

Indiana State Epidemiology and Outcomes Workgroup
Meeting Minutes from September 19, 2008

Attendance

Jeanie Alter, Dave Bozell, Lindsay Duff, Marcia French, Ruth Gassman, Marion Greene, Ashley Hobbs, Anne Jolliff, Lyndy Kouns, E. J. Last, Barbara Seitz de Martinez, Miranda Spitznagle, Rick VanDyke, Donna Wall, Diana Williams, Jim Wolf, Eric Wright

Eric: Thank you all for coming. First item, is the approval of the meeting minutes? Corrections? Oh, Harold is not here.

Marcia: Kim is playing with the flu.

Eric: OK. Is there a motion to accept? Or any objections to accepting the minutes? Hearing none, we'll say those are approved. Jim, do you want to give us an update on the survey?

Jim: Well, where we are at, we would like to suggest some changes that we'll go over. We're to a point where we had finished up the targeted amount of inspections but we had a situation where we were running short of the adolescent age group. We had been using a cell phone over sample in hopes that would allow us to achieve the goals that we needed for the 12-17 year olds. Quite unexpectedly what we were running into was a wall trying to get through to adolescent girls to talk about substance abuse. Parents were simply not agreeing to do this. This was flying in face of our previous experience about four years ago when we did an adolescence survey, we weren't running into that problem. We were basically using the same introduction to the survey but parents were much more reluctant this time around to allow us to talk to their kids, particularly their daughters, about this. And we generated some numbers, we shared them with Eric and his team over there, and essentially the bottom line is that we have found that trying to collect data by telephone from this age group is not a cost effective way to do it. We have been dialing and dialing and dialing and going through thousands of numbers and spending a lot of time and resources trying to get through to this age group to plump up those numbers a little bit so we would have an adequate number for the analysis and it just looked pretty dismal as far as trying to achieve that goal by telephone. So we met earlier this week and we had sent some information over to Eric and we talked about it. One of the proposals that we would like to make to the Committee is that we simply end this attempt to try to get through to the 12-17 year olds by phone. It's just, phone work is not the way to go, at least in Indiana it's just not working with the current strategy that we're using. It may work in other states when there's funds available to send out mass mailing, to send people out in the communities to promote the thing, financial incentives, those sorts of things but with the funds that we have available we're not going to achieve the same kind of success that we had four years ago. And so, the counter offer then would be to use the resources that we were going to expend on the 12-17 year olds and use that to build up the 18-25 year old, which is of course a real high priority group and it has been all along for this Committee. So that, I think, is probably the first key decision that needs to be made until – I don't know if there is anything else you want to add related to that?

Eric: Well, I think actually two things. One is in general related to this about the value, the ability of doing telephone surveys, and how cell phones and the culture is changing in such a

way that cell phones are more challenging. So, as I was thinking about it, the original logic we were going to focus here was this would be the evaluation tool, three points in time as well as the regular source of data the SEOW to draw on. So we talked about the idea of oversampling, shifting the sample of 12-17 year olds to 18-25 year olds with the idea then that would be the data source on adolescents. That raises some questions, or challenges, because one of the reasons we were including 12-17 year old sample was because we don't really have any way of estimating current 12-17 year olds at the county level. It's not a random sample, it's not structured that way so I think before we make a decision about this, although I'm definitely inclined to drop the 12-17 year olds if only for resource preservation here, but the larger longer term question I want to make sure is clear in everybody's mind is that means we need to really address the ATOD survey and try to find ways to make changes in it so that we can use it as a tool to generalize the county level because the whole purpose of doing this was to create a series of data sources that would be generalizable down to the county level. So that's the other long term implications of this. I think one of the things some people may ask is where are we in terms of data collection. We had asked Jim two months ago, or three months ago, to focus on the 12 funded community data collections so we could get them to the data. Making this change will mean we probably won't have any of the survey data to include in this year's epi report because if we make the change to oversample the 18-25 year olds then they are going to need more time to increase those in the 12 funded communities and since that is such a key baseline measure in the evaluation I don't want to release any information based on those data unless we are absolutely sure that is the final baseline because then the evaluation comparison point is fixed. So we have a short term release that it might not be actually accurate of changes especially since the target age is changing to 18-25. So there is a couple of consequences to this decision.

Jim: The target has been met for 18 and older for cohort 1 communities. We have that data right now. But if we decide to increase the sample size for the 18-25 year olds, then it's that strata across all those communities will have more precision but it'll take us longer to do. We stopped calling on the 18 and older on those cohort 1 counties, targeted counties, for some time.

Jeanie: Are you oversampling cohort 2?

Eric: I think yes.

Jim: Well that would be part of this plan. The resources that we were going to put into the 12-17 age, we'll put those, and make those calls in the 18-25.

Marcia: How many, what kind of numbers are we looking at that you were trying to get through that 12-17 year old population? Are we talking 5000? What kind of numbers were we targeting?

Jim: Numbers of calls?

Marcia: Number of females.

Dave: Number of responses.

Jim: Number of responses, we were shooting for, what was it?

Anne: 25 girls and 25 boys in each targeted community. And we couldn't even get that.

Jim: It was, we were calling night after night, we're talking thousands of telephone numbers being attempted multiple times trying to get through to people. And we even stopped cell phone calling and went with just, back to calling the land line because the cell phone approach wasn't working. People were getting even more upset about us contacting their children on their cell phones. It's all very understandable. So then we went back to just calling land line phones and even then parents were just far more reluctant than they were four years ago to let us talk to their kids about these issues.

Eric: It's mostly a girl effect.

Jim: Correct. This is the one case where we've had far more male respondents than female respondents in this age group. Traditionally it's always easier to get through to female respondents, they're always much more willing to do phone surveys. In this case, it's the barrier factor. It's probably more so the parental refusal.

Marcia: Would it affect the validity if it was something that was put out on MySpace and they could do the survey on their own as opposed to being asked the questions?

Jim: Yes. I mean, we really just couldn't – that's certainly another approach to data collection but the different modalities are really very dramatic.

Eric: That would be a non random survey.

Jim: Yes.

Barbara: I think the one thing that would be possible, the results of 18-25 would be to release it but have a note 'this is subject to revision because the study is ongoing' or something as opposed to not releasing the information yet? And what about, when you were saying about this new resistant, one reason why would that be and it could be many different reasons but one might be it shows progress in terms of readiness to deal with the issue. That parents would think, oh there's no problem here are now they're owning the problem and realizing child is susceptible and might be involved and that's why they're more reactive to it because they realize the vulnerability of their child to substance abuse or other kinds of – could be we've raised some awareness.

Jim: Well, I think it's first and foremost is there are a lot of questions about how the heck did you get my number or how did you know I have a kid living here. The fact is we don't. And when we were calling cell phones it was a lot of outrage with parents saying, what are you doing, who gave you permission to call my child and then we'd have to explain we didn't know but we can only hope that this is your child's number and that's why we're asking you for permission but it's more of a privacy concern. At least that's the feedback I've been getting from the supervisors who are reporting at the end of shifts about the problems that we're facing. So it's not like it's been a lot of unreasonable problems it's just the reality of the situation.

Rick: I didn't really hear any alternative. I mean, what you're saying is, it's really not working, we really just can't do it.

Jim: Right. There's no alternative. It's not like there's no way to collect data on 12-17 year old kids but for what we're trying to accomplish with our tools and the way we're operating now, this is not working.

Rick: So our decision is what to do next. How do we solve this for next year? And then the 18-24 is another consequence, how do we manage the consequence.

Jim: Correct. The 18 to, I have a lot more confidence. We've proven that we're able to get through to 18-24 year, they're adults, they speak for themselves, we can get feedback from them. We don't have as many of them responding as we'd have liked so that was why Eric was bringing up the possibility of using resources that we would have used on the teenagers and using it on the adults, which makes perfect sense. But the implications will be that we have to, you have to decide what would be best. Do we delay the epi reports until we're finished with that or do we present preliminary results and then come up with the revised 18-25 estimates once we get that higher level of precision, more sample. And how all this fits into strategy for the whole reporting process. That's what I just don't know. That's why you all have to decide.

Eric: And my thought, there is another reason why the epi report's probably going to be delayed and that is the UCR data, we recently learned, is not going to be available until the end of October. At least that's the last report we got. So, who knows how much earlier but we're not optimistic.

John: Why is that?

Eric: I don't know.

Marion: I don't know why it is. I contacted them and they had mentioned that at the earliest they expect the data to be available is between the mid and end of October. And they didn't give me a reason why.

John: I just came from the data meeting and everyone was showing all the good stuff they had and how great it is that they have this online system and you're telling me it's not going to be ready.

Eric: Is that UCR data they were showing?

John: Oh, they were showing all kinds of stuff.

Eric: They can do a lot of stuff internally.

John: Children, welfare, health family stuff with children, they had specific website with that. I was just being blown away and now you tell me it's not going to be done.

