State Epidemiology Workgroup (SEW)
MINUTES

DATE: **June 21, 2018**
TIME: **1:00 p.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: (888) 636-3807 / Access Code: 1961091#

BOARD MEMBERS PRESENT
Julia Peek, Chair, Deputy Administrator, Department of Public and Behavioral Health (DPBH)
Ingrid Mburia, DPBH, Maternal Child Health Services
Richard Egan, Office of Suicide Prevention
Ying Zhang, Southern Nevada Health District (SNHD)
Wei Yang, Nevada Center for Health Statistics and Information, University of Nevada, Reno (UNR)
Ihsan Azzam, DPBH
Bill Kirby, proxy for Marco Erickson, DPBH
Trey Delap, Group Six Partners
Brandon Delise, proxy for Kathryn Barker, SNHD
Jennifer DeLett-Snyder, Join Together Northern Nevada (JTNN)
James Kuzhippala, Truckee Meadows Community College (TMCC)
Judy Henderson, Nevada Coalition to End Domestic and Sexual Violence
Pauline Salla, Department of Child and Family Services (DCFS)

BOARD MEMBERS ABSENT
Stephanie Asteriadis Pyle, Center for the Application of Substance Abuse Technology (CASAT), UNR
Eric Ohlson, Washoe County School District
Gwen Taylor, ACCEPT
Jim Jobin, Vogue Recovery Center
John Fudenberg, Clark County Coroner
Yenh Long, Board of Pharmacy

STAFF & GUESTS PRESENT
Kyra Morgan, DPBH
Jen Thompson, DPBH
Brian Parrish, DPBH
Kyle Devine, DPBH
Victoria LeGarde, Center for the Application of Prevention Technologies (CAPT)
Bob DeMarco, DPBH
Amber Reid, Nevada Department of Education
Linda Lang, Nevada Statewide Coalition Partnership
Raul Martinez, Substance Abuse Prevention and Treatment Agency (SAPTA)
Meg Matta, SAPTA
Joan Waldock, SAPTA

1. Introductions, Announcements, and Roll Call

Ms. Peek opened the meeting at 1:01 p.m. and determined a quorum was present. She said the bylaws stated ". . . members shall maintain 75 percent attendance each calendar year. Members who are absent in excess of 25 percent or who miss three consecutive meetings may forfeit their seat on the SEW." She pointed out that Gwen Taylor, Jim Jobin, and John Fudenberg were at risk of losing their seats and that she would contact each to see if they wanted to continue as members or if someone at their organizations could represent them.

Mr. Egan commented on a recent Centers for Disease Control (CDC) suicide report covering 17 years that showed the suicide rate increased in every state except Nevada, where it went down 0.5 point. He said others states wanted to know what Nevada was doing that made the difference. He concluded it was involvement at the community level.

Mr. Yang said a University of Nevada, Reno (UNR) student completed a field study, checking every suicide case. The study showed that 70 percent of Nevada suicides involved drugs. Mr. Egan said he would be placing someone in the Clark County Coroner's Office to do a similar study and that he would like to see reports from the two coroner's offices mirror each other. Ms. Peek said that Mr. Fudenberg requested and received funds for an epidemiologist for his office. This staff member would pull similar data. She recommended Mr. Fudenberg coordinate with the Southern Nevada Health District (SNHD) to hire an epidemiologist with forensic specialties. Mr. Egan said a volunteer with the Substance Abuse and Mental Health Services Administration (SAMHSA) policy academy who is a retired doctor would collect that data for Clark County. Ms. Peek suggested they coordinate methodology that would be consistent across the state.

Dr. Azzam asked if other states counted assisted suicides as suicides. Mr. Egan replied that states having Death with Dignity laws categorized assisted suicide as medical intervention. He stated that "suicides by cop" were not considered suicides, but legal interventions. He added that the death of a Nevadan refusing medical treatment would not be counted as a suicide as the cause of death would be the medical condition he had.

Ms. Mburia announced that Maternal Child Health would issue an annual grant report in July. She said she could share highlights of the report at the next meeting.

2. Public Comment

There was no public comment.

3. Approval of Minutes from the April 26, 2018 Meeting

Dr. Azzam moved to approve the draft minutes without corrections. Mr. Kuzhippala seconded the motion. The motion passed.

4. Finalize and Approve Bylaw Revisions

Ms. Peek said changes were made in the bylaws. The most substantial changes related to the offices of chair-elect, chair, and past chair. She pointed out she needed to make one more change on page 4, using the correct terms.

Mr. Egan moved to approve the bylaw revisions with that edit. Dr. Azzam seconded the motion. The motion passed.

