STATEWIDE EPIDEMIOLOGY WORKGROUP (SEW)
MINUTES

DATE: April 27, 2017
TIME: 9:00 a.m.
LOCATION: Div. of Public and Behavioral Health
4126 Technology Way
Second Floor Conference Room
Carson City, Nevada 89706

Video-Conference
Rawson-Neal Psychiatric Hospital
1650 Community College Drive
Training Room
Las Vegas, Nevada 89146

Tele-Conference Call-In: (775) 887-5619
Conference Number: 2014#
PIN: 0427#

SEW Committee Members Present

Brad Towle	NSHD - Health Statistics, Planning, Epidemiology, & Response
Eric Ohlson	Washoe County School District
Gwen Taylor	ACCEPT
Ihsan Azzam, Epidemiologist	Division of Public & Behavioral Health (DPBH)
Ingrid Mburia (present for part of the meeting)	DPBH - Maternal Child Health Services (MCHS)
James Kuzhippala	DPBH
Julia Peek, Chair	DPBH - Office of Public Health Informatics & Epidemiology (OPHIE)
Kathryn Barker	Southern Nevada Health District (SNHD)
Marco Erickson	SAPTA
Pauline Salla	Division of Child Family Services - Juvenile Justice Programs Office
Stephanie Pyle	Center for the Application of Substance Abuse Technologies (CASAT), University of Nevada Reno (UNR)
Trey Delap	Group Six Partners
Wei Yang	Nevada Center for Health Statistics and Informatics, UNR
Ying Zhang	SNHD

SEW Committee Members Absent

Ingrid Mburia (absent for part of the meeting)	DPBH – Maternal Child Health Informatics & Epidemiology
Jennifer Snyder	
Jim Jobin	
Paul Parker	Clark County Coroner's Office
Richard Egan	Office of Suicide Prevention
Sue Meuschke	Nevada Network Against Domestic Violence
William Gazza	Clark County Coroner's Office
Yenh Long	Board of Pharmacy

Others Present

Janet Porter	CAPT
Jessica Johnson	Southern Nevada Health District
Kyra Morgan	Department of Health and Human Services
Misty Allen	Office of Suicide Prevention
Mitch DeValliere	DPBH - MCHS
Victoria LeGarde	CASAT, UNR
John Steele	Las Vegas Recovery Center

SAPTA Staff Present

Bill Kirby	Health Program Specialist I
Meg Matta	Health Services Professional Trainee
Raul Martinez	Administrative Assistant III

1.	**Welcome and Introductions** Julia Peek called the meeting to order at 9:30 a.m. A quorum for the Statewide Epidemiology Workgroup (SEW) was not established at this moment.
2.	**Public Comment** Trey Delap made a comment about how he attended the National RX Drug Abuse and Heroin Summit, and they had a (Prescription Monitoring Program) PMP track. One thing that stood out to him in the PMP reporting was instances of overdose reversals as a valuable clinical tool, plus there was also some consideration of more active engagement law enforcement using the PMP. There was an interesting analysis of the nine state regional interstate sharing of PMP data. They went over how it was modeled and how they could color code and identify hot spots. In some cases they created an outline of a state and they could identify that the prescription was received. They tried to examine and test how the PMP data could be used as a predictive model by analyzing old trend data. Julia Peek added to Trey's comment by mentioning that they are receiving PMP data from the Board of Pharmacy for 2011 through 2016.
3.	**Presentation and Approval of the Statewide Epidemiological Profile** At this moment a quorum was still not established. Julia deferred to James Kuzhippala so that he could go over edits made to the Epidemiological Profile, but she stated there would not be voting to approve until the quorum was established. James began the presentation by stating that they added a table of contents that had overarching concepts. They included the executive summary at the beginning instead of the end. They added data sources and limitations. All the data sources that they utilized for the report were included in front along with any limitations. They didn't change much to the demographics. For the mental and behavioral health clinics, they updated the most common mental health diagnoses. They also included data from National Surveys on Drug Use and Health (NSDUH) because it is an annual survey. For the emergency room and inpatient by specific medical indicators they included a row at the very bottom to indicate the number of admissions or visits that were associated with mental and behavioral health, although that number will not match the number a patients seen as for some patients may be seen for multiple conditions. Trey asked, moving forward to when the data changes to the International Classification of Disease (ICD) Version 10 (ICD-10) ICD-10 diagnostic criteria will it adjust accordingly. James answered yes. Julia established a quorum for the SEW. Trey asked a question related to acute schizophrenia that winds up in the emergency room, and if it's coded ICD-9 is there a detail in that code? Julia answered by stating that he's getting into syndromic surveillance. She went on to say that syndromic surveillance will be the chief complaint when they go in. The hospital discharge billing data that they received is coded by the person who codes the billing. What would be best is to get access to the electronic medical record, so that they can actually dive in to what is happening. With that said, this is a proxy to what they think the diagnosis was, but it's based on what the person who's doing the billing enters. Trey asked if it was discharge diagnosis. Julia responded by stating that it is discharge billing data. James went on with the presentation to talk about the graphs that showed alcohol and substance abuse related ICD codes broken out by demographics such as sex, race, ethnicity,