Eric: The reason this is such a, if it were a small sliver of the data we relied on in past years I wouldn't worry about it, except virtually every map we drew for last year's report was UCR data. And that's the one thing we have relatively reasonable county level information on as an indicator that a lot of communities, so I think, I don't think we have much choice in that regard. So, that's one contextual issue. The other issue is, what do we do with the limited survey. And I'm still of the mindset because I've discovered in the short tenure we've been doing this that the communities really grab hold of what we put out and run with it, which is why I'm really reluctant to even have a footnote. They never read the footnotes. Students never read the footnotes. So my sense would be even if we get the survey done on time, if we get it done on time and I think we might be able to, I think then the UCR data comes out we can play with the data and get everything ready to run so when the last data set comes out we can do that and then slide it into the report. The other option would be to do like we did in the first year where we actually published an addendum that was in use to make prior decisions. Which helps with next year's report. So I think if you are comfortable with that strategy, we'll move along that way. But I'm a little worried about putting out what are essentially going to be benchmarks for communities with a footnote. That's why I'm reluctant to do that. But I think we can talk about that.

Jeanie: My concern is that we're starting to put, they're starting to implement strategies and we've got to get this wrapped up before they start to do that or else it's not a good baseline point.

Eric: Right. And I'm not too worried about that because we're actually 95% of the 12 counties that are going to start. Where we don't have baseline data yet, which we will have at the end of the year is the rest of the state because we've asked them to concentrate on the 12 funded communities. Which is actually the larger volume of cases we're seeing, right? So I don't think from baseline point of view it won't affect that issue.

Jeanie: And there are some communities, like Marion County, that see some bleed over into whatever county is right below it, Johnson, because they're focusing on the lower quadrant. So you have to be careful there too.

Eric: We're not going to be able to address that quadrant because the sampling design is focused on Marion County and Johnson is part of the region separate from that county. So at the state level we'll not be able to do that. The local community would need to be able to figure out they're going to demonstrate that.

Jeanie: Right, I'm just saying that you might need watching out some of you're, if you were still sampling in Johnson County after they start implementing in Marion County, you're dirtying your water.

Barbara: Another thing, if the findings are very clear, it would be safer to print out but if can wait that would be ideal.

Jim: Do you have any sense yet, Jeanie, when things are going to start happening?

Jeanie: I would guess, I'm trying to think where Marion County is for example, within the next month or two. They're all, well not all, many of them are chomping at the bit to do something.

John: They've been planning for so long.

Eric: Well, their plans have not been approved yet, right?

Marcia: Their plans have actually, many of them have been approved. They have one more component and that is their logic model matrix, which is here's your strategy, here's the if and then, and these are the components of the evaluation. And as soon as those pieces are done, which many of them are being turned in right now, they're able to go into implementation. The nice thing is that we got a handful of them that their implementation is to focus and narrow in on where those hot spots are and they've decided that part of that implementation will be increasing their focus on getting more specific data so they'll know where those hot spots are, where to focus their energies. So that's nice but Jeanie's really, she's right on. They're strongly anticipating getting started.

Jeanie: Monroe County is just, they're really excited to get started. They're actually kind of doing some little things along the way. They're pushing the envelope a little bit.

Eric: I'm not terribly worried if there's a little bleeding over because the majority of the data, I mean, it's unlikely that in the next 25 cases are going to influence the overall estimate that much anymore. Even if they start something, program implementation takes 2 years to reach maximum impact. So I'm not too worried about that being a pretty pristine baseline. So I think that may not be that much of a concern. That's just my thought. Would you agree or disagree?

Jim: Yes.

Rick: I would appreciate having a little bit more time to get better Medicaid pieces together.

Eric: We like what you had done already.

Rick: Well, I know, but...

Eric: You're just a perfectionist.

Marcia: When we're saying more time, are we talking end of November? Are we talking – just a kind of ballpark.

Eric: Well, if they do in fact get us the data at end of October, the end of November is very feasible. If, however, like the federal government, they're not really reliable about their deadlines, it's hard to say.

Marcia: Are we comfortable saying it will be out by the end of year?

Eric: Yes, I think they'd be in trouble if they were that late with this particular data set.

John: There are several substance abuse bills that will be going forward.

Eric: Right. That's why we were, that's why I was worried about that. If to help that process along we could do prereleases on pieces of it that are related directly to that, even without the UCR data, if that was possible, just the larger thing. Our goal has always been to have something to go to legislature. And I think there comes a point at which we'll fish or cut bait. But I'm a little worried about the UCR data because that's the major indicator set.

Jeanie: I don't mean to be conspiracy theorist but there is an election coming up.

John: That's to their strength. Why would they want to hold something back which they really truly believe in?

Eric: So, if that's comfortable, I mean this is a three way, several year decision. I just want to make sure we're clear about that because if we change the sampling frame this year to being basically 18 plus, then what we're doing is making the decision for the next 3 waves, 2 waves, for the exact same sampling. So if we start changing it every year we're lacking in terms of generalization. So, if everybody's comfortable with that we'll give Jim his marching orders.

Marcia: Now, this does not preclude in any way the local communities still going after those?

Eric: No. And one thought about this was the only reason we wanted to include the 12-17 year olds was because the issue about generalization from the ATOD and because from a measurement point of view all priorities are focusing on 18-25 year olds, and so in fact having 18-25 data is actually probably more meaningful than having 12-17 year olds. So from an outcomes assessment perspective, this has really no implications and might actually strengthen the overall survey design. What it does mean then is ATOD survey becomes more critical because that will be the only source about less than 18, non adults.

Rick: So it's more of a long term model, in the sense that 18-24 girls were 12-17 year olds before they were 18-24 year olds.

Jim: In this universe.

Rick: The precursors to their 18-24 year old behavior is understand their 17.

Eric: Right. Remember this is a cross section it's not a longitudinal survey.

Rick: That's why I said long term. We still think about is there a better way to solve this problem for 12-17 year olds when moving forward in the future here.

Marcia: So if this happens and we're all comfortable with this, then what kind of adjustments would you make to the ATOD survey?

Eric: Well, I don't know if this is a conversation you want to have today, but I think what we need to do is figure out the two problems now with ATOD – one is the sensibility of the data, which the communities have also expressed and we talked about at the last meeting and trying to get some sort of way going with the local rule thing and trying to figure out, SPF-SIG communities, four of them, wanted to use ATOD survey for their community assessment but were not able to because they couldn't get schools to release the data. So there was that challenge. That was one. So the release of the data is one set of challenges. The other one is then making sure we're following the same strategy that permits the generalized release to the county level. So in the case where there is only one school that participates in the county, so those are two related questions and I think what it does is say the ATOD survey is the only source of data we have about teenagers. Are you having trouble with your tobacco survey?

Miranda: Which one?

Eric: The youth one?

Miranda: The school one?

Eric: Oh, your youth one is in the school.

Miranda: The ATOD survey is in the school but we just finished a media based survey with the youth and we did OK. Same age group.

Eric: its drugs, they don't think of tobacco as a drug.

Miranda: We didn't do any letters with the youth but we do typically with our adult surveys and usually have pretty good success. Maybe another tactic next time around?

Eric: The only reason we didn't do that this time is because that was a budgetary item.

Miranda: But it's worth it, I think. This is a larger sample than what we're used to but I think the benefits outweigh the cost in some ways. We're getting ready to implement our youth survey for this fall so we'll see. It's always a challenge, school based. Which is another drawback because you're only getting in school youth. You're not getting the kids that drop out of school. It may not have a big impact.

John: Can you do some of the alternative programs?

Miranda: We could if are sample wasn't based, if we just took straight level school in our sample. But we don't have the option to add that in.

Barbara: Three things come to mind. One is that we are looking to target counties that are not, when we look at the state areas where we don't have penetration or we don't have participation. We are planning to send out copies of monograph to get their attention, and say you could be part of this and you get this kind of information. It's expensive to mail out something that substantial. We're going to target places where we're trying to, in different years we can target

different areas in the hopes of getting that part of the state that are represented. Another thing is I just proofed a letter that's going out asking the schools to agree to allow their data to be aggregated at the county level. And the third thing that came to mind is the change in the timing of the ISTEP test which is going to mean some, we have to react to that because they're doing it twice this year to prepare to be able to shift to the fall so that will upset the length of time our survey, a year usually, we have to from the spring to the fall up the road.

Ruth: And just to add to what Barbara said, we're open to considering the adding of items to the survey that you feel were missing, so if there's some items that are critical to telephone survey that you'd like to in the school survey we'd be interested in hearing about that. After doing that analysis about what would be the most cost effective approach to administering the survey in Indiana, we considered a census approach a random sample approach and a nonrandom sample approach, which is what we're using now, and after talking to the Division of Biostats at the IU School of Medicine and John Kennedy and our own in-house experts I still come to the conclusion that our most cost effective approach is the convenient sample, is the nonrandom sample, and also not giving up, the other value is not giving up that local level data that is so much appealing to communities. As far as its representativeness, all you can really do is compare socio-demographics, urban rurality of the respondents with those that you know are in the state, or in that geographic region. And then you can say whether or not there's a similarity or not. For the regions, I think there's eight of them that we break down in our monograph. If you look at gender, race, ethnicity, urban rurality, age group, I don't see that much of a difference. There's a couple percent points difference for some of the ethnic groups, I don't really see that as a very big problem. Now the problem we're facing is we do have counties that are not represent at all, so that's why we've talked about targeting those communities and marketing to them and trying to get them to encourage their school districts to participate and if we can get some data, if we can get enough data from those counties that aren't participating then we can use putative methods to fill in missing data and I think that's as good as it gets and taking some practical considerations in mind. But we're really open to discussing this and to your ideas. We need to get the participation up in those counties that aren't participating and so we need to think about how to do that. We've often considered trying to force them and that's gone nowhere fast. The other is to try to pressure them through normative pressure from their through their Department of Public Health or local politicians or I don't know. We don't know, we're trying to figure out who the influential people are but they probably vary from County to County.

