Statewide Epidemiology Workgroup
MINUTES

DATE: **April 26, 2018**
TIME: **10:30 a.m.**

	Meeting	*Videoconference*
LOCATION:	**Division of Public and Behavioral Health** **4126 Technology Way** **2nd Floor Conference Room** **Carson City, NV 89706**	**Southern Nevada Adult Mental Health Services** **6161 W. Charleston Blvd.** **East Hall Conference Room** **Las Vegas, NV 89146**

TELECONFERENCE: **1 (416) 655-0002 US Toll / Access Code: 809 623 141**

BOARD MEMBERS PRESENT
Julia Peek, Chair, Deputy Administrator, Department of Public and Behavioral Health (DPBH)
Eric Ohlson, Washoe School District
Ihsan Azzam, DPBH
Ingrid Mburia, DPBH, Maternal Child Health Services
Heather Kerwin, as proxy for Jennifer DeLett-Snyder, Join Together Northern Nevada (JTNN)
James Kuzhippala, Truckee Meadows Community College
Kathryn Barker, Southern Nevada Health District (SNHD)
Marco Erickson, DPBH
Pauline Salla, Director of Juvenile Services, Humboldt County, and Frontier Community Coalition
Richard Egan, Office of Suicide Prevention
Stephanie Asteriadis Pyle, Center for the Application of Substance Abuse Technology (CASAT)
Judy Henderson, Nevada Coalition to End Domestic and Sexual Violence
Trey Delap, Group Six Partners
Wei Yang, Nevada Center for Health Statistics and Information, University of Nevada, Reno (UNR)

BOARD MEMBERS ABSENT
Gwen Taylor, ACCEPT
Jim Jobin, Vogue Recovery Center
John Fudenberg, Clark County Coroner
Yenh Long, Board of Pharmacy
Ying Zhang, SNHD

STAFF & GUESTS PRESENT
Kyra Morgan, DPBH
Raul Martinez, SAPTA
Jessica Johnson, SNHD
Kasey Chu, New Frontier
Dinita Smith, Adelson Clinic
Bob DeMarco, DPBH
Lea Cartwright, Nevada Psychiatric Association
Janet Porter, Center for the Application of Prevention Technologies (CAPT)
Victoria LeGarde, CAPT
Bill Kirby, SAPTA
Meg Matta, SAPTA
Brandon Delise, SNHD
Natalie Powell, CASAT
Katro Haynes, Adelson Clinic
Linda Lang, Nevada Statewide Coalition Partnership
Joan Waldock, SAPTA
Jen Thompson, DPBH

1. Introductions, Announcements, and Roll Call

Ms. Peek opened the meeting at 10:34 a.m. She determined a quorum was present.

Ms. Kerwin announced that JTNN produced their substance-related deaths data using the medical examiner's data for Washoe County. It was done for all northern Nevada coalitions. The report can be found on JTNN's website and is available here.

Ms. Henderson mentioned that the Nevada Coalition to End Domestic and Sexual Violence posted an online toolkit for providers, organized by profession.

Ms. Mburia said reported on birth outcomes for the United States. The resource document can be found here. Data can be found here and here.

