

## **Indiana State Epidemiology and Outcomes Workgroup Meeting Minutes from 7/18/2008**

### Attendance

Dave Bozell, Marcia French, Ruth Gassman, Marion Greene, Terry Jenkins, Harold Kooreman, Mary Lay, Kim Manlove, Amanda Morrison, Ramzi Nimry, Barbara Seitz de Martinez, Sharon, Sidenbender, Miranda Spitznagle, Carlie Turner, Rick Vandyke, John Viernes, Donna Wall, Diana Williams, Jim Wolf, Eric Wright

### Welcome and Approval of Minutes

Eric welcomed everybody to the meeting and introductions were made because a few new SEOW members attended the meeting: Diana Williams (previously DOC, now DMHA), Donna Wall from the Indiana State Board of Pharmacy, Terry Jenkins from the Department of Correction, and Carlie Turner (DMHA; Kim's and Marcia's administrative assistant).

Minutes from May 16, 2008, were approved.

Eric announced that four SPF SIG posters were presented at the National Rural Health Association in May; one SPF SIG poster was accepted at the American Public Health Association in October; and at the SPF SIG grantees meeting in June, the Governor of Louisiana reached out—interested in following the Indiana model.

### Update on Statewide Phone Survey

Jim: we completed the targeted number of interviews for the 12 original funded communities (cohort 1); we used random-digit-dialing to conduct the phone survey and our initial goal was to have 15% of all interviews come from cell phones; but we found that people are more reluctant to answer their cell phone and respond to the survey; productivity with cell phones much lower than anticipated, so we are a little behind in time; so far, we have about 4,300 completed interviews; we need to make decisions about a new timeline and distribution of age groups, since cell phone approach did not yield the expected results; we plan on going back to using the landline approach, screening for younger age groups; we also need to make decisions about expanding sample to include the 8 newly funded communities (cohort 2); before we do the non-targeted communities, we need to address the targeted/funded communities first; we will take the data from the counties that have been completed (cohort 1) and calculate weights for preliminary results—this can be done by next week and will be sent to the Center for Health Policy; we will need to set up a new timeline to accommodate the newly funded communities.

Eric mentioned that the money for the newly funded communities should be available by October. Also, for this year's epi report, we'll focus on the 12 original communities and statewide estimates.

Jeanie asked if the communities will be able to get a report on their data. Eric confirmed; he also stated that we should have funding to conduct the survey at least three times, in even years (2008, 2010, and 2012) to not compete with Youth Risk Behavior Surveillance System, which will be administered in odd years.

Eric asked Jim if the survey was available in Spanish and Jim replied that they have a bilingual version of the instrument but that he doesn't know the percentage of respondents who required

the Spanish version; but it seems that the need for Spanish-speaking interviewers becomes less and less even though the percentage of Latino population is increasing.

#### Update on Local Strategic Plans

Kim: Cohort 1 completed their epi profiles and started working on their strategic plans; all communities had returned their plans by the end of June; review of the strategic plans was a two-tier process, involving the GAC review work group chaired by Jeff Barber and a project team review group (including Kim, Marcia, Jeanie, Katherine Sadler, Marcia Dias, Randy Zaffuto, Eric, Harold, and Marion); all comments were funneled to Kim and Marcia; a list of comments was compiled and sent to the communities; the epi profiles were pretty consistent/similar among the individual communities, but the strategic plans varied widely; no plan was ready to go/fully developed; we asked for a 2nd draft by July 30; there might be an additional review; we really want these plans to be fine-tuned, not only acceptable to us but also to their communities; everybody's plan was a very good start; plans ranged from 5 pages to 180 pages; we asked all of them for an executive summary of the plan; hopefully we will have this rapped up by mid-August.

Eric remarked that the communities have the same struggle we (the State) had in translating the data into prevention priorities and making these logic connections; the communities' effort is quite impressive.

Kim: We were "proud parents" when the local epi reports came in and we will feel the same way when the strategic plans are complete; and yes, communities experience difficulties similar to ours when we were developing Indiana's strategic plan.

John asked how the communities are coordinating with the Local Coordinating Councils (LCCs) as they are developing their strategic plans. Kim answered that it varies by county; some funded communities are part of the LCC but in cohort 1 they are not required to collaborate; however, in cohort 2 communities, we required collaboration with LCC (the LCC will also be their LAC). Kim also said that both the epi profiles and the strategic plans are living documents and should be referred to on a regular basis.

Eric added that a capacity assessment is part of the local strategic plans and that we will also add it to this year's state epi report; we need to do a better job connecting capacity with existing needs and programs.

#### Update on Cohort 2 Communities

Marcia: We received approval from the Feds to spend left-over money on additional communities (cohort 2); we took 8 applications/communities from the initial RFS and funded them; we compiled a list of "lessons learned" and made adjustments to requirements and expectations for cohort 2; we (Kim, Marcia, Harold, and Marion) went on site visits to talk about the SPF SIG process, expectations, funding, budget, training, etc.; we already had contracts done before site visits, so communities can get initial payment quickly; we allocated funding for cohort 2 communities to contract an LEOW chair who will also write the local epi report; funds are also available to collect additional data (e.g., phone surveys, focus groups), but this is optional, not required; communities have up to 18 months to complete phase 1 but we anticipate them to be done in 12 months; phase 1 consists of assessment + epi report, capacity building, strategic planning, and process evaluation (program implementation and outcome evaluation not required); the Center for Health Policy put together a CD with resources and documents that was distributed to the communities; the Indiana Prevention Resource Center will get them

started with data from their annual school survey; the newly funded communities will be able to look at epi reports and strategic plans from cohort 1; the newly funded communities also have the advantage of having TAPs (Technical Assistance Providers; either Rebecca Smith, Maggie Lewis-London, or Katherine Sadler); the Indiana Prevention Resource Center will do local evaluation.