Eric: Two things – one is that I think all the stuff you guys are in terms of expansion is great, we've talked about that before. In terms of the survey itself, again, anticipating something that hasn't happened yet which is the whole noms initiative, requiring state to report noms as a way of getting funding, a block grant, I see that coming. There was some slight differences so we ought to go point by point.

Barbara: We have, this is something we have thought about it. One reluctance on our part to change the wording of the questions is you lose the historic value and now we've heard their likely to change the noms after just one or two years and we're so glad we didn't change our questions in response to that and then it changes again

John: Correct there, they're not going to change the noms, just the process. This whole meeting was, this whole two days was looking at how to report in specific process on reporting the noms. They're trying to look at, across states, are they uniform? They're not. There's a whole bunch of variability across states who are reporting the noms. So right now the noms really don't mean the same thing, even though they've been publishing graphs comparing what states have collected, it's not the same thing. Comparing, even though you have these bar graphs going up and down, it's not comparing the same thing so the whole two days was just on the reduced morbidity, which is the abstinence and the length of stay piece, how are states – what are the business rules for the data standards for collecting that data, there's none. It extends all the across from mental health to treatment and prevention. Nobody has the same thing so the most comparable stuff is when states fill in the tables.

Barbara: That's what we've done.

John: 27 states do it that way, 22 do it this way, so it's not comparable.

Rick: To me, whenever I looked at county level differences as opposed to regional level differences, you see more variations between counties in a region than you do between regions. So to me, if I were in a region and my county was not reporting, the strongest argument to me would be, OK, if you're county is not reporting than your region is being reported based on your neighboring county and not on you. And people that are in, particularly the rural counties realize there is rural and there is very rural and they don't want to be judged. And there's the small towns, the small cities within their region and they don't want to be judged on the basis of somebody else.

Barbara: So they need to participate.

Rick: So I think it needs to be as much information as we can put out at a specific local level will create more.

Eric: And I think in another way that's similar to the strategy we've been using with UCR, they're not reporting so they get little cross hash mark on the maps, basically saying naughty you, you're not reporting. I think we can move in that direction but then that's the one fundamental change in the ATOD strategy that has to be made if we're going to move in this direction. And that would be they don't any longer have the option of aggregating their data at the county level. The condition their getting to participate and have their confidentiality at the school level but what you also probably need to do, and I think you would have to say this, is we're making a decision here about how we're going to monitor for the future. And so if we're going to rely on the ATOD survey, it has to be done in such a way, collected in such a way, so that you know it is going to go to an aggregate measure at the school, or the county.

Ruth: Right. We're making steps toward that. I guess what we did was a step in that direction, I guess the recruitment letter was sort of a passive consent – saying you should contact us if you don't want it used, included in the county level aggregate. But what you're saying is just to tell them, if you don't want it aggregated at the county level then we aren't even going to play ball with you. You can't participate?

John: Is there a way to share it so you can share it with all the counties underneath it and then you just embarrass the counties that don't?

Eric: That's exactly where I was going. If we have a county that doesn't report because no school consented to that, that's fine and they are going to be cross hashed. We can do an approximation estimation of what we think they probably are based on what their surrounding counties are looking like.

Jeanie: There are counties with only one school district, this is what concerns me.

Eric: But, again, taking a longer term view we're trying to get everybody into this data driven decision making framework. And if all we're going to do is apply pressure here, I think that needs to be an expectation because how else is the state going to be able to make decisions about 12-17 year olds or younger?

Jeanie: Their argument is we are the ones to make those decisions.

Rick: OK, all I'm saying is if they're going to be able to opt out, all we want to say to those folks is here's the map, here's who opted in and here's who opted out.

Jeanie: That's a big difference from what we are doing right now though.

Jim: Well, right now your approach is, as I understand it, is you are providing service to schools by doing this survey. And as a byproduct of that there is this state wide data that we use to make all these estimates. So what you are proposing is switching that whole thing around, the state is funding the survey to make long term strategic plans and a byproduct of that will be services are provided at the school level but yet if the schools aren't willing to participating then the whole county is going to be left out of the equation.

Jeanie: Well, if we make a change like that, does it affect our IRB issue?

Ruth: No, I don't think so at all.

Eric: Because you wouldn't be sharing identifiable data. You probably would have to file an amendment because it's a change in your procedure but those are usually pretty easy.

John: I think if you try what Jim is suggesting it becomes a real critical issue because as we move towards a new RPF for the afterschool program, you have to incorporate principals of the strategic prevention framework. If you don't have data for those counties which will move toward that logic model, those counties won't be able to participate. That's an incentive for counties to want to participate as we work toward the RPF.

Eric: And I think, and this is back to a conversation we had, are we at a point where we need to go to the legislature and ask for their support? When we approached DOE and the governor's office about whether or not they wanted to write a letter of support to communities to say share

your data, they all rejected because they don't want to step into the home rule problem. But on the other hand, you're also worried about resources for doing the survey itself. And I think one thing might be is if we go to the legislature, the basic idea would be if we are making an investment, taking a big step in this direction and then we're going to add value and the state legislature comes back and says all the funding that we give away is dependent on having the data to make those decisions. And then they can still opt out but I think where John is going is that means that they are implicitly saying we're not going to have Afternoon Rock. And I think it might be a case where the state, the legislature might need to add in additional resources to support this at a larger scale, which is why my preferences from the beginning has been a census, not because I'm a big believer in censuses but it could be something that could be embraced by the state legislature as a state initiative, needing to know what is going on with our youths and it would be simpler to administer in my view.

John: And the way to move that forward would be through the Governor's Advisory Council, make the proposal coming to the governor's office for specific initiatives on this piece, because that's when they become very useful.

Eric: And the proposal could be to give it to them, it should be available to every school in the state of Indiana if they want it, fully funded.

Jeanie: Is there a way to partner, this could be a crazy idea, but if we consider the effects of health in general, substance abuse in particular on academic achievement, which is the way I think we need to start thinking about it with school support, is there a way to somehow with ISTEP? A one page, and we could give the healthy school report card to people. The Department of Health, all these folks, if we could ask them about their substance abuse, in one page front to back.

Miranda: When I first started in my job I learned that Florida has a school survey day. I can do a little research on how they do that but that kind of idea, there's just a lot of challenges to doing that. I think that's a good idea too, just trying to figure out how to do that because by trying to get other studies endorsed you're going to have other agencies not supporting that because they have specific mandates based on certain questions that they have to fulfill. So our idea to take a global approach to all school health to one day...

Marcia: That's what the state of Florida does? They do it one day?

Miranda: They may not still be doing it but when I first started with the child prevention, I had heard that they combined, and it may be more of a combined instrument too which is a whole other thing. Because we all have those barriers. The schools don't want to let us come in but how else do you collect the data?

Rick: If you consider something before the legislature, my argument about comparing county level to region, just adapt that to county level to legislative district because then the individual legislatures from the angle, their issue is what schools in my district are participating and how does that affect how the programs are implemented in my district.

Eric: Well, it sounds to me like there might be some, dare I say, consensus that you want to float this idea, it sounds to me more like the nuances are about how to do that. Am I correct there? So maybe if Ruth and I collaborate and try to bring something to the GAC next month?

Marcia: Next Tuesday?

Eric: Oh yeah, on Tuesday. And make some sort of written proposal, because I think if we use the GAC to say we need a better source of substance abuse data for children but then we contextualize it, I think this is really a brilliant idea politically, is to say let's consolidate all these initiatives into one. So then it becomes the states offering this resource that would have multiple public health implications. Analytically it would be a whole lot better because think of all the other things we could do with substance abuse and its relationship to physical health and I can see analytically how it'd be exciting but it's a brilliant idea. Let's use the GAC, I know Matt wants to do something with the Governor and bring this to his attention so this is the window of opportunity.

Marcia: There's an evaluation meeting in the morning and then there's the GAC 1:00-3:00.

Eric: I mean, if you can't be there maybe you and I can communicate, talk about this after this meeting and then draft something. I think the idea, the principle, the concept, and let Matt go talk to the governor about it.

Ruth: Sure. There are a lot of conversations that need to take place, I understand this is just the concept, there's just a lot more detail that we need tossed around.

Eric: No, I understand that. But I think what the question, what I'm hoping is that Matt will take this to the governor and the governor believes in data driven decision making in this initiative that he would like to take a leadership role then we could get them, or perhaps Warren Mills to pull the right people together to have the conversations about how much consolidation, obviously we consolidated things, it'd be a long survey, it would be an all day event, and that's not going to be good for the quality of the data anyway, so the question would be what is the minimum data set we would want to collect that would have broad public health implications.