Mr. Erickson announced there would be a federal site visit audit February 2019. He pointed out that the federal team emphasized SEW and the Multidisciplinary Prevention Advisory Committee (MPAC) working together to advise SAPTA on its priorities and strategies for prevention dollars. He reported that SEW would need to submit a report to MPAC on Nevada's problems and what the State planned to do. MPAC can then make decisions. Ms. Porter offered CAPT's assistance. Mr. Erickson pointed out a Block Grant revision asked for SAPTA's process, which includes SEW and MPAC. Ms. Morgan asked what the timeframe was for updates to the epi profile. Mr. Erickson replied it would need to be presented to MPAC before July and would need to be reviewed for recommendations before October. Ms. Peek said full epi profiling was typically done every three to five years. In intervening years, mini-profiles on special issues should be done—opioids, perinatal substance use, and marijuana could be covered. Mr. Erickson asked her to look at data regarding opioids and data from the STR project to compile what is at the forefront. The information should focus SAPTA's priorities. Ms. Peek pointed out that a great deal of money was going to opioid efforts and wondered if MPAC should focus on marijuana and meth. Mr. Erickson said SAPTA was asked to add opioid goals from the STR Grant into the Block Grant. Their goals broad and they presented strategies for how to measure and achieve them. Dr. Azzam suggested, in light of recreational use of marijuana being legal in Nevada, a limited needs assessment and a baseline assessment of where the state was at the beginning of this. It could have a limited scope to establish the use of marijuana now, then be updated every two or three years to see what has happened. Mr. Yang said the Youth Risk Behavioral Survey would have five marijuana questions from 2017, right before recreational use was legalized and that pregnancy risk questions have been added. Ms. Smith said Dr. Adelson has done research which her clinic can make available to the workgroup. Ms. Lang pointed out that some doctors are gathering marijuana and pregnancy data at the local level. A doctor in Churchill County found that 60 percent of those pregnant were using marijuana, indicating an uptick of marijuana use during pregnancy. She added that the Department of Taxation produced an educational flyer that can be placed in physicians' offices. Ms. Peek pointed out there were priority cut outs within the Block Grant—for pregnant women, intravenous (IV) drug users, Human Immunodeficiency Virus (HIV), and primary prevention. Mr. Erickson said this information would drive MPAC to make a primary prevention recommendation. Ms. Peek suggested forming a subcommittee to put together the epi profile before MPAC meets in July. SEW should meet in June to vote on the epi profile before sending it to MPAC. Those interested in meeting with the data team to discuss what can and should be included were invited to volunteer. Ms. Porter said CAPT could assist with the report and provide technical assistance to prepare SAPTA for the federal site visit. Mr. Erickson and Mr. Kuzhippala volunteered for the Data Profile Update Subcommittee, with Ms. Thompson serving as a non-voting member.

2. Public Comment

There was no public comment.

3. Approval of Minutes from January 18, 2018 Meeting

Mr. Kuzhippala moved to approve the draft minutes. Dr. Azzam seconded the motion. The motion passed. There were none opposed and there were no abstentions.

4. Discussion and Approval of Bylaw Revisions

Ms. Peek went through changes that were needed in the bylaws:

- Leadership would become a chair elect, chair, and past chair
- Article 2.1—change Mental Health and Services Division
- Article 3.2
    - 3.2.1 Remove, covered by MPAC
    - 3.2.2 Remove, covered by MPAC
    - 3.2.3 Remove, covered by MPAC
    - 3.2.5 Remove, covered by MPAC
    - Keep—look at data-driven outcomes

There was consensus on the changes. Mr. Martinez pointed out that amendments to bylaws need to be submitted in writing to the Chair 14 days in advance of the next meeting, at which members would be provided the bylaws and the changes to vote on.

- Article 4.3
    - 4.3.1 ". . . by making a nomination to SAPTA administrative staff or the Chair."
    - 4.3.1 ". . . by nomination by SEW members, the Chair, the Chair-Elect, or SAPTA administrative staff."
    - 4.3.2 ". . . to either the Chair, the Chair-Elect, or SAPTA administrative staff . . ."
- Article 4.4
    - 4.4.1 "The SEW shall elect the Chair-Elect . . . The Chair-Elect will become the Chair the following year for one year. The Chair will become the Past Chair for a one-year term. The individual will serve for three years total."
    - 4.4.2 This should be modified to say that the Chair-Elect will serve in the Chair role should the Chair be absent.
    - 4.4.3 "If for any reason neither the Chair nor the Chair-Elect is available for a meeting, the Past Chair may serve in that role."
    - 4.4.5 "When the position of the Chair is vacant, the Chair-Elect shall assume the duties prior to their year."

Article 4.4 will be modified for consistency.

- Article 4.5
    - 4.5.1 "Members or proxies for the members of the SEW . . ."
      "… may forfeit their seat on the SEW."
    - Add—proxies will be noted in the minutes.

In reviewing attendance requirements, she mentioned those who had missed 50 percent of this year's meetings. She said they would be contacted to find out if they wanted to keep their seats on the workgroup.

- Article 4.7
    - 4.7.1 "Co-chairs" will be amended
- Article 5
    - ". . . including the Chair, Past Chair, and Chair-Elect shall have one vote."
- Article 7
    - 7.1 "SAPTA and Central Analytics . . ."
- Article 8
    - 8.2 Remove, as "quorum" was defined earlier
- Article 9
    - 9.1 "Either the Chair or Chair-Elect . . . can appoint subcommittees . . ."

