% of total patients.
The patients who provide the full reporting information could be randomized for each site, by SAMHSA (or contracted entity) or by the agency, so that the bulk of clients experience expedited enrollment, i.e., questions related to the most salient questions.
With this approach, significant data could be collected on a minority of patients. While this would be additional work compared to the current process, it would not be as onerous as the reporting structure proposed.

Thank you for your consideration,

Fred Rottnek, MD, MAHCM
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STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

MIRIAM E. DELPHIN-RITTMON, PH.D.
COMMISSIONER

Agency Information Collection Activities: Proposed Collection
COMMENT REQUEST

To: Summer.king@samhsa.hhs.gov
Submitted by: Lauren Siembab, SOR grant Project Director

a. Whether the proposed collections of information are necessary for the proposer performance of the functions of the agency, including whether the information shall have practical utility.

Assuming that the "agency" is the SSA, the collection of client level data via the GPRA is *not necessary* since this SSA already has a mechanism for collecting client level data for SAMHSA funded treatment projects, as we do for TEDS reporting. We are able to evaluate "connect to care" and "re-admission to treatment" rates with this same data. However, the GPRA interviews *do* provide richer data from the participant perspective, and could be measures that are of specific value for SOR beyond the generally available treatment data the SSA usually gets. Unfortunately, SAMHSA does not allow adequately for the cost of administering 3-4 GPRA interviews per client, particularly if these are conducted by the preferred "neutral" third party rather than the service provider(s).

The version of the GPRA given to the SOR sites to review is markedly different from the version currently in use for most of the CSAT projects. Although there certainly can be value in modifying the instrument so that there are items of specific interest for a particular project, keeping the majority of the items the same (or similar) in content and format would enhance ease of training and administration, as well as the ability to compare results across projects. If additional components are added, it seems that MAT-specific questions would be useful.

b. The accuracy of the agency's estimate of the burden of the proposed collection of information.

Overall, the estimate of burden is for GPRA interviews time is correct for the current version in use. However, the proposed version is longer and more confusing and will likely take longer to administer. What is not taken into account in the "burden estimate" is the amount of time expended trying to locate the individuals to conduct the follow-up interview(s), which in some cases is substantial.

c. Ways to enhance the quality, utility and clarity of the information to be collected.
1. Stick to one version of GPRA for the long-haul
2. Reduce the number of questions and pages SUBSTANTIALLY.
3. Remove the requirement for the 6 month follow-up or provide adequate funding for tracking and administration.

d. Ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Consider separate "frameworks"/formats for States to use for reporting treatment, prevention, recovery support, training and TA, and naloxone purchases; minimal detail beyond #'s served.

From:	Noble Shaver
To:	King, Summer (SAMHSA/OPPI)
Subject:	Reporting requirements for SOR
Date:	Thursday, October 18, 2018 1:47:00 PM

The GPRA for STR is a long tool, it adds a 3 month reporting time (not required with STR), so if the benchmark is 80% compliance in reporting like STR, this will add a layer of time for something that for us that is already very labor intensive in tracking , locating and administering. I fear we might lose potential consumer's wanting treatment because of the lengthy requirements to receive services. The Medication First model works well because it eliminates red tape and puts the consumer in front of a physician quickly. I fear if we start to add new requirements now the ability to act quickly and efficiently could fade. I believe that the collaboration taking place in Missouri between providers, Department of Behavioral Health, and Missouri Institute for Mental Health requiring the GPRA is a duplication of data collection.

Thank you for your time

Noble Shaver Jr., MA, LPC, CRADC, NCC
Chief Clinical Officer Substance Use Disorders, Housing, & Outreach Services 573-888-5925 ext. 1501
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From:	Moody-Geissler, Stephanie
To:	King, Summer (SAMHSA/OPPI); Bankhead, Jamal (SAMHSA)
Cc:	Gazioch, Ute
Subject:	60-Day FRN for State Opioid Response Grant (Short Title: SOR) Data Collection Tool
Date:	Monday, December 3, 2018 12:16:47 PM
Attachments:	Attachment A - SOR TOR Client Instrument_EDITS.docx

Dear Summer King,

Thank you for the opportunity to comment on the on the State Opioid Response Grant (Short Title: SOR) Data Collection Tool. Please find attached comments and edits I would like to put forth for the tool.

Please feel free to contact me if you have any questions concerning this document, edits, or comments.

Thank you,
Stephanie Moody-Geissler

Stephanie M. Moody-Geissler, MPH
Lead Epidemiologist
Overdose Prevention
Office of Substance Abuse and Mental Health
Florida Department of Children and Families
1317 Winewood Blvd., Bldg. 6, Room 272
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Office: (850) 717-4329
Stephanie.Moodygeissler@myflfamilies.com

From:	Kyle Mead
To:	King, Summer (SAMHSA/OPPI)
Subject:	Re: URGENT - Please respond (SOR) Program Data Collection and Performance Measurement—NEW
Date:	Thursday, October 25, 2018 1:16:36 PM
Attachments:	Outlook-v5lto2o0.png Outlook-cid_image0.png

I would like to reiterate what so many of my colleagues have already stated. The implementation of an electronic health record should have made data collection and sharing much easier and it has internally. However, external sharing is incredibly complicated already and as a small non-profit the time spent on staff dedicated to redundant data entry into multiple electronic systems is becoming overwhelming.

The human factor of errors as a result of repetitively entering the same information into multiple systems is neither efficient nor effective. We are already burdened with fixing this errors that are inevitable with redundancies such as we already experience.

There simply must be a better way than adding this to our already stretched resources. We already gather so much of this information and have to enter it into at least 2 systems and often as many as 4 systems dependent upon the payer and referent. Integration with the state CIMOR system here in Missouri would be more logical than passing this burden down to the providers who should be using their resources to provide consumer care.

Kyle Mead
Vice President of Behavioral Health Services
Heartland Center for Behavioral Change
816 421-6670 ext. 1296
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From: shauntay McCollough <shauntay@newbeginningscstar.org>
Sent: Tuesday, October 23, 2018 11:05:21 AM
To: 'Bock, Nora'; 'Gardine, Cheryl'; 'Menzies, Suneal'; 'Johnson, Clif'; 'Cori Putz'; 'Geoff Moeller'; lmccallister@placesforpeople.org; 'NCADA - St. Louis - Nichole Dawsey'; 'NCADA St Louis - Jenny Armbruster'; 'New Beginnings - Freda Theus'; 'Cheung, Chi'; 'New Horizons - Laura Porting'; 'New Horizons - Shanna Behrens'; 'New Horizons - Stacy Doggett'; 'North Central MO - DeAnna Savage'; 'Irvine, Lori'; 'North Central MO - Tammy Floyd'; 'Francis, Lisa'; 'Mieseler, Vicky'; 'Ozarks Medical Center - Curtis Cook'; 'Ozarks Medical Center - Joy Anderson'; 'Pathways - Amy Blake'; 'Pathways - Becky Camden'; 'Pathways - Elisabeth Brockman-Knight'; 'Pathways - Gloria Miller'; 'Pathways - Julia Bozarth'; 'Yach, Kristen'; 'Pathways - Linda Grgurich'; 'Pathways - Mel Fetter'; 'Pathways - Shannon Crowley-Einsphar'; 'Pathways - Todd Martensen'; 'Foster, Tonie'; 'Greening, Andrew'; 'PFH - Andrew Schwend'; 'Hutton, Ann'; 'Putz, Cori'; 'PFH - Darlene Harrell'; 'PFH - Jason Hinckley'; 'PFH - Lorinda

Meyer'; 'PFH - Marilyn Nolan'; 'PFH - Nancy Atwater'; 'PFH - Rhonda Ferguson'; 'PFH - Una Bennett '; 'Phoenix - Laura Cameron'; 'Phoenix - Rhiannon Ross'; 'Phoenix - Teresa Goslin'; 'Phoenix Health Programs - Tracy McIntyre'; 'Places for People - Diane Maguire'; 'Places for People - Nicole Stewart'; 'Bayliff, Scott'; 'Places for People - Tiffany Lacy Clark'; 'Spruell, Sharon'; 'Flory, Alan'; 'ReDiscover - Elizabeth Deason'; 'ReDiscover - Jennifer Craig'; 'ReDiscover - John Dean'; 'ReDiscover - Lauren Moyer'; 'ReDiscover - Marsha Page'; 'Busiek, Gary'; 'Beck, Kimberly'; 'SAMHSA Regional Administrator Region VII - Kimberly Nelson'; 'Angela Toman, CRPS'; 'Brenda Felkerson'; 'Cathy Schroer BS'; 'Dan Adams MBA'; 'Jason W. Gilliam MBA MHA AICP'; 'Storey, Janice'; 'Swope Health - Kortney Carr'; 'Swope Health - Mark Miller'; 'Holm, Christy'; 'Tri-County - JoAnn Werner'; 'Tri-County - Talina Nelson'; 'Tri-County - Tom Petrizzo'; 'Truman Medical Center - Barbara Warner'; 'Zaiger, Bethany'; 'Truman Medical Center - Jodi Gusman'; 'Truman Medical Center - Mark VanMeter'; 'Truman Medical Center - Sharon Freese'; 'Turning Point - Catie Franklin'; 'Turning Point - Heather Higgins'; 'Allyson Ashley'; 'Fred Rottnek'; 'Menzies, Percy'; 'Arthur Center - Kristin Fishback'; 'Arthur Center - Rachel Ward'; 'BASIC - Keturah Ibrahim'; 'BASIC - Kirby Anderson-El'; 'Johnson, Lola'; 'BASIC - Michael Batchman'; 'BASIC - Robin Smith'; 'Singleton, Yulonda'; 'BHR Worldwide - Angela Tate'; 'BHR Worldwide - Bart Andrews'; 'BJC - Karen Miller'; 'Bootheel Counseling - David Terrell'; 'Kassinger, Micaela'; 'Brandon, Teresa'; 'Bridgeway - Craig Miner'; 'Bridgeway - Jack Barnett'; 'Morrison, Mike'; 'Burch, Mitzi'; 'Burell - CJ Davis'; 'Burrell - Cristin Martinez'; 'Burrell Center - Adam Andreassen'; 'Burrell Center - Austin Burdine'; 'Burrell Center - Bethany Silliman'; 'Burrell Center - Brent Sugg'; 'Burrell Center - Christopher Orr'; 'Burrell Center - Denise Mills'; 'Burrell Center - Gina Burroughs'; 'Burrell Center - Hunter Houston'; 'Burrell Center - Lauren Pratt'; 'Burrell Center - Leslie Corbiere'; 'Gass, Mathew'; 'Burrell Center - Megan Steen'; 'Burrell Center - Sally Gibson'; 'Burrell Center - Shae Hitchock'; 'Burrell Center - Stephanie March-Hopkins'; 'Burrell Center - Stephen Koch'; 'Burrell Center - Wes Starlin'; 'Camp, Timothy'; 'CCC - Brenda Robertson'; 'CCC - Lonnie Lusk'; 'Ridenour, Brad'; 'Clark CMHC - Debbie Schoon'; 'Beatie, Laura'; 'Clark Mental Health - Christy Henley'; 'CMHC - Jenny Wright'; 'Anderson, Carl'; 'CMHS - Jenny Duncan'; 'CMHS - Julie Pratt'; 'CMHS - Tara Yardley'; 'CommCARE - Erica Immenschuh'; 'Compass Health / McCambridge - Angela Allphin'; 'COMTREA - Agnes Jos'; 'COMTREA - Andrea Cuneio'; 'COMTREA - Jonathan Cochran'; 'COMTREA - Rachael Bersdale'; 'Susan Curfman'; 'Crider - Carrie Rigdon'; 'Crider - Laura Heebner'; 'Crider - Nancy Gongaware'; 'Crider - Victoria Walker'; 'Family Guidance - Elizabeth Sprung'; 'Family Guidance - Kristina Hannon'; 'Family Guidance - Rachel Evans'; 'Family Guidance - Raven Hutchison'; 'Family Guidance - Rebekah Quillin'; 'Family Guidance - Robin Reynozo'; 'Family Self Help - Alison Malinowski Sunday'; 'Family Self Help - Gwen Ewing'; 'FCC - Ashley Singleton'; 'FCC - Kelley Wilbanks'; 'FCC - Melissa Weatherwax'; 'FCC - Randy Ray'; 'FCC - Shawn Sando'; 'First Call - Susan Whitmore'; 'Freeman Health - Melissa Moore'; 'Freeman Health - Spencer Ellis'; 'Feaman, Kimberly'; 'Doherty, Steve'; 'Hannibal Council dba Turning Point - Jennifer Wilson'; 'Hannibal Council dba Turning Point - Kettisha Hodges'; Carolyn Ross; Kyle Mead; 'Hinton, Tineen'; 'Hopewell Center - Barbara Tucker'; 'Butler, Dwayne'; 'Hopewell Center - Lynette Jones'; 'Franklin, Wil'; 'Higginbotham, Jennifer'; 'Independence Center - Jocelyn Hertich'; 'Independence Center - Paul Schoenig'; 'Karl, Barbara'; 'Lafayette House - Teddy Brown'; 'Mark Twain'; 'McMahon, Cory'; 'Midwest Assessment - Catie Platt'; 'Mineral Area CPRC - Karen Ferrell'; 'Mineral Area CPRC - Vicky Winick'; 'Terry Trafton'; 'Beck, Kimberly'; 'Busiek, Gary'; 'eydie caughron'; 'CMHC - Jerry Morris'; 'CMHC - Kate Hogsett'; 'CMHC - Nate Gulliford'; 'CMHC - Terri Morris'; 'Lafayette House - Deb Allman'; 'Lafayette House - Teddy Brown'; 'Moore, Jonathan'; 'Salvation Army - TSA Midland Contracts'; 'Turning Point - Gary Stoner'; 'Turning Point - John Pruett'; 'Turning Point - Virginia Frese'; 'Westend Clinic - Pamela Byes'; 'Miller, Oval'; 'Carter, Hardy'; 'CMHC - Cindy Brannan'; 'CMHC - Jerry Morris'; 'Swinfard, Tim'; 'Comprehensive - Jenny Miller'; 'Pigg, Margo'; 'Family Guidance - Garry Hammond'; 'Jackson, Derek'; 'Brown, Joshua';

'FCC - Ken Tombley'; 'FCC - Misty Brazel'; 'FCC - Noble Shaver'; 'Parrigon, Mary'; 'Gibson Center - John Gary'; 'Payden, Vernon'; 'Gibson Recovery - Ryan Essex'; 'Gibson Recovery - Sherry Eakers'; 'Camp, Timothy'; 'Preferred - Pam Leyhe'; 'Brawner, Paula'; 'Queen of Peace - Clara Stevenson'; 'Tri-County MHS - Jan Pool'; 'Truman Medical - Douglas Burgess'; 'Carter, Wardell'
Cc: 'Brent McGinty'; ''Emily Conde''; 'Rembecki, Mark'; 'Cook, Natalie'; 'Turner, Rhonda'; 'Rudder, Timothy'; 'Smyser, Melissa'; 'Blume, Susan'
Subject: RE: URGENT - Please respond (SOR) Program Data Collection and Performance Measurement —NEW

I hope and pray that this is not something that will be implemented here in Missouri. Our facility along with others are doing a greater job than just a year ago with the tools that we have now and adding additional data request will only cause the loss of consumer participation along with loss of billing due to a non reimbursable additional questionnaire. I understand the need for the data but, this seems to be more about numbers and data instead of the actual service to the consumer. Thank you for your time and I hope the response's from myself and others will make a direct impact on the decisions being made.

Shauntay McCollough B.S.
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Mathew 20:16

-----Original Message-----
From: Bock, Nora [mailto:Nora.Bock@dmh.mo.gov]
Sent: Thursday, October 18, 2018 1:04 PM
To: Gardine, Cheryl; Menzies, Suneal; Johnson, Clif; Cori Putz (cmoore@pfh.org); Geoff Moeller; lmccallister@placesforpeople.org; NCADA - St. Louis - Nichole Dawsey; NCADA St Louis - Jenny Armbruster; New Beginnings - Freda Theus; McCollough, Shauntay; Cheung, Chi; New Horizons - Laura Porting; New Horizons - Shanna Behrens; New Horizons - Stacy Doggett; North Central MO - DeAnna Savage; Irvine, Lori; North Central MO - Tammy Floyd; Francis, Lisa; Mieseler, Vicky; Ozarks Medical Center - Curtis Cook; Ozarks Medical Center - Joy Anderson; Pathways - Amy Blake; Pathways - Becky Camden; Pathways - Elisabeth Brockman-Knight; Pathways - Gloria Miller; Pathways - Julia Bozarth; Yach, Kristen; Pathways - Linda Grgurich; Pathways - Mel Fetter; Pathways - Shannon Crowley-Einsphar; Pathways - Todd Martensen; Foster, Tonie; Greening, Andrew; PFH - Andrew Schwend; Hutton, Ann; Putz, Cori; PFH - Darlene Harrell; PFH - Jason Hinckley; PFH - Lorinda Meyer; PFH - Marilyn Nolan; PFH - Nancy Atwater; PFH - Rhonda Ferguson; PFH - Una Bennett ; Phoenix - Laura Cameron; Phoenix - Rhiannon Ross; Phoenix - Teresa Goslin; Phoenix Health Programs - Tracy

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Cc: 'Brent McGinty'; 'Emily Conde' (econde@mocoalition.org); Rembecki, Mark; Cook, Natalie; Turner, Rhonda; Rudder, Timothy; Smyser, Melissa; Blume, Susan
Subject: RE: URGENT - Please respond (SOR) Program Data Collection and Performance Measurement —NEW

Thanks, Cheryl.