Jeanie: And there may have to be some incentive for the schools that, I mean, the argument may be if people are not doing well in the ISTEP, it's bringing them in during the summer and drilling them in math equations may be less effective than improving their health. But that needs to be part of it too. So maybe some more grant money needs to go to these kids that aren't achieving well.

Eric: But that data set allows us to do that. If we're getting ISTEP data and you have prevalence information about the use of drugs and alcohol I would bet there's going to be a strong correlation between greater drugs and alcohol and poor ISTEP.

Jeanie: Absolutely.

Eric: I mean, I would be shocked if there wasn't. Which would raise the whole higher, this public health implication into this in a sense and even then we would have to have a lot of academic individual level information because it'd still correlate with ISTEP scores. So I think there's a lot of utility here, and then the second half of that question is moving towards establishing a standard that you have to be able to report on your community, or school district, in order to be eligible for money. And it's a carrot.

Jeanie: Exactly. If you don't pay attention to this, so what. So you know that these two things are related, so what. So what are you going to do about it? Who's going to throw some money in the pot to do what?

Eric: It might be that the agencies that are already spending money on this consolidate their budget somewhere else into a pool of money.

Dave: But it's also the opportunity to open the door to start getting some legislative funds for some of the things that we are doing, which we don't get now. So if we tie those two together and get something going.

Marcia: And there is also that, we've got the first cohort and they've been really good about going to schools and saying let's get this information. Now we've got the second cohort that's added another eight, now we've got twenty counties out of the ninety-two and if we're looking down road a little bit and this is the ultimate of what it could be, if we then go to regions and say we've got about two different counties in each region that we can start aggregating data then we would have a regional profile then we do have the stand to go to each one, I mean every community within the state would be accountable then so you've got it coming from the state level but you've also got it coming from the people within going out and saying we really need your participation in this. They've done a really admirable job, I think, going and trying to get more schools within their counties on so if we could look down road to where it might be regional we could get about a two perspective encouragement for those schools. But, to do that we've got to make sure that the resources are there too. I mean, that's a big question. What if we get to the point and we all of the sudden say we don't have resources to fund this? Are those available I guess is the bottom question.

John: Well, we probably have to have a step by step discussion with Eric and Dave and Diana on that because there are resources there, it's how we allocate those. Indiana traditionally uses all of our admin dollars but not for admin purposes. And what we have to start taking a look at, the 5%, that we have in the admin, let's just allocate the other 95% to services and then starting taking a look at how to better use that 5%, not use all the admin dollars. We just have to make a case for it using it. But the agencies themselves like to see all the money in services but that leaves us short on any type of data driven decisions because don't have as much money in research and analysis as we should.

Eric: And I also think though we might expand the conversation beyond substance abuse. We could frame this as part of building an infrastructure for data driven decision making. And I think we have gotten to the point where we are sort of giving up on that and saying, look they don't want to touch local rule, home rule, but then we're going to rely on the grass roots and then this

way, now top down to make change. I'm actually confident that the advocacy that has been going on at the community level is pretty darn impressive. And I think between those and our now taking the step to move this to the legislative level discussion I think has promise.

Rick: I would guess that those twenty counties represent something like 50% of the population of the state?

Marcia: Yes.

Eric: And don't forget, they were all identified because they have a high needs substance abuse.

Rick: So there's sort of a snowballing effect here that can happen and so this massive solution may be at some point we're just doing what we need to do but do it more efficiently. We're already doing it in pieces.

Eric: And we're doing it in conjunction, you don't want to do everything, just basically enhance ATOD and then supplementing that with the bi-annual adult population survey. Because then we would have two regular reliable data sources to report out on.

Rick: I mean, the home rule objection becomes less loud if the majority of the population is participating already anyway. So those that are objecting to their home rule, keeping the data out, become the oddball.

Dave: They don't care.

Eric: But, home rule issue is more of an issue for schools than it is for the SPF SIG communities. Because that's the battle they keep fighting locally.

Rick: Right, sure.

John: Well, they say they don't care but they do care. You hear that because people go on to submit their political ad slots. I grew up in a modest house, we had good schools, we had good things. So they do care. Just listen to the political ads on local candidates. They care. They care how well they're doing compared to neighbors, so they do care.

Eric: So I will draft a little concept paper, I will e-mail that to you and then we can go back and forth on that.

Marcia: So that will become an agenda item on Tuesday? Are you comfortable with that?

Eric: Yes. Any other discussion on the state wide survey?

John: I just want to get, what's the input from our student delegation there. What do you guys think?

Marcia: Do you have the ATOD, Alcohol, Tobacco and Other Drug surveys that we do annually in your schools? You're in two different schools, right?

Lindsay: No, we're in the same school.

Ashley: They usually give them to us during our smart period, which is like a 42-minute thing we have every Tuesday. That's when they give us the surveys and I'm never in the room and I'm not required to take them.

Lindsay: I think the freshman and sophomores are required to take them.

Ashley: They have to stay in the room but juniors and seniors can go. And most of the teachers aren't very strict on it. And I know that, and I'm sure you guys all know this, that most teenagers are like no, no, no, no.

Marcia: Yes, we've heard that from almost, probably half of our communities, from the youth groups. But that was another concern, that we need to get the message out to the youth that are taking them that these really are important and it's not just a, it doesn't help to get it in every school if kids aren't taking it seriously and how do we address that.

John: Well, is there a way to eliminate those where they just go right down?

Ruth: Yes, we pick up on that stuff.

Eric: But I think this is not just a youth issue. I mean, adults lie too.

Jim: They'd just be a little more creative about it.

Eric: I mean, there's a difference between scribbling on the thing versus knowing whether it's a systematic bias. And the nice thing about doing things that are not social desirable is we usually know which way the bias is so we always know if these are underestimates. So if a school and adult population, you can pretty confidently assume it's an under estimate. And I would never assume it's an overestimate. The bias is clearly towards the, if you're doing sex, drugs, or crime those are the things that people underestimate. Unless you're a teenage boy, then you overestimate sex. You know which direction the bias is. That can be inherent in any survey about substance use.

Ashley: Well maybe if the surveys we were given, if our teachers could like have something that they could say to us to address what it is instead of just, here you have to fill out the survey. This is really important information, this is coming from our group thing, its important information, we really need you to take it seriously and fill it out.

Marcia: Are they giving any kind of spiel about that this is confidential, this will not be told?

Ashley: We have this is confidential and that's about it. Maybe it's not every teacher but I know I've been in like two or three different classes and they are just like, kids are getting older and

could care less and teachers are just like whatever so they just hand out the surveys and just please fill this out.

Eric: And those were sort of the same problems you were alluding to earlier in terms of, the one bad thing about doing school based surveys is you don't, unless you have a researcher in the room you don't have a lot of control over the actual administration.

Ruth: We provide them with a video that displays how it's supposed to be distributed, explained but you're right. We can't control whether they actually do that.

Eric: Maybe we should give them a video to show before the students do it.

Ruth: Well, the idea is they're supposed to be watching it before passing it out.

John: That never happens.

Eric: Oh. Well, with web based technology you could have a streaming video online, that probably with the way schools are going, that would be an easy way to distribute that.

Jeanie: Yeah, or just avoid teacher doing it all and just let the students watch the instructions.

Eric: That's what I was thinking.

Ashley: We also have a mass media thing at our school, I don't know if other schools have this, but we have TV announcements and I'm on that so if there's any way we did another survey I could put that on announcements so people would watch it. Because announcements play on Tuesdays during the smart period.

Marcia: That's a good idea. So it's the youth telling their peers, take it as opposed to teachers getting up there.

Eric: That's true. There's the dynamic video. Put you and a couple people from all over the state talking about it and how important it is, I think that's a cool idea. And have a streaming video and teachers just not pay attention, just pass it out so teachers would like it better.

John: That's a good solution.

Marcia: Good idea.

Eric: We'll work on that proposal over this weekend. It will probably be a one pager concept thing with the basic idea that we would like to ask state legislature to take action on the idea of funding a statewide survey and expanding access to the ATOD survey to more communities and then the second part would be to basically change policy so that all funding decisions around substance abuse prevention would be key to having data they can report on for their community based on the ATOD survey. One two punch. OK, update on the funding communities?

Marcia: Communities are just now getting approval to move on, are just now on the implementation phase, which is phase two. We have twelve communities, probably 6 of them are with a green light and ready to go and move forward. We are hitting a challenge with cohort one communities saying we've always had when it comes time to renew contracts, contracts are a little behind. And what we have done is encourage them to take the funding that they did not use in phase one and roll that over to phase two because there's a big question mark on whether or not there will be any type of no cost extension here. We've asked them to take those funds that they have and roll them over and use them. We've got a huge span. I've got one community that has got \$35,000 left over and another community that has \$1,300 left over. So there's a huge span there in cohorts.

John: Is the carryover dollars in their accounts?

