DATA AND EVALUATION TASK FORCE

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

Task Force Chairs: Joseph Villers and Marty Boldin

April 20, 2018

In Person: Marty Boldin, Kathleen Mullen, Andrew Chalsma, Rachel Kohn, Sandra Kiplagat, Joanne Lahaie, Jennifer York, Kim Fortier, Djelloul Fourar-Laidi, Sean Marden, Joanne Miles Holmes, Joe Harding, Maureen Mustard, Jonathan Stewart, Deirdre Boulter, Jill Burke, Amy Pepin and Kevin Irwin

On Phone: Allison Parent

I. Defining the Scope of the Problem, Group Discussion

- M. Boldin opened the meeting, stating that it is vital to remember that the data indicators we work on from our various departments are essential in informing policy and/or program changes.
    - Currently, there is no agreed upon construction of behavioral health. There is no coordination, accurate information as well as action in what we're doing.
- Governor Sununu recently announced that we have secured five years of alcohol funding. However, the issue is developing a concrete plan to explain how we are using this funding to implement policy changes to our funders.
- Joanne Miles Holmes discussed the importance of accessibility and availability of treatment funding in our state. However, some challenges that were cited include:
    - Limited staffing capacity with the Bureau of Drug and Alcohol Services (BDAS).
    - Massive limitation also on the providers.
    - The G&C process is a lengthy process.
    - Additional capacity and resources needs to be targeted towards this area.
- M. Boldin highlighted three questions that the data and evaluation task force needs to work on:
    - What is the current problem?
    - What are we doing about our current problem?
    - How is our evaluation guiding our path forward in addressing our problem?

II. Evolution of the Data and Evaluation Task Force

- J. Stewart provided a brief overview of the origin of the Data Task Force mandated by the Governor's Commission and that the task force also serves as the State Epidemiological Outcomes Workgroup (SEOW).
    - SEOW was created in an effort to bring diverse data stewards together to inform the prevention, treatment and recovery program
- The Data and Evaluation Task Force is required to report on key metrics mandated by legislature every 6 months (mid-year and annual report).
    - However, our charge is much broader than producing mid-year and annual reports.
    - There needs to be discussion on the ongoing behavioral work in our state.
    - Some key questions include: what's a better way to describe the nature of our problem? Who is our target audience?
- J Stewart reviewed a one-page hand out of existing data indicators that are currently included in the semi-annual reports. These include:
    - Treatment access and client counts

    - Burden of disease/ social justice consequences
    - Social justice consequences
    - Prevention and intervention activities (counts)
    - Prevention and intervention outcomes- (YRBS, Treatment Outcomes, National Outcomes Measures (NOMS)

- What is the disconnect between the indicators we have now and our ability to sufficiently describe the nature of the problem?
    - BDAS treatment data is somewhat limited since it serves only those funded sites. Expand to Medicaid data.
    - We need to identify the high risk, high need areas.
    - Missing data indicators on social determinants of health and its relationship to substance use and behavioral health.
    - Stigma is still prevalent in the state
    - Changes in prescribing patterns; naloxone acquisition / administration.
        - BDAS distributed nearly 15,000 kits; no way to know who has received the kits or how many have been used.
    - J. Miles, S. Mardin and DJ Fourar-Laidi describe the CDC-funded initiative to gather more detailed information on opioid-related deaths. Can we understand contributing factors better? Are there existing data sources to link into medical, health, social factors? The missing link is social determinants of health.
    - Mitre recently did an analysis using All Payer All Claims data in Massachusetts
    - A. Chalsma noted that there is no authority to integrate claims and health records. You could do some of this with Medicaid data but not with Commercial data.
- The fatal overdoses data is not mined for alcohol and other drugs present in the individual's system.
    - Approximately 10% of fatal overdoses are from out of state.
    - The CDC Opioid Grant team has been working close with neighboring states such as Vermont, Maine
- There is need for additional demographic factors to build a state profile.
    - Dj Fourar-Laidi suggested that Assistant Drug Medical Examiners (ADME) can probe deeply to find the data indicators/ variables.
    - The data collection is an archaic process that has not been updated. Some challenges include:
        - The ADME's rely on anecdotal accounts from family members or by-standers.
        - None of the deaths have notes on previous overdoses on the individual.
        - If someone is transported by EMS, the ADMEs are not allowed to the scene to investigate.
        - There is no standard template for ADMEs to do data collection.
        - In addition, workforce capacity remains an issue. Currently there are 15 ADMEs but we need 10 more ADMEs.
- The group discussed Adverse Childhood Experiences as an area where more data collection and reporting is needed to inform program/policy work.
    - ACE screening occurs at the clinical / individual level. Are there mechanisms for gathering ACE scores at a population level to develop profiles of at risk youth and adults?