5. Election of Chair-Elect

Ms. Peek announced that upon the election of a chair-elect, she would become the past chair for one year and Mr. Kuzhippala would become chair. Ms. Peek nominated Kathryn Barker of SNHD for chair-elect. Mr. Kuzhippala said Ms. Barker was currently the injury and biostatistics epidemiologist at SNHD. As such, she regularly analyzes birth, death, and hospital discharge datasets to monitor fatal and non-fatal injuries in Clark County. The datasets include drug overdoses, suicide, and violence. She serves as a member of the Southern Nevada Injury Prevention Partnership and is an active member of the Council of State and Territorial Epidemiologists (CSTE) injury

workgroup which developed the new injury indicators using International Classification of Disease, 10th Edition, Clinical Modification (ICD-10-CM) hospital discharge data. While at SNHD, she has provided data for local efforts in opioids, syringe vending, and neonatal abstinence syndrome. She holds a Master of Public Health in Infectious Disease Epidemiology and Biostatistics from Boston University. She would be honored to serve as chair-elect of SEW and support its efforts to address the substance use needs of Nevadans.

Mr. Kirby moved that nominations be closed. Dr. Azzam seconded the motion. The motion passed. Ms. DeLett-Snyder moved to elect Ms. Barker as chair-elect. Mr. Egan seconded the motion. Ms. Barker was elected.

6. Review and Approve Data Profile for Multidisciplinary Prevention Advisory Committee

Ms. Thompson reported the subcommittee met and sent a draft to the regional behavioral health boards for feedback. The health board changes were incorporated into the current draft report. The death data should be finalized by June 28. Ms. Morgan asked when the final copy was due. Ms. Peek replied that federal guidance required three groups to meet for the Partnership for Success (PFS) grant—the Multidisciplinary Prevention Advisory Committee (MPAC), the Evidence-Based Prevention Workgroup, and SEW. The first two have not met in two years. The SEW reviews the data and provides recommendations for the populations affected, making suggestions about funding needed. The SEW works with the Evidence-Based Workgroup to define evidence-based programs that could support the populations at risk. Mr. Devine added that the MPAC would take all of the information into consideration and make recommendations to SAPTA for grant applications and planning. Ms. Peek said MPAC's next meeting is scheduled to review the data profile in order to make recommendations about funding for the new five-year cycle for PFS funding.

Ms. Peek pointed out that the demographic snapshot seemed straightforward. Ms. Morgan added the report was based on one produced two years ago, the major difference being the structure. When originally produced, information was organized by "state speak." The regional behavioral health boards said they would prefer to follow topics by subject. She asked if the workgroup would provide the context for the data. Data that looked weird would require more research or looking at the topic in a different way.

Ms. DeLett-Snyder said the topic of the next PFS was underage drinking, plus two other drugs. She asked if the report would inform the MPAC for the next PFS grant, rather than for the one that was ending. Mr. Devine replied the report should inform the MPAC about the current application for the new PFS. Ms. DeLett-Snyder noted the executive summary did not include anything about underage drinking. Ms. Thompson said the Youth Risk Behavioral Survey (YRBS) was included in a special section on youth population. Ms. Peek said they could use specialized data from YRBS related to alcohol and youth for the MPAC, or SEW could speak more broadly about what it saw in substance use, speaking to the Block Grant and the other funding streams. Mr. Devine said he discouraged focusing only on alcohol. Based on the recommendation of the MPAC, SAPTA could work toward other priorities—substances or specific populations that need to be targeted. He said the more information given to the MPAC, the better decisions they could make. Ms. DeLett-Snyder stated that while alcohol was not in the executive summary, marijuana and methamphetamines were.

Dr. Azzam asked if this was a standalone report or if it was directed to supporting grant applications. Ms. Morgan replied it was a draft based on available data. SEW would need to make the report meaningful, providing context for the data. She pointed out that if analytics drove the content without program input, the report would have no value. Ms. Peek asked if the information could be presented to the MPAC in July so they could make decisions. Mr. Devine asked if the data in the draft was solid. Ms. Morgan said it was solid, but death data was preliminary because the 2017 data was not finalized. She expressed concern that the draft had not gone through their rigorous internal review process. If deemed final, it would be missing the finishing touches. Mr. Devine replied that if what MPAC needed was in the draft, it could be presented as a preliminary report. The main findings could be presented to give MPAC enough information to make their decisions, and the

report could be finalized later. Dr. Azzam asked if they could approve the report as a draft. Ms. Peek did not think it was necessary; the report could be finalized at the next meeting. She said the SEW needed to agree on what content to provide to MPAC and on recommendations to MPAC about funding for certain data projects since a portion of PFS funding was to support the SEW. In the past, those funds were used to support the data needs of the SEW—YRBS, the Behavioral Risk Factors Surveillance Study (BRFSS), and the perception questions related to youth for some of the coalitions. $150,000 has been budgeted to support SEW's efforts. Mr. Yang asked if there was interest in data related to pregnant women. Ms. Peek suggested some funds go to the Pregnancy Risk Assessment Monitoring System (PRAMS). Other funds overseen by SAPTA specifically relate to women of childbearing age. She added that PRAMS data would be one of the only valid sources of perinatal substance use information. Mr. Yang said the CDC provide basic support for PRAMS. He pointed out the PRAMS data was ongoing. Ms. Mburia stated the CDC required PRAMS to collect data for at least one year before the information could be shared publicly because the data needed to be weighted before being analyzed. Mr. Yang said the information could be used internally. Ms. Peek explained that data regarding substance use and pregnant women has been self-reported on birth records and occasionally noted in discharge billing. Her team has used discharge billing to understand the population affected, but PRAMS will become their primary source. Ms. DeLett-Snyder referred to birth data on page 49 of the report that showed alcohol as the second highest-used drug by pregnant women, with marijuana being first.