Marcia: They're in their accounts. They're with them in their own communities. So that's one of the challenges. I think we have about two-thirds as we speak that they now have the vouchers for this new amendment. There were a couple of amendments that happened within a few months so it's really wrapped things up. Cohort 2 communities on the other hand, 70% of their contracts are done and they don't start putting their vouchers in until October 1, that's their starting date so I don't anticipate them having a lot of challenge. We have started to go to every other month site visits with cohort 1 communities just because of time, there's not enough hours in the day to hit all of them in a month. So Kim and I have split cohort 1 and the cohort 2 communities we are going every month. We have gone through contracts, they've all signed their contracts. They have identified, for the majority of them, their epi writer/chair for the LEOW. That's a big change from our cohort 1, kind of a lesson learned, that we asked them to allocate the dollars to the epi writer and have that funded like we did at the state. We have two that are using IUS, Indiana University Southeast, employees. We have two that are using Roosevelt University up in Chicago; other ones are tapping into their own resources. We have one that is using a local businessman who has done a lot of this prior and has brought in his resume. So they've got those pieces done, they're starting to bring on board, we've got a huge span of how they're setting up their own staffing. Most of them are doing program director and a coordinator, some are jostling that so they've got four. The most interesting community, I think, in our cohort 2 is Newton County. If you're familiar with this county, it is very, very small, and very provincial I guess is a good word to use. When I was out there he said I don't know how I'm going to find enough people to pull from a pool that have a college education, and when we were talking about diversity, said I would like to have, I was trying to explain what cultural competency was, he said there's not a whole lot of diversity. And I said, well percentage wise, African American/black? We do have a small population of Hispanic growth, and I said population? And he said we have 4 families. And that's in the county. So it's very small, unless they've had a momentum in the last two weeks. I didn't know how anyone could know in their entire county that they had zero black population. He's the one that said we're going to take three or four positions and divided them up and have them all trained. And they're starting to understand the concept of how we start building, we're up at the top 10% with our numbers and showing we've got the problem but our resources are really low. So we've got a whole lot of diversity in cohort 2 that really didn't come across in cohort 1. Even our lowest capacity, meaning just resources and availability with Green/Davies is miles ahead of what a Newton County is going to be. So we're anticipating a lot of new exciting changes. Everybody is on board, everybody is getting

geared up and we will start with cohort 2 and the team is out there every month as of October 1. And the data, Marion, do you want to talk a little about the CD you provided and everything that was on that so they understand what they are getting as resources?

Marion: We just created a CD that contains a lot of information that we think will be helpful to the new communities. Besides the state epi report it contains all the local epi reports that have been written, it has guidance documents on how to establish the LEOW, a template for how to write the epi profile, how to work on your strategic plan, things like that. So it contains a lot of resources. We make that available to all of the communities. If you are interested in that just let me know. We think it contains a lot of good stuff.

Marcia: One of the things we're most excited about is they took all of the links that everybody could use to create different data in the first cohort and they put that into one data source that they can pick it up and say oh, I want this data. They've got it broken down so they can get this at county level, at national level, whatever, and then they've got the link. So all they do is go, I want this source and click on the link and it takes them right to the site. Nothing that we had available in the very beginning. So that's been a great asset.

John: Marcia, how many of the cohort1 contracts have not going through state system? Have you signed contracts but not been signed by the state?

Marcia: I think four.

John: Four? Do you know which contracts they are?

Marcia: Lake County, let me get that for you.

John: Because we need to see how to walk those through and try to get those signed as soon as possible.

Marcia: That'd be great.

Eric: It's about 10:20, do people need a break or do you want to plow through? Preference?

Marcia: Plow.

Eric: Plow. OK, next item is the, you have the table that Marcia was discussing is similar and based on the data sources so these are the ones we are working on for the 2008 epi report. So I don't know if anybody has any additions they want to make? It's primarily informational.
Marion?

Marion: Well, not only, during the last SEOW meeting we had talked about providing data sources where all of the agencies that are represented here at the SEOW would recommend them to be used.

Eric: So in light of that discussion, basically the idea here is this would be something you as an agency representative would then make available to the communities you work with, say here's the best data sources in this area. I think this is on your website too? Pieces of it anyway. The idea is then this formal motion to say these are the data sources sanctioned by the SEOW. Any objections to saying these are the official data sources? Recommended data sources?

Miranda: I just wanted to, I had one thought as I looked through the list. There's a couple of them on here that are kind of like an aggregate source and I didn't know if you wanted to group a couple of those together and move them? Only because I felt like the actual point source of where that data comes from is multiple sources to give that a little different category.

Eric: Which one are you thinking of?

Miranda: On page two, the state epi, I just noticed it looked like it contained several data sets?

Marion: Yes, it does.

Miranda: And then, the epi indicators, page one, just because it wasn't one source from one instrument.

Marion: Yes, I know what you mean, and you are absolutely right, it's not one data source those two are referring to but whole, basically like a package where you can choose different data sets.

Eric: So we should probably list those underneath?

Marion: Well, actually they are already contained individually in the list as well, I just wanted to make that available that you also can just click on this website and see what they provide.

Eric: OK.

Barbara: Do you want to include the GIS in prevention county profiles? Because they provide county and state and national level for substance abuse specific risk factors as well a demographic data. For example, median income for the county as well a for the state, the nation.

Marion: OK. What is it called again?

Barbara: It's the county profiles, GIS and prevention profiles.

Marion: Is that, that's not available on your county level epidemiological indicator site?

Barbara: The one you have here is the SIS.

Marion: Yes, changed to CLEI.

Barbara: Those two really integrated, and maybe this year we'll get that done.

Marion: OK.

Barbara: So it's a different website. I always go through our home page so I don't recognize what it is but I can get that to you.

Marion: I know what you mean, I can find it and I'll add it to the list, that's not a problem.

Barbara: We have a new elegant platform, that's asp.net driven, much slicker than before. Harold will like it a lot.

Eric: Any other suggestions or additions? So we'll make these changes, we'll send out another new and improved copy with the word sanctioned or approved by the SEOW and then if you as an agency want to put this on the website or give to client these data sources then these are the ones that are recommended by the SEOW. I don't know if we need to do, can do, anything more than that?

Marcia: Would you like to introduce some verbage to that and send it to me?

Eric: OK. S now we move to discussion of the 2008 epi report. One thing we, or I didn't remember that we were going to put on here and I'll start there is the public health burden chapter. Just to update you on that, there are a lot of strategies for doing that particular piece, and we decided, or rather I should say I decided, that we are going to follow the federal governments model for estimating the public health burden, which essentially is the economic burden of substance abuse. We had talked about doing other forms of that but then it started mushrooming, and so we thought for this year's report we would follow the federal governments model because right now there is no good state single estimate about the burden of substance abuse in Indiana. So, the public health burden chapter will be focusing entirely on that slice, which basically means what we do is we cut across all the chapters and attach numbers to them and estimate the total impact of substance abuse in Indiana. So that's where we are going. Hopefully we'll have a draft of that next month. Any questions about that?

John: If you put that economic impact on that, and you say you are taking slices of each of that, how reliable will the impact be? Because when we send this report to the state legislatures they are going to take a look at that very closely. I mean, Dr. Monroe did some public health pieces on substance abuse itself last month. So there is a heightened, or raised awareness on what the challenges are for Indiana in terms of trying to address some of the substance abuse issues and its impact on the prison system, on healthy families and with the Health Department having a requirement to actually formalize the pea soup program, even though they don't have any money yet, it becomes a critical area of review in that report.

Eric: Well, that's the problem. I don't think there's a single scientific way of doing this, and I think that's why as I was going through the different models I was gravitating towards the way, the federal model takes these indicators and applies some sort of valuation factor to each of these. So for example, they would combine treatment, the number of treatment episodes, the estimated cost of those treatment episodes, then number of contacts, police contacts, how much it costs for that, and then you just do this sort of cumulative adding up of that. And the reason I was

gravitating towards that is because there is no single model for doing that. And the federal government only did it at the federal level, they didn't do it at the state by state level and so the goal here would be is to aggregate Indiana's data on the same federal model. And I should look at what Dr. Monroe did just to make sure.

John: You might want to make sure that some of the Medicaid data is also shared.

Rick: Yes, I was going to ask that, how that model treats health care consequences?

Eric: It breaks then down by known data sources.

Rick: So, maybe we can meet and talk about that. Because I now have a starting number I can say, OK, the substance abuse population is more costly to Medicaid than non substance abuse by how much.

Eric: Right and that will definitely integrate.

Rick: 110 million per year. Now, that assumes that there is no covariant factor, that the actual cost is purely through substance abuse, which we know there are co-occurring mental health so you can't attribute that number just to substance abuse.

John: The other issue is that the administration wants to hold down Medicaid costs. At least 5% increase annually, I think that's what they are holding costs down to and so it becomes critical for quality in Indiana.

Rick: That component is increasing much more than 5%.

John: That's the issue. So prevention in terms of keeping costs down becomes critical in terms of Indiana trying to maintain some balance in terms of how fast Medicaid expenditures increase for this population.

Eric: Which is why, as I was going through the literature, it was clear to me that's where the focus should be from a public policy making point of view, so it makes it less expansive, makes it a little more doable. It's not an easy methodology, not straight forward unfortunately. Which is why I'd be interested to see what Dr. Monroe did, just because if she's got a methodology in mind she likes, maybe they're trying to apply it consistently, we should try to follow that.

Ruth: The good thing about it, the federal approach you are adopting, it's transparent. I mean it's very clear about what is included, what's not included, what the basis was for the calculations. So no one can argue with that. If they want to bring up a point that something else wasn't included in that, just tell them it wasn't counted, we didn't have data for it, we didn't know how to crunch it.