    - Some states are incorporating an ACE type module in the BRFSS
- EMS reports overdoses by geography i.e. city and county as part of the DMI report. J. Harding inquired if we can develop a profile and describe the patterns in each area.
    - What are the risk factors prior to substance misuse?
    - Look at ACES at community, county level etc.

III. Current sources for describing substance use prevalence

- Prevalence data research is somewhat limited in the state beyond the YRBS. We rely on National Survey of Drug Use and Health (NSDUH) that has many limitations including:
    - Excludes homeless, and incarcerated individuals
    - Based on a small sample size of approximately 300 people.
    - NSDUH estmates that 1 in 10 individuals diagnosed with SUD need SUD treatment.
- K. Irwin described an alternative methodology that should be considered - Rapid Assessment Response and Evaluation (RARE) – a low cost, small sample approach that has been deployed in developing countries for more real time assessment of community conditions influencing health outcomes.
    - New Hampshire could use the RARE approach to understand the characteristics and profiles of specific communities or regions.
    - Qualitative data collection methods are primarily used; however, quantitative work is included.
- Discussion and questions pertaining to this suggestion included:
    - Will this tool be beneficial in identifying programmatic needs in one region compared to another?
    - K Irwin confirmed that this process allows for cross-collaboration across diverse service sectors.
    - The analysis will drive the questions to understand the risk profiles and what is happening in the community.
    - The RARE model can also be used to survey individuals in treatment so we account for this missing data.
    - This approach could also help to understand supply issues related to observed substance use prevalence.

Overall Discussion

- M. Boldin emphasized there needs to be a clear and concise way to use qualitative and quantitative data to tell a story beyond the focus on opioid overdose deaths.
- R. Kohn described the Young Adult Assessment Survey, a social media-based survey targeted to NH young adults aged 18-30, that addresses some of these questions.
- J. Stewart inquired about the possibility of the IDN-related date collection efforts being a source for linking social determinants and behavioral health data. A. Chalsma and K. Irwin indicated that there is some potential, but that the data is still somewhat limited.

Next Steps

- A. Pepin suggested that we need to include “Review GC Strategic Plan” in the meeting scheduled in May. The plan is scheduled to be finalized in 6 weeks.
    - The D&E task force will review the recommendations of the strategic plan and provide feedback as well as strategies on the GC strategic plan.

- M. Boldin assigned task force members to do some analysis of the populations the work with in comparison to prevalence estimates from NSDUH.
    - According to NSDUH, 1 in 10 people require SUD treatment. How does this estimate compare to the populations you work with?
    - Each TF member was assigned an area of focus (table below)
    - Jennifer York was asked to compile everyone's analysis into one document. Sandra will send out Jennifer's email to the group.

Name	**Assignment Focus**
Andrew Chalsma	Medicaid Claims
Allison Parent	DCYF
Joanne Lahie	EMS
Deirdre Boulter and Kim Fortier	DOS/ Law Enforcement
Djelloul Fourar-Laidi	Opioid Data
Sean Marden	AHEDD Syndromic Surveillance
Joanne Miles Holmes	Relationship between Prevention and Education
Maureen Mustard	Commercial Insurance Data
Rachel Kohn	Juvenile Diversion Data
Joe Harding, Kevin Irwin and Jonathan Stewart	Evaluate the "truthiness" of current existing data sources

Next Meeting: May 18
Community Health Institute
501 South Street, Bow, NH