Ms. Peek asked what age group was considered youth for the PFS grant. Mr. Kirby said for underage drinking, youth are ages 9-20. Ms. DeLett-Snyder pointed out that there could be pregnant moms in that population. Ms. Peek asked if it would be helpful to have information broken down by the age of the mother. Mr. Yang said the information was available. Mr. Devine stated the grant application was looking for priority populations, so if MPAC and SEW recommended addressing the priority population of newborns or mothers, it could be done. Ms. DeLett-Snyder noted that at their coalition meeting they talked about pregnant and breastfeeding mothers who were using marijuana. The school district surprised them by wanting the information for their schools. Ms. Peek said if the PFS focused on ages 9 to 20, the data presented should be focused the same way. Ms. Morgan suggested inserting a special population for them at the end of the report. Ms. DeLett-Snyder pointed out that the whole grant was not only focused on that age group. Ms. Thompson suggested adding a chart pertaining to neonatal substance use.

Ms. DeLett-Snyder asked what "Substance Use Chief Complaints" on page 34 meant. Ms. Morgan said there was an area that explained their data sources; this one related to syndromic surveillance so the data was collected before diagnosis coding—not what the patient disclosed, but what the intake person in the emergency department viewed as the chief complaint.

Mr. Kirby pointed out that the PFS grant could include substances besides alcohol—it could include marijuana and methamphetamines for all ages. Ms. Morgan asked if it made sense to make the executive summary geared toward PFS indicators. Mr. Kirby replied that the report did not need to be geared toward the PFS application since the report was broader than that. Ms. DeLett-Snyder said she thought the goal of the MPAC was to advise on the grant. She believed if this report was going to be owned by MPAC, it would need to include the priorities of PFS. Mr. Devine recommended including all the major findings in the executive summary, prioritized by the top three. That way, the report would be applicable to more than just the PFS grant. Ms. Peek recapped that the executive summary should include alcohol use by those ages 9 to 20, methamphetamine and marijuana use, and identify the populations most affected so the MPAC could make it recommendations.

Mr. Yang said the YRBS was in two sets—one was from schools picked by the CDC. He asked if Ms. Thompson used the data from those schools or the data collected by the State at the census. Ms. Thompson said she used data collected by Nevada. Mr. Yang pointed out some formatting corrections needed. Ms. DeLett-Snyder asked if the data used on pages 44-45 was specific to Nevada. Ms. Thompson replied that national data for 2017 was not yet out. Ms. DeLett-Snyder asked why the data was not compared to the data from 2015. Mr. Yang said a new report was recently

completed that would compare the two years. Mr. Egan asked for clarification on Figures 11 and 13. Ms. Morgan said Figure 11 was data based on the chief complaint when a person presented at an urgent care or emergency room (ER), prior to a diagnosis being assigned. Figure 13 was based on a different data source—the claims for billing data for emergency rooms after a diagnosis code was assigned to the visit. It did not include data from urgent care centers. Ms. Thompson asked if Figure 11 should only contain 2018 data to show what was happening now. Ms. Morgan explained that Figure 13, ER data, has been solid for many years. Figure 11 was based on Syndromic Surveillance, a fairly new program. There will be an increase shown over time as facilities report data. Ms. Morgan suggested removing 2016 data and only offering 2017 data. Mr. Devine reminded the group that suicide and suicide ideation could be the result of any one of the underlying conditions. If the suicide rate were going up, all of the anxiety disorders, depression, bipolar, and post-traumatic stress disorder (PTSD) should be going up as well. The diagnoses may not be suicidal ideation, but could be PTSD with a secondary diagnosis of suicidal ideation or attempt. Ms. Morgan suggesting they use the data in combination, understanding that the data sources differ. She pointed out that at admission, there could be only one chief complaint while hospital billing data could include up to 33 diagnosis codes for a single visit.

Regarding Figure 16, Mr. Delap asked what caused the difference in suicide ideation in years 2015, 2016, and 2017. Ms. Morgan agreed that it look odd, although she pointed out that 2016 was the first year that ICD-10 codes were being used. She was not sure if suicidal ideation was a diagnosis that had drastic changes made to it. She said the transition from ICD-9 to ICD-10 did not affect disease groups consistently—some disease groups remained consistent in their trends, others had greater changes. Mr. Yang said a publication was available called "ICD-9 to -10 Crosswalk" that showed the percentage of change in diagnoses, adding that some diagnoses changed up to 30 percent. Ms. Peek asked if the AVATAR table included data from outpatient clinics, as well as Northern Nevada Adult Mental Health Services (NAMHS) and Southern Nevada Adult Mental Health Services (SAMHS). Ms. Thompson replied that it did. Mr. Devine asked if suicidal ideation could be broken out by groups. Ms. Thompson said there were tables in the back breaking it out by race and age. She added they did not divide it into special populations because there was no report focused on suicides in general for Nevada. Mr. Eric said Nevada does not have a standing report. He thought that the dashboard Ms. Morgan was working on would provide data that could be used in a report. Mr. Devine said if this report was being used to guide the development of programs, it would be advantageous to have it broken into age groups and regions. There could be anomalies in the data with the information lumped together. If there were a suicide cluster with adolescents, or if the suicide rate went up for veterans, it would be helpful to be able to see that in order to zero in programmatically to improve intervention. Ms. Thompson directed the workgroup to Table 7. She said she could provide the information with each of the mental health groupings. Ms. Peek suggested a special one for suicide. Mr. Devine did not think MPAC needed that level of detail, but it would be advantageous for the Bureau to have the information. He thought MPAC would need the information if there were a correlation between an increase in suicidal ideation and an increase in alcohol usage or something like that. Ms. Peek said YRBS allowed them to crosstab to discover those correlations. Ms. Morgan said that could be done using billing claims. She suggested making the data available in supplementary data requests. Ms. Peek asked if they would be interested in outlining next year's what factual reports priorities. The group approved of the idea.

