STATE EPIDEMIOLOGICAL WORKGROUP
MINUTES

DATE: Wednesday, August 16, 2017
TIME: 1:30 p.m.

	Meeting	***Videoconference***
LOCATION:	Division of Public and Behavioral Health 4126 Technology Way Second Floor Conference Room Carson City, Nevada 89403	Rawson-Neal Psychiatric Hospital 1650 Community College Drive Training Room Las Vegas, Nevada 89146

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

BOARD MEMBERS PRESENT

Julia Peek, Chair	DPBH Office of Public Health Informatics & Epidemiology (OPHIE)
Eric Ohlson	Washoe County School District
Gwen Taylor	ACCEPT
Ihsan Azzam	Division of Public & Behavioral Health (DPBH)
Ingrid Mburia	DPBH, Maternal Child Health Services (MCHS)
James Kuzhippala	DPBH
Jennifer Snyder	Join Together Northern Nevada
Kathryn Barker	Southern Nevada Health District
Marco Erickson	DPBH
Pauline Salla	DPBH, Juvenile Justice Programs Office
Richard Egan	Office of Suicide Prevention
Trey Delap	Group Six Partners
Wei Yang	NV Center for Health Stats and Info, UNR
Yenh Long	Board of Pharmacy
Stephanie Asteriadis Pyle	Center for the Application of Substance Abuse Technologies (CASAT), University of Nevada, Reno

BOARD MEMBERS ABSENT

Jim Jobin	Vogue Recovery Center
Sue Meuschke	Nevada Network Against Domestic Violence

STAFF & GUESTS PRESENT

John Fudenberg	Clark County Coroner
Linda Lang	Nevada Statewide Coalition Partnership
Kyle Devine	DPBH
Mark Disselkoen	CASAT
Erika Pond	Department of Health and Human Services (DHHS)
Heather Mitchell	DHHS
Damaris Richardson	Substance Abuse and Mental Health Services Administration (SAMHSA)
Raul Martinez	Substance Abuse Prevention and Treatment Agency (SAPTA)
Stephen Wood	SAPTA
Joan Waldock	SAPTA
Diaz Dixon	Step 2
Lea Cartwright	Nevada Psychiatric Association
Lorne Belt	OPHIE
Michelle Frye-Spray	Center for the Application of Prevention Technologies
Henry Agbewali	OPHIE
Brian Parrish	OPHIE
Christine Medley	Fort Mojave Indian Tribe

1. Welcome and Introductions

2. Public Comment

Mr. Martinez introduced himself as the facilitator for the SEW meetings. He also introduced Ms. Waldock and Mr. Wood.

Mr. Egan reminded the workgroup of the upcoming Suicide Prevention Walk across Nevada on September 9 in 13 communities. He noted a website https://nvsuicideprevention.org/ as a resource for community members and agencies. Ms. Peek pointed out that for first time in history, Nevada is not one of the top ten states for suicide, although it is number eleven. Mr. Egan stated that, up to 1999, Nevada was number one. Between 2000 and 2010, Nevada fluctuated between number one and number five, moving to number six in 2011 and to number seven in 2012. In 2013 and 2014, Nevada moved back to number six and jumped to number eleven in 2016. Ms. Peek congratulated the team for the progress.

Ms. Medley asked if any of the opioid surveillance grant money would be allocated for tribes. Ms. Peek said that could be discussed when they were on that agenda item. They would also be discussing the opioid grant and how the surveillance funds would be slated for use, and how that data could be given to the tribes. She noted there would also be a good amount of money for treatment services. Ms. Medley asked if she, as the public health preparedness coordinator, could be added to the mailing list. Mr. Martinez gave her his contact information so that he could add her to the list.

3. Approval of April 27, 2017, Meeting Minutes

Mr. Delap pointed out some corrections that needed to be made. He noted that in agenda item 3, they had been discussing International Classification of Diseases (ICD)-9 and ICD-10 codes, while the minutes reflected ICU 10. He said they also referenced CRGs and there were typographical errors with that. On page 3, the word "effort" should be changed to "expert." They also discussed the use of current procedural codes, which was typed differently. Ms. Peek noted there were some minor grammatical and other errors. Dr. Azzam presented a few edits. The group could decide to email the minor changes to Mr. Martinez, then vote to accept the minutes at the next SEW meeting, or they could go through the changes and approve them at this meeting.