Eric: So, hopefully we'll have it for our October meeting review. Did people have a chance to look at the alcohol, tobacco, marijuana chapters? No? OK, I guess we would still ask for your

feedback then so if you wouldn't mind taking a crack at those. They are, other than UCR data, what do you think?

Marion: Yes, we have to add the UCR data and I have meeting with Rick on Tuesday, next week, and we also will have to add the finalized Medicaid data to it. But other than that, they are pretty much done. They are being edited. This is not the format that will show up in the book at the end, we'll send it to a designer, a layout specialist, she'll take care of everything. And some people have already had a chance to look over the chapters and provided me with feedback, which I have been incorporating. And Barbara wants to talk later on with me about it too.

Eric: Any other comments, questions about that? Have you guys gotten all that stuff?

Lindsay: No.

Eric: We'll make sure you get that. We need to add them to the distribution list. OK, the next item is the capacity issue and remember this is a new chapter so this is being modeled to be started with the one we did for the state strategic plan and what Marion has provided you is a list of where we're thinking of getting data. That tells you where we are and how we are starting to get that information. We already started to get some information so the idea would be to refine the estimates. I would really ask that you take a really close look at this because we really need people thinking outside the box about what we are going to count as capacity.

Marcia: This top section?

Marion: It is the substance abuse prevention, it's that table. Do you have it?

Marcia: Jason Hutchins left ICJI.

Marion: He did and because I had him on the list, I contacted him because I needed to contact somebody. He actually forwarded my e-mail to some people at ICJI and they are currently working on it. And also, if you know of any other programs or any other funding that is not in the table that I wasn't aware of, please let me know. And I need all the help I can get with trying to get the budgets and numbers together.

Dave: On the Indiana State Department of Health, the pea soup program, that's just a figure and we put in, DMHA. They put in some money.

Eric: So what do we need to do with that? Pea Soup?

Dave: There's money health puts into that was well. We fund through the block grant about 7 of their 16 sights. So they fund the additional sites.

John: They put in about \$800,000.

Dave: \$400,000 there is just DMHA. The State Excise Police put in \$500,000 annually, correct? We're putting in \$250,000 a year from DMHA, that's state money.

Marion: If you wouldn't mind, fill it out.

Dave: We'll fill it out.

Marion: Because actually, I'm getting a little bit nervous because this information I got from somebody at the excise police. She sent me that information.

John: She's under reporting

Eric: Again, if you wouldn't mind, we'll send this out again and ask you to track change everything and we'll combine everybody's into one document again.

Dianna: Are you looking for just grant money?

Eric: All money.

Dianna: Because the Department of Corrections has a whole substance abuse department so there would be money.

Marion: OK, do you know who I should contact?

Dianna: Jerry Vance.

Marion: Jerry Vance. And he's from DOC?

Dianna: Yes.

Marion: OK, then I'll find his email. Thanks.

Dave: And the way this is listed, there's a section for CSAT prevention but then there's other items actually out of that so it's going to be listed twice.

Marion: Also, Carlie and I think Tom Turney have been working on a budget for me for DMHA so I haven't had time to put it in table format yet so I just attached it to the end of the handout.

Eric: But what you're saying is that instead of saying agency we name the programs and then each program is funded by multiple agencies, indicate the sources.

John: What happens, for example, if you put put \$20,000 for pea soup it comes out of the prevention budget.

Dave: So it's going to be shown twice.

Marion: It will be shown twice, yes.

Dave: As long as you have a block for the CSAT prevention because that's where that money comes from.

Marion: I see what you mean.

Eric: That's why if we put program down and then we can have the source is CSAT for this and then four or five other programs it funds.

Marion: OK.

Eric: So the unit of analysis is program as opposed to agency. So then in theory if we had a column for each agency where they put their individual money you can cut across that.

Marion: I see what you mean. If we have the program and the various agencies who fund into that program and then the various amount and then total at the end.

Eric: Yes.

Marion: Sure.

Barbara: Funding for underage drinking?

Dave: It's not a state agency.

Eric: It's not a state agency?

Dave: It's not a state agency but they get money out of the block grant.

Eric: Are there other large programs like that?

Dianna: Indiana Additions Coalition.

Dave: That's not out of prevention dollars.

Marion: But it's still going to be a bit confusing because the Governor's Council might get funding for their council and they might give some of their funding to the different programs so it kind of moves on from program to program.

Dave: CSAT block grant prevention is 7.6 million that's distributed various ways.

Eric: We'll have to figure that out.

Marion: Yes, we have to think about that again I think.

Rick: Would it be appropriate to count as substance abuse treatment Medicaid claims where substance is the primary diagnosis?

Eric: Yes. I mean, I think this is where we all acknowledge, I fact I told everybody this, that was to be part of the strategic plan, apparently they loved it. But we knew there was an under count.

Rick: So that would be substance abuse treatment but not under DMHA budget.

John: No, it'd be under state cost in prevention. Part of our budget. We waffled on that last time.

Eric: Because that is part of our definition. I mean if you think about any dollar that is being spent on substance use is part of our capacity. We waffled on that last time. We sort of agreed if I remember right that we should do both.

Jeanie: It would seriously make it easier on Marion if it was only prevention.

Dianna: Now that you mention it, many of the counties have drug courts which their budgets would need to be included.

Marion: Yes.

John: That's true.

Barbara: This percent comes from private, this percent comes from in-kind.

Marcia: I think that's why the federal government likes it so much is because it is that monster that we're trying to eat but no other state even tries and the fact that we all get together.

Dave: We did all this in stage one.

John: But didn't have any Medicaid.

Eric: We're still building on the SIG one model, what we are doing is augmenting, we knew there were some things that are missing.

Jeanie: Again, I don't want to be a negative Nellie but is there any danger of painting a picture that, oh we have all these resources so we don't need any more?

Barbara: What is the purpose and how to use it is another matter. Because depending on who we are going to with it, they might oh you've got tons of money we want some of your money as opposed to showing effort that's going into. And it's great information.

Eric: And I think that's one reason why treatment versus prevention distinction can be really important. Medicaid says we're going to spend enormous amounts on treatment, we're not going to spend so much. That ratio itself will be telling and politically important I think.

John: For \$3 in treatment, we spend a penny.

Eric: Right. The public health argument has now come into question but for every \$1 on prevention in public health we're supposed to save \$7 on health care costs. That's the ratio everybody throws around. There was a recent article in the New England Journal of Medicine that said that was hogwash.

John: There's a California study on Prop 36. For every \$1 they spend on substance abuse for Prop 36, prisoners, they save \$4.50 for those prisoners. I'll send you the reference.

Eric: OK. So clearly we still have a lot of work to do on this one and we've got lots of people's e-mails so we'll send this out as a separate e-mail. We're going to do this careful so we keep stuff in your inbox, so we'll send out chapters so you know to delete it when you're done and you can go on to the next one so it'll be like a task list. While we are in planning for the deadline we prefer to get as much of this done upfront so when the UCR data, whenever it comes it, we can focus on that. So the sooner we get your feedback the better. And especially this kind of stuff because I suspect to add something we're going to have to chase it down and find the right person.

Marcia: So as I'm understanding, there are only two things you're waiting for to complete the epi. You're waiting for the UCR and then you're going to add the Medicaid information, correct?

Eric: And maybe the survey.

Marion: Those are the data sources, yes.

Marcia: Thanks.

Eric: Anything else?

Marion: Actually, yes. I just want to mention that we sent out the local drug fact sheets that we have gotten so far, I think 5 or 6, so if you have any comments to them – I had a couple of e-mails saying some of them contained quite a few typos so we'll provide that feedback to the community and let them know. If there is anything else that you want to mention, suggest, just either talk to me or send me an e-mail about that.

Eric: Well, one question which we talked about last time was exactly what would be the format in the report. Some of them had gone to great lengths to do graphic designs and make them pretty and that's fine. I'm kind of reluctant now after looking at all the effort that went into doing that just to change that. So my thought is to take the survey data is the way I'm envisioning the chapter, start talking about in general terms and then say here's the local fact sheets and then just slice in the documents so basically it would appear as they were created.

Jeanie: I think it gives it some local flavor.

Marion: I think so too.

Marcia: Exactly. I like that.

Jeanie: I think they did a great job on that.

Eric: Because originally I think we had talked about meshing them and making them all more edited together and I just wanted to make sure everybody was comfortable with that choice. That was easy. And Ruth has new business.

Ruth: Yes. I wanted to share with you questions that we are asking the YRBS to add to their survey instrument this year. I only have six copies. As you might remember the IPRC is collaborating with the Department of Education this year to administer the YRBS survey and they have allowed approximately twelve questions to be added to surveys. And so these are the twelve that we've identified and want to show them to you and solicit any feedback from you. If there's one that you don't see here that you'd like to see, speak up. We're interested in hearing from you. Most of these items came from YRBS's that are administered in other states, so they are standardized and we didn't just pull them out of the air. Some of them we're asking because of programs that we operate at our centers, such as the Tobacco Retail Inspection Program, that's why we're asking people if you tried to buy cigarettes during the past month were you asked to show proof of age. And the alcohol piece too is just starting up too now with the survey for alcohol compliance so we asked that about alcohol as well. We added items about prescription drug use, over the counter drug use, number 9. We felt like one of the things that has been missing is some information about accidents and unintended consequences, since that's one of the leading causes of death for this age group. And we did suggest adding three gambling items because we do operate the Indiana Problem Gambling Awareness Program as well.

