

Center for Behavioral Health Statistics and Quality/Office of Evaluation Listening Sessions

Tribal Grantee Listening Session | February 29, 2024

Executive Summary

To inform the Substance Abuse and Mental Health Services Administration's (SAMHSA) redesign of the client-level performance management tools, the Center for Behavioral Health Statistics and Quality (CBHSQ) in collaboration with the Office of Tribal Affairs and Policy (OTAP) convened a listening session with grantees on February 29, 2024. Participants provided input on (1) how SAMHSA should decrease burden and increase data quality; (2) approaches to streamline reporting for the Government Performance and Results Act (GPRA); (3) parts of the tool that are valuable for participants; and (4) how participants use the data and constraints to using the data. There are seven main themes from the listening session:

1. SAMHSA should shorten the redesigned tool, so it is less time intensive and redundant.
2. SAMHSA should ensure all grantees have sufficient resources to collect and enter requested information.
3. SAMHSA should modify the wording of questions to achieve greater clarity.
4. SAMHSA should revise how grantees enter, download, and analyze data.
5. SAMHSA should revise the data collection timeline to be sensitive to clients' needs and experiences.
6. SAMHSA should ensure the redesigned tool provides data that grantees value and can use.
7. SAMSHSA should regularly communicate with grantees about how it uses and makes decisions regarding data.

The organizations listed below participated in the discussion, but this list is not comprehensive because not all participants named their affiliations. Appendix A includes the names of participants who introduced themselves in the chat.

1. Hualapai Health Department
2. Choctaw Nation of Oklahoma
3. Santee Sioux Nation Society of Care (Nebraska)
4. Wabanaki Public Health and Wellness
5. Albuquerque Area Southwest Tribal Epidemiology Center
6. Mathiesen Memorial Health Clinic
7. Chickasaw Nation Tribal Opioid Response (TOR) program

8. Red Lake Chemical Health Programs (Red Lake Band of Chippewa Indians)
9. Northwest Portland Area Indian Health Board
10. Oneida Nation Behavioral Health

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) is committed to reducing burden related to grant performance data collection and reporting. To achieve this goal, SAMHSA is working to significantly redesign client-level performance management tools currently in use. SAMHSA plans to shift client-level Government Performance and Results Act (GPRA) tools to a single, brief, client-level tool for all client-level grant programs. The agency is working toward standardization, transparency, and reduction in burden. To support their redesign efforts, SAMHSA seeks to incorporate partner input as much as possible. To this end, SAMHSA scheduled and facilitated four listening sessions with Tribes, Tribal organizations, and evaluators to better understand areas for burden reduction while ensuring equity and accuracy in the final tool. This document summarizes the session held with grantees on February 29, 2024

Approach

The listening session occurred on Thursday, February 29, 2024, from 3:30-4:30 pm ET. CAPT Kari Hearod, Director of the OTAP, and Steven Whitehorn, Public Health Analyst with OTAP, facilitated the discussion over Zoom. OTAP recorded the meeting. Participants included Tribal grantees and organizations that help Tribal grantees implement the SAMHSA grants. Based on the participant list in the Zoom meeting, an estimated 70 individuals logged on to the Zoom call. Twenty (20) participants provided approximately 50 comments, both verbally and via chat. Exhibit 1 presents participants' roles and organization, when provided. Appendix A catalogues this information and participants' names, but these data are not comprehensive, because not all participants introduced themselves, and not all chat introductions highlighted participants' affiliations.

Exhibit 1. Participants' organizations and roles

Participant organization and role
Hualapai Health Department, Director
Choctaw Nation of Oklahoma, Evaluator
Santee Sioux Nation Society of Care (Nebraska), Director
Choctaw Nation Tribal Opioid Response (TOR) Program, Program Manager
Wabanaki Public Health and Wellness, Evaluation Specialist
Albuquerque Area Southwest Tribal Epidemiology Center, Tribal Behavioral Health Director
Mathiesen Memorial Health Clinic
Tribal Opioid Response Program Manager

Participant organization and role
Choctaw Nation, Grant evaluator
Chickasaw Nation TOR program, GPRA and Data Coordinator
Tribal Behavioral Health Consultant
Red Lake Chemical Health Programs, Red Lake Band of Chippewa Indians, GPRA and Data Coordinator
Northwest Portland Area Indian Health Board, TOR Consortium Evaluation Team
Eugene, Oregon (no role or specific organization provided)
Medications for Opioid Use Disorder Grant, Choctaw Nation of Oklahoma, Integrated Behavioral Health Specialist
Oneida Nation Behavioral Health