Mr. Yang moved to approve the Data Profile Update Subcommittee of Mr. Erickson and Mr. Kuzhippala, with Ms. Thompson as a non-voting member. Dr. Azzam seconded the motion. The motion passed with none opposed and without abstentions.

- 9.2.1 Delete "A subcommittee shall remain active until the work is completed."

- Article 10
  Remove, as it is noted in Article 7

Ms. Pyle moved to accept the changes and to present the final draft at the next meeting to vote to approve. Mr. Erickson seconded the motion. The motion passed with none opposed and none abstaining.

5. Elect the Chair
Mr. Delap moved to table this item until the next meeting. Ms. Pyle seconded the motion. The motion passed with none opposed and none abstaining.

6. Suicides in Nevada
Mr. Egan reported on suicides in Nevada, focusing on those who died of a substance-use issue. He stated that 44,965 in the United States take their lives in a year. Approximately 51.1 percent of those suicides in the U.S. used firearms. Historically, suicides in Nevada were completed with a firearm 57 percent of the time. In 2014, that number moved to 54 percent; in 2015, to 52.5 percent; and in 2016, to 51.3 percent.
Suicide rates have fluctuated in Nevada, moving downward until something occurred. Prior to and including 1999, Nevada had the highest suicide rate in the nation. From 2000-2010, Nevada fluctuated from number 1 to number 5; in 2011, Nevada was number 6; in 2012, number 7; 2013 and 2014, number 6; in 2015, number 11; in 2016, number 5. Between 2015 and 2016, the number went from 558 to 650 people who committed suicide.
Mr. Egan speculated as to what could have caused decrease in the number of suicides by firearms:

- Suicide by medications or opiates may have gone up.
- Washoe County hired a new coroner. He said it was possible that identification of suicides changed—single-occupant car accidents, gun cleaning/hunting accidents, and accidental overdoses may be suicides.
- Maybe more drug overdoses were identified as suicides rather than accidental overdoses.

Mr. Egan pointed out that Idaho has a lower suicide rate, but their coroners list what families want put on death certificates. Once he has access to Ms. Morgan's dashboard, he can study the statistics better, and will look at the data to either prove or disprove his theories.
Mr. Egan reported that 63 percent of suicides in Clark County have involved drugs, alcohol, or a combination thereof. He pointed out that suicide attempts occur during the hangover phase. He added that 25 percent of youth suicides across the nation involve alcohol for those ages 17 and under. In Nevada the number one cause of death for 8 to 17-year-olds is suicide. The number two cause of death for 18 to 48-year-olds is suicide. While alcohol, drugs, or a combination was a factor in at least 63 percent of those, he believes they are involved in more, just not on board at the time. Nevada has more suicides than automobile accident fatalities and homicides combined. He pointed out that Nevada has done much to prevent automobile accident deaths and homicides ,and that more should be done to prevent suicides. The Nevada Coalition for Suicide Prevention maintains a website at www.nvsuicideprevention.org that has trainings for the public posted. The State's webpage is www.suicideprevention.nv.gov. The trainings on the State webpage are either national or worldwide evidence-based programs that have been proven to enhance the ability of any community member to engage someone with thoughts of suicide. Some courses teach how to connect a suicidal person to an appropriate resource, others teach how to do the intervention, assess the risk, and build the safe plan with them.

In 2016, Nevada lost 19 youth ages 17-and-under to suicide. Mathematically, that would mean there were 1,900-3,800 attempts in that age group. Across the lifespan, there is a 25-to-1 ratio of attempts to actual suicides. Among the elderly, there is a 4-to-1 ratio of attempts to suicides. Nevada's elderly community has had the highest suicide rate in the nation every year, except for 2013 when 65-years-old-and-older were second-highest rate in the nation and in 2015 when that age group's suicide rate was fourth in the nation. It is his belief that Nevada has the infrastructure in place to make a difference. He would like to see as many people trained in suicide alertness as are trained in CPR.