Ms. Mburia mentioned that she was listed as both present and absent. Ms. Peek reminded her that she had left the meeting early, so quorum was an issue. Quorum was maintained by Dr. Azzam's joining the meeting. Ms. Peek noted that Mr. Erickson was no longer with the Department of Education.

Dr. Azzam moved to approve the minutes with his written edits and the others mentioned. Dr. Yang seconded the motion. The motion passed without opposition or abstention.

4. Legislation Overview – AB 474

Ms. Peek reported that the Governor's substance use bill received a lot of support during the legislative session. In relation to SEW, drug overdose became a reportable condition under Nevada Administrative Code (NAC) and Nevada Revised Statutes (NRS) 441A, the set of statutes and regulations affecting epidemiology and disease reporting. While this was not an action item, Ms. Peek wanted to describe the process so the group could discuss it. Once they developed a draft of the regulations, they would be given to the group for approval. The revision codified that a physician, nurse, or veterinarian licensed in accordance with state law or a physician's assistant would now be required to report a drug overdose. Regulations would be very specific about what "drug overdose" meant. One concern presented was that "drug overdose" was a broad statement that could make it reportable if someone overdosed on blood pressure medication. That was not the intent behind the bill and created the need to very specifically express what it means in the regulation. Ms. Peek stated they met with their internal team of Dr. DiMuro, Dr. Woodard, and the biostatistics staff to dig into this. Their tentative consensus was that health care providers would need to report a suspected overdose or a confirmed overdose of a Schedule I, II, III, IV, or V drug as defined by the Drug Enforcement Agency (DEA). Dr. Azzam asked how providers would report Schedule V drug overdoses. Ms. Peek replied that a different bill defined "opioid related drug overdose." Her team had talked about using that definition, but thought they would limit it to the ICD-10 codes, which

has a code for suspected overdose. She reported it likely that the definition would apply to the relevant ICD-10 codes. Audit would be done in that manner as well—to see if a provider billed for one of those codes, but did not report a drug overdose.

Mr. Delap asked if this would be reported to the Prescription Monitoring Program (PMP). Ms. Peek replied that it would be reported to the Chief Medical Officer or his designee and the Office of Public Health Informatics and Epidemiology (OPHIE) at the Nevada Division of Public and Behavioral Health. As originally presented, AB 474 required the reports be sent to the relevant local health authority, but it would have been a burden on them to do the additional data reporting, so the bill was amended to require that the report be sent to a single source. They determined that, since drug overdose is not communicable, the local health authority does not need to immediately intervene to stop the spread of infection among the public.

Mr. Delap asked if reporting was a mechanism providers were familiar with, or if they would require training. Ms. Peek replied there would be a need for provider education. She stated they were trying to figure out how best to do this. If a new data system were required, they would have to go through the Request for Proposal (RFP) process. Their initial solution would be to use a fillable PDF morbidity form that could be faxed if the provider could not send it electronically. For the Legal 2000 population, something would be done in Emergency Rooms (ERs) whereby providers would fill out a PDF and place it in the secure file transport protocol file, then OPHIE would be able to pull the information for analytics and for referral. They would like to get some sort of web-based mechanism in place.

Dr. Yang asked if there would be any link to laboratory tests, as NRS did not specify that labs had to report likely communicable disease. Ms. Peek replied that the provider report would include the lab results, the type of sample (blood, urine, hair, etc.), and some additional information because labs would not be directly reporting. Dr. Azzam stated that most communicable diseases were reported by labs, very few by others. He stated they could not have high expectations that providers would report every overdose at the beginning of implementation. He suggested that the information be gathered retrospectively from hospital discharge data and then they would know how much they were missing. Ms. Peek stated that through the State Targeted Response (STR) Grant for opioids, an intervention with a hub and spoke model should take place. That would include having people in the ERs who could work to get overdose patients into treatment. In the major hospitals, there would be someone who knew about the reporting. She added they did not want the reporting to be a burden, but that they need the data. Currently, access to the data was delayed until there was a discharge diagnosis.

Ms. Barker recommended that, if they were planning on using ICD-10 codes to help form the definition of what is to be reportable, they could use a list the drug poisoning indicators workgroup has that classified these. She thought this list would make it easier to determine which they would look at for reporting.