Ms. DeLett-Snyder stated there were typographical and spelling errors throughout the report. Mr. Delap pointed out Figure 18, showing utilization of state mental health clinics by gender, showed utilizations going down. He suggested data be included for those who do not identify as male or female. Ms. Peek said information could be identified by Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) qualifiers. Ms. Thompson said the reason that data was not used was it would show almost a straight line on zero because it was such a small group. Ms. Morgan agreed it was a small number, but the number was important because it affected funding, the implementation of the Affordable Care Act (ACA), and Medicaid expansion—context that needed

to be added to the report. She said Medicaid did not have many standing reports, but she could add enrollment so the upward Medicaid enrollment trend could be seen. Mr. Devine asked for a comparison of the trend in use of state facilities and the trend in use of services in the community. Ms. Morgan pointed out that Medicaid was the only data source available. Mr. Delap asked if the effective date of ACA could be noted. Ms. Morgan said this information was not specific to a diagnosis code, but reflected those who had episodes at state-funded facilities. She suggested they define which services people went to state facilities for, then identify that population in Medicaid data.

Ms. Zhang asked about the methodology involved. She mentioned the CSTE recommended a document called, "Surveillance Indicators for Substance Abuse and Mental Health." The document presented all of the methodologies for recommended indicators. She asked if they were aware of this reference when they wrote their draft. Ms. Morgan said she was not. Ms. Peek said she would send the document to Ms. Morgan and Ms. Thompson. Ms. Thompson said she used a methodology similar to what the CDC required they use for the other PFS grant, except that CDC only looked at a primary diagnosis.

Ms. DeLett-Snyder asked who the intended audience for the report was. Ms. Peek said MPAC and the regional behavioral health boards were. Ms. DeLett-Snyder suggested they include a summary of the data sources. Mr. Egan appreciated that most of the data was broken down by age group, providing a direction to go. Mr. Delap pointed out that hospital billing data was cited in the beginning. He asked if billing codes for Medicaid would be helpful. Ms. Morgan said it would depend on what they were looking at. With hospital billing data, they based their analyses on diagnosis codes, but that data was only available for hospital facility claims and would not include community providers. For Medicaid data, the same thing can be done and claims could be pulled at the provider level based on diagnosis code. She added that in AVATAR, a claim did not have to be based on a diagnosis code. But could be based on an episode of care or a bundled rate—making it difficult to identify a visit with a diagnosis. Mr. Delap pointed out that if someone wanted to look for the cost to the public for preventing or treating or intervening, hospital billing codes could follow that. If someone wanted to make decisions or inform people who would make decisions about where to put resources, it would be helpful to know if there were good performers. Ms. Morgan clarified that hospital billing data did not include the actual amount paid on the claims; therefore, the billing data could not be related to a cost. She and Mr. Yang explained they received the data for Medicaid claims only. Ms. Morgan said, because of contractual arrangements, no data could be released that would reveal a managed care organization's (MCO's) payment structure. She explained there was transparency on the Medicaid fee-for-service side, so costs related to fee-for-service could be reported, but added fee-for-service accounted for only 25 percent of the Medicaid population.

Mr. Devine mentioned that the substance abuse section of the profile compared Nevada with the United States. He asked if significant differences between what was happening in Nevada and what was happening in the country could be flagged to direct where to put resources. Ms. Morgan said it would depend on whether the information was given in percentages or if they were provided the data behind the percentage. She agreed it would be helpful. Ms. Thompson said she added confidence intervals for the tables. Ms. Peek suggested the information showing significant increases or decreased be noted. Ms. Morgan said they could flag anything significant in the appendix and it could be written in the executive summary. Mr. Yang asked if marijuana was included in Figure 26 regarding illicit drug use. Ms. Thompson said she would clarify definitions to find out if marijuana was considered illicit since it continued to be illegal in many states. Ms. Thompson added that marijuana was listed with methamphetamines in ICD-9. In ICD-10, it has separate codes.

