Government Performance and Results Act (GPRA)

CSAT State Opioid Response (SOR)/Tribal Opioid Response (TOR) Program Instrument –

Frequently Asked Questions (FAQ)

May 2022

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Transition to New Program Instrument

1. **To clarify, we will use the new paper form from April 1 – June 30, 2022, and hold these until the new form is in SPARS (in July), then update?**

   Yes. Grantees will use the paper form for Q3 (April 1 – June 30, 2022) until the SPARS system has been updated in July 2022, which is when Q3 data will be due.

2. **Since we will not receive clarification on these questions until late April, will it be sufficient to state in the Quarter 3 report that we were not gathering the data because we were not sure of what exactly SAMHSA was asking us to capture?**

   Grantees should make every effort to report complete data for the questions in the SOR/TOR – Program Instrument. SAMHSA use these data to demonstrate tangible contributions to meeting GPRA objectives, report to Congress, provide timely and accurate information to stakeholders, and justify that grant awards are being spent effectively. If you have questions, please contact your Government Project Officer.

3. **What if we will not have data for March until after April 30?**

   - Grantees should report the number of naloxone kits purchases and distributed for Q2 (i.e., January – March 2022) by April 30, 2022.
   - Grantees will start collecting the information and data in the revised instrument in Q3 (i.e., April – June 2022), and enter Q3 data into SPARS by the end of July 2022.

   If you have any challenges reporting your data by the deadlines mentioned above, please contact your Government Project Officer.

Naloxone Kits, Fentanyl Test Strips, & Overdose Reversals

4. **There are two naloxone doses in a kit. So, if we purchase 10,000 kits, do we report that as 20,000?**

   Grantees should report the total number of kits purchased wholly or in part with SOR/TOR funding. Therefore, if you purchased 10,000 kits (that include 20,000 doses), you will report 10,000 kits in SPARS.

5. **Should we report only distributed naloxone kits and fentanyl test strips that were purchased using SOR funds? Or should we report all distributed naloxone kits and fentanyl test strips, regardless of whether they were purchased with SOR funds?**

   Grantees should only report the number of naloxone kits and fentanyl test strips distributed that were purchased wholly or in part with SOR/TOR grant funds. Grantees are allowed to use other funds in

addition to SOR/TOR funds to purchase naloxone kits and fentanyl test strips; however, grantees will need to delineate which kits and test strips were purchased with SOR/TOR funds.

6. **Our program is only partially funded by the SOR grant, which makes it difficult to determine the exact number of kits and activities using SOR dollars. Is it ok to report total numbers for the entire program?**

   No. Grantees should not report the full numbers of the program. Grantees should only report the information and data for all programs and activities funded wholly or in part by the SOR/TOR grant.

7. **Do we report only reversals for kits distributed since last period? Or all reversals since last report, regardless of when the kit was distributed?**

   Grantees should report all reversals using SOR/TOR purchased kits since the last reporting period, regardless of when the kit was purchased or distributed.

8. **How do we track the number of overdose reversals using the naloxone kits we distributed?**

   Approaches to track overdose reversals may vary but can include collecting data from local public health agencies and other community sectors. Some examples include, but are not limited to:

   - Working closely with Emergency Medical Services (EMS), poison control centers, Syringe Services Programs (SSPs), and other local health agencies to keep track of and collect the number of overdose reversals. For more information on SSPs, please refer to https://www.cdc.gov/ssp/index.html
   - Providing an online form via a link or QR code, email address, or phone number on each naloxone kit distributed throughout the communities to report usage. This strategy might be used during community trainings and to organizations distributing naloxone to the public.
   - Developing mobile applications for first responders and community members to report incidences of overdose and recovery.
   - Developing a tracking sheet and/or distribution log to identify whether the naloxone distributed led to an overdose reversal. In the tracker, an individual will state the reason for the refill or whether the naloxone was used to successfully reverse an overdose. This strategy might be used by substance use treatment programs, emergency departments, and homeless outreach programs.

   If you have questions about other local strategies, we encourage you to contact your Government Project Officer.

9. **If we cannot link naloxone kits to overdose reversals, can we still provide the number of reversals and note that we were unable to confirm if SOR-purchased naloxone was used?**

   The intent of this question is to gather data on the number of overdoses reversed using naloxone kits funded through SOR/TOR. Grantees should only report the actual number for a question. Therefore,

if a grantee is unsure if the kit led to a reversal, the reversal should not be reported. The grantee should provide an explanation of why the overdose reversal was not reported in the space provided.