The following questions guided the discussion:

1. What should SAMHSA consider as we prioritize decreased burden and high-quality data?
 - a. How can collecting and reporting client-level data be streamlined to enhance efficiently?
2. Which questions are most valuable for meeting your data collection requirements?
3. In what ways are you leveraging the data acquired from your SAMHSA grants to enhance and evaluate your programs? If not, what are the constraints preventing its utilization?
4. In what ways are you leveraging the data acquired from your SAMHSA grants to enhance and evaluate your programs? If not, what are the constraints preventing its utilization?

Considerations

Some considerations affecting data collection, as summarized below.

- **The information does not generalize to all Tribes.** The insights and recommendations from the listening session capture perspectives from, or about, a small fraction of the many Tribes and Tribal-supporting organizations that SAMHSA works with. Tribes are diverse and unique, so the feedback does not apply to all Tribes.
- **Self-selection bias might have influenced the insights and recommendations that participants offered.** People volunteered to join the listening session, and within the discussion, they volunteered to share experiences with the client-level tools and recommendations for improvement. As a result, the data might reflect insights from those who have very strong feelings about reporting and the client-level tools.

Results

Seven main themes emerged from the listening session, as presented below. Participants provided approximately 6 verbal comments and 44 chat responses. Participants generally agreed about the recommendations. Participants had different views about how SAMHSA should achieve suggestions associated with the fourth and sixth themes, and two (2) participants differed in views about the usefulness of questions about housing.

1. SAMHSA should shorten the redesigned tool so it is less time intensive and redundant

- Many participants expressed that the client-level tools are too long and repetitive, which makes them time-intensive to complete.
- One (1) participant said that providers should be able to complete the tool in 10 minutes or less because a longer tool burdens clients who are managing withdrawal or multiple diagnoses. Several people agreed with this recommendation.
- One (1) participant said the tool should be “as short as possible” because there are questions from other instruments that clinicians and providers raise during intake.

2. SAMHSA should ensure all grantees have sufficient resources to collect and enter requested information

- A few participants raised capacity as a consideration for SAMHSA, noting that providers are not only short on time to complete such extensive instruments, but that communities do not have enough people to do so. For example, one (1) participant said that smaller communities have difficulty hiring staff and are often unable to hire someone to specifically oversee GPRA data collection. As a result, providers who

already have a lot on their plate end up interviewing with the GPRA tool, which takes time away from their being able to do “the important work of treatment.” In turn, this can lead to staff turnover in communities that are already stretched thin. Another participant (1) who agreed with this sentiment reinforced that communities and providers are stretched thin.



Take the burden off of staff and let them do the work they were hired to do.

Listening session participant

- One (1) participant recommended that if it is not possible to shorten the tool, it would, at minimum, be helpful to receive best practices about breaking down the tool so it feels more manageable.

3. SAMHSA should modify the wording of questions to achieve greater clarity

- A few participants said some questions in the tool are confusing.
- Two (2) participants noted that some questions have backward wording; if the question is framed in the affirmative, it asks for a response in the negative, or vice versa. For example,

according to one (1) of these participants, questions that include “client does not report” require the provider to select “yes” if the client does not report the item. Also, for questions that include “client has not received,” the provider must select “no” if the client has received the item.

- One (1) participant said clients frequently find the questions in the tool confusing unless the provider breaks the questions down. For example, clients find the following question confusing: “In the past 30 days, which FDA-approved medication did the client receive for the treatment of an alcohol use disorder?” A (1) participant agreed with this statement.

4. SAMHSA should change how grantees enter, download, and analyze data

- Several participants suggested changes to the structure of the GPRA tools to facilitate effective and streamlined data entry. As outlined in Exhibit 2, they had varied perspectives about what should change.

Exhibit 2. Participants’ recommendations about the structure of the tools

Recommendation	Justification or additional details
Use tables to store information and data	One (1) participant said filling out a narrative, and including data points within this narrative, is not useful for providers or communities.
Do not require people to enter 0s	Two (2) participants thought it was ineffective to input 0s for every question for which something does not apply, and that it would be better to only enter data for “positive answer questions.”
Divide the tool into modules	One (1) participant said a module structure would allow programs to only complete data that is relevant for them and their clients. Two (2) other participants agreed with this recommendation.
Use Excel or a survey to collect data	One (1) participant suggested changing the tool so it is a simple Excel spreadsheet or monthly or quarterly online survey that asks grantees for data. Five (5) other participants agreed with these recommendations.