Ms. Peek moved on to the special section for LGBTQ. She asked if YRBS included gender questions. Mr. Yang said it did. Ms. Thompson said she could add the information to the LGBTQ section. Ms. DeLett-Snyder pointed out that they went from the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV to DSM-V. She said she knew some providers in Washoe County

were still using DSM-IV, which could make a significant difference. Ms. Morgan said they would be careful, when noting something was changing significantly, to not identify why. They might include a statement such as, "This corresponds with the timeframe in which the ACA was implemented." Mr. Yang said labeling something significant could be misleading. If the data collection was based on a small number, a significant change might not show up, but there could be social or clinical significance. Ms. Peek said the SEW should meet again after the PowerPoint presentation was put together, prior to its being presented to MPAC. Ms. Morgan asked if a PowerPoint was needed or if the draft could be presented. Ms. Peek said she would be presenting information to a general audience, so Ms. Morgan should give them a PowerPoint of the areas discussed—youth (ages 9-20) alcohol use, marijuana use, methamphetamines, and any other areas of significance that were found. Mr. Devine suggested the PowerPoint presentation be based on the executive summary that would highlight the areas appearing to be significant. The written draft report could also be given. Ms. Peek said SEW would present it to MPAC. Mr. Martinez said the PowerPoint would have to be posted prior to the MPAC meeting on July 12. Ms. Peek suggested SEW meet on July 9 to review edits to the profile and to review the PowerPoint presentation.

Mr. Devine asked if the report could highlight the contrast between the LGBTQ population and the general population to see if that population used substances significantly more. Ms. Thompson said such data was not available. Mr. Yang said YRBS would have a report, but not for 2017. All of the 2015 data was compared. Ms. Morgan said they could go through the special populations section for LGBTQ with information based on BRFSS and YRBS. Ms. Peek said another section of the Agency was working on an LGBTQ strategic plan, but a special report could be done for them. Mr. Devine pointed out that MPAC would identify special populations to address. They could not be identified if not contrasted with the general population. Ms. Peek tabled approval of the report until the October meeting. Mr. Devine said SEW was required to give the data to MPAC so they can make decisions and suggested it be finalized prior to the October meeting. Ms. Peek said they could do sub-reports for the behavioral health boards. Ms. Morgan said she could provide the regional boards their reports prior to this report being finalized. Ms. Peek said the report could be reviewed at the October meeting. It was pointed out that the behavioral health boards would need their reports before they have to submit Bill Draft Requests (BDRs). Ms. Peek tabled approval of the profile until the October meeting. Mr. Devine said individuals could send Ms. Peek edits, but the profile would need to be approved by SEW as a body. Mr. Kuzhippala clarified that at the July 9 meeting, the PowerPoint would be approved and the report would be approved if it was ready, otherwise it would be tabled to the next meeting. Mr. Martinez pointed out that the SEW would use the PowerPoint to make its presentation to MPAC.

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

Mr. DeMarco reported the Central Data Repository (CDR) was in the user acceptance testing phase, which was extended due to resource constraints and in order to do a more thorough testing. He said they were testing in a "black box" environment where they input data that was then processed, but they did not know what was going on in the system. He said his team ran reports and viewed data elements after providers uploaded their files into the CDR. He said the next step was the Treatment Episode Data Set (TEDS)/National Outcome Measures (NOMS) extract. Because he does not have the source data, they have manufactured data. With that data, they look for relevancy and to make sure the correlations are there. Their goal has been to test each data field to validate that the documentation given matched the function of the software. They have been evaluating the system as the programs execute, not by what the documentation says. The documentation comes from the extracts. Ms. Morgan asked if they were making mock data to run through the logic. She wondered if they could take a TEDS extract being submitted a different way and feed it through the CDR so that it would be a real test submission. Mr. DeMarco said they could not because the data her team used was formatted differently and was in a different order so was not usable. Some of their data could be used to build a test case. He stated there were many more data elements and required fields

than were included in the past. FEI Systems has been contracted to help with this. They have been testing to ensure data successfully goes to TEDS; they have not been looking at data quality. He reported that data quality was important to make sure, at the field level, information was accurate. He said they have talked with some electronic health records (EHR) vendors about the process. The vendors have seen the file structure. They will not have the vendors do any analysis until the CDR is in production to ensure the documentation matches the system. No timetable has been set.