Ms. Peek stated they needed to decide how often providers would report. She pointed out that for communicable diseases, providers were required to report within 24 hours of the diagnosis; for cancer, reporting requirements vary from 10 to 30 days, even longer for hospitals. The team met and concluded that reporting should take place within seven days of discharge from the facility. Dr. DiMuro felt that would give the physician time to do discharge notes and give the one reporting time to get that information to the state. That would also allow the state to know within a week if a problem existed in a community. She stated there were other mechanisms in place that could identify a problem more quickly. She concluded that their group thought seven days would be a reasonable amount of time to allow for the information to be sent to the state. Dr. Azzam asked if that meant seven days from the date of discharge. He asked what would happen if the patient were hospitalized for three weeks or if the patient died. He felt that the discharge date was a qualitative variable, but quantitatively, they should be looking at the date of admission. Ms. Peek replied that in communicable diseases the onset date is used, rather than the discharge date. She continued that the reason Dr. DiMuro recommended using the discharge date was that he thought this would be least burdensome in the business process of a hospital because the discharge notes would already be prepared. Dr. Azzam asked if they could require the report within 10 or 30 days of admission. Ms. Peek said that major hospitals run toxicology onsite, which does not take a lot of time, but the Rurals must send out toxicology and do not have results for several days. Dr. Azzam pointed out that would be the reason for requiring reporting within 10 or 30 days of discharge. He felt that the diagnosis of overdose could be made

immediately upon examination of the patient. He thought two to four weeks from the date of admission was plenty of time to make up their minds regarding diagnosis of overdose. It would be a stable date. Dr. Yang mentioned that when the patient no longer had symptoms, he would be discharged even if there were no final lab results.

Ms. Peek asked for more input, but there was none. She moved on to the topic of the content of what would be reportable. She stated that for a communicable disease report, that would include name, address, telephone number of the case; name, address, telephone number of the health care provider; the occupation, employer, age, sex, race, date of birth of the patient; if available, the date of diagnosis and date of onset. Her group definitely wanted to require the demographic information and information regarding the provider. In addition, since labs would not be reporting, they would want lab results with information about where the sample came from. They also thought there would be value in requesting the Prescription Drug Monitoring Program (PDMP) printout. The Division of Public and Behavioral Health (DPBH) would be able to get into the PDMP or have the data to validate information if the individual had a prescription. This would create another opportunity for the physician to go into the PDMP again, which is what they were trying to emphasize. A PDMP lookup could be required or optional, but Dr. DiMuro thought that was important to include. They also decided that information on the disposition of the patient—was he in the ER, Intensive Care Unit (ICU), in the ER initially and transferred to the ICU—while at that facility would be helpful. There should be self-reporting on previous overdoses in the patient's history, which might not be a reliable variable. They also determined they want to include ICD-10. She asked if any members of the workgroup had anything they saw as important that they would like included in the report. Ms. Mburia would like information regarding if the patient was pregnant. Dr. Yang thought it would be helpful to know if the admission was the result of a 911 call and if there was Emergency Medical Services (EMS) assistance. Ms. Peek pointed out that EMS was not considered a provider of health care in statute. Dr. Yang agreed that Emergency Medical Technicians (EMTs) did not make diagnoses, but they had a category they assigned to patients. Ms. Peek replied that, under the EMS statutes, there might be a requirement to report overdoses. She stated she would consider that and have the information for next meeting. She also stated that she did not know if they had the ability and latitude to reference a different NRS chapter when using the title "provider of health care." She suggested that if they chose not to quote NRS 441A and quoted NRS 629, a "provider of health care" means 25 different types of health care providers—a licensed psychologist, a marriage and family therapist, a clinical professional counselor, a music therapist, a chiropractor, or an athletic trainer—who would not see an overdose, but would be the type of provider required to report. She did not think EMTs were overseen by a physician, operating under a physician's license but are independent practitioners. Dr. Yang pointed out that EMS has access to medical doctors, if needed. He agreed that she was correct that EMS did not do onsite diagnosis, but they had a protocol for overdose as they saw overdoses often. Ms. Peek clarified that EMS would speak to suspected overdoses. She stated that at the next SEW meeting they would have someone from EMS explain what they reported into their system, although EMS is considering a new system. She was not sure if EMS would fall under NRS 441A requirements because "provider of health care" did not include them. Dr. Yang said EMS would normally send suspected overdose patients to the ER, but some patients decline treatment. He mentioned that he thought law enforcement should be included in reporting. Dr. Azzam suggested including first responders. He said he had seen an EMS report that stated, "overdose on insulin." He felt that if they could report that, they should be more capable to say there was a drug overdose. Ms. Frye-Spray suggested EMS could report if naloxone had been provided. Ms. Peek said they were trying to figure out what level of detail they could get from EMS.