10. **Data on overdose reversals are delayed. For example, reversals that occurred in May, may not be reported until September of the same year. How should the reversal data be reported in SPARS given the delay?**

    Grantees should report the reversals in the quarter that the reversal occurred. If a naloxone kit was distributed in Q1, the kit distribution will be reported as part of your Q1 data. If that naloxone kit led to an overdose reversal in Q2, then the overdose reversal data would be reported with your Q2 data. If you did not find out about the Q2 reversal until Q3, then you can update your Q2 data to report that reversal once you become aware of the reversal (e.g., in Q3).

Prevention Training & Education Activities

11. **Can you clarify how to count community sectors? Do we count the number of sectors that receive overdose prevention training or the number of people?**

    Key community sectors are individuals that do not fall under the category of first responders but are individuals that are very important in addressing the opioid and/or stimulant crisis(es) in their communities. These individuals may be unique to your locality, community, or neighborhood.

    Grantees should count the number of individuals trained within each sector. For example, if a training included 250 peers, 30 military service members, and 40 social workers, then the total number of individuals (key community sectors) trained would be 320.

12. **How should we define "key community sectors?"**

    Key community sectors are individuals that do not fall under the category of first responders but are individuals that are very important in addressing the opioid and/or stimulant crisis(es) in their communities. These individuals may be unique to your locality, community, and neighborhood. They include, but are not limited to:

    - Family members of an individual who has experienced opioid and/or stimulant misuse.
    - "Peers" – individuals who have been successful in the recovery process and who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.
    - Individuals who are actively serving in the military (i.e., Army, Navy, Marine Corps, Space Force, Coast Guard, Commission Corps of the National Oceanic and Atmospheric Administration, and Commissioned Corps of the Public Health Service).
    - Individuals working in criminal justice settings (i.e., social workers, parole officers, case managers, and probation officers).

- Individuals who are members of community groups that are interested in addressing the opioid and/or stimulant crisis(es) in your communities.

- Individuals who are members of a coalition. A coalition is defined as a community-based formal arrangement for cooperation and collaboration among groups or sectors of a community in which each group retains its identity, but all agree to work together toward a common goal of building a safe, healthy, and drug-free community.

Additional examples of key community sectors in **Tribal communities** might include Elders, youth, Tribal leaders, Tribal health department employees, and other Tribal government employees.

13. Would the medical community count as a key community sector?

Key community sectors are individuals that do not fall under the category of first responders but are individuals that are very important in addressing the opioid and/or stimulant crisis(es) in their communities. These individuals may be unique to your locality, community, or neighborhood.

14. When counting key community sectors, do we include first responders?

Key community sectors are individuals that do not fall under the category of first responders but are individuals that are very important in addressing the opioid and/or stimulant crisis(es) in their communities. These individuals may be unique to your locality, community, or neighborhood.

15. How does SAMHSA define "the consequences" of opioid and/or stimulant misuse?

Consequences refers to the outcome of a particular action. Below are SAMHSA resources that discuss consequences associated with opioid and/or stimulant misuse:

- SAMHSA Opioid Overdose Prevention Toolkit https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf

- SAMHSA TIP 33 Treatment for Stimulant Use Disorder https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-004.pdf

Refer to SAMHSA's Evidence-Based Practices Resource Center https://www.samhsa.gov/resource-search/ebp and SAMHSA's Publications and Digital Products https://store.samhsa.gov/ for more resources. If you have questions, please contact your Government Project Officer.

Media Campaigns

16. Can you give examples of how we would report "number of people educated" through a bus ad campaign or billboard?

Grantees can determine the number of individuals reached through advertising using several methods depending on the type of campaign.

- **Social media campaigns.** Using standard key performance indicators (KPIs), grantees will be able to access quantifiable measure of performance over time for a specific objective. Examples of KPIs include reach, impressions, link clicks, etc. that will help

identify how many people were reached through the campaign. For more information refer to: https://www.cdc.gov/socialmedia/Tools/guidelines/

- **Billboards.** The organization and/or agency that placed the advertisement or manage the billboard will be able to provide this data.
- **Other media campaigns (i.e., television and radio).** The networks will be able to provide you with data. Data detailing the number of times a particular ad ran, along with the viewership/listenership during those hours are usually reported monthly.

17. Billboards and radio ads give estimates of impressions, not individuals reached. Is that acceptable to report?

Yes, it is acceptable to report the number of media impressions.

18. Would you like us to include the number of media impressions from an awareness campaign?

Yes, media impressions related to educating people on the consequences of opioid and/or stimulant misuse should be reported.

School-based Prevention & Education

19. Are school-aged children considered K-12?

Yes. School-aged children are children in Kindergarten through 12th grade.