Mr. DeMarco said his team was working through scenarios for the test cases. He said they were currently receiving so many errors that they have had to retool. Ms. Morgan reiterated that the data providers would submit through the CDR for TEDS would be a different format extract than what they currently submit. She asked if providers were aware that they would have to have their vendors build new extracts in order to resubmit TEDS. She said it took years to get 80 percent of providers to submit their TEDS extracts in the current format. She hoped work was being done with them prior to bringing the CDR online so that they were aware of the changes in reporting requirements. Mr. DeMarco said AWARD and Methasoft are the major EHR vendors, covering 90 percent of the providers. AVATAR providers were coming over to WITS so will continue to extract as is until they change from AVATAR to WITS. He said data formats were presented to AWARD and Methasoft and both vendors understand the process and the rewrite required. Providers have been informed that they would be collecting more data with required fields. Ms. Peek pointed out providers were given information well in advance about the coming changes. Ms. Morgan recommended there be an overlap period for quality control purposes. Mr. DeMarco said they would provide training in a production environment. Once in production, providers will submit in the new way. He said there would be a period of parallel testing until they were sure the system worked properly. He said they did not know what the extent and level of effort the changes to the front end EHRs would be and what the impact would be on the staff collecting the data. He pointed out they needed to be careful not to overburden them with required fields. TEDS and NOMS data will have to be entered. He hoped the EHR systems will not have them put it in on Day One, but have it there before they submit it. Under the current process, providers submit data to the State, then it is run out to TEDS. If warnings or errors are found, the State fixes them in the database and resubmits them. No changes can be made in the CDR, so the information will go back to the providers to correct. He suggested process changes be put in place about the providers' data. He noted the system would provider better data integrity, but could be perceived as more work. Mr. Devine said the CDR was being created to collect more data than just TEDS data—it will collect TEDS, NOMS, and grant-required data and will be the one source for all data needed for reporting. As such, there are additional required fields. They have found two issues—a systems issue of being able to collect data in the right format from providers' EHRs; and a user input issue. Extensive field work will be done, with the WITS team going out to each provider to make sure staff inputs data the way required. A file submitted with errors will be returned to the provider to fix. Ms. Peek asked if they could tie that to reimbursements, but that might result in providers not being able to pay their staff. Mr. Devine said it would be different for prevention because prevention was adopting WITS. Ms. Peek said there has been an ongoing issue with submitting correct and complete monthly TEDS data. Mr. Devine explained that TEDS was a federal standard. Ms. Morgan pointed out they were well aware of the difficulties Nevada had with its providers and that Nevada has not been completely compliant with reporting the data. Mr. Devine added that SAMHSA was glad Nevada moved to WITS. Mr. Kuzhippala asked why other providers were still using Methasoft and AWARDS if a system was developed for some providers to use WITS. Ms. Morgan pointed out that WITS was an EHR. Mr. Devine said Methasoft has opioid functions that WITS does not. The function could be built into WITS, but it has to be determined if there is value in doing that. He said it did not matter which EHR an agency used as long agencies provide the data in the prescribed manner for reports. The State has made WITS available, but no one would be forced to use it. Ms. Morgan said the CDR allows them to submit TEDS without adopting WITS.

Mr. Devine pointed out that SAPTA would be able to see prevention data through WITS. Mr. DeMarco said prevention did not have a system now, so providers were happy that the WITS' prevention system would interact with the State. Providers will input plans and strategies for approval online. Reporting will be in the system, too. Providers will be able to get their own reports. He thinks the system will be mutually beneficial. Regarding payments, Ms. DeLett-Snyder said prevention might hold environmental strategies meetings. There could be meetings and activities and policy changes involved, but it would not be one specific thing like seeing a client. She said at some point, she would say a meeting took place with a specific number of people and this was the outcome. Payment for the meeting would not be much, but would be based on the time involved, which is different than the way treatment bills.
Quorum was lost at approximately 3:15 p.m.

8. Present the Department of Education's School Climate Survey

Ms. Reid, with the Office for a Safe and Respectful Learning Environment, said her office was created in 2015 when Governor Sandoval made sweeping provisions to the state's anti-bullying laws and simultaneously proposed the Social Workers in Schools state block grant. With passage of those two measures, over $17 million was allocated to put social workers or other licensed mental health workers into schools with identified needs. A survey or mental health screener was required to identify those needs Ms. Reid said the Nevada Department of Education (NDE) worked with the American Institute for Research (AIR) to develop the school climate survey, known as the Nevada School Climate/Social-Emotional Learning survey (NV-SCSEL). She said the fourth administration of that survey was completed in May, adding three different school climate surveys were administered in the state—Washoe County School District and Clark County School District each has its own survey and owns the data from them. She said Washoe County publishes its reports and shares its findings. Clark County allows only school-level administrators to view the data; the Department of Education has not been able to access their results. Ms. Peek asked if the Nevada Revised Statutes (NRS) was written in a way that allowed NDE to view results. Ms. Reid replied the school climate survey was within a budgetary bill, so it was not in NRS. She said she had to have Clark County's results in the initial round of awards and that AIR helped rank the schools across the state and across the three different surveys. Since then, they have been flat-funded at $11.1 million per year. Because of the flat funding, they have only been able to maintain the positions in schools that were awarded them initially. Data from Washoe and Clark Counties was not needed to fund additional positions because they have not had the funding. She anticipated that some of the Governor's School Safety Taskforce recommendations would include an expansion of the Social Workers in Schools program. She expected there would be strings attached in terms of what she can and cannot see and what she can publish.