Ms. Peek reported there was also legislation related to naloxone discussed during the session, part of the new grants. She stated there would be huge quantities of naloxone purchased that would be given to law enforcement, EMS, and community providers. She reminded them that a challenge they had in the past was being able to track naloxone distribution, let alone administration. They have been trying to figure out if they could create a central repository of naloxone, like the way they hold immunizations until they are needed by community providers. If a provider needed immunizations they could contact DPBH, who would contact the Centers for Disease Control and Prevention (CDC) to order what was needed. Then they could get that to the provider and track usage from local supply. She has spoken with Office of the Attorney

General (AG), which expressed interest in pooling the money for naloxone. The AG's Office's audience would be law enforcement and EMS. She felt that DPBH could meet the needs and not duplicate other providers who wanted that information, so they would like to centralize it into a true or a virtual warehouse for distribution. Ms. Frye-Spray mentioned that she thought Wyoming was looking at a similar model and that she would get them connected. Ms. Mburia asked about collecting provider information. She pointed out that it would be helpful to have the patient's address to know the county the patient came from. Ms. Peek replied that they have typically done that. She reiterated that the report would include all the patient's demographic information. Ms. Mburia was interested in obtaining the county of residence for the patient. Mr. Delap stated that, for therapeutic purposes, the type of opiate might not be identified, but for forensic purposes whether it was a synthetic opiate or fentanyl would be helpful to know. He continued that, when considering the definition of what an overdose is, the subclass of the opiate should be disclosed, as it would be helpful for surveillance and determining if there had been an increase in fentanyl-laced drugs.

Mr. Martinez asked for clarification regarding having someone from EMS go over what is reported in their system added to the next agenda. He asked if Ms. Peek wanted one of their staff members to attend the next meeting to tell SEW what sort of overdose is reported. Ms. Peek agreed and added she would also present a version of the language of the 441A regulation as an action item.

Dr. Yang pointed out that if they could not get a completed reporting system, they would want to know the prevalence and the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Surveillance System (YRBSS) could help. People are already being asked if they have used a drug. A follow-up question could be added, asking if they have ever overdosed or been treated for an overdose. Ms. Peek suggested they discuss that when they got to agenda item 11. She stated that when Mr. Kuzhippala prepared data for the Legislature, the BRFSS questions related to prescription drugs was a subset of a subset of a subset that did not give a true reflection of what is occurring. She recommended discussion of what would be a better question to get at the opioid issues that exist in Nevada.

Dr. Azzam asked what the timeframe was. Ms. Peek answered that they would be requesting a number from the Legislative Counsel Bureau (LCB) this year, which would start the timeline that requires it be implemented in two years, but added they hope to do it faster than that. Ms. Peek stated that her goal was to have good language by December so that it could be reviewed by SEW and by lobbyists before holding public hearings and workshops to move this through the process more quickly.

Ms. Zhang wondered if this useful information would be available to prescribers. If a patient overdosed, went to an ER, received a reversal agent, and went to see their Primary Care Physician (PCP) the next week, the PCP would not know about the overdose if the patient did not disclose the information. The doctor could decide to prescribe again, leading to another overdose. That would not fix the recurring problem. Ms. Peek said she would get with the Governor's Office to see if any of the bills addressed that issue. Once a patient has been identified as having an overdose, they consider the PDMP note for a legitimate prescription. That information could be provided to the prescriber, but they would have to determine who would notify the prescriber—DPBH or the Board of Pharmacy. She agreed that it would be valuable information for the prescriber to know there had been an issue with his patient. Dr. Azzam added that could be addressed in a general way through a professional education update because it is not known when this would happen, but it is happening and will continue to happen. He stated they would want prescribers to be aware. Hopefully, they would also be able to track it and provide remedies for it. Ms. Peek reiterated that this has happened, more broadly in the community with overdose. Plus, there have been notifications to providers regarding specific clients, to work with providers to get that patient treatment services or whatever would be necessary. Dr. Azzam pointed out that providers should prescribe narcotics for patients with diagnoses, not for patients with symptoms. He further stated that back pain is a symptom, not a diagnosis. A patient with back pain should be referred to a surgeon for a diagnosis. That is part of the education that should be provided. Ms. Peek mentioned that JTNN put on a workshop recently at which Dr. DiMuro and others presented information about getting to a diagnosis, how you get to a diagnosis, and the responsibilities of a physician. That event was well attended by northern Nevada providers. Dr. Yang added that discharge diagnosis could be a factor to consider. Ms. Peek suggested they could review Medicaid claims data for that information. They could look at pharmaceutical claims as compared to diagnostic claims