20. Can you clarify what is considered "school-based prevention?"

School-based prevention are prevention activities or curriculum that are offered or take place in a school-based setting (i.e., activities for children in Kindergarten through 12th grade). These include but are not limited to: PAX Good Behavior Game, Positive Action, Project Towards No Drug Abuse, Second Step, Sources of Strength, and Too Good for Drugs.

21. Should we count the number of school-aged children who participate in the PAX Good Behavior Game? The activity does not specifically address opioid misuse; however it does have evidence-based outcomes related to a reduction in opioid misuse later in life.

Grantees should report the number of school-aged children that received school-based prevention and education activities. Examples include but are not limited to: PAX Good Behavior Game, Positive Action, Project Towards No Drug Abuse, Second Step, Sources of Strength, and Too Good for Drugs.

22. In Question 11, do we include the number of school-aged youth reported in Question 9?

For Question 11 – grantees should report the total number of people that were educated on the consequences of opioid and/or stimulant misuse through prevention activities since the last reporting period. This number should include school-aged children who were educated through school-based prevention and education activities.

Data reported for Question 9 should be the number of school-aged children who received school-based prevention and education activities on the consequences of opioid and/or stimulant misuse since the last reporting period.

Outreach to Underserved/Diverse Populations

23. Does SAMHSA have a definition of which populations count as underserved/diverse?

Underserved and/or diverse populations are groups of people who have systematically experienced greater obstacles to health based on specific factors. These factors can be defined by:

- Race (e.g., American Indian/Alaska Native, Asian American, Native Hawaiian, Pacific Islander, and Black/African American)
- Ethnicity (e.g., Hispanic/Latino)
- Sex/Gender (including transgender, lesbian, gay, and bisexual populations)
- Age
- Disability status

24. Can you please clarify what constitutes an "outreach activity?"

Outreach is defined as a person or group who provides an approach to share information with a targeted audience to get them into services. This is usually accompanied by an outreach plan. Outreach is not stationary, but mobile; in other words, it involves meeting someone in need of an outreach service(s) at the location where they are to get them into care and treatment services.

Outreach activities may vary. Examples can include the dissemination of information, connecting with local settings or agencies, or any activity surrounding engagement.

25. What types of "outreach activities" should we include in our response (e.g., radio ads and billboards, trainings, education programs)?

Outreach activities should engage, and target, underserved and/or diverse populations. Examples of outreach strategies include but are not limited to:

- Employing culturally-specific engagement strategies, such as connecting with culturally-similar support groups; collaborating and partnering with faith-based organizations and institutions; and identifying community-embraced first responder (e.g., quick response teams).
- Meeting people where they physically are, whether at their homes after an overdose or on the street using outreach teams.
- Creating culturally-tailored public awareness campaigns using native language, phrases, jargon, and images.

Below are some SAMHSA resources on strategies for specific underserved and/or diverse populations:

- The Opioid Crisis and The Black/African American Population: An Urgent Issue https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf
- The Opioid Crisis and The Hispanic/Latino Population: An Urgent Issue https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002-compressed.pdf
- The National Tribal Behavioral Health Agenda https://store.samhsa.gov/sites/default/files/d7/priv/pep16-ntbh-agenda.pdf

Refer to SAMHSA's Office of Behavioral Health Equity https://www.samhsa.gov/behavioral-health-equity/about for more resources.

26. There could be overlap in the numbers reported in Questions 8 and 12, depending on the definition/examples used for "outreach activities."

Individuals may be counted in multiple categories if they participated in more than one activity.

27. Can we use population-based estimates for race/ethnicity, etc. to determine percentages of the population who are members of an "underserved" population?

SAMHSA recognizes that there are data limitations associated with underserved and/or diverse populations. We encourage you to review all available data sources to determine the best source(s) that are representative of your locality, and community. Examples of some data sources include but are not limited to:

- United States Census Bureau https://data.census.gov/cedsci/
- Treatment Episode Data Set (TEDS) https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set

Grantees should ensure that outreach activities focus on the needs of the underserved and/or diverse population in their locality and community. Outreach activities should engage, and target, underserved and/or diverse populations. Examples of outreach strategies include but are not limited to:

- Employing culturally-specific engagement strategies such as connecting with culturally-similar support groups; collaborating and partnering with faith-based organizations and institutions; and identifying community-embraced first responder (e.g., quick response teams).
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- The National Tribal Behavioral Health Agenda https://store.samhsa.gov/sites/default/files/d7/priv/pep16-ntbh-agenda.pdf

Refer to SAMHSA's Office of Behavioral Health Equity https://www.samhsa.gov/behavioral-health-equity/about for more resources.