Everyone: Again, please respond formally via the process outlined in the e-mail – SAMHSA needs to hear from you!

From: cheryl gardine <cheryl@centerforlifesolutions.org>
Sent: Thursday, October 18, 2018 1:02 PM
To: Menzies, Suneal <sunealmenzies@arcamidwest.com>; Johnson, Clif <cjohnson@semobh.org>; Bock, Nora <Nora.Bock@dmh.mo.gov>; Cori Putz (cmoore@pfh.org) <cmoore@pfh.org>; Geoff Moeller <gmoeller@fchcstl.org>; lmccallister@placesforpeople.org; NCADA - St. Louis - Nichole Dawsey <ndawsey@ncada-stl.org>; NCADA St Louis - Jenny Armbruster <JArmbruster@ncada-stl.org>; New Beginnings - Freda Theus <fredatheusnb@gmail.com>; McCollough, Shauntay <Shauntay@newbeginningscstar.org>; Cheung, Chi <chi.c@mo-newhorizons.com>; New Horizons - Laura Porting <LPorting@mo-newhorizons.com>; New Horizons - Shanna Behrens <sbehrens@mo-newhorizons.com>; New Horizons - Stacy Doggett <doggett@mo-newhorizons.com>; North Central MO - DeAnna Savage <deanna@ncmmh.org>; Irvine, Lori <lori@ncmmh.org>; North Central MO - Tammy Floyd <tfloyd77@gmail.com>; Francis, Lisa <lkfrancis@freemanhealth.com>; Mieseler, Vicky <vlmieseler@freemanhealth.com>; Ozarks Medical Center - Curtis Cook <Curtis.Cook@ozarksmedicalcenter.com>; Ozarks Medical Center - Joy Anderson <Joy.Anderson@ozarksmedicalcenter.com>; Pathways - Amy Blake <ablake@compasshn.org>; Pathways - Becky Camden <bcamden@compasshn.org>; Pathways - Elisabeth Brockman-Knight <eknight@compasshn.org>; Pathways - Gloria Miller <gmiller@compasshn.org>; Pathways - Julia Bozarth <jbozarth@compasshn.org>; Yach, Kristen <kyach@compasshn.org>; Pathways - Linda Grgurich <lgrgurich@compasshn.org>; Pathways - Mel Fetter <melf@compasshn.org>; Pathways - Shannon Crowley-Einsphar <seinspahr@compasshn.org>; Pathways - Todd Martensen <tmartensen@compasshn.org>; Foster, Tonie <tfoster@compasshn.org>; Greening, Andrew <agreening@pfh.org>; PFH - Andrew Schwend <aschwend@pfh.org>; Hutton, Ann <ahutton@pfh.org>; Putz, Cori <cputz@pfh.org>; PFH - Darlene Harrell <dharrell@pfh.org>; PFH - Jason Hinckley <jhinckley@pfh.org>; PFH - Lorinda Meyer <lomeyer@pfh.org>; PFH - Marilyn Nolan <mnolan@pfh.org>; PFH - Nancy Atwater <natwater@pfh.org>; PFH - Rhonda Ferguson <rferguson@pfh.org>; PFH - Una Bennett <ubennett@pfh.org>; Phoenix - Laura Cameron <lcameron@phoenixhealthprograms.com>; Phoenix - Rhiannon Ross <rross@phoenixhealthprograms.com>; Phoenix - Teresa Goslin <tgoslin@phoenixhealthprograms.com>; Phoenix Health Programs - Tracy McIntyre <tmcintyre@phoenixhealthprograms.com>; Places for People - Diane Maguire <dmaguire@placesforpeople.org>; Places for People - Nicole Stewart

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Subject: RE: URGENT - Please respond (SOR) Program Data Collection and Performance Measurement —NEW

I agree with the others that this would create a lot of extra time.

From: Suneal Menzies <sunealmenzies@arcamidwest.com<mailto:sunealmenzies@arcamidwest.com>>
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Subject: RE: URGENT - Please respond (SOR) Program Data Collection and Performance Measurement —NEW

I agree – this will create a good deal of additional administrative and clinical work.

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Subject: RE: URGENT - Please respond (SOR) Program Data Collection and Performance Measurement —NEW

For us and Preferred doing the GPRA for STR, this is a longer tool, it adds a 3 month reporting time (not required with STR), so if the benchmark is 80% compliance in reporting like STR, this will add a layer of time for something that for us that is already very labor intensive in tracking , locating and administering. For instance, we are currently tracking 95 STR GPRAs needing completion as of yesterday.

[cid:image001.jpg@01D466E2.FD575C70]
Clif Johnson CRAADC | Director of Clinical Compliance and Physician Services | 573-756-5749 O
+15737606084 M
1565 Ste. Genevieve Avenue-PO Drawer 459 | Farmington, MO 63640-0459

From: Bock, Nora [mailto:Nora.Bock@dmh.mo.gov]
Sent: Wednesday, October 17, 2018 4:53 PM
To: Cori Putz (cmoore@pfh.org<mailto:cmoore@pfh.org>); Geoff Moeller; lmccallister@placesforpeople.org<mailto:lmccallister@placesforpeople.org>; NCADA - St. Louis - Nichole Dawsey; NCADA St Louis - Jenny Armbruster; New Beginnings - Freda Theus; McCollough, Shauntay; Cheung, Chi; New Horizons - Laura Porting; New Horizons - Shanna Behrens; New Horizons - Stacy Doggett; North Central MO - DeAnna Savage; Irvine, Lori; North Central MO - Tammy Floyd; Francis, Lisa; Mieseler, Vicky; Ozarks Medical Center - Curtis Cook; Ozarks Medical Center - Joy Anderson; Pathways - Amy Blake; Pathways - Becky Camden; Pathways - Elisabeth Brockman-Knight; Pathways - Gloria Miller; Pathways - Julia Bozarth; Yach, Kristen; Pathways - Linda Grgurich; Pathways - Mel Fetter; Pathways - Shannon Crowley-Einsphar; Pathways - Todd Martensen; Foster, Tonie; Greening, Andrew; PFH - Andrew Schwend; Hutton, Ann; Putz, Cori; PFH - Darlene Harrell; PFH - Jason Hinckley; PFH - Lorinda Meyer; PFH - Marilyn Nolan; PFH - Nancy Atwater; PFH - Rhonda Ferguson; PFH - Una Bennett ; Phoenix - Laura Cameron; Phoenix - Rhiannon Ross; Phoenix - Teresa Goslin; Phoenix Health Programs - Tracy McIntyre; Places for People - Diane Maguire; Places for People - Nicole Stewart; Bayliff, Scott; Places for People - Tiffany Lacy Clark; Spruell, Sharon; Flory, Alan; ReDiscover - Elizabeth Deason; ReDiscover - Jennifer Craig; ReDiscover - John Dean; ReDiscover - Lauren Moyer; ReDiscover - Marsha Page; Busiek, Gary; Beck, Kimberly; SAMHSA Regional Administrator Region VII - Kimberly Nelson; Angela Toman, CRPS; Brenda Felkerson; Cathy Schroer BS; Clif Johnson CRAADC; Dan Adams MBA; Jason W. Gilliam MBA MHA AICP; Storey, Janice; Swope Health - Kortney Carr; Swope Health - Mark Miller; Holm, Christy; Tri-County - JoAnn Werner; Tri-County - Talina Nelson; Tri-County -

Tom Petrizzo; Truman Medical Center - Barbara Warner; Zaiger, Bethany; Truman Medical Center - Jodi Gusman; Truman Medical Center - Mark VanMeter; Truman Medical Center - Sharon Freese; Turning Point - Catie Franklin; Turning Point - Heather Higgins; Allyson Ashley; ARCA - Fred Rottnek; Menzies, Percy; Menzies, Suneal; Arthur Center - Kristin Fishback; Arthur Center - Rachel Ward; BASIC - Keturah Ibrahim; BASIC - Kirby Anderson-El; Johnson, Lola; BASIC - Michael Batchman; BASIC - Robin Smith; Singleton, Yulonda; BHR Worldwide - Angela Tate; BHR Worldwide - Bart Andrews; BJC - Karen Miller; Bootheel Counseling - David Terrell; Kassinger, Micaela; Brandon, Teresa; Bridgeway - Craig Miner; Bridgeway - Jack Barnett; Morrison, Mike; Burch, Mitzi; Burell - CJ Davis; Burrell - Cristin Martinez; Burrell Center - Adam Andreassen; Burrell Center - Austin Burdine; Burrell Center - Bethany Silliman; Burrell Center - Brent Sugg; Burrell Center - Christopher Orr; Burrell Center - Denise Mills; Burrell Center - Gina Burroughs; Burrell Center - Hunter Houston; Burrell Center - Lauren Pratt; Burrell Center - Leslie Corbiere; Gass, Mathew; Burrell Center - Megan Steen; Burrell Center - Sally Gibson; Burrell Center - Shae Hitchock; Burrell Center - Stephanie March-Hopkins; Burrell Center - Stephen Koch; Burrell Center - Wes Starlin; Camp, Timothy; CCC - Brenda Robertson; CCC - Lonnie Lusk; Gardine, Cheryl; Ridenour, Brad; Clark CMHC - Debbie Schoon; Beatie, Laura; Clark Mental Health - Christy Henley; CMHC - Jenny Wright; Anderson, Carl; CMHS - Jenny Duncan; CMHS - Julie Pratt; CMHS - Tara Yardley; CommCARE - Erica Immenschuh; Compass Health / McCambridge - Angela Allphin; COMTREA - Agnes Jos; COMTREA - Andrea Cuneio; COMTREA - Jonathan Cochran; COMTREA - Rachael Bersdale; Susan Curfman; Crider - Carrie Rigdon; Crider - Laura Heebner; Crider - Nancy Gongaware; Crider - Victoria Walker; Family Guidance - Elizabeth Sprung; Family Guidance - Kristina Hannon; Family Guidance - Rachel Evans; Family Guidance - Raven Hutchison; Family Guidance - Rebekah Quillin; Family Guidance - Robin Reynozo; Family Self Help - Alison Malinowski Sunday; Family Self Help - Gwen Ewing; FCC - Ashley Singleton; FCC - Kelley Wilbanks; FCC - Melissa Weatherwax; FCC - Randy Ray; FCC - Shawn Sando; First Call - Susan Whitmore; Freeman Health - Melissa Moore; Freeman Health - Spencer Ellis; Feaman, Kimberly; Doherty, Steve; Hannibal Council dba Turning Point - Jennifer Wilson; Hannibal Council dba Turning Point - Kettisha Hodges; Heartland Center - Carolyn Ross; Heartland Center - Kyle Mead; Hinton, Tineen; Hopewell Center - Barbara Tucker; Butler, Dwayne; Hopewell Center - Lynette Jones; Franklin, Wil; Higginbotham, Jennifer; Independence Center - Jocelyn Hertich; Independence Center - Paul Schoenig; Karl, Barbara; Lafayette House - Teddy Brown; Mark Twain; McMahon, Cory; Midwest Assessment - Catie Platt; Mineral Area CPRC - Karen Ferrell; Mineral Area CPRC - Vicky Winick; Terry Trafton (ttrafton@CommCARE1.org<mailto:ttrafton@CommCARE1.org>); Beck, Kimberly; Busiek, Gary; Center for Life Solutions - Eydie Caughron; CMHC - Jerry Morris; CMHC - Kate Hogsett; CMHC - Nate Gulliford; CMHC - Terri Morris; Gardine, Cheryl; Lafayette House - Deb Allman; Lafayette House - Teddy Brown; Moore, Jonathan; Salvation Army - TSA Midland Contracts; Turning Point - Gary Stoner; Turning Point - John Pruett; Turning Point - Virginia Frese; Westend Clinic - Pamela Byes; Miller, Oval; Carter, Hardy; CMHC - Cindy Brannan (cmhc.nmh.cbrannan@gmail.com<mailto:cmhc.nmh.cbrannan@gmail.com>); CMHC - Jerry Morris (cmhcjerry@sbcglobal.net<mailto:cmhcjerry@sbcglobal.net>); Swinfard, Tim; Comprehensive - Jenny Miller (jemil@thecmhs.com<mailto:jemil@thecmhs.com>); Pigg, Margo; Family Guidance - Garry Hammond (ghammond@FGCnow.org<mailto:ghammond@FGCnow.org>); Jackson, Derek; Brown, Joshua; FCC - Ken Tombley (ken.tombley@fccinc.org<mailto:ken.tombley@fccinc.org>); FCC - Misty Brazel (mistyb@fccinc.org<mailto:mistyb@fccinc.org>); 'FCC - Noble Shaver'; Parrigon, Mary; Gibson Center - John Gary (garyj@gibsonrecovery.org<mailto:garyj@gibsonrecovery.org>); Payden, Vernon; Gibson Recovery - Ryan Essex (essexr@gibsonrecovery.org<mailto:essexr@gibsonrecovery.org>); Gibson Recovery - Sherry Eakers (eakerss@gibsonrecovery.org<mailto:eakerss@gibsonrecovery.org>); McCollough, Shauntay; Camp, Timothy; Preferred - Pam Leyhe

(pleyhe@pfh.org<mailto:pleyhe@pfh.org>); Brawner, Paula; Queen of Peace - Clara Stevenson; Tri-County MHS - Jan Pool (janp@tri-countymhs.org<mailto:janp@tri-countymhs.org>); Truman Medical - Douglas Burgess (douglas.burgess@tmcmed.org<mailto:douglas.burgess@tmcmed.org>); Carter, Wardell
Cc: 'Brent McGinty'; 'Emily Conde' (econde@mocoalition.org<mailto:econde@mocoalition.org>); Rembecki, Mark; Cook, Natalie; Turner, Rhonda; Rudder, Timothy; Smyser, Melissa; Blume, Susan
Subject: URGENT - Please respond (SOR) Program Data Collection and Performance Measurement—NEW
Importance: High

THIS WILL HUGELY IMPACT THE DATA REQUIREMENTS FOR SOR – I cannot emphasize enough how important it is for you to review the proposed requirements and provide feedback!!

Nora

From: Gowdy, Rick
Sent: Wednesday, October 17, 2018 4:49 PM
To: 'Winograd, Rachel' <rachel.winograd@mimh.edu<mailto:rachel.winograd@mimh.edu>>; Horn, Philip <philip.horn@mimh.edu<mailto:philip.horn@mimh.edu>>; Bock, Nora <Nora.Bock@dmh.mo.gov<mailto:Nora.Bock@dmh.mo.gov>>; Rudder, Timothy <Timothy.Rudder@dmh.mo.gov<mailto:Timothy.Rudder@dmh.mo.gov>>; Epple, Laurie <Laurie.Epple@dmh.mo.gov<mailto:Laurie.Epple@dmh.mo.gov>>; Anderson-Harper, Rosie <Rosie.Anderson-Harper@dmh.mo.gov<mailto:Rosie.Anderson-Harper@dmh.mo.gov>>; Stuckenschneider, Angie <Angie.Stuckenschneider@dmh.mo.gov<mailto:Angie.Stuckenschneider@dmh.mo.gov>>; Cahalan, Connie <Connie.Cahalan@dmh.mo.gov<mailto:Connie.Cahalan@dmh.mo.gov>>
Subject: FW: Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW

10-17-18.

See note below from Mr. Clark.

Written comments should be received by December 3, 2018
RNG.