	and age groups. He then talked about suicide related Emergency Room (ER) visits broken out by the specific categories in suicide. Trey asked, referring to the code, what substance abuse would include. James responded by stating that it would include any drugs that aren't alcohol or tobacco. Trey also asked if the substance abuse codes include any of the prescription drugs. Julia answered by stating that it does include any substance but they can drill down further. Julia stated that there has been research done and they've been consulting with other states related to marijuana, and they saw interesting stuff with their hospital billing data marijuana overdose. It was resident versus non-resident, and the resident data was pretty static, but the non-resident data for people who overdosed on marijuana was clearly forcing their trend line to go up. So, when they start looking at the marijuana issues in their emergency rooms they do need to start looking at it by resident status. Dr. Ihsan commented that substance abuse is considered prescription drug abuse or illicit drugs. Anti-viral medication is not considered abuse, it's either over or misuse. So, when they talk about substance abuse specifically they are referring to prescription opioids or illicit drugs because, for example, if someone really abuses Tylenol that would be considered suicidal. And, the fact is that they would have to take huge amounts to overdose and that is why they are considered overuse or misuse. It was brought up that in the ICD codes it identifies substance abuse as dependent use and non-dependent use. Julia brought up how staff pulled additional data that showed how many of the emergency room visits specifically related to opioids were by the same person, and they had only a quarter's worth of identifiable data, but in that example, there were about 2-3 people that had more than 2 visits to the ER related to overdose in the quarter. That'll be something that they will be looking at. Additionally, they looked at how many of those folks were now deceased and if they were admitted into inpatient, and it turned out to be 10%. Stephanie asked if efforts initiatives in the ER regarding recidivism were being tracked. Julia said that she would check with Dr. Woodard regarding which facilities were being tracked, and that it would be beneficial to have this information broken down by facility to see which facilities have higher rates of recidivism and whether they did SBIRT (Screening Brief Intervention Referral to Treatment) or not. Trey asked if they could also break the data down by resident and non-resident. James pointed out that all the data that they were looking at was residential. The first gentleman also requested information on the public health cost of non-resident emergency services. Julia asked to add one slide at the beginning of the epidemiology profile presentation regarding overdoses in the ER, resident and non-resident data, as well as uninsured and payer information. Trey added that a large portion of the study on the impacts of marijuana, the Emergency Medical Services (EMS) capacity based on resident and non-resident use, spiked because of visitation. There was an impact on capacity for law enforcement and EMS. Trey also pointed out that even if an insurance company is being billed, there is still someone occupying a bed which deprives it from a resident. Julia said that they will start tracking this when they get to marijuana but it may also be relevant to overdose data as well. Trey pointed out the Centers for Disease Control (CDC) had not standardize marijuana syndrome which makes it difficult to monitor.

	Julia said that they had discussed all the different data sets related to marijuana which will be gone over at the next meeting. Julia then moved on to the topic of inpatient admissions. James then explained what the data covered. Julia then asked if someone who is treated in the ER and then moved to inpatient was counted on both billing records. Kyra Morgan answered that it depended on how each specific facility bills. Trey asked if there was a way to assess the influence on the data of the frequency of billing. Kyra answered that starting 2015 there are identifiers present that help them determine how many people there were versus how many visits, however, this cannot be done retroactively. Dr. Azzam commented frequency of admission can give the false impression that we are getting more anxious and more depressed, as the number is increasing. He then went on to ask if there is a way to address that using the denominator of the amount of people that are under control. Kyra answered that the identifiers will allow them to see how many visits there were as opposed to the number of people that were seen. Dr. Azzam clarified that he is concerned about the rate that is being reported because to quantify the problem—if it has bettered or worsened—those numbers would need be needed. Julia suggested providing total number of hospital visits versus total number of population. Dr. Azzam added that what would be ideal is if they could see the rate of all depressed people compared to the total people admitted to the hospital which in turn would help them understand whether there has been improvement or not. Kyra answered that it was possible to do a denominator for hospitalization. Wei Yang said that they should be capable of looking at previous data, which had a unique ID, and understanding if individuals had been readmitted. Ihsan agreed. Julia said that they would follow up on the data and was unsure if the information carried over across facilities. Wei Yang said that each patient had a unique ID that followed them even if they went to a different institution. Julia then discussed the research and presentation of an intern and how it relates to Ihsan's discussion. Trey asked if they could compare billing. Kyra answered that they have all the procedure codes for the hospitals, but they don't have the clinical knowledge to know which codes are relevant to the diagnosis that they are looking at. Trey estimated that a correlation might be found to discover certain relevant procedures that are more frequent and that certain conditions will cost more and require more procedures. Wei Yang agreed with Trey's point. Even Clinical Risk Groups (CRG) is better than just ICD 10 or ICD 89. (Current Procedural Terminology) CPT is harder because there is a lot of judgment for the procedures.