He reported on things that are recognizable in hindsight. Around 90 percent of people reached out for help before ending their lives. The number of the 10 percent that may have reached out to a stranger cannot be known. 25 percent of the elderly who end their lives visited a doctor the day they ended their lives. The stigma of suicide steers us away from this conversation. If these people went to the doctor the day they ended their lives, they had to have given clues that they wanted help. In our society, 40 percent of the people who ended their lives saw a medical professional within 30 days of their deaths. Nevada has emphasized training, education, and resources. There are national strategies for suicide prevention from 2012 and state guidance for suicide prevention that was rewritten in 2017.

Mr. Egan said a report from 2015 said between 2000 and 2014 the suicide rate across the nation increased by 25 percent. Every state's suicide rate increased, except Nevada's. Nevada's went down by 0.5 point. It could be a result of the trainings that were available or legislation from 2015 that now requires behavioral health professionals to take suicide prevention training. Assembly Bill 105 passed in 2017, making it mandatory that all medical personnel take the trainings. When other states have asked what Nevada was doing, Mr. Egan said Nevada took a grassroots approach that got everyone involved. No one entity can do it alone. It has to be done as a team by community.

He said stated that he looks into suicides in the Las Vegas Valley so he knows, township by township, what the hot spots are. Ms. Morgan's data will give him the ability to look at the whole state. The highest number of suicides in his area are in Green Valley, Henderson, and Centennial Hills. For youth, they are scattered across the valley. For military and veterans—most suicides are in Sunrise Manor and Whitney. He knows exactly where the hot spots are and helps steer what the agencies there do. When he talks with the Veterans Administration, he will point them to Sunrise Manor and Whitney and what is happening there.

Mr. Erickson asked if Mr. Egan had a set of specific measurable items Nevada could focus on to reduce suicides so that we could compare ourselves against them. He would like for us to be able to show change from our own data.

Ms. Peek asked if education tools on substance use prevention relate that to suicide by pointing out that 25 percent of the deaths among youth are drug and/or alcohol related. Mr. Erickson said it would if it is included in the curriculum school districts use. The Mental Health Block Grant, has a zero suicide initiative built into it. Nevada's suicide rates are stagnant, but other factors could play into that—movement, new people and industries coming into the state, poverty, and other issues. As Mr. Egan reported, other states do not report suicides the same way Nevada does. There is no standardized method of reporting suicides. Mr. Egan agreed with Mr. Erickson. He said the Suicide Fatality Review Committee reviews upwards of 30 suicides daily. The national numbers are just an overview of the nation that is not specific to Nevada's situation. To steer what needs to be done in the Nevada, a study must be done of trends in Nevada. Ms. Peek pointed out that the suicide rate is an artifact of how coroners code. She said she asked Mr. Fudenberg how he coded overdoses. He told her that, unless there is a suicide note and/or the person posted something on social media indicating they were depressed, the death would not be considered a suicide. She wondered if this was true across the state in how deaths were coded. If Nevada's suicides are high by that standard, Nevada does have a high suicide rate. She asked if the Centers for Disease Control (CDC) have looked at how coroners code suicides. Ms. Morgan said a biostatistician at CDC was going to look

at the discrepancies in the data because the data that Mr. Egan reported was a lot higher than what was in vital records.

Ms. Thompson added that the National Center for Health Statistics coded all states the same. Ms. Peek asked whether suicide or drug overdose would be listed as the primary cause of death. Ms. Thompson said the method would be listed first, then what caused the death. So, a death would be listed as suicide, then strangulation or car accident or whatever caused the death. Ms. Peek asked if they could see how many drug overdoses were coded as suicides. Ms. Thompson said they could. Ms. Peek thought that would show the discrepancies in coding throughout the state. Ms. Morgan said that as these issues are brought up, they should expect to see the trend go up because coroners will be paying attention to the topic coding more accurately on death certificates. Mr. Yang pointed out that when coding for diabetes standards changed, there appeared to be a 25 percent increase because physicians had learned how to code it. He noted a paradox existed—the greater the surveillance, the more incidents appeared. Ms. Peek said they point out that an increase could be the result of additional training. Abstracters in coroners' offices look at the National Violent Death Reporting System (NVDRS) for reasons for death to make sure suicides were counted. The Enhanced State Opioid Overdose Surveillance Grant (ESOOS) allows the state to look at overdose is providing more information on overdoses, suicides or not. Data should be coming in from those. She thought it would be interesting to look at the data and to talk to an abstracter to understand what indicators they look at.