From: Clark, Spencer (SAMHSA/CSAT/DPT)
<Spencer.Clark@samhsa.hhs.gov<mailto:Spencer.Clark@samhsa.hhs.gov>>
Sent: Wednesday, October 17, 2018 4:44 PM
To: lauren.siembab@ct.gov<mailto:lauren.siembab@ct.gov>;
Michael.parks@maine.gov<mailto:Michael.parks@maine.gov>;
Tom.Connors@maine.gov<mailto:Tom.Connors@maine.gov>;
Katherine.Coutu@maine.gov<mailto:Katherine.Coutu@maine.gov>;
Allison.bauer@state.ma.us<mailto:Allison.bauer@state.ma.us>; amy.sorensen-alawad@state.ma.us<mailto:amy.sorensen-alawad@state.ma.us>;
Nicole.m.schmitt@state.ma.us<mailto:Nicole.m.schmitt@state.ma.us>;
Jennifer.miller@state.ma.us<mailto:Jennifer.miller@state.ma.us>;
Hannah.Lipper@state.ma.us<mailto:Hannah.Lipper@state.ma.us>;
Abby.Shockley@dhhs.nh.gov<mailto:Abby.Shockley@dhhs.nh.gov>;
Donald.Hunter@dhhs.nh.gov<mailto:Donald.Hunter@dhhs.nh.gov>;
Cynthia.Thomas@vermont.gov<mailto:Cynthia.Thomas@vermont.gov>;
Megan.Mitchell@vermont.gov<mailto:Megan.Mitchell@vermont.gov>;
Mariah.Ogden@vermont.gov<mailto:Mariah.Ogden@vermont.gov>;
sgoldsby@daodas.sc.gov<mailto:sgoldsby@daodas.sc.gov>;
dwalker@daodas.sc.gov<mailto:dwalker@daodas.sc.gov>;
ckraeff@daodas.sc.gov<mailto:ckraeff@daodas.sc.gov>;
bpowell@daodas.sc.gov<mailto:bpowell@daodas.sc.gov>;
rbraneck@daodas.sc.gov<mailto:rbraneck@daodas.sc.gov>;
taryn.sloss@tn.gov<mailto:taryn.sloss@tn.gov>;
linda.mccorkle@tn.gov<mailto:linda.mccorkle@tn.gov>;
Anthony.jackson@tn.gov<mailto:Anthony.jackson@tn.gov>;
richard.sherman@illinois.gov<mailto:richard.sherman@illinois.gov>;
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Rebecca.Buhner@fssa.IN.gov<mailto:Rebecca.Buhner@fssa.IN.gov>;
Jeremy.Heyer@fssa.IN.gov<mailto:Jeremy.Heyer@fssa.IN.gov>;
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BullardS@michigan.gov<mailto:BullardS@michigan.gov>;
SmithA8@michigan.gov<mailto:SmithA8@michigan.gov>;
dave.rompa@state.mn.us<mailto:dave.rompa@state.mn.us>;
faye.bernstein@state.mn.us<mailto:faye.bernstein@state.mn.us>;
Ellen.Augspurger@mha.ohio.gov<mailto:Ellen.Augspurger@mha.ohio.gov>;
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Sharon.Kearse@ks.gov<mailto:Sharon.Kearse@ks.gov>; Gowdy, Rick
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rachel.winograd@mimh.edu<mailto:rachel.winograd@mimh.edu>;
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tamara.gavin@nebraska.gov<mailto:tamara.gavin@nebraska.gov>;
Marlies.Perez@dhcs.ca.gov<mailto:Marlies.Perez@dhcs.ca.gov>;
tfsunia@dhss.as<mailto:tfsunia@dhss.as>;
herbert.sablan@gmail.com<mailto:herbert.sablan@gmail.com>;
bvictor@fsmhealth.fm<mailto:bvictor@fsmhealth.fm>;
athena.duenas@gbhwc.guam.gov<mailto:athena.duenas@gbhwc.guam.gov>;
temengil.ej@gmail.com<mailto:temengil.ej@gmail.com>
Subject: Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW

Dear STR and SOR Project Directors and Staff:

This is in follow-up to my correspondence to you of last week, indicating the publication of a Federal Registry Notice (FRN) containing the proposed reporting guidelines for the SOR and TOR Grant initiatives.

Please find attached below the proposed SOR information plans and reporting instruments that were referenced in the recent posting of the Federal Register for your review and comment.

I cannot emphasize too greatly how important it is for you to carefully review and comment on these reporting tools, and provide whatever recommendations that you have regarding implementation issues.

I am hopeful that with your feedback we can enter into a meaningful dialogue to maximize the usefulness of this reporting, and minimize any unnecessary reporting burden.

Send comments to Summer King, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland 20857, OR email a copy to summer.king@samhsa.hhs.gov<mailto:summer.king@samhsa.hhs.gov>.

Written comments should be received by December 3, 2018.

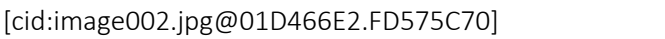
I would appreciate your copying me on any feedback that you provide in this process so that I can be fully prepared to particiapte in this dialogue.

Thank you and best regards,

Spencer Clark

Spencer Clark, MSW, LMSW, ACSW,
Public Health Advisor/
Government Project Officer,
Opioid State Targeted Response, State Opioid Response, and MAT-PDOA Grant Initiatives,
Division of Pharmacologic Therapies,

Center for Substance Abuse Treatment,
Substance Abuse and Mental Health Services Administration,
Department of Health and Human Services,
5600 Fishers Lane, Office 13E25C,
Rockville, MD 20857
Email: Spencer.Clark@samhsa.hhs.gov<mailto:Spencer.Clark@samhsa.hhs.gov>
Personal Direct Telephone: (240) 276-1027
Main Office Telephone: (240) 276-2700



From: King, Summer (SAMHSA/OPPI)
Sent: Tuesday, October 09, 2018 10:19 AM
To: Clark, Spencer (SAMHSA/CSAT/DPT)
<Spencer.Clark@samhsa.hhs.gov<mailto:Spencer.Clark@samhsa.hhs.gov>>
Cc: Jacobus-Kantor, Laura (SAMHSA/CBHSQ) <Laura.Jacobus-Kantor@samhsa.hhs.gov<mailto:Laura.Jacobus-Kantor@samhsa.hhs.gov>>
Subject: RE: SAMHSA Internal Request for More Information on the Proposed Project and to Obtain a Copy of the Information Collection Plans for the SOR and TOR Grant Initiatives

Hi Spencer,
Attached are copies of the information plans and the instruments. Please let me know if you need anything else.
Thanks,
Summer

From: Clark, Spencer (SAMHSA/CSAT/DPT)
Sent: Tuesday, October 9, 2018 10:07 AM
To: King, Summer (SAMHSA/OPPI)
<Summer.King@samhsa.hhs.gov<mailto:Summer.King@samhsa.hhs.gov>>
Subject: SAMHSA Internal Request for More Information on the Proposed Project and to Obtain a Copy of the Information Collection Plans for the SOR and TOR Grant Initiatives

Dear Summer:
Please provide me with a copy of the information collection plans and copies of the instruments as described below in the FRN released last week:
In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed project or to obtain a copy of the information

collection plans, call the SAMHSA Reports Clearance Officer on (240) 276-1243.
Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.
Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW
The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) is requesting approval from the Office of Management and Budget (OMB) for data collection activities associated with the State Opioid Response (SOR) and Tribal Opioid Response (TOR) discretionary grant programs. Approval of this information collection will allow SAMHSA to continue to meet the Government Performance and Results Modernization Act of 2010 (GPRMA) reporting requirements that quantify the effects and accomplishments of its discretionary grant programs which are consistent with OMB guidance. Information collected through this request will be used to monitor performance throughout the grant period.
There will be up to 359 award recipients (states, territories, and tribal entities) in these grant programs. Grantee-level data will include information related to naloxone purchases and distribution. This grantee-level information will be collected quarterly.
All funded states/territories and tribal entities will also be required to collect and report client-level data on individuals who are receiving opioid treatment services to ensure program goals and objectives are being met. Client-level data will include information such as: Demographic information, services planned/received, mental health/substance use disorder diagnoses, medical status, employment status, substance use, legal status, and psychiatric status/symptoms. Client-level data will be collected at intake/baseline, three months post intake, six months post intake, and at discharge.
CSAT anticipates that the time required to collect and report the grantee-level data is approximately 10 minutes per response, and the time required to collect and report the client-level data is approximately 47 minutes per response. CSAT's estimate of the burden associated with the client-level instrument includes an adjustment for data elements that are currently being collected by entities that are likely to be funded by the SOR/TOR grant programs. Start Printed Page 50117
Table 1—Estimate of Annualized Hour Burden for SOR/TOR Grantees

SAMHSA data Collection

Number of respondents

Responses per respondent

Total number of responses

Burden hours per response

Total burden Hours

Grantee-Level Instrument

359

4

1,436

.17

244

Client Level Instrument: Baseline Interview

165,000

1

165,000

.78

128,700

Client-Level Instrument: Follow-up Interview 1

132,000

2

264,000

.78

205,920

Client-Level Instrument: Discharge Interview 2

85,800

1

85,800

.78

66,924

CSAT Total

165,359

516,236

401,788

Notes:

1 It is estimated that 80% of baseline clients will complete the three month and six month follow-up interviews.

2 It is estimated that 52% of baseline clients will complete this interview.

Send comments to Summer King, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland 20857, OR email a copy to summer.king@samhsa.hhs.gov<mailto:summer.king@samhsa.hhs.gov>. Written comments should be received by December 3, 2018.
Start Signature
Summer King,
Statistician.
End Signature End Preamble
[FR Doc. 2018-21576<https://www.federalregister.gov/a/2018-21576> Filed 10-3-18; 8:45 am]
BILLING CODE 4162-20-P

Thank you and best regards,

Spencer Clark

Spencer Clark, MSW, LMSW, ACSW,
Public Health Advisor/
Government Project Officer,
Opioid State Targeted Response, State Opioid Response, and MAT-PDOA Grant Initiatives,
Division of Pharmacologic Therapies,
Center for Substance Abuse Treatment,
Substance Abuse and Mental Health Services Administration,
Department of Health and Human Services,
5600 Fishers Lane, Office 13E25C,
Rockville, MD 20857
Email: Spencer.Clark@samhsa.hhs.gov<mailto:Spencer.Clark@samhsa.hhs.gov>
Personal Direct Telephone: (240) 276-1027

Main Office Telephone: (240) 276-2700

<< OLE Object: Picture (Device Independent Bitmap) >>

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Behavioral Health

December 3, 2018

Summer King
SAMHSA Reports Clearance Officer
5600 Fisher Lane, Room 15E57-B
Rockville, Maryland 20857

Dear Ms. King:

The Louisiana State Opioid Response Grant (grant #6H79TI081691-01M001) through the Department of Health, Office of Behavioral Health, is filing this comment in regards to the proposed protocols for the State Opioid Response (SOR) Program Data Collection and Performance Measurement, document citation 83 FR 50116, document number 2018-21576.

As per Funding Opportunity Announcement (FOA) No. TI-18-015, the federal register language invites comments on the following:

> *(a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.*

The following narrative describes our concerns:

Regarding (a) we believe that requiring 4 data collection periods is excessive, and lacks utility. Instead, we recommend that data collection at intake of services, six months post intake, and at discharge would provide the grantee and funder with all information needed to understand the impact of the program. It has been our experience with the Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) initiative that this recommended data collection process is the most effective. In addition, collecting client progress every three months may inadvertently limit the ability to capture client improvement because of such short data collection intervals.

Regarding (b), based on our experience administering the GPRA for MAT-PDOA, which is an abbreviated version (22-page GPRA); on average the administration would take 45 min. - 1hr. Therefore, we recommend that 47 minutes (32-page GPRA) per

interview proposed, is an under estimation of the length of time to administer the SOR GPRA. Based on this historical data, we anticipate that it may take closer to 87 minutes to administer, as a more accurate assessment of time.

Regarding (c), we believe that addressing the earlier point regarding one fewer data collection point will be less burdensome on both clients and providers, and in turn will positively impact the validity of the data.

Regarding (d), we believe that the restriction of SPARS access to state level grantee employees alone creates an excessive burden on these staff members and it could impact the quality of data presented to SAMHSA. It would be more efficient, and would lead to fewer data entry errors, if we were able to employ a different process. The best option would be to provide sub-contractors providing services with direct access to SPARS. However, without SAMHSA adjustment to this policy, the only feasible way this much data could be entered by individuals who do not have direct access to clients, given current funding amounts, is by a secure, easy to use, and functional batch uploading process. Ideally, this would employ a web-based data collection system developed by SAMHSA that would then be made available to data collection staff and grantee staff for data preparation prior to SPARS submission. Having a uniform system developed by SAMHSA would be important in order to minimize inaccuracies in data collected across grantees. The security of data is a particular concern, because there are clinical and ethical issues associated with data transfer outside of a clinical setting, potentially leading to a violation of HIPAA protections.

We would appreciate your consideration of these comments and recommendations and look forward to your response. If you have questions or need additional information, please contact me either by phone at 225-342-8952 or via email at Quinetta.womack@la.gov.

Regards,

Quinetta Rowley Womack, LAC, CCGG, CCS
LaSOR Principal Investigator
Louisiana Department of Health/Office of Behavioral Health

Cc:
Dr. Janice Petersen, Deputy Assistant Secretary
Louisiana Department of Health/Office of Behavioral Health

Dr. Samuel Robinson, Ph.D., Assistant Professor of Research
LSU Social Research and Evaluation Center

Peyton Fisher, LaSOR Project Director
Louisiana Department of Health/Office of Behavioral Health

SOR Data Collection Review

Grantee Quarterly Data Collection:

No comments, requirements include:

1. Naloxone overdose reversal kits that were purchased using grant funds.
2. Naloxone overdose reversal kits that were distributed using grant funds.

Seems like Britni Reilly already collects all of this information, just will have to add sites.

Client level data collection:

Broad Comments

Data collection Methods and time points:

1. "The SOR/TOR data collection will not interfere with ongoing program operations that facilitate information collection at each site as state/territories and tribal entity are already using collecting and reporting program data as a component of other SAMHSA grants."
   This doesn't make sense – these SOR data points are in addition to other SAMHSA data collection requirements e.g. block grant, in some cases items are duplicative, but are not collected at all of the same time points.
2. Also, more instructions per section for staff would be helpful in ensuring that SOR data will be collected in a consistent manner.

Data Collection Time Points:

1. SOR/TOR grant programs will collect data at four time points: intake, three months post intake, six months post intake, and discharge. The post intake data collections may occur after the client has been discharged from the program. These 4 time points is more than most SUD programs typically submit. Most complete 2 assessments (enrollment and discharge), only MAT programs submit more (addition of a periodic assessment, completed quarterly).

Difficulties:

Both of the sections noted below, requires programs to complete a clinical assessment prior to completing these sections and related fields.

1. Behavioral Health Diagnoses: Depending on the type of program serving OUD patient under SOR, it may be difficult to capture DSM 5 diagnoses/ICD 10 codes related to SUD and MH (E.g. atr, wraparound or case management services). If there is no masters level or higher clinician to make a clinical diagnoses, what is the data reporting expectation? Is this a diagnosis that was made at the time of current treatment, or a previous diagnosis? What if staff entering this data don't know at the time of admission? There is only an option "none of the above". Should "don't know" be added?
2. 2: Services Planned: Documenting all planned services during this current episode treatment, would require a full clinical assessment assessing clients clinical and wraparound needs prior to this point in time.

Question Specific Comments

Records Management:

1. Interview type – by having grantees fill his in an open ended space – it may be tough to track what is baseline, 3 month, six months, and discharge (e.g. what if discharge was at 6 months, and technically they missed the actual 6 m assessment). Of course analysts at the back end can figure this out, but may be messy. Perhaps having 2 questions that get at which of the 4 time points this assessment is for, and a second question that collects what month the actual assessment was completed.

Demographics

1. Question 3a – people who are transgender should be able to answer this question. Currently the note says if sex=female, more directions might be helpful for staff completing these assessments.
2. Question 3a- would be helpful to know how far a long someone is in their pregnancy? Could inform treatment
3. Question 5 is missing a don't know option (each question should consistently have a don't know and a declined option)
4. Question 4 – for Hispanic/Latino/a, or Spanish origin - add Salvadoran
5. Ethnicity is not collected. Suggestion – adding this element might be critical for evaluation looking at cultural competency. (recommended responses: African, African American, American, Asian Indian, Brazilian, Cambodian, Cape Verdean, Caribbean Islander, Chinese Eastern European, European, Filipino, Haitian, Japanese, Korean, Laotian, Latin American Indian, Middle eastern, Portuguese, Russian, Thai, Vietnamese, Unknown, Unknown, Other – specify)
6. Currently no data collection related to Tribal community associations
7. Perhaps Q 9,10,11 should move under medical status

Medical Status

1. M1 and M1b. Might be helpful to ask these questions regarding past year as well.
2. M! and M1b – is there a maximum of digits?

Employment/Support Status

1. No comments/questions

Substance Use

1. Needs instructions. Yes/no, or indicating how many days?
2. For the alcohol us in the drug table, there is no definition for intoxication, or instructions for completion

Substance
Alcohol (any use at all)
Alcohol (to intoxication)

3. What about past year use?
4. For route of administration might be important to add vaping/e-cigarettes
5. Substance table is confusing in terms of how Opioids are captured – there should be a clarification that this is non-medical use of prescription Opioids

6. D19 – 20. Remove “abuse” language, change to alcohol use disorder, and drug use disorder
7. D19-D22 what if treatment episodes were for “addiction”/multiple SUD how would a client respond to number of prior treatments by drugs or alcohol

Legal Status

1. Question L2 – asks if client is on parole or probation, is it potentially important to distinguish these two categories (i.e. change the format of this question)

Family/Social Relationships

1. Question F4 has an option of “refused” which is inconsistent with all other SOR questions that have the option as “declined”
2. Question F5 is missing the question number next to the question
3. Question F5 has an option of “refused” which is inconsistent with all other SOR questions that have the option as “declined”
4. Questions skip from F10, to F18
5. Question F31 and F33 are out of order (they come after F34)

Psychiatric Status

1. For questions P1-2 Is there a maximum number of fields for number of times treated?
2. For P4 – P11, how should this be filled out (yes or not? Number of times?), also what about options for don’t know in declined? These questions could benefit from instructions.

Modified Colorado Symptom Index

1. For self-report measure of psychological symptomatology. Has good reliability and validity (Conrad, K. J., Yagelka, J. R., Matters, M. D., Rich, A. R., Williams, V., & Buchanan, M. (2001) Reliability and validity of a modified Colorado Symptom Index in a national homeless sample. *Mental Health Services Research*, *3*(3), 141-153.)

