DATA AND EVALUATION TASK FORCE

Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery

Task Force Chairs: Joseph Villers and Kevin Irwin

May 18, 2018

In Person: Kevin Irwin, Amy Pepin, Joe Villers, Kimberly Fortier, Rachel Kohn, Maureen Mustard, Sean Marden, Joanne MilesHolmes, Cheryl Pacapelli, Joanne Lahaie, Jill Burke, Allison Parent, Sandra Kiplagat, Jonathan Stewart, Michelle Ricco Jonas and Dave Mara

On Phone: Amy Costello, Jennifer York.

I. Restructuring of the Data and Evaluation Task Force

- Kevin Irwin, Chair of the IDN in Seacoast Region, has been appointed as the new co-chair of the Data and Evaluation Task Force.
- It is crucial to remember that Governor Sununu is highly engaged with behavioral health and we need to strategize priorities based on the data that is useful and meaningful.

II. Overview of Governor's Commission (Draft) Strategic Plan (Amy Pepin)

- The Center Staff in collaboration with Commission members and Task Force chairs have been working on the Governor's Commission Strategic plan.
- The Governor's Commission recently reviewed the goals and objectives of the strategic plan.
  - The GC Strategic Plan is still in its draft form.
  - The final version is due at the end of June.
- Each task force has provided input on the plan with the exception of Data and Evaluation task force. Amy wanted to bring forth the draft plan to familiarize and gather input from the team.
- The overarching goal of the plan will be to reduce the misuse of alcohol and other drugs across the lifespan.
- Based on the plan, each and every strategy will not be evaluated. However the team needs to select and identify strategies that would need to be reported on.

III. Discussion on the Governor's Commission (Draft) Strategic Plan

- Michelle Ricco Jonas mentioned that she recently attended the fiscal meeting and the discussion focused on measuring outcomes in prevention work to understand effectiveness of the program.
- J. Stewart highlighted some key questions for the task force to consider:
  - Do we have available data at the population level required for the mid-year and annual report?
  - If we observe trends in these data, what programs or policies influencing the change we do see?
  - If we need to see changes, do we have the data systems in effect to explain?
- Dave Mara suggested that we need to have goals and objectives for each priority rather than the broad goals.
  - It was mentioned that the goals and objectives need to be S.M.A.R.T (Specific, Measurable, Attainable, Realistic, and Time-Bound).
  - What's the available data? What's the missing data?

- For example, there needs to be discussion on fatal and non-fatal overdose. Majority of the focus on overdoses has been on fatal overdoses.
    - Based on DMI and EMS data reports, the non-fatal overdoses are increasing.
    - We need to consider alternative data sources i.e. ARDI for morbidity and mortality data.

- Joanne MilesHomes suggested that the Opioid Surveillance Data funded by the CDC project employs standardized data collection parameters for statewide and nationwide reports.
  - J. Stewart suggested that the Opioid Surveillance project can present during the Data and Evaluation Task Force meeting.
  - Joanne Lahaie mentioned that TEMSIS database includes pre-hospital data that is underestimated.

IV. Guidance on Data Sources and Indicators for Measuring Plan Progress (Kevin Irwin, Group Discussion)

- It was mentioned that the DMI report focuses mostly on opioids. J. MilesHolmes indicated that her project focuses on availability of data caused by multiple drugs.
  - Jonathan wants to connect with Joanne to compare the data from CDC ARDI tool
  - The Healthy People 2020 Objectives may be another important resource.
- There was discussion on determining unintentional vs. suicidal overdoses. J. Lahaie mentioned that EMS providers can try to determine this.
  - In the past year, 428 opioids deaths occurred. Of these deaths, 410 deaths were determined to be un-intentional overdoses so only a small portion is related to suicidal.
- Since we are currently tracking the Opioid Overdose Deaths. Some objectives may include:
  - Reduce the number of opioid related deaths from XX to XX by this Date.
  - Reduce the number of alcohol related deaths from XX to XX by this Date.
- We cannot arbitrarily pick a percentage as the baseline data; there needs to be trend and inputs to be considered.
  - M. Ricco Jonas echoed this point by stating that we need to understand and assess yearly data to refine the strategies to fit the yearly data.
- J. Villers mentioned that we need to include the "Significance: reduction. The main headlines indicate opioid crisis is mainly attributed to fentanyl. Although methamphetamine is on the rise, this is not indicated as a sharp incline.
- Currently, we have limited available data sources include: PDMP, YRBS, and NSUDH. M. Ricco Jonas indicated the team will be employing a new database that can reports on diagnosis code, payment group etc.
- K. Irwin indicated that we miss the key indicators if the sole focus is based on negative consequences.
  - K. Fortier mentioned that the DMI can assist with the data that is currently not being captured.
  - Potential data indicators may include:
    - DWI data to include for alcohol morbidity and mortality causes.
    - Early Childhood Adverse Experiences (ACEs)
    - Mental Health Data