Ms. Barker said the Southern Nevada Health District has worked closely with the coroner's office on special projects with vital statistics to improve cause of death reporting. Ms. Peek asked if there would be data available by the time of the June meeting. Ms. Barker said that might be too soon.

Dr. Azzam was not sure why Nevada's suicide rate did not increase as the other states did. He asked if the rate of increase had been in every category or was specific to opioids or firearms. To him, it looked like a paradox in reporting that did not occur in Nevada. He would like to see how causes increased, which causes of suicide changed the most. He did not see how the coroners' subjective reporting and level of education would explain it.

Mr. Egan clarified that the increase was 25 percent overall—some states increased a tiny bit, others increased a lot. When comparing the states in the same timeframe, Nevada was the only state to go down. He confirmed that he converts the data into a percentage. If there were 100 suicides and 60 percent are by firearms, he could develop a strategy for that—holding conversations and doing training. Through the office of Suicide Prevention and the coalition, he has talked to at least 9,000 firearm owners. He wonder if that could have had an effect. At the same time, opiate addiction and other factors exist. He reminded members there was not a single cause for suicide—it was always the result of a combination of things going on in a person's life—relationships, finances, health, or losses. Firearms might be available for some people, but there are portion of the suicides our actions did not affect. For instance, education about firearms would not have an effect on a home and suicide where a firearm was not available. He also cautioned about drawing a straight line from bullying to suicide as not every bullied youth views suicide an option. It can be a risk factor. He suggested looking at what was behind the action to see if a combination of factors might lead people to think suicide was the only option. Mr. Yang said mountain west states have more firearms suicides compared to other places. He pointed out that some suicides were easy to define. But overdose and other methods like car accidents are more common in other cultures. Mr. Egan agreed—with firearms it is more obvious that intended to take their life. The coroner's office has to show an intent to die in order to call a death a suicide rather than an accident. He mentioned there has been a study regarding the effect altitude might have on suicide numbers. A multi-disciplinary approach to suicide prevention is the key. Ms. Peek pointed out the workgroup's main purpose in this was to recommend to the MPAC how they should direct funding. She asked if prevention efforts included conversations about substance use and suicide rate. Ms. Lang said schools a classroom-based program called the Signs of Suicide Program. The coalitions work with local school districts to get psychologists and backup support for those who

identify as having suicidal ideation during that time. The program is two-fold, with an educational piece, which is more acceptable to parents and a screening that is done. Adult mental health first aid, youth mental health first aid, law enforcement-focused first aid, and opioid- focused first aid tie in through the section on suicide. Some evidence-based curricula touch on the topic.

Ms. Lang shared that two middle-school students in Pahrump recently committed suicide. For one of those students, all of the resources—including the Safevoice program through the Department of Education—were used. During the short time between when the youth exposed his intention to a friend and that friend's mother contacted Safevoice, the youth shot himself while in a restroom at Walmart. Not just the youth and the middle-school students, but the people of Pahrump including those who were at Walmart, shoppers and employees, have been traumatized. NyE Communities Coalition director, Stacy Smith, is trying to figure out what to do. She said the community was doing everything it could, yet this happened. She wanted to know what else they could be doing. Ms. Lang said her partnership is concerned that what was already in place did not work. Mr. Egan said he was connected to the individuals involved in what happened in Pahrump. His assembled team will go to Pahrump to support the partners as they support their community in its recovery and grief process.

Ms. Peek suggested pulling data on youth suicide, highlighting those in which substances were used. She would like to cross-tabulate suicide ideation questions with substance use. With that information, a recommendation could be made to MPAC to ensure that funding devoted to substance prevention was coupled with mental health first aid or the appropriated program.