Since there has been flat funding, the NDE set a participation rate threshold. In order to maintain social workers or to be eligible for additional social workers should funding become available, schools were required to have a 55 percent response rate for the 2016-2017 school year. For the following year, there had to be a 75 percent response rate. The data is not meant to be used as high stakes accountability. Different business rules accompany the administration of the survey. For the fourth administration of the survey, 47,263 students did not opt out. Of those, 45,915 completed the survey. The 256 schools eligible did not include Washoe or Clark County schools, except for Delta Academy—a Clark County district-based charter school. All the other State Public Charter School Authority schools and the fifteen rural and frontier districts used the survey. Esmeralda School District does not participate because it is very small district. Of the 256 schools, 248 participated; 225 reached the 75 percent response rate threshold; 135 were above a 90 percent response rate. When the NDE does program evaluation and other types of analysis, they can have a higher level of confidence in the data. The reports are available at http://reports.nevadaschoolclimate.org/. The development of Nevada's school climate survey was the model for the United States Education Department (USED) school climate survey. All of the items from Nevada's survey were incorporated

into the U.S. survey. Nevada's questions are clustered differently in terms of metrics. Nevada's survey looks at

- Engagement
  - Cultural and linguistic confidence
  - Relationships
- Safety
  - Physical safety
  - Emotional safety
- Social and emotional competency

The first four metrics are the students' perception of their school environment. Social and emotional learning is the students' perception of their own competence across seventeen items the Washoe County School District developed and uses. There are two metrics that equate across the three surveys—relationships and social and emotional learning. The four school climate metrics are reported as an index score of 100-500, with higher scores indicating better outcomes. Social and emotional competence is reported as a percentage, 0-100.

The NDE has noticed interesting patterns, looking at data across types of communities and locale codes—small, frontier communities and towns and urban communities—to see how they vary. They have done analysis, looking at schools with social workers and those that do not. The social workers' first year was the 2015-2016 school year. 2016-2017 school climate data should not have shown much movement. The data verified that social workers were placed in the correct schools, because the schools with social workers scored lower on the metrics than schools that did not. They hope to be able to use data collected regarding discipline events and attendance to see if the programs vary depending on whether a school has a social worker.

The national School Climate Social and Emotional Learning survey completed benchmarking studies. Nevada's scores for the coming year have been recalibrated according to the national benchmarks. The scores will now be reported and disaggregated across additional subgroups with *N* numbers represented. Previously, Nevada could say its students of two or more races scored lower on all metrics. In some of Nevada's smaller schools, that is only a few students. These reports will be provided in addition to school-specific reports that give trend data with their previous scores recalculated according to the new national benchmarks. Some peer matching has been done so that schools can compare themselves to schools like them. For example, when Silver Stage High School looks at the state benchmark they can know what that means and it is not compared to Western High School. Schools will be able to see where they fall in terms of the national benchmarks. With benchmarking for the four metrics of cultural and linguistic competence, relationships, physical safety, and emotional safety schools can be compared to each other. Comparing physical safety and emotional safety, based on the data recently collected, Nevada students report 30 points higher on physical safety than they do emotional safety. This is good for the Governor's School Safety Taskforce to consider. She said this was true predominantly for rural and frontier districts and charter schools.

Ms. Reid said NDE is working with Washoe and Clark County School Districts. Clark County would like to use the state survey. Washoe County has 11 years of longitudinal data that NDE would not want them to lose, but if they could incorporate enough items from the state's school climate survey, an equating study could get the other metrics to come in line.

Ms. Reid said this was the last year NDE had the support of AIR in administering the survey. The next step is for NDE to own administration of the survey. They have submitted a budget request for a full time employee to do that. The employee would be shared between their office and the assessments and data accountability measurement team.

One thing that has helped drive participation rates is a decision that is spurious on the statistical side. Schools hitting the percentage of participation benchmark were given two bonus points in the student engagement category on their Nevada School Performance Framework (NSPF) Accountability rating scores which generate schools' star ratings. The total points available per

school is 100. One school achieved a score of 102. She said she appreciated the carrot that offered for schools to participate in the survey, but it will be removed after this year. She said NDE is trying to create a matrix similar to the performance framework that does not carry the weight of high stakes accountability. They do not want the survey to have the burden of high stakes accountability because it could skew the stress level of educators and students. She pointed out there were schools in Nevada with a 60 percent transient rate, meaning two-thirds of the students in each classroom at the beginning of the school year were not in the class by the end of the school year. No matter what these schools do, they will not be able to impact academics the way they would like. She said they would like to give schools credit for the things they do well that are not reflected in data. They will be developing a matrix that can stand next to the NSPF. With this work, two BDRs will be supported by the Governor's School Safety Taskforce. There currently are not definitions in statute for behavior incidents. When you look at statewide data on suspensions and expulsions based on threat of violence to staff or students, possession of a deadly weapon, possession of drugs with intent to distribute, and significant bodily harm have no standardized definitions. When they collected their applications for the Social Workers in Schools grant, they expanded the data collected and asked for data on some of the big discipline events and data on special populations—free-and-reduced lunch category, Individualized Education Plan (IEP) students, and English-learners. A small rural high school of about 400 students reported they had 1,800 incidents of threats to staff. They coded things as threats to staff that other school districts coded as defiance, disrespect, or insubordination. To do analysis on state-level data, NDE does not have confidence there is enough common understanding of terms.

Ms. Reid said they want to be able to disaggregate data by subgroup more cleanly. They do not disaggregate data if not mandated by NRS or federal requirements. After reviewing the new reporting requirements under the Every Student Succeeds Act which shows all the subgroups, they would like things in statute so they can look at disproportional practices and outcomes.

Last year and this year, NDE used the Data-Ready Nevada Roadshow that went to four regions in the state, providing training on how to use data from the Nevada report card and the school climate surveys for their school improvement planning and continuous improvement processes. They will provide additional trainings on: chronic absenteeism, opportunity gaps, and college and career readiness. This will teach schools why the school climate data is valuable to them and how it impacts their academic outcomes.