- Two (2) participants discussed challenges with downloading and analyzing data, noting the processes and systems are not user friendly or intuitive. One (1) participant, for example, said that using the codebook to analyze data is difficult and takes time. Another (1) participant said data analyses seemingly require that grantees have an analyst or data-focused staff member on staff, which is often not the case. These participants did not offer specific recommendations to address these challenges.

5. SAMHSA should revise the data collection timeline to be sensitive to clients’ needs and experiences

- A few participants discussed challenges with collecting data early in a client’s recovery journey. For instance, one (1) participant said that using the tool within seven days of intake is not effective “because a lot of patients are coming in ‘unwell’ and want minimal interaction at intake appointment.”

- A few participants said collecting follow-up data is difficult because of what clients are experiencing at that time. Three (3) participants agreed that the follow-up timeline fails to consider “the transient nature of clients,” and that it is consequently difficult for providers to reach clients at this time.

6. SAMHSA should ensure the redesigned tool provides data that grantees value and can use

- A few participants described how they use data from the tools. For example, they use the tools to better understand clients’ needs and experiences, such as their current and former diagnoses; mental health symptoms; and quality of life. A few talked about using the GPRA data to secure additional funding, such as TOR or SAMHSA grants.
- Many participants said the GPRA data, as currently collected, are not valuable for Tribes, but they had varied opinions about why data are not helpful and what should change to improve usefulness. For example, one (1) participant does not think housing questions are useful for grantees, but another (1) thinks they could inform services and supports. Exhibit 3 presents information about the different factors influencing the usefulness of the GPRA tools and data.

Exhibit 3. Factors influencing grantees’ use of GPRA data and how they value the tools

Factor influencing value, meaningfulness, or use	Context or recommendations
<p>The data are not culturally responsive, relevant, or reflective</p>	<p>Many participants raised the importance of collecting data that capture and advance cultural practices and Indigenous Ways of Knowing. However, participants think the current tools do not reflect or probe this cultural information.</p> <p>One (1) participant thinks usefulness largely depends on whether and how the data speak to Tribes’ cultures, but the data do not presently achieve this goal. The participant added that cultural practices are effective for improving Native people’s wellbeing, but the data do not currently show this.</p> <p>Several participants raised the importance of ensuring the redesigned tool captures the culturally appropriate practices that providers are using with Native communities. One (1) participant suggested that SAMHSA engage Tribes to outline the information they would want to track related to incorporating cultural practices into their programs, and several people agreed with this recommendation.</p> <p><i>“There are so many times that we’re trying to incorporate cultural practices and show that practicing them does work in helping people heal, but it doesn’t appear that we ever get the recognition we should be getting on utilizing those practices [to help] people becom[e] well. It’s because we don’t have the opportunity to show that this is evidence-based treatment we are providing.”</i></p> <p><i>-Listening session participant</i></p>

Factor influencing value, meaningfulness, or use	Context or recommendations
The data are not high quality	One (1) participant said that even if GPRA data were used, they would not be very helpful because the quality is “likely so poor that any conclusions drawn would be suspect.”
The tools do not capture qualitative data	A few participants raised the usefulness of incorporating voices and elevating the human element through qualitative data, especially through asset-focused language. Some suggested probing (1) how the Tribal program is doing and helping clients meet their needs, (2) what clients are proudest of in their recovery journeys, and (3) how clients are using the strategies they learned in their programs.
Questions are duplicative	Grantees have their own intake processes that provide answers to the questions in the GPRA tools.
The data are aggregated	<p>Tribal programs are diverse and offer many “disparate services,” so people cannot compare the data in a meaningful way. Participants likened aggregation to combining “all the apples, oranges, kiwis, and grapes,” and that this process “seems pointless” because of the differences.</p> <p><i>“Data that SAMHSA collects should, at the very least, reveal the vast differences and strengths between and among the 574-plus Tribes. Right now, the data collected assumes a ‘group’ of people.”</i></p> <p><i>-Listening session participant</i></p>
The data feel obligatory and misaligned with what grantees want or need	The data are not meaningful because they do not capture programs’ and grantees’ true, on-the-ground efforts, progress, and priorities.