Marcia: Is this targeted at 12-18? Is that the age?

Ruth: Well, it's actually grades 8, 10, and 12.

Eric: On number 9, I'd be hard pressed to figure out how to interpret that? What is an unintended consequence here from this point of view? Are you think it'd be kind of like an accident so it'd be an unintended consequence for your physical well being? You might need a little more description or definitions. And unintended consequence could be, oh I just got married.

Jim: I was thinking more, I just got grounded.

Ruth: Accident is the word we think youth might be more likely to understand. On the other hand, unintended consequence is the language that is used by the CDC in their reporting.

Eric: But is that representing a collapsing or aggregation?

Ruth: It is an aggregation.

Eric: That's where I would avoid the use of aggregated term because it really is capturing a lot of stuff, I think going with accident alone might be a better way of capturing.

Barbara: We were thinking unintended injury instead of accident, we were thinking kids would understand better unintended injury.

John: I'd say unintended health consequences that's negative, because pregnancy could occur but it's not an accident.

Barbara: We thought that may come to mind, without asking the question implicitly it might be one of the many things, you fall on your face.

John: It would be an unintended negative health consequence.

Barbara: OK.

Eric: The only bad thing about that being so broad is trying to understand. But if you want to disaggregate that, if young women are thinking about it in terms of pregnancy and young men are thinking about falling off their motorcycle.

Ruth: We can't disaggregate it.

Eric: So I guess the question I was always asked is what are we going to learn from that question the way it is worded. Is this just to come up with a point prevalent estimate of unintended injury or physical health consequences?

Barbara: We might find that people who are using substances, a huge percentage of them have some negative consequences.

Rick: I think it's appropriate for me to say, we just last week looked at where substance abuse is a secondary diagnosis and it's mainly hospitalization and I was amazed at how many, and then we looked at what were the primary diagnosis were associated with. Of course there was a lot of alcohol related diseases and behavioral, schizophrenia, those were big ones. But I was amazed at how much injury, the injury diagnosis were first and substance abuse was second.

Eric: I'm not.

Rick: I know it makes sense, but to see it.

Eric: Native Americans have the highest substance abuse rate, the leading cause of death per males until they're 50 is injury. I mean, there's a strong relationship there. Your question implies to me that you want to be able to compare between those that drink and those that don't, then having the tag as a result of substance abuse although there might be other questions in the YRBS that talks about injuries. So I guess one questions would be is do we really need this if we know what their alcohol use is and we also know they are having other injuries, wouldn't you be able to do that without asking this question?

Ruth: We'll look at it. I can't answer that question now.

Eric: The only other thing that, I don't want to dominate the conversation, but the one thing that popped out at me was social host thing. It might be good to add a question about that because I know that's going to be a hot topic in the next year or two and so having data on how they got it...

Marcia: You know it's interesting though because that phrase is not picked up. Do you know what that is, social host?

Ashley: No.

Marcia: See?

Ruth: It's already on there.

Eric: Oh, it is?

Marcia: It's interesting because youth, they did a survey I think it was in Lake, I don't remember what county it was now, and the social hosting was almost a nonexistent response.

Eric: They use the word differently.

Marcia: That's right. And that's what I said, do you know what social hosting is. I think some of it is just getting the right wording in. Social hosting is parents having a party and providing alcohol, so they're hosting a party.

Ruth: I think the way we phrase it is sort of like, where did you get it last time, who provided it.

Jim: Is that question included? Because that was one issue I was asked.

Ruth: It's in there already.

Jim: Where did you get your tobacco or where did you get your alcohol? OK.

Ruth: They're already in the state survey.

Jim: Good.

Eric: Well, I guess the reason I got prompted was when you ask them at my home, other persons home, the questions I would ask there is, were any adults there, which sort of gets a little different, it's not just the source but it's whether or not adults were aware of underage use, because Lisa and I had this conversation about this when we were at the legislature. And that was a question about whether, it's not just their sources but are they being allowed to drink when there's adults around.

Ruth: Or you could make it one of the options, at my home with adults present, at my home with no adults present, at another person's home with no adults, with adults.

Marion: And I don't know that's if necessary but do you want to add or define adults as somebody 21 or over? Because generally we think of 18 and over as an adult but it still would be illegal for alcohol consumption.

Eric: My big brother could be there but my mother's not there.

Dave: Did you have a question?

Ashley: It's just about number 1, I was wondering how that is relevant. What kind of alcohol they're consuming in number 1.

Ruth: Yes, that's the first one, right. What type of alcohol do you usually drink?

Ashley: I'm not arguing or anything but how is that relevant to rest of the information?

Ruth: You're wondering what the relevance of that item is?

Ashley: Yes. I know if I were taking this survey I would be like why are they asking me that? What difference does it make? You know what I mean?

Ruth: Yes. Well I think you could look at it by whether it's males or females, what age groups and it could give you an idea on how to intervene.

Jeanie: I would guess that it's whatever in the world I can get my hands on.

Ashley: Yes, especially kids our age, they're drinking to get wasted, for the feeling to get completely gone and I doubt the next day they wake up remembering oh I drank some Smirnoff Ice, you know what I mean?

Jeanie: And it may be whatever Mom and Dad likes to drink and is around.

Ashley: Right.

Ruth: So you are questioning whether that one should even be included.

Ashley: Right.

Ruth: OK, that's good. Thank you. I know one of the major responses we get on our ATOD survey about what are the reasons for your drinking, one of the top reasons is for the taste. I mean, that kind of flies in the face of what you are saying, you don't really care. But at the same time we know that the manufacturers are marketing flavor beverages so that it tastes good.

Eric: And those really work for young women.

Ruth: Absolutely.

Eric: I mean, I'm sort of with you. It's interesting because one of the things is how well the marketing messages that they are working on are getting. Because there really is a gender difference and that might impact how you approach it.

Jim: If the first one tastes great, is the next one less filling? No, I did want to make a point. Once you are done revising this, you may want to take advantage of your After School Rock program and do some pilot testing and after the kids answer the questions do a little cognitive interviewing and ask them what they were thinking, what does that phrase mean to you, unexpected consequences, to make sure that they're understanding the way you hope they are.

Rick: Well, is there still the beer versus hard liquor myth, I mean is that still out there?

Barbara: What is the myth?

Rick: Like my stepfather wasn't an alcoholic because he drank only beer.

Eric: Yes.

Rick: I'm just asking the question because kids have the perception that oh, it's just beer, it's not so bad.

Eric: What is the stuff, I'm stupid about this, but there's that Red Bull XXX that actually has alcohol in it?

Ruth: I thought that was an energy drink of something.

Marcia: That's what they want you to think.

Jim: You'd have a lot of drunk athletes.

Dave: It's combining the drink

Eric: That's right. I was watching something that was talking about the marketing of these things and how they'll put them side by side and so the kids are actually pulling them.

Marcia: It was Lisa Hutchinson and we were up in Lake County, which actually wouldn't be a bad thing to maybe have her come in and do her little spiel.

Eric: Yes, she reported on a case where a father had let his son go into a convenience store to get essentially what was a Red Bull who walked out with the alcohol version of the Red Bull because the packaging was so similar and the father was just livid. He didn't even know they did this.

Dave: At the Red Bull sales places if you bought it separately, you could buy a Red Bull for \$3 and you could buy the vodka to go with it.

Eric: Which actually you see at the bars a lot. People do it all the time. But what I didn't know was now they're packaging it together.

Marcia: Just kind of an FYI, on November 7th at the Radisson at the airport, and we've invited all the communities, Lisa Hutchinson is doing social marketing and I believe there will be some of the components in there. She has opened it up to anybody who is interested so that's something if you'd like to attend, I would e-mail Lisa Hutchinson.

Dave: That's part of the ICAN conference. We're paying for it through part of our contract with them.

Marcia: Oh, we're supporting – DMHA is paying for that. I'm sorry, I thought it was Lisa.

Dave: No. Also, if people are just doing new business here, with the PRC we have launched a new prescription and over-the-counter drug website so we'd like for folks, it's still a work progress, so if folks could take a look at that and give us any comments on what we have there and what we can add. It's keeprxsafe.com.

Dawn: I wanted to ask couple of things quickly about questions 5 and 6 on the prescriptions. One is will this age bracket know what an oxycontin, percocet, adderall and ritalin, just to ask if those are common terms that they would understand what those are?

Ashley: Well, I know this sounds pretty sad but there's a lot of these drugs in songs that a lot-a lot of kids are listening to so I'm sure if know one or two of them it would make sense to them.

Dawn: And the second part when you are asking with a doctor's prescription are you wanting to be specific, say that the recipient had the doctor's prescription or are you just saying there was a doctor's prescription involved.

Eric: That is really important because it goes to access. That will tell us more.

Ruth: We need to specify what we mean, we mean that the respondent had the prescription.

Dawn: And even then you can add the possibility did you go to one of these online sites and fill out a questionnaire and the doctor gave you a prescription.