National tragedies have helped them see the need to pay attention to not just physical safety, but emotional safety in schools. Safe Voice, an anonymous tip reporting system, rolled out across the state and is collecting good data. The first tip was received on January 8; to date, there have been nearly 2,600 distinct tips. The bulk are bullying complaints, but there have been approximately 150 suicide threats resulting in numerous incidents where students were deterred from completing their suicide plans. Students can use an app, report online, or call in to report substance abuse, smoking, physical and sexual abuse, and sexual harassment. There have been 23 reports of sexual harassment. The NDE hopes to crosswalk the three places information is collected on safety or mental health. Ms. Reid said she wants to see if the data schools give NDE on bullying and cyberbullying lines up with data from Safe Voice or the school climate survey. Ms. Peek pointed out the YRBS has bullying data. Ms. Reid said some YRBS questions align with school climate questions. Ms. Peek added that if YRBS becomes a computer-based survey, the results could change.

Ms. Reid said the school climate surveys have been done in the spring, but there is research indicating it would be better to assess school climate at the end of the first semester rather than in the spring when other testing is done. She said NDE might test in December and in the spring to see if there were changes between the two. Traditionally, the climate tends to decline as students get older.

Ms. Peek said SEW had access to Crisis Call Center data. A meeting was planned with NDE to look at how to combine funds for crisis calls. Ms. Reid said the Crisis Call Center provided immediate

intervention while Safe Voice was a software platform where users can enter data that is tracked. School teams and law enforcement agencies access it. It is a way to collaboratively case-manage those things, which is not what the Crisis Call Center does. When the Crisis Call Center takes a call, it is often referred to NDE, which had a button for reporting bullying. That button now redirects to Safe Voice, as does Clark County School District's. Safe Voice is a research grant. Cohort 1 schools rolled out in January; Cohort 2 schools, the rest of the state, will roll out in August. Every tip a student submits through Safe Voice is sent to a team of at least three-people at the school involved. If there is an acute concern, law enforcement immediately takes it and does a welfare check. Digital threat assessments can be done. When Safe Voice does not have a student's name and the school cannot track him, law enforcement has the resources to do so. Follow-up will be done at the school. The school team will connect with the family, making sure the family has referrals and the resources needed. She found it alarming that they have received 2,600 unique tips in such a short amount of time, but each student kept from harming themselves or causing long-term trauma was a victory. They have had challenges with student information systems, but have found a workaround. The federal government is revisiting the Family Educational Rights and Privacy Act (FERPA). Nevada has been asked to spearhead that, as Nevada has the qualitative and quantitative data to explain why access to student information is needed.

Ms. DeLett-Snyder asked if substance use data was in any of the survey questions. Ms. Peek thought there used to be a question related to drinking. Ms. DeLett-Snyder said there was an issue in Washoe County because they removed all the perception questions related to substance use. They have added them back, but are concerned because of the length of the survey. Ms. Reid said Clark County had the same problem—their survey has become unmanageable. The climate survey added six questions for Safe Voice this year. Two school districts include some of the YRBS questions in their surveys every year. Ms. Peek asked if NDE had access to the data. Ms. Reid replied they do. She said when AIR did an equating study last year, they could not equate physical safety or cultural and linguistic competence with Washoe County's survey. The social emotional learnings were identical items. She confirmed the survey does not ask about substances. It asks about physical safety with weapons. Ms. DeLett-Snyder said Washoe's survey was the only source they had for perception data. Mr. Yang helped Ms. Ross and others figure out some perception questions because they are not being asked. She added she hoped Washoe County would not dump its survey because they have so much good data. Ms. Reid said she thought they could find a middle ground with Washoe County, suggesting they incorporate some YRBS questions as those two other school districts have done. Mr. Yang said the YRBS is done every other year. In the year it is not done, questions could be included in the school surveys. Ms. DeLett-Snyder said it would be helpful to have questions regarding prescription drugs, marijuana, and alcohol use.

9. Recommendations for Substance Abuse Prevention and Treatment Agency (SAPTA) Funding for Data Projects

This item was tabled to the July 9 meeting due to lack of quorum. Ms. Peek mentioned that YRBS was funded in the past. The perception questions survey would likely coming out of PFS. Mr. Kirby said $150,000 was set aside in the budget. Ms. Peek asked the workgroup to consider what the data gaps were they would recommend be funded. She added she would like to fund PRAMS and the moms and babies population.

Ms. Peek said the July meeting would include reviewing the PowerPoint, the epi report, and public comment. She said the meeting would be held July 9, 11:00 a.m. to noon.

10. Make Recommendations of Agenda Items for the Next Meeting on October 18 at 9 a.m.
    - Maternal Child Health highlights related to substance use issues
    - Decide on priority reports for the next year
    - WITS update

- Approval of minutes
- Legislative issues, including a BDR for real-time overdose reporting for emergency medical services and law enforcement
- Approval of final draft of the data profile

11. Public Comment
There was no public comment.

12. Adjourn
The meeting was adjourned at 3:55 p.m.