SOR/TOR Specific Questions

1. Subsequent to question 2, might be helpful to ask if Narcan was administered
2. For question 3, in the instructions indicate which section and question to refer back to for this skip logic.

Services Provided

1. For baseline assessment, what is the timeframe for services received? Past year, past 6 months, etc.?

Discharge Status

1. Are staff supposed to fill out this portion, as well as all of the previous questions at discharge? If so, directions would be helpful.

GPRA direction comparison to SOR client tool

1. Order of sections is different between two tools
2. Interview type is more clearly defined on gpra versus SOR tool

Gpra

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake ***[GO TO INTERVIEW DATE.]***

6-month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

3-month follow-up ***[ADOLESCENT PORTFOLIO ONLY]*** →
Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

Discharge → → → Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

SOR

Interview Type (SELECT ONLY ONE TYPE)

- ○ Baseline
- ○ Reassessment: |____|____| months
- ○ Discharge: Patient completed services
- ○ Discharge: Administrative (SKIP TO SECTION X)

3. GPRA asks about screening for co-occurring disorders, SOR does not

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

1. Was the client screened by your program for co-occurring mental health and substance use disorders?

○ YES
○ NO ***[SKIP 1a.]***

1a. ***[IF YES]*** **Did the client screen positive for co-occurring mental health and substance use disorders?**

○ YES
○ NO

[SBIRT CONTINUE. ALL OTHERS GO TO SECTION A "PLANNED SERVICES."]

4. Planned services, gpra provides instructions, SOR tool does not
5. Planned services, medical services section is longer on SOR than GPRA (8 items versus 4)
6. SOR asks for ICD 10 codes related to behavioral health diagnoses, GPRA does not
7. Gender is captured differently
8. GPRA military section has skip logic, SOR does not
9. SOR does not ask about active duty, GPRA does
10. GPRA asks about family military involvement, SOR does not
11. Substance use history has different format, sor is missing instructions
12. GPRA has more detail regarding defining use (e.g. to intoxication, more than 5+ drinks in one sitting), SOR does not have that

	Number of Days	REFUSED	DON'T KNOW
1. During the past 30 days, how many days have you used the following:			
a. Any alcohol ***[IF ZERO, SKIP TO ITEM B1c.]***	_____	○	○
b1. Alcohol to intoxication (5+ drinks in one sitting)	_____	○	○
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	_____	○	○
c. Illegal drugs ***[IF B1a OR B1c = 0, RF, DK, THEN SKIP TO ITEM B2.]***	_____	○	○
d. Both alcohol and drugs (on the same day)	_____	○	○

13. Past 30 days usual living arrangements are different
14. F6 – satisfaction scale is different

SOR

F6. Are you satisfied with these arrangements?

○ Yes
○ Indifferent
○ No

○ DON'T KNOW
○ DECLINED

GPRA

How satisfied are you with the conditions of your living space?

○ Very Dissatisfied
○ Dissatisfied
○ Neither Satisfied nor Dissatisfied
○ Satisfied
○ Very Satisfied
○ REFUSED
○ DON'T KNOW

15. SOR no longer has a military section, SOR has three questions that are at a much higher level, e.g.

SOR

7b. [IF YES] Have you ever been deployed to a combat zone?

○ Yes
○ No

○ DECLINED
○ DON'T KNOW

5b. Have you ever been deployed to a combat zone? ***[CHECK ALL THAT APPLY.]***

○ NEVER DEPLOYED
○ IRAQ OR AFGHANISTAN (E.G., OEF/OIF/OND)
○ PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
○ VIETNAM/SOUTHEAST ASIA
○ KOREA
○ WWII
○ DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
○ REFUSED
○ DON'T KNOW

16. Gpra section on mental and physical health problems and treatment/recovery is more detailed than SOR, which is now broken out into separate sections and does not have the same level of detail
17. Services received in gpra, is now called services provided in SOR
18. Discharge status is different

SOR

3. **What is the patient's discharge status?**

- ○ Mutually agreed cessation of treatment
- ○ Withdrew from/DECLINED treatment
- ○ No contact within 90 days of last encounter
- ○ Expulsion from program
- ○ Incarcerated (NEWLY OR RE-INCARCERATED)
- ○ Clinically referred out
- ○ Death (SPECIFY CAUSE OF DEATH IF KNOWN) _____
- ○ Other (SPECIFY): _____

GPRA

2. **What is the client's discharge status?**

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

If the client was terminated, what was the reason for termination? ***[SELECT ONE RESPONSE.]***

- ○ 01 = Left on own against staff advice with satisfactory progress
- ○ 02 = Left on own against staff advice without satisfactory progress
- ○ 03 = Involuntarily discharged due to nonparticipation
- ○ 04 = Involuntarily discharged due to violation of rules
- ○ 05 = Referred to another program or other services with satisfactory progress
- ○ 06 = Referred to another program or other services with unsatisfactory progress
- ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- ○ 11 = Transferred to another facility for health reasons
- ○ 12 = Death
- ○ 13 = Other (Specify) _____

19. HIV questions not included in SOR, that are in GPRA

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

1. **Was the client screened by your program for co-occurring mental health and substance use disorders?**

- ○ YES
- ○ NO *[SKIP 1a.]*

1a. ***[IF YES]*** **Did the client screen positive for co-occurring mental health and substance use disorders?**

- ○ YES
- ○ NO

[SBIRT CONTINUE. ALL OTHERS GO TO SECTION A "PLANNED SERVICES."]

From: Pelotte, Tara M
To: King, Summer (SAMHSA/OPPI)
Cc: Clark, Spencer (SAMHSA/CSAT/DPT); Coutu, Katherine
Subject: FW: [EXTERNAL SENDER] Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW
Date: Monday, December 3, 2018 4:17:39 PM
Attachments: Attachment A - SOR TOR Client Instrument.docx
Attachment B - SOR TOR Program Instrument.docx
SOR TOR OMB SS-A 10.4.2018.docx
SOR TOR OMB SS-B 9.20.2018.docx

Good morning, Ms. King-

Please see the *comments* below from the State of Maine re: the proposed data collection instruments:

SSA Comments:

Based on the language of these documents, our understanding is such that in order to operationalize these data collection protocols properly, Maine will require the use a staff resource or contracted resource to collect the required data from program providers as outlined in Attachments A and B. Program providers in Maine will Not be asked to complete a separate form, which would cause duplication and undue administrative burden in the midst of an opioid crisis, they will only be asked to update their own EHR assessments and tools in order to comply with these new SOR reporting requirements (if necessary).

Provider comments:

In regard to the information Katherine has requested we gather in our assessment there are a few challenges from a logistical standpoint. To that end, the measure would need to be done separately and in addition to the biopsychosocial assessment. To that end however, many of the questions asked by the instrument would also assist in gathering and starting the discussion for much of the information for the biopsychosocial itself.

My overall clinical consensus is that a good share of the information gathered will answer much of the questions asked of us to gather but will be cumbersome on both ends for the state to pull it from our biopsychosocial. In addition,although some of the information/data is gathered as part of our biopsychosocial assessment: some of the questions regarding behaviors and circumstances for specific time periods would not be (i.e., past 90 day mental health symptoms, etc) . To ask these questions with program clients in a general interview with such specificity in the psychosocial interview would in many instances feel fragmented and awkward for the clinician and the client.

Lastly, the section regarding past 30 day substance use will be skewed with many of our clients in the jail for obvious reasons. Will this issue be considered and weighted when the state/ feds look at our indicators and outcomes? When I reviewed the instrument again I noticed that the job questions had a fine print guiding how incarcerated individuals should answer so that is helpful.

Overall, I personally feel comfortable with administering this instrument as an additional piece to the assessment . More instrument equates to more time needed to assess a client in any setting; so as long as that is understood by all then it should be fine. Clinically speaking, administering the intrustrument should be explained as such to the client as a way to gather information for current and future program needs and outcomes as opposed to the biopsychosocial which is done to understand the individual.

Thank you and please reach out to me if I can offer additional information.

- Tara

Tara M. Pelotte
SAMHS Project/Grant Manager
Maine Department of Health and Human Services
Office of Substance Abuse and Mental Health Services
#11 State House Station, 41 Anthony Avenue
Augusta, ME 04333-0011
Desk (207) 287-2516 Cell (207) 458-4587

From: Clark, Spencer (SAMHSA/CSAT/DPT) [mailto:Spencer.Clark@samhsa.hhs.gov]
Sent: Wednesday, October 17, 2018 5:44 PM
To: lauren.siembab@ct.gov; Parks, Michael <Michael.Parks@maine.gov>; Connors, Tom <Tom.Connors@maine.gov>; Coutu, Katherine <Katherine.Coutu@maine.gov>; Allison.bauer@state.ma.us; amy.sorensen-alawad@state.ma.us; Nicole.m.schmitt@state.ma.us; Jennifer.miller@state.ma.us; Hannah.Lipper@state.ma.us; Abby.Shockley@dhhs.nh.gov; Donald.Hunter@dhhs.nh.gov; Cynthia.Thomas@vermont.gov; Megan.Mitchell@vermont.gov; Mariah.Ogden@vermont.gov; sgoldsby@daodas.sc.gov; dwalker@daodas.sc.gov; ckraeff@daodas.sc.gov; bpowell@daodas.sc.gov; rbraneck@daodas.sc.gov; taryn.sloss@tn.gov; linda.mccorkle@tn.gov; Anthony.jackson@tn.gov; richard.sherman@illinois.gov; terry.cook@fssa.in.gov; Rebecca.Buhner@fssa.IN.gov; Jeremy.Heyer@fssa.IN.gov; Cassandra.Anderson2@fssa.IN.gov; Mark.Loggins@fssa.IN.gov; Kelly.Welker@fssa.IN.gov; ScottL11@michigan.gov; BullardS@michigan.gov; SmithA8@michigan.gov; dave.rompa@state.mn.us; faye.bernstein@state.mn.us; Ellen.Augspurger@mha.ohio.gov; Sanford.Starr@mha.ohio.gov; joyce.allen@wisconsin.gov; Jason.Harris@dhs.wisconsin.gov; Scott.stokes@dhs.wisconsin.gov; tcroom@odmhsas.org; monica.wilke-brown@idph.iowa.gov; Sharon.Kearse@ks.gov; rick.gowdy@dmh.mo.gov; rachel.winograd@mimh.edu; philip.horn@mimh.edu; tamara.gavin@nebraska.gov; Marlies.Perez@dhcs.ca.gov; tfsunia@dhss.as; herbert.sablan@gmail.com; bvictor@fsmhealth.fm; athena.duenas@gbhwc.guam.gov; temengil.ej@gmail.com
Subject: [EXTERNAL SENDER] Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW

Dear STR and SOR Project Directors and Staff:

This is in follow-up to my correspondence to you of last week, indicating the publication of a Federal Registry Notice (FRN) containing the proposed reporting guidelines for the SOR and TOR Grant initiatives.

Please find attached below the proposed SOR information plans and reporting instruments that were referenced in the recent posting of the Federal Register for your review and comment.

I cannot emphasize too greatly how important it is for you to carefully review and comment on these reporting tools, and provide whatever recommendations that you have regarding implementation issues.

I am hopeful that with your feedback we can enter into a meaningful dialogue to maximize the usefulness of this reporting, and minimize any unnecessary reporting burden.

Send comments to Summer King, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland 20857, *OR* email a copy to *summer.king@samhsa.hhs.gov*.

Written comments should be received by December 3, 2018.

I would appreciate your copying me on any feedback that you provide in this process so that I can be fully prepared to particiapte in this dialogue.

Thank you and best regards,

Spencer Clark

Spencer Clark, MSW, LMSW, ACSW,
Public Health Advisor/

Government Project Officer,
Opioid State Targeted Response, State Opioid Response, and MAT-PDOA Grant Initiatives,
Division of Pharmacologic Therapies,
Center for Substance Abuse Treatment,
Substance Abuse and Mental Health Services Administration,
Department of Health and Human Services,
5600 Fishers Lane, Office 13E25C,
Rockville, MD 20857
Email: Spencer.Clark@samhsa.hhs.gov
Personal Direct Telephone: (240) 276-1027
Main Office Telephone: (240) 276-2700

Behavioral Health is Essential to Health • Prevention Works • Treatment is Effective • People Recover

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From: King, Summer (SAMHSA/OPPI)
Sent: Tuesday, October 09, 2018 10:19 AM
To: Clark, Spencer (SAMHSA/CSAT/DPT) <Spencer.Clark@samhsa.hhs.gov>
Cc: Jacobus-Kantor, Laura (SAMHSA/CBHSQ) <Laura.Jacobus-Kantor@samhsa.hhs.gov>
Subject: RE: SAMHSA Internal Request for More Information on the Proposed Project and to Obtain a Copy of the Information Collection Plans for the SOR and TOR Grant Initiatives

Hi Spencer,
Attached are copies of the information plans and the instruments. Please let me know if you need anything else.
Thanks,
Summer

From: Clark, Spencer (SAMHSA/CSAT/DPT)
Sent: Tuesday, October 9, 2018 10:07 AM
To: King, Summer (SAMHSA/OPPI) <Summer.King@samhsa.hhs.gov>
Subject: SAMHSA Internal Request for More Information on the Proposed Project and to Obtain a Copy of the Information Collection Plans for the SOR and TOR Grant Initiatives

Dear Summer:

Please provide me with a copy of the information collection plans and copies of the instruments as described below in the FRN released last week:

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed project or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276-1243.

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) is requesting approval from the Office of Management and Budget (OMB) for data collection activities associated with the State Opioid Response (SOR) and Tribal Opioid Response (TOR) discretionary grant programs. Approval of this information collection will allow SAMHSA to continue to meet the Government Performance and Results Modernization Act of 2010 (GPRMA) reporting requirements that quantify the effects and accomplishments of its discretionary grant programs which are consistent with OMB guidance. Information collected through this request will be used to monitor performance throughout the grant period.

There will be up to 359 award recipients (states, territories, and tribal entities) in these grant programs. Grantee-level data will include information related to naloxone purchases and distribution. This grantee-level information will be collected quarterly.

All funded states/territories and tribal entities will also be required to collect and report client-level data on individuals who are receiving opioid treatment services to ensure program goals and objectives are being met. Client-level data will include information such as: Demographic information, services planned/received, mental health/substance use disorder diagnoses, medical status, employment status, substance use, legal status, and psychiatric status/symptoms. Client-level data will be collected at intake/baseline, three months post intake, six months post intake, and at discharge.

CSAT anticipates that the time required to collect and report the grantee-level data is approximately 10 minutes per response, and the time required to collect and report the client-level data is approximately 47 minutes per response. CSAT's estimate of the burden associated with the client-level instrument includes an adjustment for data elements that are currently being collected by entities that are likely to be funded by the SOR/TOR grant programs. Start Printed Page 50117

Table 1—Estimate of Annualized Hour Burden for SOR/TOR Grantees

SAMHSA data Collection	Number of respondents	Responses per respondent	Total number of responses	Burden hours per response	Total burden Hours
Grantee-Level Instrument	359	4	1,436	.17	244
Client Level Instrument: Baseline Interview	165,000	1	165,000	.78	128,700
Client-Level Instrument: Follow-up Interview [1]	132,000	2	264,000	.78	205,920
Client-Level Instrument: Discharge Interview [2]	85,800	1	85,800	.78	66,924
CSAT Total	165,359		516,236		401,788

Notes:

[1] It is estimated that 80% of baseline clients will complete the three month and six month follow-up interviews.

[2] It is estimated that 52% of baseline clients will complete this interview.

Send comments to Summer King, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland 20857, *OR* email a copy to summer.king@samhsa.hhs.gov. Written comments should be received by December 3, 2018.

Start Signature
Summer King,

Statistician.

End Signature End Preamble
[FR Doc. 2018-21576 Filed 10-3-18; 8:45 am]
BILLING CODE 4162-20-P

Thank you and best regards,

Spencer Clark

Spencer Clark, MSW, LMSW, ACSW,
Public Health Advisor/
Government Project Officer,
Opioid State Targeted Response, State Opioid Response, and MAT-PDOA Grant Initiatives,
Division of Pharmacologic Therapies,
Center for Substance Abuse Treatment,
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Main Office Telephone: (240) 276-2700

<< OLE Object: Picture (Device Independent Bitmap) >>

From:	Nora Murphy
To:	King, Summer (SAMHSA/OPPI)
Cc:	Loretta Dixon
Subject:	Minnesota Dakota Consortium and Lower Sioux Indian Community Feedback on the Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW
Date:	Friday, November 30, 2018 4:50:28 PM

Hello Ms. King,

Below please find comment on the TOR collection data requirements from the Lower Sioux and the MN Dakota Consortium, a TOR grantee.

Consortium members (including Dr. Rosemary White Shield, psychologist Dr. Hawkins, and a community LADC) express great concern about the SPARS/CSAT-GPRA tool. One of the concerns is that its use may cause harm and re-trigger many of our tribal members and lead to increased, not decreased, opioid use. Furthermore, the tool is divergent to the Kinship System Circle Model (KSCM). KSCM is the model that our Consortium is piloting through the TOR project. Therefore, the four tribes, led by Lower Sioux, have sent a formal request to SAMSHA for exemption from using the proposed GPRA tool. A copy of our formal request signed by the leaders of all four tribes is available upon request.