Jeanie suggested that we should have training opportunities with cohorts 1 and 2 during which the efforts of cohort 1 should be recognized. Kim and Marcia agreed, stating that they already told cohort 2 about such mentoring opportunities with the original 12 funded communities; cohort 1 should have an active role in the training of cohort 2.

#### Draft Resolution to Recommend School Participation in Survey

During the last SEOW meeting we discussed the effectiveness of sending a letter (possibly from the Governor's Office) to the school system to encourage school participation in the Indiana Prevention Resource Center's annual "Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents (ATOD)" survey. Eric had mentioned this to Jeff Barber (DOE) who didn't think that such a letter would have much effect.

Mary: The ATOD survey is not based on a randomly selected sample—schools can choose to participate; in the first SIG, school participation in the ATOD survey was required to receive funding; in the first SIG, we only had one community who didn't receive funding because they didn't participate in the survey—interestingly enough, they now participate in the survey; we cannot mandate school participation in the survey but we can strongly encourage it.

A discussion ensued about the state's ability to mandate/encourage participation.

Eric declared that the idea of recommending school participation is good and will move Indiana closer toward data-driven decision-making. Ruth suggested that since so many state agencies are represented at the SEOW, we could put out a collaborative recommendation.

Eric stated that there are two overlapping issues: measure of use (e.g., have you used substance x in the past 30 days?) and data source (e.g., ATOD survey, YRBSS, etc.); we could use a hybrid model; for example, National Outcomes Measures (NOMs)—ATOD survey could change to get closer to the NOMs. Dave replied that we need to wait for things to stabilize; they are already reviewing the NOMs for changes. John added that currently the NOMs are primary social services indicators, now they want to see how the NOMs can also be included into a public health model; as substance abuse becomes viewed more and more as a public health issue, things such as traffic accidents, liver cirrhosis, crime, etc. need to be addressed; but those discussions will take at least a few years before any results will come up. John also remarked that a lot of questions we currently ask will change; we are developing a risk-prevention model with mental health and substance abuse components.

Jeanie said that one of the questions we have to ask ourselves is, are we interested in comparing ourselves to ourselves (over time) or to others; that's why IPRC is resistant to change the ATOD survey because we want to compare our status now to back then.

Eric said that it might be the best approach to focus on data sources that are considered acceptable; we can come up with a list of sources, and get the okay from each agency; each agency tends to think their data source is the best, so we will include a variety of sources; we will take a stab at identifying a list, come back with a letter of formal recommendation to

circulate among the agencies, get their buy-in, and I think, we also should involve the Governor's Office.

Mary agreed saying that it might give the ATOD survey some additional credibility; it might sway people who feel unsure about participation.

### State Epi Profile

Eric suggested the following lay-out for the 2008 state epidemiological profile: the primary value of the report is as a reference, so to preserve this function it would be essential to continue the same chapters as in previous versions but add additional chapters; the new features include a capacity assessment—for that we will try and improve on what has been identified in the state strategic plan; we will look at funding sources and who does what [Mary mentioned that she is currently working on something similar, so we will coordinate our efforts]; the local profiles should be included in some form—the complete report is too long, so we will add drug fact sheet from each of the cohort 1 communities [we will make a template for the drug fact sheets and send them to the LEOW chairs; they will return a draft and we will get together for an interview/discussion on the community drug fact sheets]; also, a public health chapter will be added to the next profile—this chapter will focus on key trends, broad cause-and-consequence ideas on the macro-level.

Eric: Some of the communities, especially East Chicago, have requested Spanish materials; this will be difficult to do with the complete epi report but should be doable with the drug fact sheets; we will look into having the drug fact sheets translated into Spanish [potentially Spanish Department at IUPUI].

Eric: We are working on getting new data sources for the next epi report; we have formally applied to the Indiana State Board of Pharmacy to gain access to the INSPECT database (Indiana's prescription drug monitoring program); we might not be able to get access to the data in time for this year's report but hopefully for next year's profile.

Rick provided handouts from the Office of Medicaid Policy and Planning, Data Management and Analysis—analyses he had done on substance abuse in the Medicaid population. He explained: There is a huge population in Medicaid with a substance abuse diagnosis—the problem has grown over the years; some overlap with DMHA's treatment population; very few Medicaid recipients have substance abuse as their primary problem, it is generally marked as their secondary diagnosis; the “other drug” category is very large—we assume that refers to prescription drug abuse; from a financial perspective, substance abuse is more of a [financial] problem when it is the secondary diagnosis and contributing to another [primary] diagnosis; I want to point out how rapidly substance abuse has been increasing in the Medicaid population over the last few years.

Eric and Marcia added that providers generally don't get reimbursed by Medicaid for substance abuse treatment, so they often provide a different primary diagnosis and mark “substance abuse” as secondary. It is difficult to estimate comorbidity from the dataset because of a possible systematic bias, since Medicaid doesn't fund substance abuse treatment without any other primary diagnosis.

Other Business

Eric stated that the Center for Health Policy has been working on an issue brief for prescription drug abuse and will have 1,000 copies printed for the National Prevention Network conference in August.

Then, Eric adjourned the meeting.

**The next SEOW meeting will be held on Friday, August 15,  
from 9am through 12 noon, at the IGCS, conference room 5.**

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