Ms. Lang said she viewed Carson City data from a report that was done for four counties, breaking down all deaths related to substance use. Suicides were broken into mode of death, age group, and special populations. Mr. Delap wondered if they could focus on the hot spots and overlay that information with other data, including what might be issues—how many people own guns, the number of medical providers, how many schools received the training, providing an inventory of what resources have been deployed. The subcommittee could then give recommendations. Ms. Lang liked the idea of using geographic location. She wondered if it would behoove SAPTA to say that in a particular hot spot, special attention needed to be paid to suicide. Ms. Lang pointed out there was a difference between 2015 data and what was known in real time from law enforcement regarding opioids. Currently, cocaine use is the bigger problem—there has been 400 percent more use of cocaine and meth and stimulants like Adderall. If old data is used to define focus, it does not allow communities to focus on what the current concerns are. Ms. Peek said older data can be given to MPAC, with the suggestion that MPAC not limit funding for current data. Ms. Henderson mentioned that teens struggling in violent relationships may be susceptible to suicide ideation and substance use. An intern for them is going over data from the past 10 years, looking at domestic violence-related homicides and will soon have available data on how many teens are reaching for help regarding drugs and suicide ideation. She added out that Nevada was number 2 in the nation for domestic violence-related homicides. Ms. Peek stated there was a question in YRBS on intimate partner violence. She suggested cross-tabbing suicide ideation and how that impacts drug use. Mr. Yang said Pregnancy Risk Assessment Monitoring System (PRAMS) has a question on intimate partner violence. YRBS has Adverse Childhood Experiences (ACEs) regarding parental abuse of a child.

7. Review of NAC 441A Overdose Reporting Efforts

At the last meeting, SEW members talked about some of the changes being incorporated into overdose reporting based on feedback, including extending to 30-day reports. Ms. Peek suggested they go over the revised overdose reporting requirements for the permanent regulations and discuss progress on the emergency regulations.

For the permanent regulations, it was requested the report occur as soon as possible so personnel and resources could be directed to the locations where overdosing occurred. 30-day reporting felt too far from the event, so 7-day reporting was suggested. Many items were causing heartache for

reporters, such as toxicology. They will still have to look at ICD-10 coding, but will have to do it quickly. Many providers do not have coding at 7 days. Insurance standards require they have coding done by 30 days. Reports will not be complete at seven days. Much work with reporting entities will be required. Ms. Thompson said the data was raw, so she was not able to compile statistics for this meeting. Of the 390 overdose report received, 87 were missing diagnostic coding. Many reporters used different ICD-10 codes that were not included in the permanent regulations. 37 facilities have reported. Ms. Peek said some facilities reported on behalf of their clinicians. NAC 441A requires health care provider reporting, not facility reporting. She hoped they would pull information from the Electronic Health Records (EHRs) so that it would not be a burden; several providers did that. There have been major data quality issues. Ms. Thompson said facilities resubmit everything, so even if they send it to her at 7 days, they resubmit it when they send the following week's data. If they update an ICD-10, they send it. Ms. Peek said that further out, there would be a more complete record on patients. Ms. Morgan did not think that the current reporting could be used to look at any specific drug because 20 percent of the reports do not have coding. She added that many of the records had ICD-10 codes that have nothing to do with overdose. Ms. Morgan said receive reports on poisonings of scheduled drugs. Mr. Yang suggested checking who made those errors so could be trained on coding. Ms. Peek said even in a 7-day report an anomaly in a facility or a region would be apparent. If facilities updated the records, public reporting of trends could be made after 45 days. Ms. Morgan did not know if the reporting could have a drop down menu identifying suspected substance poisoning before toxicology. Ms. Peek said it would work if the information was put in manually, but not if it was not on a facility's EHR. Ms. Peek said they wanted to look at how overdose reporting compared to the same quarter of hospital discharge billing in the Center for Health Information Analysis (CHIA). She added they would continue to compare to CHIA and provide technical assistance to the facilities that appear to have huge discrepancies.

The last part of the permanent regulations develop administrative procedures for collecting and reporting this information. It will tell how they look at auditing the records. More details should be available for the June meeting because the permanent regulations will be in place. Ms. Mburia said PRAMS asked questions on drug use, spelling out the specific drugs the mothers used. She said they pull from birth certificates and use special coding when they send out the surveys, but they would be able to link the mother back to the birth record. She added that mothers were informed their information might be moved to other data sets in the state for analysis. Ms. Peek asked if the information was used to identify trends, as one of SAPTA's priority areas is perinatal substance use. Ms. Barker asked if a process was being developed for when the aggregate or counts for a type of overdose could be released to local health authorities or how the information would be disseminated. Ms. Peek said they agreed to do that. Once the permanent regulations are in place they should be able to send an agency its cases—with many caveats. Ms. Morgan said the data they currently have would be more dangerous than valuable. Ms. Peek said they would include disseminating the information to local health departments and coalitions in their administrative procedures. Ms. Peek stated they would post information to the Prescribe 365 website.