- Untreated mental illness remains a key priority for the next strategic people. At least 50% of people diagnosed with SUD have an unmanaged or untreated mental illness.
- The Data and Evaluation Task Force want to incorporate high risk populations. Amy Pepin mentioned that this was originally included in the plan but removed as we need to strategically identify using data driven high-risk populations.
  - The original plan included high risk populations: people who experienced early childhood trauma, young people in the foster care system, transition age adults (18-20), children in military families, perinatal women, veteran's spouses.
    - However, the DMI reports that highest risk has been middle-aged white men.
    - J. Lahaie completed an EMS run with substance misuse. Nearly 66% of these individuals were between ages 20-50.
    - Out of this group, 2 out of 3 males are reported to be in the ED.
  - Realistically, we cannot serve all high risk populations. We need to identify specific sub-groups.

V. Data and Evaluation Task Force Recommendations for the Strategic Plan (Jonathan Stewart, Group Discussion)

- Recommendations from other task forces include the following recommendations: support ongoing work/ increasing/decreasing/improving etc.
- J. Stewart shared the one-pager of the data and evaluation plan which somewhat overlaps the recommendations identified in strategic plan.
- M. Ricco Jonas proposes to discuss state sharing with the PDMP.
  - By July, an analyst will be hired for the Prescription Drug Monitoring Program. This will contribute to the advancement of the PDMP program.
- C. Pacapelli was wondering if there any reportable outcomes – contracted providers do report change over time. There is a follow-up period with the clients.
- There was discussion on the relative value on the waitlist data use. This report has no ability to assess the appropriateness of treatment modality.
  - The wait-time is required by the legislation on the GC report.
  - Legislature hears from Legislature hears from the public there is limited available beds available. What would be more beneficial is:
    - Treatment locator to have real-time indicators.
    - Establish criteria by ASAM level- the number of day waiting
    - Centralize it.
- If you have comments or additions on the one-pager, please send Jonathan and Sandra an email.

VI. Updates on Assignments

- During last meeting in April, M. Boldin indicated based on NSDUH, 1 in 10 people require SUD treatment. How does this estimate compare to the populations you work with?
- J. Lahaie used TEMSIS data (pre-hospital) data which identified as Manchester and Nashua with 51% of the overdose deaths.
  - 1 out of 32 deaths

    - Males between ages of 20-30 had been taken to hospital for overdose deaths.
- Sean Marden computed monte-carlo simulations on historic ED data. This was de-identified data with indicators including zip-code, birth date, gender, and ethnicity.
    - The diagnosis code: chief complaint was Alcohol or SUD.
    - The findings were not significantly different from the 2015-2016 NSDUH findings for Alcohol or SUD.
    - The data compared to the NSDUH age categories: 12-17, 18-25. Among the 26 and years older, ED would suggest higher rate but slightly difference with NSDUH.
- ***Joanne Lahaie and Sean Marden will share findings with the team.***

VII. National Emerging Threats Discussion (Kim Fortier)

- K. Fortier indicated that HIDTA and NEDI agreed to implement an emerging threats initiative in New Hampshire.
- NEDI requires a variety of data sources to start this process: DEA ARCOS, PDMP, RPHN work, Needle Exchanges, Poison Control Center: State Lab- What they're testing: Fusion Centr: Felony Drug Level, Other Drugs, PDMP vs. YRBS
        - Is there any missing data indicators?
- There was discussion that John from NEDI is planning to revisit NH.
    - Most real time indicators are treatment.
    - Treatment centers and recovery centers have a pulse on what is in the street
    - Still unclear on the reporting approach.
    - This group or maybe develop will be a sub-group will be the NEDI task force.
- Kim will reach out to the task force members for additional data sources.
        - ***M. Ricco Jonas will send the annual PDMP to Kim.***
        - The next meeting will be scheduled in June in the state.
        - ***Kim Fortier will send the information to the group to attend the meeting.***

Next Meeting: June 15
Community Health Institute
501 South Street, Bow, NH