Sincerely, Nora Murphy

Nora Murphy
Tribal Planner & Grant Writer
Lower Sioux Indian Community
Phone: (507) 697-8638
Email: nora.murphy@lowersioux.com

MICHAEL L. PARSON
GOVERNOR

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www.dmh.mo.gov

December 1, 2018

To Whom It May Concern:

Missouri Opioid STR/SOR leadership and treatment providers have reviewed and discussed the potential impact of the proposed data collection and outcomes measurement tool and our concerns are outlined below.

With resources limited and costs associated with a new treatment model being difficult to project, the Department of Mental Health (DMH) spent Opioid STR direct treatment dollars six months ahead of schedule as we implement the Medication First Model, a chronic disease/medical model, in Missouri. Due to increased costs associated with this model and in an effort to make this model financially viable we are looking to fund administrative positions at our treatment locations to support their efforts. With the added requirement of the proposed data collection tool we would also need to reimburse our providers for the added work and time.

Our projected fiscal impact of this added requirement:
Our projected consumer target is 2,662. Assuming intake GPRAs are collected on each individual and an 80% follow-up rate throughout our projected cost on services is **$527,990**. If intake GPRAs were collected on each individual and maintain a 50% follow-up rate throughout our projected cost is **$379,907**. This does not take into account any administrative time, personnel costs, or additional costs associated with follow-up tracking activities. Previous GPRA follow-up tracking and locating efforts have included phone calls, letters, emails, and even home-visits. These additional costs on added services are difficult to project, but minimum calculations estimate a fiscal impact between **$132,780** - **$265,561** in added services and an approximate administrative burden of **$500,000** on our Opioid SOR treatment provider system. Department staff conducted mock interviews with the proposed tool and found it more time intensive than the GPRA tool used with two STR providers as part of an independent evaluation with *Mathematica*. Without factoring in the administrative cost to our providers, conservative estimates place fiscal burden at **$512,687** and perhaps more realistic projected cost of **$793,551**.

Additionally, Missouri's Medication First model dictates that our treatment providers collect and report relevant information related to medication utilization for STR/SOR clients and this has placed an added un-billable administrative burden, which would increase with the proposed tool. The Department of Mental health eliminated or edited most all intake requirements to allow for someone in active withdrawal to be seen by a physician almost immediately, and the proposed SOR data collection tool will add a significant barrier to the intake process utilizing the Medication First Model. It is noted the beginning of the proposed tool is from the Addiction Severity Index (ASI), one such component eliminated from the immediate intake process. Having to collect information upon intake which is not minimally needed to be seen by a doctor was top priority for our Medication First Model and adding this requirement will deeply impact the time associated with an intake and the number of individuals that may access treatment on a given day as our treatment locations are limited by staff availability and staff time.

Sincerely,

Tim Rudder, LMSW, State Opioid Coordinator
Missouri Department of Mental Health

TR:ldn

From:	Gavin, Tamara
To:	King, Summer (SAMHSA/OPPI)
Cc:	Clark, Spencer (SAMHSA/CSAT/DPT)
Subject:	SOR Data reporting feedback
Date:	Monday, December 3, 2018 10:06:53 PM

Please accept the following feedback specific to SOR reporting information that was sent for state feedback.

During the webinar on Friday, 11/30/2018, it was clarified that grantees will not be able to contract out with 3rd party vendors to assist in SPARS data collection and entry. This is allowed in other SAMHSA discretionary grants and, as such, Nebraska has established processes and contractual relationships that make this a very efficient process. News that this will not be an allowable activity and that grantees must be the point of SPARS data entry creates significant barriers—and will likely create substantial delays in ability to conduct data entry—as systems will need to be updated in order to allow for this. If any reconsideration could be made to this restriction, it would be greatly appreciated.

Additionally, it was clarified that the client-level data tools that are awaiting OMB approval have not been released for review; therefore, we ask if there will be an opportunity to review and provide feedback on the client-level tool that will be used?

Tamara Gavin | *Deputy Director Of Behavioral Health Services*
BEHAVIORAL HEALTH

Nebraska Department of Health and Human Services
OFFICE: 402-471-7732

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From: shauntay McCollough
To: King, Summer (SAMHSA/OPPI)
Subject: SOR Program Data Collection
Date: Tuesday, October 23, 2018 12:32:59 PM

I hope and pray that this is not something that will be implemented here in Missouri. Our facility along with others are doing a greater job than just a year ago with the tools that we have now and adding additional data request will only cause the loss of consumer participation along with loss of billing due to a non reimbursable additional questionnaire. I understand the need for the data but, this seems to be more about numbers and data instead of the actual service to the consumer. Thank you for your time and I hope the response's from myself and others will make a direct impact on the decisions being made.

Shauntay McCollough B.S.
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Mathew 20:16

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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SUBMITTED VIA EMAIL*: *summer.king@samhsa.hhs.gov

December 3, 2018

Summer King
SAMHSA Reports Clearance Officer
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 15E57-B
Rockville, Maryland 20857

RE: Agency Information Collection Activities: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurements

Dear Officer King:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I submit the following comments on the *State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurements*, in response to the Substance Abuse Mental Health Services Administration (SAMHSA) agency information collection request, dated October 4, 2018. Established in 1972, the NPAIHB is a tribal organization formed under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, representing the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on health care issues. In the Portland Area, 75% of the total IHS funding is compacted or contracted and includes 6 federally operated service units, 17 Title I Tribes, 25 Title V Tribes, 3 urban facilities, and 3 treatment centers. NPAIHB operates several important health programs that support our member tribes, including the Northwest Tribal Epidemiology Center,[1] and works closely with the Portland Area Indian Health Service (IHS). NPAIHB appreciates the opportunity to provide comments on the accuracy of SAMHSA's estimate of the burden of the proposed collection of information on SOR and TOR grantees.

Background

American Indian/Alaska Native (AI/AN) communities experience disparities in many health outcomes[2] including overdose deaths[3]. In 2015, AI/ANs had the

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.l. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

[2] Indian Health Service. Indian Health Disparities. In. https://www.ihs.gov/newsroom/factsheets/disparities/; 2017.

highest drug overdose death rates and the largest percentage increase in the number of deaths over time[4]. The opioid pain reliever-related overdose death rate for AI/ANs was 22.1 per 100,000 population in 2015[5]. In 2010, the opioid overdose death rate among AI/AN women was 7.3 per 100,000 population, compared with a rate of 5.7 among white women and 4.2 among all U.S. women[6].

In addition, national trends documenting this disparity appear to be consistent regionally, by IHS Areas and states, where AI/AN-specific data are available. In the Portland IHS Area (Idaho, Oregon, and Washington) a race-corrected analysis found the age-adjusted drug overdose death rate for AI/ANs for opioid, prescription drug, and all drug overdoses to be twice that of non-Hispanic whites (NHW)[7]. Limited access to specialized health care services contributes to and exacerbates disparities in nonfatal and fatal opioid overdose among AI/ANs. Tribal communities are often located far from urban facilities where various specialized health services for opioid addiction treatment are available. In 2014, there were only eight tribal health facilities with Medication-assisted treatment (MAT)/Office-based Opioid Agonist Treatment (OBOT) services, and six tribal programs with MAT/OBOT policies and procedures[8].

The SAMHSA TOR grant program aim is to address the opioid crisis in tribal communities by increasing access to culturally appropriate and evidence-based treatment, including MAT using one of the three Food and Drug Administration (FDA)-approved medications for the treatment of opioid use disorder (OUD). The intent is to reduce unmet treatment need and opioid overdose-related deaths through the provision of prevention, treatment and/or recovery activities for OUD.

Overall, 35 of the 43 Tribes in the Idaho, Oregon and Washington received SAMHSA TOR funding. NPAIHB was awarded SAMHSA TOR funding for a consortium of 22 Tribes in Idaho (2), Oregon (6) and Washington (14) including Burns Paiute, Chehalis, Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians (CTCLUSI), Confederated Tribes of Umatilla, Coquille, Cow Creek Band of Umpqua, Hoh, Kalispel, Klamath, Kootenai, Lower Elwha Klallam, NW Band of Shoshone, Nooksack, Quinault, Samish, Shoalwater Bay, Skokomish, Spokane, Stillaguamish, Suquamish, Swinomish, Upper Skagit.

The NPAIHB TOR Consortium is working to address the opioid crisis in tribal communities by increasing capacity to address the complex factors associated with a comprehensive opioid response, including: access to culturally appropriate prevention, treatment and recovery activities with the intent of reducing unmet treatment need and opioid-related deaths, as well as a focus on

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[3] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas - United States. MMWR Surveill Summ 2017;66(No. SS-19):1-12. DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1<https://www.cdc.gov/Other/disclaimer.html

[4] *Id*.

[5] *Id*.

[6] Warner M, Chen LH, Makuc DM, Anderson RN, Miniño AM. Drug poisoning deaths in the United States, 1980--2008. Hyattsville, MD: National Center for Health Statistics; 2011.

[7] Sujata Joshi, NPAIHB Biostatistician, personal communication; 2017.

[8] Indian Health Service. Division of Behavioral Health Fact Sheet. In: Services OoCaP, editor. https://www.ihs.gov/asap/includes/themes/newihstheme/display_objects/documents/matfactsheet_0814.pdf; 2014.

using cultural and community-based services as strengths for prevention. TOR funding is also strengthening NPAIHB's ability to carry out core public health functions, address tribal health priorities, and progress towards key Healthy People 2020 and 2030 objectives related to public health infrastructure, social determinants of health, and substance use prevention. Our proposed activities are strengthening our partnerships with Northwest Tribes, SAMHSA, IHS, and the states of Idaho, Oregon, and Washington.

The NPAIHB TOR Consortium is reinforcing many of the **Tribal Behavioral Health Agenda (TBHA)** priority areas and strategies, including but not limited to: (1) *Programming that Meets Community Needs* (PR1.4: Treat mental and substance use disorders as chronic conditions that require support and services across the spectrum – from prevention for individuals at all levels of risk through recovery), (2) *Community Mobilization and Engagement* (PR2.1: Formulate and implement long-term, communitywide engagement and mobilization strategies that emphasize community ownership of their issues and solutions), and (3) *Funding Mechanisms* (BH2.4: Develop flexibility that allow tribes with multiple federal grants to lower administrative costs, increase integration of funded programs, and enhance collaborative reporting)[9].

General Comments and Recommendations

The SAMHSA Center for Substance Abuse Treatment (CSAT) is requesting approval from the Office of Management and Budget (OMB) for data collection activities associated with the SOR and TOR discretionary grant programs. Approval of this information collection will allow SAMHSA to continue to meet the Government Performance and Results Modernization Act of 2010 (GPRA) reporting requirements that quantify the effects and accomplishments of its discretionary grant programs, which are consistent with OMB guidance. Information collected through the approved data collection process will be used to monitor performance throughout the grant period.

There are 359 award recipients (states, territories, and tribal entities) in these grant programs. Grantee-level data will include information related to Naloxone purchases and distribution. This grantee-level information will be collected quarterly. Not all TOR grantees will be purchasing Naloxone as part of this grant. NPAIHB recommends allowing TOR grantees to opt out of reporting this information if Naloxone distribution is not in their work plan.

According to SAMHSA, all funded states/territories and tribal entities will also be required to collect and report client-level data on individuals who are receiving opioid treatment services to ensure program goals and objectives are being met. Client-level data will include information such as: demographic information, services planned/received, mental health/substance use disorder diagnoses, medical status, employment status, substance use, legal status, and psychiatric status/symptoms. Client-level data will be collected at intake/ baseline, three months post intake, six months post intake, and at discharge.

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[9] SAMHSA. (2016a). *The National Tribal Behavioral Health Agenda.* Rockville MD: Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

CSAT anticipates that the time required to collect and report the grantee-level data is approximately 10 minutes per response, and the time required to collect and report the client- level data is approximately 47 minutes per response. CSAT's estimate of the burden associated with the client-level instrument includes an adjustment for data elements that are currently being collected by entities that are likely to be funded by the SOR/TOR grant programs. On-the-ground tribal evaluators and NPAIHB member tribes have estimated the burden of client-level data collection to be closer to 4 hours per person due to difficulty in locating individuals (lack of phone or permanent address). Provider-level burden to complete these surveys is unrealistic and will take away from direct medical care services in an already over-burdened medical system.

Additionally, our TOR grantees in the Northwest are small tribal clinics with limited staff capacity to collect this additional information. We are grateful for the funding amounts provided in the TOR and SOR opportunities, but there was no specific funding added for tribes to include an FTE dedicated to the proposed data collection and reporting requirements. Also, not all TOR Grantees will be developing a MAT program with these grant funds. NPAIHB is concerned that the creation of a completely new set of measures that leads to additional requirements will deter tribes from providing MAT treatment services or applying for future SAMHSA TOR grant opportunities.

SAMHSA must reduce the administrative burden and costs of data and reporting requirements on tribes to allow more resources to be directed to patient care. Data collection and reporting requirements should be voluntary for tribes or must be aligned with other data reporting that tribes are already performing. The measures should not be separate from what is already being done because of the administrative burden put on tribal grantees. SAMHSA must work with tribal programs to reduce the burden on tribal programs.

Therefore, NPAIHB requests that SAMHSA honor the government-to-government relationship with tribes for TOR (and all opioid funding – including MAT-PDOA) as to data collection and reporting. This would require that SAMHSA establish a data collection and reporting structure similar to IHS as set forth under Tribal Self-Governance Amendments of 2000 (P.L. 106-260), 42 CFR Part 36, et seq., which states the following:

> 42 CFR §137.203: *May a Self-Governance Tribe participate in a voluntary national uniform data collection effort with the IHS? Yes, in order to advance Indian health advocacy efforts, each Self-Governance Tribe will be encouraged to participate, at its option, in national IHS data reporting activities such as Government Performance Results Act, epidemiologic and surveillance reporting.*

In order to uphold tribal sovereignty and self-determination, SAMHSA should be consistent with IHS data collection and reporting language applicable to Self-Governance Tribes. Under 42 CFR § 137.203, tribes are encouraged to participate, at their option, in IHS data reporting activities such as GPRA and SAMHSA should similarly encourage tribes to participate rather than mandate participation.

> 42 CFR § 137.204: *How will this voluntary national uniform data set be developed? IHS will work with representatives of Self-Governance Tribes, in coordination with the Tribal Self Governance Advisory Committee (TSGAC), to develop a mutually-defined annual*

> *voluntary uniform subset of data that is consistent with Congressional intent, minimizes reporting burdens, and responds to the needs of the Self Governance Tribe.*

NPAIHB also recommends, in alignment with 42 CFR § 137.203, that SAMHSA work with tribal representatives to develop a mutually-defined annual voluntary uniform subset of data that is consistent with Congressional intent, minimizes reporting burdens, and responds to the needs of the tribes.

Specific Comments

(B) Accuracy of the Agency's Estimate of the Burden of the Proposed Collection of Information.

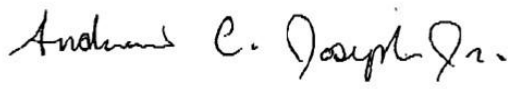
CSAT anticipates that the time required to collect and report the grantee-level data is approximately 10 minutes per response, and the time required to collect and report the client-level data is approximately 47 minutes per response. CSAT's estimate of the burden associated with the client-level instrument includes an adjustment for data elements that are currently being collected by entities that are likely to be funded by the SOR/TOR grant programs.

On-the-ground evaluators and NPAIHB member tribes have estimated the burden of client-level data collection not to be 10 minutes per person but closer to 4 hours per person due to difficulty in locating individuals (lack of phone or permanent address). Provider-level burden to complete these surveys is unrealistic and will take away from medical care in an already over-burdened medical system. Also, not all TOR grantees will but developing a MAT program with these grant funds so there must be consideration that not all TOR grantees will be submitting this information.

Conclusion

We thank you for this opportunity to provide comments and recommendations on the GPRA reporting requirements for TOR and SOR grantees, and we look forward to further engagement with SAMHSA to meet critical opioid overdose challenges in Northwest tribal communities. If you have questions or would like more information about our consortium or our recommendations discussed above, please contact Laura Platero, Government Affairs/Policy Director and Jessica Leston, Clinical Programs Director at (907) 224- 3888 or by email to jleston@npaihb.org.

Sincerely,



Andy C. Joseph, Jr.
NPAIHB Chairperson
Colville Tribal Council Member

From:	Skiles, Jodi
To:	King, Summer (SAMHSA/OPPI)
Cc:	Thierry, Kim (SAMHSA); DiDomenico, Ellen
Subject:	SOR Collection/Proposed Collection
Date:	Friday, November 9, 2018 4:18:45 PM
Attachments:	image004.png image009.png
Importance:	High

Good Afternoon Summer:
Please see comments and questions submitted per instructions for document number 2018-21576, Proposed collection for SOR.

