
WV's Partnership to Promote Community Well-Being

Epidemiological Workgroup Meeting Notes

June 23, 2005 ♦ 1:00 – 3:00 p.m. ♦ WVPRC

Members Present: Penney Baughman, Dan Christy (representing Joe Barker), Jim Elzey, Steve Heasley, Helen Snyder

Members Absent: Ron Childress, Mary Emmett, Larry White

Staff Present: Michele Bush, Wayne Coombs, Andy Whisman

Guests: Paula Flaherty

Meeting Minutes from March 31, 2005

The minutes were reviewed and discussed. Dr. Mary Emmett has agreed to join the workgroup but was unable to attend this meeting.

Although Ron Althouse was suggested as a workgroup member at the previous meeting, particularly in regard to the possibility of developing an adult ATOD survey. Dan Christy reported having spoken to Dr. Althouse recently and that if the Partnership wanted to pursue an adult consumption survey that the West Virginia University Survey Research Center currently has the capacity to provide assistance.

Workgroup Members

The Partnership By-Laws require 3 Partners on each workgroup. Fred McDonald has resigned from the Partnership leaving Joe Barker and Steve Heasley as the Partners on the Epi Workgroup. A third Partner needs to be recruited to join this work group. It was decided that Steve Mason will be contacted about becoming a workgroup member.

To Do: Ask Steve Mason if he would be interested in becoming a member of the Epi Workgroup. – **Andy Whisman**

Make a motion at the Partnership meeting to add Steve Mason as a workgroup member. – **Steve Heasley**

Revised Timeline

CSAP has indicated that we can utilize more targeted as opposed to competitive funding during the planning year. The Epi Workgroup will look at archival data and data obtained through community assessment surveys to make recommendations to the Partnership. Our plan had to be revised and therefore the time line for rewarding the planning grants has been modified. The timeline is still tentative based on CSAP approval of our plan.

Andy provided a brief overview, for the new members, of the SPF SIG grant. He indicated that \$1.6 million will be re-awarded to communities. CSAP wants this to be a

data driven process as opposed to competitive. Analyzing the data and making recommendations to the Partnership is the primary function of the Epi Workgroup. During the planning year communities will supplement the data with local level data. For example, the Department of Education may share school level data from the PRIDE survey with local communities, whereas only county level data is available from the Epi Workgroup. .

SASI Indicators

Many additional indicators have been added. Data collection has become more focused on consumption and consequence data. Risk factor data was being used and we have had to back track for the consumption/consequence data. Because of small number issues, many indicators represent data aggregated over time and geography. For example, Adult Alcohol Use in 2001 from the BRFSS is actually aggregated from 1999-2003. In order to see if there has been a change or impact we would have to wait up to 5 years to do a statistical analysis.

Assessment of High-Risk Counties

A county level risk assessment has been started utilizing a comparison of county data to state data. Level of risk is based on the county's percentage above the state level. Originally county indicator data was organized on a three tier basis (0 to 25%, 26 to 50%, and >50% above state rates). To simplify the risk assessment for communities indicators will be categorized in 2 tiers; 1 to 25% and >25% above the state rate.

The question is – What criteria do we want to use to assign risk levels counties? The workgroup will need to give this question further consideration as county profiles are derived from the indicator data. Once priorities are established and high risk counties are identified, more detailed analysis can look at demographic characteristic, e.g., high risk age groups, etc. and other mediating factors.

Treatment Data

Treatment indicators in the current data set were obtained from the 2003 National Survey of Substance Abuse Treatment Services (N-SSATS) administered by SAMHSA. This is a point prevalence survey of treatment facilities, and county estimates derived from the survey depend on the county of location of facilities, and are aggregated according to the 3 to 5 county catchment areas of the WVPRC Community Development Specialists (CDS)

The problem with this data is what is it really a consequence of? What are all of the contributing factors? Local areas would need to be engaged to determine what is really happening.

Other areas of concern include:

- high level of treatment can be due to a low level of tolerance in that community
- low level of treatment can be due to treatment being unavailable in that community

To Do: Send email to group members with the link for state level data available on the SAMHSA website. – **Andy Whisman.**

APS Healthcare Data

Treatment and evaluation services data however, there are the following limitations:

- Medicaid and Behavioral Health funded people only—not private treatment facilities
- Co-occurring incidents (substance abuse and mental health) lead to higher re-admission rates. However, treatment estimates may be skewed—i.e., a person with a co-occurring MH/SA diagnosis, but what is reported is dependent on the specific treatment (MH or SA). As well there is a lack of evidence-based programs for co-occurring issues.
- Data is available primarily just for folks in treatment—there may be many untreated in the population.
- Medicaid and Behavioral Health monies also go to contract agents and 13 comprehensive facilities.

There is not very good data on illegal drug consumption among WV's adult population. Is it possible to get data on this from APS? It is available, but it would be just best estimate. This information is often underreported. Another problem is that this data is often just a snapshot view because the reporting changes.

Future Meetings

Wednesday, September 28, 2005

(Time and location to be determined)