8. Youth Perception Questions

Mr. Yang said UNR worked with Ms. Ross from the PACT Coalition to create a survey additional to the Youth Risk Behavior Survey (YRBS) that will go to Boys and Girls Clubs. There will be five more mental health questions, including questions on depression, suicide ideation and attempts, in addition to the 16 perception questions—for a total of 30 questions. UNR will help with the questions and with data analysis. Ms. Lang asked if the survey could be made available to other Boys and Girls Clubs. Mr. Yang said they were trying to compare the data with the YRBS so they will have to use the same sampling measure—they will need to cover three grades. Mr. Yang said as long as the sample size was big enough, coalitions could give the survey to other Boys and Girls

Clubs throughout the state. Ms. Peek said data would be collected over the summer and would be available later in the year.

9. Update on Web Infrastructure for Treatment Services (WITS)

Mr. DeMarco gave an update. He reported that there were three main parts of WITS—the centralized data depository (CDR); the electronic health record which includes treatment, contract management, and billing; and the prevention module.

Phase 1will bring up the centralized data repository for electronic health record vendors that are certified state providers to submit their data. The target date for that system to be ready to receive data is May 15.

Phase 2 is the WITS electronic health record. That should be available July 23. Providers and their subrecipients will be able to enter data.

For Phase 3, the initial pilot is China Spring. The date for transmitting data has not yet been determined, but should be known in a few weeks.

Once the pilots are completed, Phase 4 will be the roll out plan for all of the electronic health record vendors to come over to the CDR. Freedom House will be the guinea pig for electronic health records. They will be brought over at a date to be determined after July 23. Phase 4 will bring Bristlecone and AVATAR users over. The CDR will accept Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMS) data and Block Grant and Opioid STR data.

Prevention is on a different track. Their pilot will be all of the coalitions for the Substance Abuse Prevention and Treatment funding. The date should be close to July 23 or sometime in August. Data might be entered in July, but they will also have to enter their strategies and activities.

Ms. Peek pointed out that a deficiency they had in substance use data in the past was that treatment data reported in TEDS was unusable. They were able to get treatment data in the national survey. She suggested they consider improving the treatment data in the form of expanding WITS and getting access to the other EHRs. With access to the EHRs, they could get identifiers and have the information about a person in treatment prior to an overdose. She suggested recommending to MPAC that funds from the Block Grant be devoted to this data collection pool and that the data be used to direct resources. Ms. Morgan added that, in order to get statewide TEDS data, additional resources have to be put toward staffing to collect the data. There is only one analyst who spends nearly all of her time collecting from 19 facilities that are SAPTA-funded providers. There are 97 additional facilities that are SAPTA-certified. There is no way that work can be absorbed by one person. Ms. Peek pointed out that would be a difficult decision for MPAC because substance use block grant can go to prevention and treatment. A portion of the Substance Abuse and Mental Health Services Administration (SAMHSA) Partnership For Success (PFS) Grant is supposed to go to SEW. Right now that goes to YRBS. If additional staffing is needed in central analytics to give the data needed to make decisions, that can be a recommendation to make to MPAC. She asked Mr. Erickson if the PFS will continue. He said he was hopeful it would. Ms. Peek pointed out there is also money that the Office of the Attorney General gave to supplement if PFS is not continued. Ms. Morgan said it would be helpful to add analytic staff, but another administrative staff could communicate with the providers.

10. Make Recommendations of Agenda Items for the Next Meeting on July 19 at 9:00 a.m.

The date of the next meeting will be in June. Ms. Peek shared the items she had for the agenda for that meeting:

- Review the MPAC profile and summaries
- Finalize the bylaws
- Review the attendee and membership list
- Elect a chair-elect
- Sign the disclosure statement

- Ms. Barker's efforts with the coroner
- WITS
- Department of Education's School Climate Survey
- Funding for the Maternal and Child Health Services Block Grant

11. Public Comment
There was no public comment.

12. Adjourn
The meeting was adjourned at 12:52 p.m.