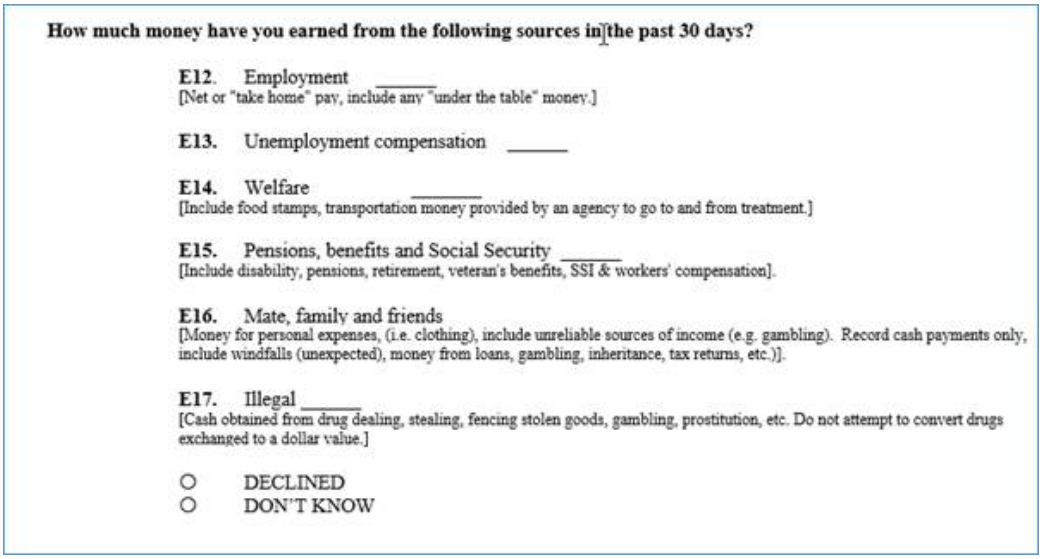
- Record Management
  - Site ID: what does this correspond to? Will we need to provide the list of provider agencies in the SOR network and SPARS will assign an ID for each location where services may be provided?
  - Date of Admission: Is this something that is asked at Baseline and then prepopulated at other interview types, or do we expect the user to fill this out at each interview type?
  - Was the interview conducted? = No: would all of the sections of the instrument be skipped or only selected ones? What are the expectations for data collection when the interview is not conducted
  - Interview type: is the first interview called an Intake or a Baseline interview? We see mentions of intake throughout this document and others.

- Services Planned
  - Under the Case Management Services, question 3b. is listed as "Employment Couching", this should likely be "coaching" and seems to be a typo.
  - The numbering under Treatment Services should likely start at 1. for Medication-assisted treatment (instead of 8) in order to be consistent with the other sections on that page.
  - Should this section only be asked at Baseline?

- Behavioral Health Diagnoses
  - Are we expected to collect Primary, Secondary and Tertiary diagnoses, or is it a single select?
  - Are there any rules related to the section of the diagnoses that we should be aware of?
  - Is this section asked at each interview type?

- Demographics
  - Is this section asked at each interview type? If yes, would some fields be prepopulated from baseline as they would not likely change (i.e DOB, sex, ethnicity, race,…)

- Employment/Support Status
  - Question E20. The help text mentions "if the patient has been incarcerated or detained in the past 30 days" but we are not sure what that references and if a business rule needs to be implemented based on the answer to question L26 in the Legal Section which comes later in the tool? This may only be instruction text and not a business rule to implement, we just would like clarification.
  - Questions E12-E17: do we need to provide a Declined and Don't know option for EACH question or are Declined or Don't know for the entire section. It seems like all other questions have their own Declined/Don't know so we wanted some clarification on this one.



How much money have you earned from the following sources in the past 30 days?

E12. Employment _____
[Net or "take home" pay, include any "under the table" money.]

E13. Unemployment compensation _____

E14. Welfare _____
[Include food stamps, transportation money provided by an agency to go to and from treatment.]

E15. Pensions, benefits and Social Security _____
[Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation].

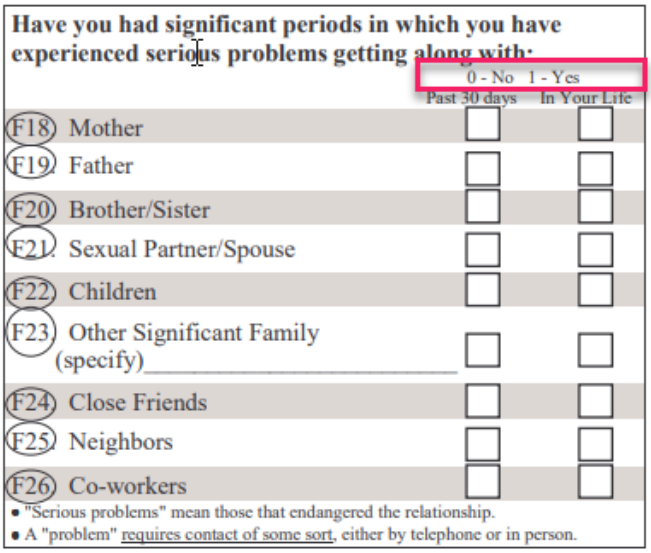
E16. Mate, family and friends
[Money for personal expenses, (i.e. clothing), include unreliable sources of income (e.g. gambling). Record cash payments only, include windfalls (unexpected), money from loans, gambling, inheritance, tax returns, etc.)].

E17. Illegal _____
[Cash obtained from drug dealing, stealing, fencing stolen goods, gambling, prostitution, etc. Do not attempt to convert drugs exchanged to a dollar value.]

○ DECLINED
○ DON'T KNOW

- Substance Use
  - The entry under Prescription Opioids for "OxyContin" is misspelled as "OxycContin"

- Family/Social Relationships
  - There is no number for the question "In the past 30 days, where have you been living most of the time?"
  - Questions F18 to F26 do not have the mention of Yes, No, Declined, Don't know. Should we assume these are the valid response options? See below these questions are expecting Yes or No in ASI Lite:



Have you had significant periods in which you have experienced serious problems getting along with:

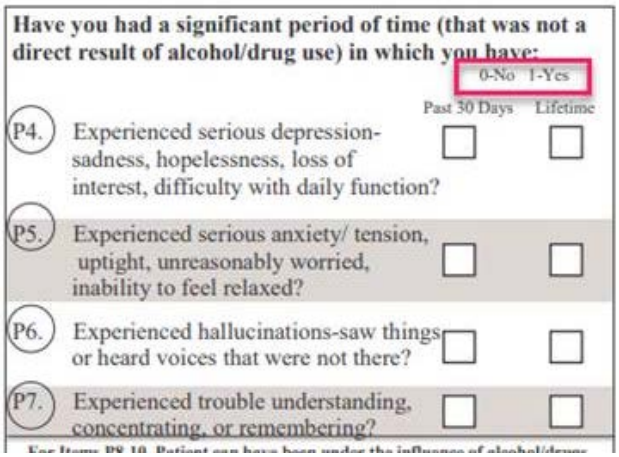
	0 - No 1 - Yes Past 30 days	In Your Life
F18 Mother	☐	☐
F19 Father	☐	☐
F20 Brother/Sister	☐	☐
F21 Sexual Partner/Spouse	☐	☐
F22 Children	☐	☐
F23 Other Significant Family (specify)_____	☐	☐
F24 Close Friends	☐	☐
F25 Neighbors	☐	☐
F26 Co-workers	☐	☐

• "Serious problems" mean those that endangered the relationship.
• A "problem" requires contact of some sort, either by telephone or in person.

- Psychiatric Status
  - Questions P4 to P11 do not have the mention of Yes, No, Declined, Don't know. Should we assume these are the valid responses? See below

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

	Past 30 Days	In Your Life
P4. Experienced serious depression, sadness, hopelessness, loss of interest, difficulty with daily function?		
P5. Experienced serious anxiety/tension, uptight, unreasonably worried, inability to feel relaxed?		
P6. Experienced hallucinations-saw things or heard voices that were not there?		
P7. Experienced trouble understanding, concentrating or remembering?		



- Modified Colorado Symptom Index
  - What do the numbers 1 to 9 represent? Is a scoring expected for this tool (if yes, then what is the calculation? why is Don't know a 9 for example?)?

	How often have you experienced these problems?							
	Not at all	Once during the month	Several times during the month	Several times a week	At least every day	RF	NA	DK
1. How often have you felt nervous, tense, worried, frustrated, or afraid?	0	1	2	3	4	7	8	9
2. How often have you felt depressed?	0	1	2	3	4	7	8	9

- Services Provided:
  - Why do we have the option of "No" for each service? In GPRA if a service was not provided the user would enter a 0. Do we have to support 0 and No options? Or if the answer is not "No" then it has to be a positive number? Is the user supposed to either enter a number or select "No" for each service?
  - We noticed that Recovery Support and Peer Recovery Support services are not listed here but are part of the Planned Services section. Is this intentional?
  - At which interview type is this section asked? Each Reassessment and Discharge?

- Overall:
  - What fields are required? The paper tool does not designate what fields are required. Should we assume everything or nothing is required? Please provide guidance.
  - Are there any other rules not listed on the paper form that we should be aware of?
  - Is this tool to be conducted on any client receiving services with SOR funding? Does it include Prevention, Treatment and Recovery services?
  - Most importantly, what is the timing for the new tool?

- Is it the tool to use at the beginning of services in Jan 2019?
- Should we assume the GPRA for Jan 2019 client level data collection? Then what would be the transition plan to the new tool?

From: Skiles, Jodi
Sent: Wednesday, November 07, 2018 9:31 AM
To: Stonesifer, Brian <c-briaston@pa.gov>; Newell, Jennifer <jennewell@pa.gov>
Subject: FW: SOR
Importance: High

fyi

From: Thierry, Kim (SAMHSA) <Kim.Thierry@SAMHSA.hhs.gov>
Sent: Wednesday, October 31, 2018 3:40 PM
To: Skiles, Jodi <joskiles@pa.gov>
Cc: Somerville, Gerlinda (SAMHSA/CSAT) <Gerlinda.Somerville@samhsa.hhs.gov>; DiDomenico, Ellen <edidomenic@pa.gov>
Subject: RE: SOR
Importance: High

Hi Jodi. Attached are proposed SOR information plans and reporting instruments that are referenced in the recent posting of the Federal Register bulletin. (attached)
Comments are requested by 3 Dec. and information on where to send those comments is referenced in the Federal Register Notice.
I hope this information is useful.
Kim T-E

Kim Thierry English, M.ED, NCAC II, MAC
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Health Systems Branch
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AWS (off duty),Fridays

From: Skiles, Jodi <joskiles@pa.gov>
Sent: Wednesday, October 31, 2018 2:52 PM
To: Thierry, Kim (SAMHSA) <Kim.Thierry@SAMHSA.hhs.gov>
Cc: Somerville, Gerlinda (SAMHSA/CSAT) <Gerlinda.Somerville@samhsa.hhs.gov>; DiDomenico, Ellen <edidomenic@pa.gov>
Subject: RE: SOR

Kim:
Just an FYI. We were on a call with some other states regarding our data system and potential enhancements and some of them were saying that they heard that it may be the same GRPA that we collected for STR? Not sure if there

is any fact to that, but thought that if we thought that might be the route that we could at least begin serving individuals from this funding stream.
Thank you for understanding!!
Jodi

From: Thierry, Kim (SAMHSA) <Kim.Thierry@SAMHSA.hhs.gov>
Sent: Wednesday, October 31, 2018 12:28 PM
To: Skiles, Jodi <joskiles@pa.gov>
Cc: Somerville, Gerlinda (SAMHSA/CSAT) <Gerlinda.Somerville@samhsa.hhs.gov>
Subject: RE: SOR

Hi Jodi. I apologize., but I do not have any updates. I will re-forward your previous inquiry to CSAT Leadership and request a response.
Thank you,
Kim T-E

Kim Thierry English, M.ED, NCAC II, MAC
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e-mail kim.thierry@samhsa.hhs.gov
AWS (off duty),Fridays

From: Skiles, Jodi <joskiles@pa.gov>
Sent: Wednesday, October 31, 2018 10:09 AM
To: Thierry, Kim (SAMHSA) <Kim.Thierry@SAMHSA.hhs.gov>
Subject: SOR

Good Morning Kim!
Hope that you are well! I wanted to follow up with you on data and expectations. We have projects ready to go, and are hoping to understand the requirements, and if we can get started.
Any insight would be helpful.
Thanks so much Kim.

Jodi Skiles | Director
Bureau of Treatment, Prevention and Intervention
Department of Drug and Alcohol Programs
One Penn Center, 5th Floor
2601 N 3rd Street, Harrisburg, PA 17110
Phone: 717.736.7454 |Mobile 717.503.6326 |Fax: 717.787.6285
www.ddap.pa.gov

Follow us:

From: Cori Putz
To: King, Summer (SAMHSA/OPPI)
Subject: SOR/TOR potential reporting requirements
Date: Monday, October 22, 2018 3:27:48 PM

Good Afternoon;

There is no doubt that we value outcomes and want to know that our applied interventions are having a positive impact in the lives of those we serve. However, over the past 18 months, Missouri DMH, in conjunction with Providers, has done an incredible job of minimizing/removing barriers to assist those most in need to access services in a timely manner & remain engaged in treatment. This accomplishment is primarily the result of the removal of stringent requirements for specified services in order to be admitted and/or to remain enrolled in services.

We have made great strides in delivering only those services that the individual believes he/she will benefit from. The introduction of a mandated service brought about by these reporting requirements at the said intervals (admission, 3 months, 6 months, and discharge) will place undue expectations on those that we serve and is in direct conflict with the service model that we have worked so very hard to create.

This instrument is all too familiar to those of us in Missouri given that it is the Addiction Severity Index (ASI) with several extra pages of questions on each end of it. Asking an individual at time of admission, who is usually in active withdrawal, to be alert and sit with us patiently while we complete a questionnaire that takes about 45 minutes, is not reasonable nor is it a client-centered practice which is exactly why Missouri, not so long ago, extended our assessment completion time frame. As a side note, there are still many agencies currently utilizing the ASI for assessments in Missouri within a multitude of electronic medical records, this will be duplicative for both the client and the clinician.

Facilitating this instrument at each said interval also has the potential to divert approximately $1 million away from direct service that will benefit the client for every 1,000 individuals served through these funds in Missouri. This number accounts for the direct service hours expected to be associated with facilitation of this service since Providers will need to be reimbursed for facilitating this tool at each said interval, including admission. This does not take into account the additional necessary staff time that will need to be dedicated to locating or contacting dis-engaged clients and clients who have very low frequency/intensity of service in order to meet the 80% threshold of completion.

Reducing the number of fields to “critical information only” coupled with less frequent intervals of completion may be helpful in making this more palatable for those we serve OR we can utilize the GPRA at Admission, 6 months, and Discharge.

Sincerely,
cori

Corinna Putz

Exec VP Substance Use Disorders
Preferred Family Healthcare

From:	Wolfgang, Tiffany
To:	King, Summer (SAMHSA/OPPI)
Cc:	Baltzer, Breinne; Rachel Oelmann; Bankhead, Jamal (SAMHSA)
Subject:	FW: State Opioid Response 60-Day FRN for Data Collection Tool
Date:	Monday, December 3, 2018 4:53:11 PM
Attachments:	SOR TOR 60-Day FRN.pdf

Ms. King,

Please accept the below comments as part of the public comment period related to SOR/TOR attached notice. Per the direction, South Dakota would like to submit the below as cited in the attached document:

Comments are invited on:

(a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility;

The instruments as designed do not appear to collect much information regarding actual opioid use, but rather focus on potential co-occurring behavioral health diagnoses, medical status on issues not related to substance abuse or treatment, employment status, household cash flow sources, incarceration/law enforcement history, pension payments, etc. What and how will this information be used for in terms of programmatic enhancement or improvement at the federal level in combating the opioid crisis? Some of the information collected may be useful at the state level, however the current tool is intrusive and will result in clients not retaining in much needed treatment and recovery services. South Dakota would not find the proposed data to be useful nor necessary for proper performance nor to have practical utility.

(b) the accuracy of the agency's estimate of the burden of the proposed collection of information;

The GPRA Baseline and Follow-up/Discharge Instrument is considerably longer and more intense than the state's assumptions upon creating a cost proposal to support administrative and data collection efforts in SOR. In comparison, the baseline assessment GPRA tool presently used on the state's SBIRT grant is limited to six (6) questions upon screening, an additional question series about past-30 day use of alcohol or illegal substances upon delivery of a service, and brief questions upon discharge as well as one follow-up interval. Should the drafted instruments move forward and be required for use in SOR, the state will need to do significant re-planning with existing MAT providers to ensure the data elements can be collected in a way that does not significantly impact clinic work-flow. If this process is placed on the contracted entities to conduct with their patients (best case scenario to ensure data is captured), it is burdensome to the point the state fears entities may opt to not contract for MAT expansion/enhancement services, either pursuing on their own or more likely not pursuing at all.

The practical application of asking a patient seeking treatment or peer recovery supports for OUD the breadth of these questions presents a host of concerns, not the least of which will undoubtedly be turning off patients from actually proceeding with the treatment or supports they were originally seeking. The estimated burden for collecting this information is noted as 30 minutes in the cover sheet; ironically, this is the same level of burden associated with the previously mentioned GPRA client outcomes tool used in the state SBIRT grant program which contains fewer questions and less sub-questions/skip logic. The ability to ask and attain answers to this complexity and number of questions upon intake into services is unreasonable and is anticipated to be off-putting to patients.