7. SAMHSA should regularly communicate with grantees about how it uses and makes decisions regarding data

- Many participants described not knowing why SAMHSA collects GPRA data and how the agency uses the information, beyond compliance. For example, two (2) participants raised questions about how the agency has used their data to administer grant dollars.
- One (1) participant offered an example of SAMHSA’s data use, speaking to the agency’s partnerships with external contractors that conduct cross-site studies and use the data to write and publish peer-reviewed articles.

- One (1) participant offered a possibility for SAMHSA and other government agencies to use data to better support Tribal communities. They said the current tools include questions about factors—such as housing and employment—that, when answered, can reveal gaps or opportunity areas in Tribal communities. The participant said the questions could help SAMHSA understand what Tribal communities need and use the information to provide targeted funding for these needs.



There are a lot of questions in [the tools] about housing, employment, and training, and in Tribal communities, especially ours, there is no housing or employment. So, I am asking questions nobody has solutions for, so it is discouraging for me and them. I hope SAMHSA would look at the data and see [that these] Tribes need housing and use the grant to purchase or heavily renovate [homes]...The TOR grants are super minimal to build sober living. I hope SAMHSA would be looking at our data for ways to release NOFOs or build another NOFO for things like that.

Listening session participant

- One (1) participant said they have “never seen anything come of all the GPRA data,” and they encouraged SAMHSA to avoid collecting data “for the purpose of collecting data.” They suggested that SAMHSA determine what data are necessary to collect and consider aggregating reporting from grantee program records using a small list of existing data points, such as the number of new clients and substance use disorder diagnoses.
- One (1) participant said they did not understand how SAMSHSA makes decisions about classifying race for Indigenous people. For example, they questioned how SAMHSA would categorize a White and Native American client in reporting and data.

Conclusion

Seven themes about SAMHSA’s client-level performance management tools emerged from the listening session:

1. SAMHSA should shorten the redesigned tool, so it is less time intensive and redundant.
2. SAMHSA should ensure all grantees have sufficient resources to collect and enter requested information.
3. SAMHSA should modify the wording of questions to achieve greater clarity.
4. SAMHSA should change how grantees enter, download, and analyze data.
5. SAMHSA should revise the data collection timeline to be sensitive to clients’ needs and experiences.
6. SAMHSA should ensure the redesigned tool provides data that grantees value and can use.
7. SAMSHSA should regularly communicate with grantees about how it uses and makes decisions regarding data.

Appendix A

List of participants and their affiliations

Participant name	Role and agency	Tribal membership or citizen status
Dave Dawley	Director, Hualapai Health Department	Not specified
Pamela Jumper Thurman	Evaluator, Choctaw Nation of Oklahoma	Citizen of the Cherokee Nation
Greg Donovan	Director, Santee Sioux Nation Society of Care (Nebraska)	Not specified
Latoya James	Program Manager, Choctaw Nation TOR program	Not specified
Bentley Davis	Evaluation Specialist, Wabanaki Public Health and Wellness	Not specified
Charlene Poola, PhD, LCSW	Tribal Behavioral Health Director, Albuquerque Area Southwest Tribal Epidemiology Center	Not specified
Monica Lewis RN	Mathiesen Memorial Health Clinic	Not specified
Stacy Hilde	Tribal Opioid Response Program Manager	St. Croix Tribe of Chippewa Indians
Celia Stall-Meadows	Grant evaluator for Choctaw Nation	Tribal member of Choctaw Nation of Oklahoma
Brooke Tolle LMSW	GPRA and data coordinator, Chickasaw Nation TOR program	Not specified
Roy Pack	Tribal Behavioral Health Consultant	Not specified
Dacia Juarez	TOR Project Director, Red Lake Chemical Health Programs, Red Lake Band of Chippewa Indians	Not specified
Tamara	TOR consortium evaluation team, Northwest Portland Area Indian Health Board	Not specified
Vlada Rayec	Eugene, Oregon (no role or specific organization provided)	Not specified
Nichole Krausch, LPC	Integrated Behavioral Health Specialist, Medications for Opioid Use Disorder Grant, Choctaw Nation of Oklahoma	Not specified
Mari Kriescher	Oneida Nation Behavioral Health	Not specified
Anette Hubbard	Not specified	Not specified
Maurine Lilleskov	Not specified	Not specified
Trina Resari-Salo	Not specified	Not specified
Jaime Lee	Not specified	Not specified