SAVING LIVES, IMPROVING HEALTH: REDESIGNING OPIOID USE DISORDER CARE

Grant Q&A Conference Call Transcript
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1) **When you say "medical home" do you mean that the lead applicant must provide the patient's primary medical care?**
The lead applicant will tend to all of the patient's medical and psychiatric needs, and provide ongoing care for their medical, psychiatric, and addiction care. They may not be that person's primary care practice for life, we don't expect that, but we do feel as though they would need to be able to offer comprehensive services for patients with Opioid Use Disorder (OUD).

2) **Will be the opportunity to include attachments e.g. letters of support to affirm collaborations?**
Please submit up to two along with the application.

3) **Will there be future grant opportunities for for-profit entities? i.e. start-ups and those working more on the outskirts of the system?**
This is something we certainly have on our radar screen. We are aware of some of the innovative work that's being done, particularly in the IT space, so we may consider it in the future, but I don't have any more information at this point.

4) **Can a single site with multiple locations be involved in more than one application?** Yes.

5) **Could you explain a bit more about the letters of support? If there are 2 organizations involved in the proposal, do the letters of support need to come from organizations outside of those two?**
We are asking for up to two letters of support from the collaboration, ideally from organizations other than the applicant.

6) **Can you speak more to the under-resourced areas and how that may be determined?**
Feel free to make a case for why you think your area is under-resourced. Some data we will be looking at is the hot-spotting map of opioid use across the state and available local resources for addiction treatment, particularly medications for addiction treatment given our impetus to try to increase immediate access to that type of treatment. We would be open to considering other

explanations of “under-resourced,” but that would be one thing we will be one thing we will basing our decision on.

7) **You mention in the guidelines that new or existing organizations can apply. Does one take precedence over the other?**
We don’t have a preference. We are hoping to make this a feasible application for areas that may not have existing resources and recognize that can take some support and time to build-up. This is why we decided to have the design period at the beginning to allow an area that may have a great need and not necessarily a track record of having delivered this type of care a chance to really think about and begin to build these necessary collaborations.

8) **How many different entities should be in a coalition and do you have expectations that there will be more than 2 in each application? Also, can a municipality be included in a group?**
We don’t want to be prescriptive about how you form your collaboration. We know that at the community level there’s no one size fits all solution, and we want to hear from you about the best ways to approach the problem in your area. So, as many as you feel are necessary – I would expect that there will be two at a minimum, hence the collaboration, and yes, municipalities can be included in the group.

9) **What are the expectations for research and evaluation on the intervention or initiative that is funded?**
We will be working with the applicants that are chosen to determine the outcomes we hope to collect, and will be providing guidance around that, to ensure we get rigorous evaluation and to support organizations that may not have the resources for this level of data collection. So, we will be working closely with the cohort to jointly develop our outcome and evaluation measures.

10) **Can you provide the source for information outlining vulnerable populations?**
The Department of Public Health has put out a Chapter 55 report. Chapter 55 is the legislation that allowed a unique linking of more than a dozen data sets across the state that has generated research into better understanding who’s been affected by opioid-related deaths. There have now been two reports released, and there’s a lot of really important information – but one component that’s particularly useful as we think about this grant is which populations across the state are at highest risk of dying of overdose. Some of those examples include people who have recently been released from prison or jail, people who have experienced homelessness, and pregnant and parenting women.

11) **What are the criteria that will be used to decide which project will move forward after the planning phase?**
This is one of the things we will decide when we see who is in the cohort, and we will work with the grantees very closely to be transparent about what we expect and how we will make the decision of who moves forward.

12) **The guidelines state that the lead does not have to be the PC medical home but can also be a behavioral health organization but must partner closely with the PC provider. Most BH**

organizations don't have MAT treatment on site but have partners. Would this meet the lead requirements?
We are open to creative solutions. Our biggest goal is to reduce any delays in care or gaps in care, so there would need to be a compelling plan for how people will be able to immediately access treatment (as in same day access to medications for addiction treatment when that's indicated.)

13) **Can the lead agency be different than the applicant? For example, if a community coalition were applying in conjunction with a community health center, could the community coalition be the applicant and the health center be the lead agency?**
We would allow that, again our goal is to be flexible and pragmatic, and make sure we meet the objectives of this grant in terms of increasing access to care.

14) **If you are in an under resourced area for treatment but plans with this grant would be to increase access to treatment. Would that be looked upon as favorable?**
That gets at what we were discussing before about under-resourced areas. We absolutely want to focus on areas that have less access to treatment, so any application that would present a plan for improving access to this sort of treatment in an area that doesn't have it would be looked upon favorably.

15) **Other than letters of support are there other attachments that could be included if relevant?**
You need to attach the budget template and the workplan. We would ask that you restrict yourself to that. We have a very short timeframe in which to review these applications, so if you could keep it to the specific items that we requested, we would appreciate it.

16) **Do all collaborations between organizations need to be established with LOIs for the Phase 1 Deadline? If during the planning phase, it makes sense to partner with an additional organization, is that possible?**
We would absolutely support that, especially again recognizing that we want to make this feasible for areas that don't necessarily have existing partnerships across necessary collaborative organizations.

17) **Would the grant fund greater integration of services within departments of a single institution or a single ACO? for instance between a ED and a behavioral health home in the same organization?** We absolutely would consider that as long as it meets the other criteria of immediate access to treatment, long-term care, and a focus on vulnerable patient populations.

18) **What is the working definition of on-demand treatment? In other words, what does a program/proposal need to look like in other to fit in this definition?**
We think of this as: What does treatment look like for any other illness? When patients are in crisis with any other condition, they aren't made to wait unnecessarily to access treatment – so with OUD, on-demand means access to medications for addiction treatment as one component of the overall comprehensive strategy that happens the same day as the initial evaluation. We

want patients who are struggling to be able to walk in to whatever the health home is and be able to see someone, be evaluated, and be started on treatment that same day.

19) **What's the best way to follow up with RIZE if we have additional questions while completing application?**
You can email Julie.Burns@rizema.org or submit questions to info@rizema.org and we will do our best to answer them. If we think the question is relevant to all applicants, we will post it.

20) **How important is it for the grant to be innovative or leverage technology**?
Given the history of addiction treatment, we would expect all your proposals to be very innovative in treating addiction like we treat any other illness. Our biggest focus is on the notion of on-demand treatment and long-term follow-up care, and integration within existing systems of care. Leveraging technology is not a requirement, although we imagine many organizations will use electronic health records, but there is no need to include for the use of medical use technology.

21) **Would an existing high functioning collaboration have an advantage over a newly formed/or forming collaboration?**
All applications will be reviewed by a diverse group of subject-matter experts, and they will be judged equally on the criteria laid out in the guidelines. Our goal is to meet the needs of as many people who are truly suffering as possible with the best possible programs, whether they are new or existing.