The types of questions asked (e.g. legal status, including arrest/charge records, # of days in the past month the patient has been engaged in illegal activities for profit, experience and extent of family problems) may be off-putting to patients, not necessarily garner truthful responses, and may be a barrier to them seeking support/care/treatment.

The cost allocation to South Dakota for data enhancements (capped at 2% of the total award per year, or $80,000) along with the timeline required for deployment (not formally defined but anticipated to be ASAP, at the latest upon approval of the data collection tools from OMB) do not at all align with needing to revamp an existing data system as previously mentioned or create a new data system to capture these outcomes for a two-year grant period.

(c) ways to enhance the quality, utility, and clarity of the information to be collected; and
The state originally envisioned leveraging its existing statewide treatment data collection system (STARS) to capture the required client-level outcomes data for SOR. This system is used by accredited substance abuse providers in South Dakota, so they are familiar with its functionality and have access to it for the report of state-funded treatment outcomes data. Upon review of the proposed baseline instruments, very few questions overlap between the proposed instruments and what is presently reported in STARS, and thus significant enhancements to STARS and/or creation of an entirely new system will be required to achieve the desired outcome and comply with the federal requirements set forth.

(d)ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.
A critical control point in the SBIRT process has been to ensure screening and data collection tools are integrated into the electronic medical record; if not integrated, the successful collection and retention of that information is subject to staff time/availability and training to do so. Given the rapid deployment of a data collection solution for SOR grantees (essentially now) required by SAMHSA, the fact that adoption of electronic medical records is not consistent across SD treatment agencies, and the fact that clinics serving as a MAT prescriber in this case do not consistently use the same EMR platform, significant technological hurdles will need to be overcome to ensure that the data can be captured in a way that is not paper-based, burdensome to the clinic/treatment agency, and accurate and timely in its collection. Partnership with the State's HIE is possible, but not in the timeline required. Consideration should be given to data currently collected for TEDS and then assessing what additional questions are needed to capture effectiveness/impact for OUD patients is our recommendation.

Tiffany Wolfgang
Director, Division of Behavioral Health
Department of Social Services
3900 W Technology Circle, Suite 1
Sioux Falls, SD 57106
(605) 367-5236

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From: Clif Johnson CRAADC
To: King, Summer (SAMHSA/OPPI)
Subject: GPRA feedback SOR grant
Date: Friday, October 19, 2018 11:57:03 AM

Please consider our feedback, we are currently doing the GPRA for the STR grant:

a. **Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility;** The collection of the data currently is separate from the "function" of performance of our agency. We currently provide the GPRA for the STR grant, we do not get consistent and timely data back to allow the information to "provide practical utility", this may be due to the period of time data has been collected to allow for a large enough data pool.

b. **The accuracy of the agency's estimate of the burden of the proposed collection of information**; The new GPRA tool for the SOR is much longer, causing a corresponding increase in the time our staff must expend completing the instrument. The addition of a 3 month follow up to be completed adds additional time for support staff to track due dates, and schedule a time to complete the instrument. We currently, expend considerable resources spent just scheduling and tracking the six- month follow up.

c. **Ways to enhance the quality, utility, and clarity of the information to be collected;** The pressure to get an 80% completion rate may affect the accuracy of the information collected. We are expending resources to collect the data, but are not receiving feedback timely enough to be as efficient in recognizing deficit and strength areas. More frequent reports would help the agency identify trends for action planning. A stipend to incentivize the patient to complete the follow up tools would help in increasing participation.

d. **Ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.** Remove that 3 month collection point for sure. Reduce the number of questions and pages to the document. The sheer length of it would cause any person to not want to "self-complete" it as an option. Development of a web-based system that allows individuals to complete the instruments at the required times from their home, or smart phone.

Clif Johnson CRAADC | Director of Clinical Compliance and Physician Services | 573-756-5749 O +15737606084 M
1565 Ste. Genevieve Avenue-PO Drawer 459 | Farmington, MO 63640-0459

From:	Andrea Buford
To:	King, Summer (SAMHSA/OPPI)
Cc:	Clark, Spencer (SAMHSA/CSAT/DPT)
Subject:	URGENT - Please respond (SOR) Program Data Collection and Performance Measurement—NEW
Date:	Tuesday, November 27, 2018 3:35:24 PM

Hello, we would have to agree with the responses of many of our colleagues. A reporting requirement of this magnitude and frequency would put a huge strain on providers and support staff and create the need to consider how to capture reimbursement for time spent collecting information. The number of times this information is to be gathered is likely to be a deterrent for clients who are in recovery and who have adjusted to the Medication First Model. The very nature of the questions and stringent reporting requirements would set our processes back and could blur the concept and practice of service first. The information requested is duplicative and would be better obtained via an automated system where information could be extracted from existing data fields and query enabled features within agency EHRs.

Regards,

Andrea Buford MSW, LCSW | Addiction and Telehealth Director, Behavioral Health

Swope Health Services - Imani House | 3950 E. 51st Street, Kansas City, MO 64130
Office: 816-599-5659 | FAX: 816-599-5936
Email: abuford@swopehealth.org | Web: www.swopehealth.org

State of Tennessee Comments

Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW

- Record Management
  - Site ID: what does this correspond to? Will we need to provide the list of provider agencies in the SOR network and SPARS will assign an ID for each location where services may be provided?
  - Date of Admission: Is this something that is asked at Baseline and then pre-populated at other interview types, or do we expect the user to fill this out at each interview type?
  - Was the interview conducted? = No: would all of the sections of the instrument be skipped or only selected ones? What are the expectations for data collection when the interview is not conducted?

- Services Planned
  - Under the Case Management Services, question 3b. is listed as "Employment Couching", this should likely be "coaching" and seems to be a typo.
  - The numbering under Treatment Services should likely start at 1. for Medication-assisted treatment (instead of 8) in order to be consistent with the other sections on that page.
  - Should this section only be asked at Baseline?

- Behavioral Health Diagnoses
  - Are we expected to collect Primary, Secondary and Tertiary diagnoses, or only one?
  - Are there any rules related to the section of the diagnoses that we should be aware of?
  - Is this section asked at each interview type?

- Demographics
  - Is this section asked at each interview type? If yes, would some fields be pre-populated from baseline as they would not likely change (i.e DOB, sex, ethnicity, race,…)

- Employment/Support Status
  - Questions E12-E17: do we need to provide a Declined and Don't know option for each question or are Declined or Don't know for the entire section?

- Substance Use
  - The entry under Prescription Opioids for "OxyContin" is misspelled as "OxycContin"

- Family/Social Relationships
  - There is no number for the question “In the past 30 days, where have you been living most of the time?”
  - Questions F18 to F26 do not have the mention of Yes, No, Declined, Don’t know. Should we assume these are the valid response options?

- Psychiatric Status
  - Questions P4 to P11 do not have the mention of Yes, No, Declined, Don’t know. Should we assume these are the valid responses?

- Modified Colorado Symptom Index
  - What do the numbers 1 to 9 represent? Is a scoring expected for this tool (if yes, then what is the calculation? Why is Don’t know a 9 for example?)

	How often have you experienced these problems?							
	Not at all	Once during the month	Several times during the month	Several times a week	At least every day	RF	NA	DK
1. How often have you felt nervous, tense, worried, frustrated, or afraid?	0	1	2	3	4	7	8	9
2. How often have you felt depressed?	0	1	2	3	4	7	8	9

- Services Provided:
  - We noticed that Recovery Support and Peer Recovery Support services are not listed here but are part of the Planned Services section. Is this intentional?
  - At which interview type is this section asked? Each Reassessment and Discharge?

- Overall:
  - What fields are required? The paper tool does not designate what fields are required. Should we assume everything or nothing is required? Please provide guidance.
  - Are there any other rules not listed on the paper form that we should be aware of?
  - Is this tool to be conducted on any client receiving services with SOR funding? Does it include Prevention, Treatment and Recovery services?

From: Janice Storey
To: King, Summer (SAMHSA/OPPI)
Subject: FW: URGENT - Please respond (SOR) Program Data Collection and Performance Measurement—NEW
Date: Thursday, October 18, 2018 5:05:20 PM
Attachments: image001.png
Importance: High

Summer I wanted to submit some feedback on the attachments above:
Completing the GPRA for SOR program would be very labor intensive to collect and document the data. If the expected compliance is 80% it would be difficult to achieve. It also adds an additional reporting time at the 3 month period.
The process we have now with "Medication First" allows the client to see the physician sooner rather than later and avoids having the client go through a more lengthy assessment that contains most of the same data as the Integrated Assessment we use now. Although I can see why data is important for supporting programs, I think that the consumer impact to this also needs to be taken into consideration.
Thanks for your consideration.

Janice Storey, LCSW
Clinical Director
Tri-County Mental Health Services, Inc.
3100 NE 83rd Street, Suite 1001
Kansas City, MO 64119
816.877.0444 (direct line)
816.468.6635 (fax)

Building a Resilient Tri-County

Dear STR and SOR Project Directors and Staff:

This is in follow-up to my correspondence to you of last week, indicating the publication of a Federal Registry Notice (FRN) containing the proposed reporting guidelines for the SOR and TOR Grant initiatives.

Please find attached below the proposed SOR information plans and reporting instruments that were referenced in the recent posting of the Federal Register for your review and comment.

I cannot emphasize too greatly how important it is for you to carefully review and comment on these reporting tools, and provide whatever recommendations that you have regarding implementation issues.

I am hopeful that with your feedback we can enter into a meaningful dialogue to maximize the usefulness of this reporting, and minimize any unnecessary reporting burden.

Send comments to Summer King, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland 20857, *OR* email a copy to *summer.king@samhsa.hhs.gov*.

Written comments should be received by December 3, 2018.

I would appreciate your copying me on any feedback that you provide in this process so that I can be fully prepared to particiapte in this dialogue.

Thank you and best regards,

Spencer Clark

Spencer Clark, MSW, LMSW, ACSW,
Public Health Advisor/
Government Project Officer,
Opioid State Targeted Response, State Opioid Response, and MAT-PDOA Grant Initiatives,
Division of Pharmacologic Therapies,
Center for Substance Abuse Treatment,
Substance Abuse and Mental Health Services Administration,
Department of Health and Human Services,
5600 Fishers Lane, Office 13E25C,
Rockville, MD 20857
Email: Spencer.Clark@samhsa.hhs.gov
Personal Direct Telephone: (240) 276-1027
Main Office Telephone: (240) 276-2700

Behavioral Health is Essential to Health • Prevention Works • Treatment is Effective • People Recover

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From: King, Summer (SAMHSA/OPPI)
Sent: Tuesday, October 09, 2018 10:19 AM
To: Clark, Spencer (SAMHSA/CSAT/DPT) <Spencer.Clark@samhsa.hhs.gov>
Cc: Jacobus-Kantor, Laura (SAMHSA/CBHSQ) <Laura.Jacobus-Kantor@samhsa.hhs.gov>
Subject: RE: SAMHSA Internal Request for More Information on the Proposed Project and to Obtain a Copy of the Information Collection Plans for the SOR and TOR Grant Initiatives

Hi Spencer,

Attached are copies of the information plans and the instruments. Please let me know if you need anything else.
Thanks,
Summer

From: Clark, Spencer (SAMHSA/CSAT/DPT)
Sent: Tuesday, October 9, 2018 10:07 AM
To: King, Summer (SAMHSA/OPPI) <Summer.King@samhsa.hhs.gov>
Subject: SAMHSA Internal Request for More Information on the Proposed Project and to Obtain a Copy of the Information Collection Plans for the SOR and TOR Grant Initiatives

Dear Summer:

Please provide me with a copy of the information collection plans and copies of the instruments as described below in the FRN released last week:

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed project or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276-1243.

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) is requesting approval from the Office of Management and Budget (OMB) for data collection activities associated with the State Opioid Response (SOR) and Tribal Opioid Response (TOR) discretionary grant programs. Approval of this information collection will allow SAMHSA to continue to meet the Government Performance and Results Modernization Act of 2010 (GPRMA) reporting requirements that quantify the effects and accomplishments of its discretionary grant programs which are consistent with OMB guidance. Information collected through this request will be used to monitor performance throughout the grant period.

There will be up to 359 award recipients (states, territories, and tribal entities) in these grant programs. Grantee-level data will include information related to naloxone purchases and distribution. This grantee-level information will be collected quarterly.

All funded states/territories and tribal entities will also be required to collect and report client-level data on individuals who are receiving opioid treatment services to ensure program goals and objectives are being met. Client-level data will include information such as: Demographic information, services planned/received, mental health/substance use disorder diagnoses, medical status, employment status, substance use, legal status, and psychiatric status/symptoms. Client-level data will be collected at intake/baseline, three months post intake, six months post intake, and at discharge.

CSAT anticipates that the time required to collect and report the grantee-level data is approximately 10 minutes per response, and the time required to collect and report the client-level data is approximately 47 minutes per response. CSAT's estimate of the burden associated with the client-level instrument includes an adjustment for data elements that are currently being collected by entities that are likely to be funded by the SOR/TOR grant programs. Start Printed Page 50117

Table 1—Estimate of Annualized Hour Burden for SOR/TOR Grantees

SAMHSA data Collection	Number of respondents	Responses per respondent	Total number of responses	Burden hours per response	Total burden Hours
Grantee-Level Instrument	359	4	1,436	.17	244
Client Level Instrument: Baseline Interview	165,000	1	165,000	.78	128,700
Client-Level Instrument: Follow-up Interview [1]	132,000	2	264,000	.78	205,920
Client-Level Instrument: Discharge Interview [2]	85,800	1	85,800	.78	66,924
CSAT Total	165,359		516,236		401,788

Notes:

[1] It is estimated that 80% of baseline clients will complete the three month and six month follow-up interviews.

[2] It is estimated that 52% of baseline clients will complete this interview.

Send comments to Summer King, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland 20857, *OR* email a copy to *summer.king@samhsa.hhs.gov*. Written comments should be received by December 3, 2018.

Start Signature
Summer King,

Statistician.

End Signature End Preamble
[FR Doc. 2018-21576 Filed 10-3-18; 8:45 am]
BILLING CODE 4162-20-P

Thank you and best regards,

Spencer Clark

Spencer Clark, MSW, LMSW, ACSW,
Public Health Advisor/
Government Project Officer,
Opioid State Targeted Response, State Opioid Response, and MAT-PDOA Grant Initiatives,
Division of Pharmacologic Therapies,
Center for Substance Abuse Treatment,
Substance Abuse and Mental Health Services Administration,
Department of Health and Human Services,
5600 Fishers Lane, Office 13E25C,
Rockville, MD 20857
Email: Spencer.Clark@samhsa.hhs.gov
Personal Direct Telephone: (240) 276-1027
Main Office Telephone: (240) 276-2700

<< OLE Object: Picture (Device Independent Bitmap) >>

From:	John Pruett
To:	King, Summer (SAMHSA/OPPI)
Subject:	FW: SOR Data Collection
Date:	Friday, October 19, 2018 11:47:58 AM
Attachments:	image001.png

Sending again kicked back

From: John Pruett [mailto:jpruett@turningpointrc.org]
Sent: Friday, October 19, 2018 10:44 AM
To: 'summer.king@samhsa.hhs.gov.' <summer.king@samhsa.hhs.gov.>
Subject: SOR Data Collection

Ms. King,

In reviewing the documents I feel they are excessive and will put an extra burden on our agency.

Whether large or small, this will create problems for agencies due to the excessive amount of data and the time needed to retrieve and record the data. Not all agencies can devote as much time to this process as would be required to still meet all the other requirements needed both administratively and clinically for other functions.

John Pruett LCSW
Clinical Director

TURNING POINT recovery centers

146 Communications Drive
Hannibal, Missouri 63401

Phone: (573) 248-1196
Fax: (573) 231-0982
Email: jpruett@turningpointrc.org
Website: www.turningpointrc.org

From:	Catie Franklin
To:	King, Summer (SAMHSA/OPPI)
Cc:	"Jennifer Wilson"; "John Pruett"
Subject:	URGENT - Please respond (SOR) Program Data Collection and Performance Measurement-NEW
Date:	Monday, October 22, 2018 12:12:20 PM

Good morning. I am the Program Director for the STR program we have here at Turning Point Recovery Centers in Hannibal, MO and I interact with STR consumers on a daily basis. I am writing in response to the Data Collection email that was sent out last week. My concern is that it appears to be a very long and time consuming process and that at this time, it would take away from the main focus of individualized consumer care and become more about completing paperwork, specifically with the 80% required completion. Thank you for your time.