Jeanie: Don't we want to know when they are taking it without a doctor's prescription?

Ruth: You are right. That should be without.

Jeanie: Which removes that problem.

Eric: But then there's the other issue, are they abusing prescriptions of their own versus are they stealing it out of the medicine cabinet. And so you could have a prescription, something without a prescription but you don't necessarily know what the source was.

Jeanie: Would it be better to word it in terms of how many times have you used these medications...

Marcia: In a way other than prescribed.

Jeanie: Right. Exactly. It will be an access issue.

Dawn: Then they'll say that's what it says on the label.

Jim: The way the question has always been asked in the federal surveys is have you used for non medical purpose. And if the question is yes, well then did you use it to get high.

Ruth: But a lot of these kids are using these things for the same reason adults are from my understanding. You know, to get to sleep, to stay awake, to lose weight, to kill pain and so they could be using it the way it was intended but it wasn't prescribed to them.

Dawn: One other one that we are seeing is people are using provigil, which isn't a controlled but it's a drug that is used to keep people awake. And I'm seeing that abuse in the adult community more and more. They actually tested it on airplane pilots in the Army and it keeps them awake for extended periods of time to be able to concentrate. So I know that one is used a lot more.

Jeanie: How do you say that again?

Dawn: Provigil.

John: Provigil. But it's not only on airline pilots, medical students, dental students...

Dawn: They're all using it but what we were told is it was tested within the Army, or rather within the Air Force, that's where they did some of their medical testing with this. But it's not controlled but it's a substance that I think is being abused because of instant caffeine, I guess their getting a 'script for that.

Ruth: Do you have any suggestions on how to word this question about taking a prescription drug without a doctor's prescription?

Dawn: Can we work on it and get it back to you?

Ruth: Yes, that would be wonderful.

Eric: Do you want to send this to use electronically and then we can distribute it get feedback that way?

Dawn: And we could get these students to work on it so we get the right phraseology.

Ruth: Thank you.

John: I'm glad you guys are here.

Eric: And also Lindsay and Ashley came in late, so these are our student representatives officially, changed over since we've changed school years.

Marion: I have Lindsay on my list. Don't you receive reminders, SEOW materials?

Lindsay: I have you on my list. Maybe I have a wrong e-mail address.

Marcia: But Ashley's new.

Ashley: I'm new.

Marion: And I've got her e-mail address now.

Eric: Do you want to say a little bit about yourselves?

Lindsay: I'm a junior at Hamilton Southeastern High School, I have been a part of the Governor's Advisory Council since freshman year, and I play tennis a lot.

Ashley: I'm Ashley, I'm a senior at Hamilton Southeastern, and I'm football manager and I spend a lot of time doing that. I wasn't sure about this when Lindsay told me about it so I came to the meeting and it's pretty interesting. I like hearing about all this stuff and having a say in stuff like this. It's really interesting. I like doing this. It's fun.

Eric: Cool. Well, we're glad to have you. Any other new business?

John: Oh, one business, your prescription drug report has received some form of notoriety at the federal level. I gave it to Nick Reuter on Tuesday and he said this is good stuff. It also helps us in terms of what we're trying to do, I'm glad you guys are here because what we are trying to do is, have you been contacted by Nick on the ethnography study?

Eric: I have a proposal to give you before you leave.

John: Oh great.

Dave: The prescription drug report was also put in all the bags at the conference.

John: So it was pretty good stuff. Actually, they're going to do an ethnography study on why people are coming into Indiana to get methadone treatment. And it will do I guess four clinics? Two in Indiana.

Eric: We proposed four of each actually. I'll show you the proposal.

Marcia: Who's doing it?

John: They are.

Eric: Well, not me. Lyndy is going to be the chief field officer of that. She's our field office person, she's like queen of interviewing. She can get anybody to talk.

Dawn: Can I get a copy of that study?

Eric: I brought a few copies.

John: The end of the report will be to take the information gained from the ethnography study back to the states where people are coming in and to give them the reason why they even need to increase the number of services they are currently providing. Or, help their consumers who come to Indiana pay a higher cost. We got information from you guys that physicians across the country can access the Inspect Program, and that will help the clinics in Ohio, Kentucky, West Virginia to check on other drugs that these patients are coming in, so it's a good thing. I'm glad you guys are working with us because we'll really get some stuff to report.

Dawn: And I think this information is very valuable because the front line pharmacist who has accumulated it and that has to spend the time gets very frustrated if they think they're doing something they don't think anyone is doing anything with. So if we could go back and share that information with those folks, this is how the data is being used and we're looking at it and it really is being used, it works out much better.

Eric: And did you want to update us on the proposal to use the inspect data that was part of the epi profile? I know you said you wouldn't probably have access to until, but I thought we were going to get a proposal before the board here soon?

Dawn: Possible but I don't know what is. I'll have to just check with Marty or have those guys check, I know they turned over the person who was in charge of it so I'm not sure where it is.

Eric: OK. But just to update everybody, we have given them a proposal in writing to use inspect data for the epi profile but the timing was such that the board meets when, every other month?

Dawn: Oh, that group meets next Friday.

Eric: I thought it was around the end of September. But anyway, they're going to give us ultimately permission to use these data. And we're pretty confident we're wouldn't be able to do it in this year's epi profile but this is laying a brick in our foundation for other data sources for the future.

Dawn: Are you going to go present to that group?

Eric: I haven't been asked to.

Dawn: I'm going to go down and talk to them, let me see. To me, it'd make more sense if you went and presented.

Eric: Because I volunteered to do that but I just hadn't heard anything.

Marcia: Just kind of an FYI as well, all of fact sheets that were put out by the SEOW at the last Governor's Youth Council meeting, the youth put those together in the packets and they have disseminated 850, so instead of sitting up in our office like they have for nine months they are out hopefully in community hospital waiting rooms, in deans office waiting rooms, guidance counselors, things like that where youth and other community population would be sitting waiting, picking up magazines that would hopefully pick up the SEOW fact sheets and will increase awareness as to what we found in our reports in the spring.

Ashley: Are you guys in control of the drug testing at the schools?

Eric: We have no control anywhere.

John: I'll tell you what, the next meeting we'll make sure Jeff Barber is here, you can ask him that question.

Ashley: Because in our schools when do drug testing, the random drug test, you only get tested for it if you're a driver and you have purchased a parking pass for the school. Because you have to fill out the random drug sheet/parking pass sheet. So, I'm kind of naughty but I haven't bought a parking pass yet because I just haven't gotten around to it. I've been driving for a year at school and I haven't been drug tested and then freshman and sophomores are also using drugs, it's not just the older people, I mean a lot of them are doing it and they're not getting tested because they don't drive yet

Marcia: We'll make sure Jeff's here next month.

Eric: Yes.

John: I thought athletes also had to be drug tested.

Ashley: Athletes, that's true.

Lindsay: Yes.

Ruth: Is this in Owen County?

Ashley: Hamilton. And they don't have to be, it's just random.

John: Do you want to be?

Ashley: I'll be clean so it doesn't matter, but I'm just saying.

Eric: OK, well if there is no other new business?

Ruth: Just it would be nice to learn more about the inspect database, maybe you could put that on the agenda some month when we meet. We don't know, a lot of us don't know anything about the inspect database and we'd like to learn about it.

Dawn: Oh, alright. I'm not sure I can be here next month, but we can look at November, maybe I can do a short presentation, or maybe I'll get somebody from the Bureau to come up and talk to you guys about it.

Eric: Actually, let's put it on the November agenda and in October hopefully finish the report and get as far along as we can. So, we'll probably have more time in November. Oh, also just as an FYI, Carlie had asked us to give dates for future meetings. So, we've asked for monthly meetings, July and August – or July and November and then every other month, January, March, May, and then we start up in July so it's not going to be every month because that's been the pattern we had and it seems to work. Any other business?

John: Yes, I better tell because I know people have been hearing. I am retiring. My last day on job will be November 28th. I think I'll be here for the last week in November and then I'll be retired for good from Indiana. I'll be the Director for LA County Substance Abuse Administration, which is the fourth largest substance abuse program in the country. And the other counties that are just as large as LA which is right below it is Orange County and San Diego County. It's 8 million people. It's going to be interesting, I've already started getting information from them. One of the things that just passed I guess, is being considered in California health right now is the bill called NORA, which is Non-Violent Offender Rehab and it creates two different levels of correction in departments, or secretaries, under the governor and by its provisions for the children who are either youth who have substance abuse problems or incarcerated or about to be incarcerated, as a result of substance abuse problems. But it'll raise about \$490 million dollars with an additional tax on people who live there. The tax is only appropriated, only goes to people who make \$150,000 or more.

Jeanie: Which in California is probably plenty.

John: Really, I looked at the average income in Los Angeles and the average income is \$38,000 per household.

Eric: There are a lot of poor people in southern California. It's not all Hollywood.

Rick: It's still higher than Indiana.

John: So, it's been fun. I'll see you guys. I leave you in better hands than when I found you.

Eric: Congratulations. So, we are officially adjourned.

Meeting adjourned at 11:15.

The next SEOW meeting will be held on 10/17/2008 from 10am through 12 noon, at the IGCS, conference room 1.