	Kyra said that in the billing data they only have the dollars billed and not the dollars paid which is drastically different. But, when examining this, you would see the frequency of procedures that were billed for. James clarified that we were not able to tell which procedure coincided with a certain diagnosis. Kyra answered that we would just pull all the procedures that took place for a given diagnosis, and then look at the frequency. Trey suggested that the clinical team could help in understanding the codes associated with the data. Ihsan said that this information will also help with quality assurance for patients, and having a clinical team will help to understand the data. Kyra asked James to make sure that they take Diagnosis Related Groups (DRGs) into account because they are directly related to severity and cost. Wei Yang said that the program would merge the ICDs and the DRGs. Kyra said that we do not have the software to do that, but the source of the information might, otherwise they may not have a DRG on every report. Julia suggested that the epidemiology profile be approved, so they can get it to the Multidisciplinary Prevention Advisory Board (MPAC). She also suggested a motion for a special report looking at discharge billing procedures, codes, DRG, diagnosis, and any related trends. Janet Porter said that there was little to do with prevention, risk and preventive factor data, the data that the coalitions are collecting, special populations, and health disparities in the report. She suggested that the information be included in the report so that the coalitions can use the information in their prevention work. Julia discussed how to get data on special populations. Kyra pointed out that they do not have the medical data from corrections. It would be hard to tie corrections data to substance abuse and mental health because they're not getting clinical data from the prisons. What they can determine is the substance related crimes that occurred. Julia asked if there were any other special populations that needed to be included in the report. Victoria LeGarde suggested looking at occupations, for example the population of those employed in the mining industry. Kyra said that they had access to self-reported occupation data. Ihsan suggested that the data can be further broken down from that point. Then they can end with a recommendation on how to counteract the problem. Marco asked if there was a perception of harm data included. Julia was unsure if there was good data on perception, and asked what data sources they had for perception of risk. Wei Yang said that they do not have the perception data for all drugs but they do for marijuana. James said the alcohol and tobacco use should also be included. Julia asked for any other special populations. Jennifer Snyder suggested Tribal data as it relates to prescription drugs and opioids. Julia suggested that they link to the coalition data at the end especially when breaking down rural/urban data. Stephanie asked if behavioral health issues were included in the report.

	Julia clarified that this data was being collected by the coalitions. Julia then moved on the substance abuse treatment facilities section of the report. James outlined this section of the report. Julia suggested that they add information on special populations to this section of the report. Julia also stated that a lot of collaboration is going on with CPS on this data. They are also looking at ways to make sure that this data is collected more completely. James continued to describe this section of the report. Kathryn Barker offered to help make some of the data more representative of the entire state. James continued to describe this section of the report. Julia asked if there was data collected on problem gambling. Brad said that they had not asked the question. Julia asked if they had collected data on eating disorders. Brad answered that they had asked questions on sugar intake and other nutrition based questions. Julia said that SEW might recommend that the state collect more information be collected on general substance abuse such as alcohol and tobacco, eating disorders, and other relevant behavioral health conditions. Stephanie shared a circumstance where she had heard that one facility had three suicides in a summer due to problem gambling. Julia said that they are getting a grant to have coroners collect more information on those who experience a violent death including suicide and overdose. Which will provide many more indicators. Brad added that in 2017 they will be asking intervention questions regarding the discussion that takes place between a doctor and patient regarding substance abuse. Julia suggested that they cross reference that information with the depression indicators. James continued on this section of the report. Julia suggested that YRBS include questions regarding questions on gambling and eating disorders and that they should follow up to see what kind of relevant data they are collecting. Trey said that it should include gambling because there is data to show that gambling habits start in this age group. Julia suggested that YRBS (Youth Risk Behavior Survey) include questions on gambling and eating disorders. Eric Ohlson asked if there had been any additional school related data and if there was a way to get additional data from school district moving forward. He also asked about juvenile service data and suggested that it might be found in the coalition reports. Julia said that we have access to the state's juvenile justice data as well as child welfare data. She also pointed out that they do not have access to the local juvenile justice data, so, we can only see data on cases that are dealt with by the state. Kyra added, going back to a previous discussion, that there is a patient indicator that is specific to the facility. Pauline Salla added that the juvenile justice locations are collecting the information and she was not sure why the state did not have access to the information. Julia asked who has ownership over the database. Pauline said that she believed that the information was reported to the state but that the data could also be collected from the local jurisdictions.