Catie Whitaker, BS CRADC/SQP/PD
CSTAR GP Program Director
Turning Point Recovery Centers
146 Communications Drive
Hannibal, MO 63401
(573) 248-1196

From:	Porter, Rebecca
To:	King, Summer (SAMHSA/OPPI)
Cc:	Clark, Spencer (SAMHSA/CSAT/DPT)
Subject:	RE: Proposed Project: State Opioid Response (SOR) and Tribal Opioid Response (TOR) Program Data Collection and Performance Measurement—NEW
Date:	Wednesday, November 28, 2018 8:40:16 AM
Attachments:	Broad cross program outcome tool 6.1.18.docx ED Data Intake Form 8.10.18.pdf Employment Services Reporting Requirements.docx

Good Morning Summer,

I am writing from Vermont in response to the Federal request for comments on the proposed SOR data collection tools and performance measurement plan. Attached please find the data collection tools referenced in my comments that Vermont is currently using. WE have started multiple initiatives with STR funding that will be continued with SOR funding, which is why we have so many pieces in place already.

RESPONSE

Vermont Is a Medicaid expansion state with a robust system of healthcare including services for Opioid Use Disorders (OUD). Vermont has an innovative and effective statewide hub and spoke model of Medication Assisted Treatment (MAT) programs. The existing MAT programs and other OUD treatment services are Vermont Medicaid and Block Grant funded services and will remain funded in that way so Vermont is not utilizing SOR funding to pay specifically for MAT treatment. Instead, the Vermont SOR funds are used for activities and programming which augment supports for individuals with OUD engaging in MAT services and for reducing barriers for individuals with OUD to access MAT and evidence-based, non-clinical recovery support services. For instance, Vermont SOR funding will be used to pay for Employment Consultants to work with people in varying stages of engagement in treatment and recovery in existing treatment clinics and recovery centers. As the services we are funding through SOR are not treatment and are provided by non-clinicians, it would be inappropriate for these service providers to ask the full range of clinical questions included in the GPRA tool because these providers, for example, the Employment Consultants, lack the clinical expertise required and to do such is outside their scope of work. Vermont is concerned about the privacy of individuals receiving these services should the GPRA data tool be utilized and that data collected. Therefore, instead of utilizing the proposed tools, Vermont advocates that utilizing the tools Vermont is currently using for the Recovery support related services would lead to the most effective and appropriate data collection for SOR reporting.

For Employment Consultants, this tool is the Employment Services Reporting Requirements. This tool includes the 10 questions that comprise the Brief Assessment of Recovery Capital Tool (BARC-10) and has and will continue to provide Vermont with the data necessary and appropriate to capture the work funded through SOR and to make data-driven decisions around adjustments to continuously improve the programming funded by SOR . See attached tool for more details.

For Peer Recovery Coach activities under this grant, an ED data intake form (see attached) and a broad cross-program outcome tool (see attached) is being used that includes the BARC-10 questions

as well as quality of life ratings questions about the past two weeks and questions about the last thirty days in relation to the individual's:

- *Recovery Center use;*
- *Engagement in substance use treatment services;*
- *Interaction with police/arrest/incarceration/probation;*
- *Substance use – amount/frequency/types of substances used;*
- *Smoking cessation referral questions;*
- *Mental health symptoms including suicide attempts;*
- *Transportation;*
- *Childcare;*
- *Housing;*
- *Employment; and*
- *Education*

Vermont will also be using SOR funding to purchase and distribute naloxone and feels the proposed SOR/ TOR Program Instrument will match nicely with Vermont's Naloxone-related SOR-funded activities.

Best Regards,
Rebecca

VERMONT
DEPARTMENT OF HEALTH
Rebecca Porter, LCMHC, LADC
Grant Programs Manager
Division of Alcohol and Drug Abuse Programs

From:	Mayfield, Jim (DSHS/RDA)
To:	King, Summer (SAMHSA/OPPI)
Cc:	Speaker, Lyz (DSHS/RDA)
Subject:	State Opioid Response (SOR) Program Data Collection and Performance Measurement
Date:	Friday, November 30, 2018 8:56:54 PM

Summer King
SAMHSA
Reports Clearance Officer
5600 Fishers Lane, Room 15E57-B
Rockville, Maryland 20857
Via email: summer.king@samhsa.hhs.gov

Dear Ms. King:

I am filing these comments in regards to the proposed protocols for the State Opioid Response (SOR) Program Data Collection and Performance Measurement, document citation 83 FR 50116, document number 2018-21576.

First, I'd like to address something I learned on the November 30, 2018 SAMHSA Webinar. Funding Opportunity Announcement (FOA) No. TI-18-015 did not specify requirements for uploading data required for SAMHSA's Performance Accountability and Reporting System (SPARS). Based on my experience with other grants and a phone conversation months ago with Deepa, our SOR data collection plan assumed that our sub grantees would have access to SPARS and use that application to enter data directly. We were told today that only grantees will have access to SPARS. This represents a considerable addition to an already burdensome data collection environment. The solutions—an alternative web interface or batch up-load processes—will require a considerable amount effort and time for grantees and their contractors to stand up. At a minimum a substantial grace period will be necessary even if an acceptable solution is found.

Please consider the following additional comments:

(a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility.

It is unclear how these lengthy instruments are necessary for the proper performance of your agency or to the performance of grantees. Because data are only collected for individuals receiving services, it is not possible to use these data to make casual inferences about program effectiveness; even worse, simple pre-post comparisons of outcomes—a common "analysis" using these data—are particularly misleading without the context of an adequate comparison group.

While some information is useful from a program monitoring standpoint—e.g. enrollment and discharge dates, discharge reason, treatment and services, past-30-day substance use, basic socio-economic information, and demographics—there is little value in *systematically* collecting *all* measures in the proposed instruments. In the

context of SOR, there is little value to many of these measures, for example: life-time hospitalizations, non-SUD related medical problems, the distinction between years of technical or other education, the detailed questions about employment and income, the very detailed questions about criminal involvement, etc. If there is a research justification for these questions, they should be asked in the context of a specific project, not as a general, systematic reporting requirement for a project of this scale.

(b) 'Accuracy of the agency's estimate of the burden of the proposed collection of information;

The .78 hours per response is a reasonable estimate of the baseline interview, but it is a considerable underestimate of the follow-up and (non-administrative) discharge surveys. These surveys require time for scheduling, notifications, tracking down clients, repeated attempts to contact clients, etc. The populations receiving services under SOR will be more transient than patients in other interventions, which will compound these tracking and scheduling issues. This burden estimate needs considerable revision.

(c) Ways to enhance the quality, utility, and clarity of the information to be collected; and

A considerably shorter and project-focused instrument would significantly improve data quality and completeness. Also, it is unclear what kind of documentation or training are available for these new instruments. I cannot ask providers to field these instruments without sufficient documentation or training.

(d) Ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

While a technical solution seems attractive, the burden of data collection is primarily a matter of human factors: time, training, staff turnover, quality of interviewer, patient participation, the treatment environment and workflow, and invasiveness of the questions, etc. While improvements in the data entry application would certainly be helpful, these human factors and the length of the instruments are the greater challenges. Even in data collection efforts that incorporated GPRA surveys in tablet applications, most providers conduct surveys on paper and enter data later. That said, if sub grantees are not allowed to access the SPARS system, then an alternative web-based data entry system that supports batch uploads to SPARS would be very valuable.

Given the scale of the SOR grant, the administrative costs associated with the proposed data collection poses a substantial burden. I recommend the following:

1. Ensure there is adequate training and documentation for the new instruments, including Q-by-Qs, train-the-trainer, and appropriate training support for sub-grantees.

2. Use a significantly shorter survey focusing on the measures most relevant to SOR.

3. Eliminate the 3- or the 6-month follow-up survey.

4. Require only "administrative" discharges.

5. Permit sampling instead of requiring surveys for every participant.

6. Create survey modules that can be used to customize the survey based on the intervention: e.g. a low-barrier clinic established in an urban jail setting would focus on criminal justice outcomes, while a nurse care manager model in rural medical clinics could focus on employment, health and child welfare outcomes.

7. Develop a web-based interface for sub grantees to enter data and support batch uploads to SPARS. States should not have to develop this capacity independently.

8. Identity management is going to be very challenging in SOR environment. For example, a non-profit agency in Spokane providing recovery support services and tracking clients on a spread sheet, will not know if a new client received treatment at a SOR-funded jail in Seattle the month before. This identity management challenge must be confronted if SAMHSA expects grantees to assign unique IDs to all SOR-funded clients.

Thank you for taking the time to consider my comments.

Sincerely,
Jim Mayfield

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Transforming Lives

From:	Michelle Jenson
To:	King, Summer (SAMHSA/OPPI)
Cc:	Brenda Ahlemann (bahlemann@utah.gov)
Subject:	Federal Register--SOR Program Data Collection and Performance Measurement
Date:	Wednesday, October 17, 2018 5:42:19 PM
Attachments:	image002.png

Ms. King,

I would like to take this opportunity to respond to the Federal Register publication related to SOR program data collection. We were invited to comment regarding, "Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility." My response to that is that the proposed utilization of GPRA data collection for this program has absolutely zero practical utility and instead creates HUGE barriers to actual clients receiving services from the program. Clients just want to get help! They don't want to have to answer dozens of questions just to get in the door. Especially for clients looking for MAT assistance (which is what this program is focusing on), at "intake" they are not in a good state of mind or physically able to sit there for that long to answer all of these questions. Our organization has participated in at least 2 other federal grants from SAMHSA that required the use of the GPRA; in neither of those programs did we as a service provider or the clients ever find any utility with the information.

Furthermore, I believe that the estimate of 47 minutes per response for client-level data is significantly underestimated. First of all, a population seeking MAT resources is usually actively using or may be going through withdrawals. This will significantly slow down the interview process and may even require that the data be collected in multiple visits. Secondly, this estimate does not include the provider time that must be spent in tracking down the clients for any follow-up administrations. In one of our programs, we estimated that we spent on average a total of 2 hours of staff time for tracking down clients per follow-up.

We sincerely hope that you will take into consideration the barrier to care that this level of data collection creates for the individuals trying to access care. We know that government want to be accountable, and we already collect TEDS data on all of these individuals, but we should not be sacrificing client access to services to meet that accountability requirement.

Sincerely,

Michelle Jenson

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Ms. King,

Thank you for the opportunity to comment on the SAMHSA data reporting proposal for the State Opioid Response (SOR) Grant. In the following document and attachment A, please find my feedback on the proposed SOR Grant data collection requirements. High level comments can be found below. Attached you will also find more specific comments regarding the proposed GPRA client-level data collection tool. The specific GPRA client level tool comments were produced by the University of Wisconsin Population Health Institute, our state agency that has done GPRA Reporting for the MAT PDOA grants. Their expertise has helped us more fully understand the proposed burden for the new reporting outlined in the current SAMHSA proposal for the SOR Grant.

High-Level Data Collection Comments:

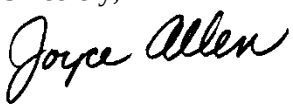
1. **Data Collection for Outcomes Management**. Wisconsin does not dispute the need for appropriate outcome indicator data collection. Wisconsin has found that assuring an appropriate level of accountability using specific outcomes indicators that are seen as valuable by funders, clients and providers can add a critical component to achieving success. We found that in MAT PDOA grant the level of evaluation of outcome indicators allowed us to have a feedback loop to our providers which spurred progress towards more effective and efficient programs.
2. **Data Collection Allocation** (2%). As noted above, Wisconsin sees considerable value in data collection and evaluation. However, we believe that two percent of the total grant is a very small amount for the scope of data that is being required for the SOR Grant. In comparison, for the MAT- PDOA grant, where a GPRA was required at three data points: at intake, 6 months and discharge, that grant allowed us to use 16% of the total award for data collection and performance management. Even with that percentage, it was difficult to attain an 80% follow-up rate. When we have asked about using additional funding for these duties in SOR which now includes four GPRA data points (intake, 3 months, 6 months and discharge), it was pointed out we could also use the 5% that states can use for state related grant oversight. However, the administration of contracts, the requirement that we fund a State Opioid Initiatives Director, and the fiscal management required of such a large grant, also must be recognized and paid for within that 5% for state operations. As a result, that truly only leaves 2% for data collection activities which will not fund the true cost of the data collection burden outlined in the SAMHSA proposed SOR Data Collection proposal.
3. **Additional Data Burden Not Recognized in SAMHSA Documents**. The SAMHSA Supporting Document, "State Opioid Response (SOR) and Tribal Opioid Response (TOR), Program Data Collection and Performance Measurement, A.3" document states, "The SOR/TOR data collection will not interfere with ongoing program operations that facilitate information collection at each site as state/territories and tribal entity are already using collecting and reporting program data as a component of other SAMHSA grants." Wisconsin does not agree with this statement. The new GPRA data elements are not collected for our existing Substance Abuse Prevention Treatment

Block Grant funding. The proposed GPRA was substantially changed from that used for the MAT PDOA grant which also allowed additional resources to be used for data collection and evaluation activities.

4. **Time to complete the GPRA**. For the MAT-PDOA grant, we estimated a time of about 45 minutes per interview, as well as 20 minutes for data entry. In your estimation only 47 minutes was given for both the interview and the data entry. This would increase the total burden hours from 401,788 to 555,984, which again is a very large amount of hours for 2% data collection allocation. As an example, if we served 1,000 people and all were provided all four interviews that would total 80 minutes per person for just the data entry, or 80,000 total hours for 1,000 people served. If we estimate an hourly rate of $30/hr. for data entry with fringe costs, that would total $2.4 million out of the Wisconsin allocation of $11.9 Million for SOR or 20% of the grant costs. That is ten times what is being proposed at 2% for data entry alone.
5. **Client Services to be Tracked**. Guidance is needed on how to record client services in the proposed GPRA system. For example, what if a client is assessed using SOR grant funding, the GPRA is completed and they begin treatment using SOR funding. Then the client transitions onto partial insurance funded treatment services but SOR is continued for those services insurance will not cover such as case management, and recovery support. Would the GPRA continue to record the non-funded Substance Use Disorder treatment services?
6. **System Implementation.** As noted in item 3 above, the proposed GPRA for SOR is a new instrument. An existing electronic instrument does not exist. In the first year of the State Targeted Response to the Opioid Crisis Grant, we served 900 people. With the additional SOR funding, we believe the number will be considerably higher. Time will be needed to give providers sufficient time to implement the GPRA in their local EHRs and clinical processes. A site-based electronic data collection system would reduce the data reporting burden. It is difficult to see how states will be able to implement this within the first grant year.

Thank you for your consideration of my feedback.

Sincerely,



Joyce Allen
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cc: Spencer Clark

From:	Morrison, Beth J
To:	King, Summer (SAMHSA/OPPI)
Cc:	Thierry, Kim (SAMHSA)
Subject:	State Opioid Response (SOR) program data collection and performance measurement - state comments - WV
Date:	Tuesday, December 4, 2018 8:10:11 AM

Summer King
SAMHSA
Reports Clearance Officer
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Via email: summer.king@samhsa.hhs.gov

Dear Ms. King:

The West Virginia Bureau for Behavioral Health is filing this comment in regards to the proposed client level protocol for the State Opioid Response (SOR) Program Data Collection and
Performance Measurement, document citation 83 FR 50116, document number 2018-21576, as referenced in Funding Opportunity Announcement (FOA) No. TI-18-015.

As with any data tool it is important that there be a balance between the amount of data collected and the burden on the participant. As you increase the burden, you decrease the accuracy of the data as patients get fatigued and often do not answer questions truthfully or refuse to answer. This tool is 32 pages long for the baseline. It is the opinion of the clinical and data team from WV's State Targeted Response (STR) funded MAT initiative that it is far too long.

Specific recommendations include:

Medical Status section:
Eliminate questions: M1 and M1b.
People are not going to remember how many times they have been hospitalized so this information is not going to be accurate.
Eliminate question M8

Employment/support status section:
E1 – I think phrasing the question this way compared to how is was in the GPRA will get less accurate results. People will be unclear, do I count per-school, kindergarten, what if they did not go to either of those? They also will not accurately recall months.
E5 – do you have an automobile available is not a good was to phrase the question. Most people who borrow a vehicle sometimes have it available and sometimes do not and it is inconsistent. Do you own an automobile would be a better question. Or does someone in your household own an automobile.
E11 – how much money have you earned from the follow sources – this level of detail is burdensome
E19 and E20 should be combined and E21 eliminated.

Substance Use chart:

It is very important to capture misuse of prescription medications or "street use", As in the individual is using a prescription medication but it is not prescribed to them. It is not clear how it would be differentiated is the person is being prescribed a medication (say benzodiazepines or opioids) or using medications not prescribed to them.

The additional questions D26, D28, D27, D29 are burdensome and will not yield meaningful data.

Legal status:
L18, L19, L20 should be added to the options listed in the chart regarding "how many times have you been arrested and charged with the following"
L27 – people WILL NOT answer this question generally and it is not a good question to ask at an initial baseline before you have earned an individual's trust.
L28 and L29 – remove. People's opinion about their legal situation or substance abuse severity at baseline is not an important data point to collect at the cost of making this assessment so long.

Family Social/relationships:
F30, F31 – redundant and should be removed. This will be captured in the chart about serious problems getting along with people

If the modified Colorado Symptom Index is being administered then the previous symptom chart can be eliminated, as they are redundant:
P4, P5, P6, P7, P8, P9, P10

SOR/TOR specific questions:

1. This is repetitive as incarceration in the past 30 days have already been asked about

Any effort to reduce the length of this tool would be of benefit. If you have questions or need additional information, please contact me via email at Beth.J.Morrison@wv.gov.

Kind regards,

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