	Julia asked if the Department of Health and Human Services was collecting the information or was it the Department of Public Safety. Pauline clarified that the program was under Division of Child and Family Services (DCFS) which is under Department of Health and Human Services (DHHS). Julia said that SEW will confirm whether or not DHHS gets that data and said that they may need to develop a data share agreement. Eric asked if they had information on the college population. Julia said that there was a college survey. Julia went over what would be added to the report as discussed during the meeting. Victoria suggested that they also add data on veterans and active military. Julia said that they would include the data on a page of additional research. Brad said that they had included a question in their survey regarding military service. Stephanie asked if they were specifically asking for veterans or active military. Julia answered that it depended on the data source. Stephanie added that it is important to add the information possibly from the Veteran's Administration (VA). Julia described how difficult it is to work with the VA to get data. Misty Allen added that she has been working with the VA on suicide prevention and said that they are working on ways to share some of this information through the county coroners, especially in the rural areas. Ihsan suggested that some of this information on special populations be included as a supplement to the actual profile report to avoid getting too far away from providing a holistic view of the State. Julia said that she was fine with adding the information in the way that the workgroup thought was most appropriate just as long as the requirement for special populations was still met. She also clarified that she does not want a new report for special populations. Julia then asked if the workgroup would be comfortable making a motion to approve the report, with the corrections, without reviewing it again, or does the group wish to meet again once the corrections are made to review the report to review it before it is presented to MPAC. Eric asked if there were any time constraints on the report or the information that Janet had suggested. Julia said that she was told that MPAC wants the data by June or July because this report helps MPAC direct state funding priorities. These priorities will be determined in September, so they need the data that is in the report before then. Julia entertained a motion to accept the report with the changes discussed at this meeting. Ihsan made a motion to accept the report with the changes discussed at the meeting. Trey seconded the motion, to include a summary of the things that are to be included in the next version of the profile. The motion passed unanimously of the members present.
4.	Julia then asked for the approval of the minutes of the previous meeting with a correction. Bill said that he was not in attendance at the last meeting and that his name needed to be removed from the list of those present. Julia then added that, from then on, they would be receiving regular updates from MAPC, and the Evidence Based Workgroup (EBW). These items would be on future agendas. Julia entertained a motion to approve the minutes of the previous meeting with corrections. Marco made a motion to approve the minutes with corrections.

	Trey seconded the motion. The motion passed unanimously of the members present.
5.	Julia then informed the members that they had receive the résumé of Kathryn Barker from the Southern Nevada Health District, who wished to become a member of the workgroup. The members were informed of Kathryn's qualifications. Julia entertained a motion to accept Kathryn as a member. Trey made the motion to accept Kathryn as a member. Ihsan seconded the motion. The motion passed unanimously of the members present.
6.	Julia then discussed the items to be place on the agenda of the next meeting. The items that will be on the agenda for the next meeting will include; MPAC and EBW updates, Statewide Epidemiological Profile, Setting of priority topics, Highlights of SCI strategic plan, and Public Comment. Ishan suggested that BRFSS and YRBS questions be added to the agenda. Julia then brought up SB166, and discussed the new survey of youth regarding substance abuse that is being proposed. Ihsan expressed concern that giving student's too many surveys may change the way they respond. Bill asked if the survey was going to just high school students. Julia responded that it would be given to both high school and middle school students. Julia said that if SB166 passes out of the fiscal committees then it will need to be an agenda item for the next meeting. Trey asked if there was any ethical concerns with asking the sort of questions proposed in the survey to children under the age of 18. Julia said that there was discussion about the type of consent that the school districts receive to administer the survey. Julia said that they would try to have their next meeting in July.
7.	Julia called for public comment. Trey brought up information from a conference that he attended. Eric asked if the Washoe County coroner was updated. Julia answered that she didn't know if they were, but they had received funding for more information.
8.	**The meeting was adjourned at 11:25 am.**