or other information to link them to see how many had specific diagnoses and how many were being treated for pain.
Mr. Delap pointed out that one challenge in reporting to the prescriber would be diversion of prescription opiates, so that mechanism should be addressed. If a provider received notification that a patient overdosed, it could be that the provider did not write a prescription for that drug. He wondered if there would be a way to verify that to save time. Dr. Azzam pointed out that patients do not prescribe drugs for themselves. In a workshop yesterday, if came out that a doctor would prescribe antibiotics fora patient with a runny nose or coughing. He reiterated those are not diseases; they are symptoms. It remained to be determined if the diagnosis was bronchitis or pneumonia. He thought they should be able to address these two issues and many others, including reporting in general, while addressing providers. Ms. Peek reported they have been linking how to work better with physicians during their medical education, teaching them about public health reporting, and responsible prescribing across the board—specifically antibiotics and narcotics. She said she did a presentation for the antimicrobial stewardship group in the north comparing the two efforts. She said she could have that information sent to the workgroup members, along with information regarding the epidemics of antibiotics and opioids. They parallel one another in terms of how many people die and the number of prescriptions. Dr. Yang mentioned that comorbidity should be a key word in this area, as there may not be a primary diagnosis.

5. New Opioid Surveillance Grants

Ms. Peek stated that Mr. Kuzhippala would be giving a report and that the vice chair would speak about the new opioid surveillance grants, which are limited to the CDC grant that is overseen by OPHIE.
Mr. Kuzhippala reported that, over the past few months, the state received supplemental funds and expansion funds for similar grants for the Partnership for Success (PFS) which is a prescription drug overdose prevention grant. That grant was in the amount of $296,000. The purpose of the grant was to oversee prescription drug overuse, misuse, abuse, and overdose and to ultimately provide trainings for prevention strategies to improve safe prescribing practices. Partnering agencies include Board of Pharmacy, CASAT, the Nevada Statewide Coalition Partnership, and potentially the Nevada Broadcasters Association. He stated that the main strategies and activities they would focus on were enhancing and maximizing the Nevada Prescription Drug Monitoring Program, implementing community, and ensuring health system interventions. A previous strategy they would like to look back into was creating a rapid response project supplement, which would link health data sets and law enforcement data sets. He reported that for that one, they have the base they started with last year, a pending application for a supplement, and expansion coming on later this year. He said the other grant they received funding for was the Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality (ESOOS). He explained that the main purpose of ESOOS was to have timelier reporting on fatal and nonfatal opiate overdoses. He stated they received the supplement and submitted an application on July 31. He said they applied for the base last fiscal year and were denied, but would be receiving funding later this fiscal year. They planned that the supplement would be distributed between the Clark County and Washoe County Medical Examiners' Offices. Ms. Peek explained that the CDC grants were focused on primary prevention and identification and data analytics. She said the information would not be going out to the community, as these were centralized data analytics, not the investigation of cases that would be in a traditional epidemiology environment. She added that her office's analysts could provide whatever data was needed. At the level of very small case counts, there would be the possibility of a data use agreement to get communities the information they need to act. She suggested Mr. Kuzhippala as a contact for that or an email sent to data@dhhs.nv.gov. She said the request could be for data sorted by zip code or broken down in a specific way. A PowerPoint could be requested for a presentation. She stated that the data team was to be viewed as the backbone of analytics for providers in relation to this issue or any substance use issue. Mr. Kuzhippala said they received these data requests all the time, so they have reports already put together. He used, as an example, that at the last tribal consultation, there was need of a PowerPoint on opioid overdoses, mortality, and morbidity, so that report exists. He added that they recently acquired access to the PDMP, so any questions regarding any opioid-related data sets can be provided relatively quickly manner.

Ms. Peek announced that they would be putting out a press release in the next few days that summarized all the opioid grants, totaling nearly $10 million for the next year, that are coming into the state because that is a lot of funding with very specific purposes that complement each other. She reported that the bulk of the grants for opioid related efforts came from SAMHSA for treatment services, but there was a lot on the public health side as well.

6. Overview of National Violent Death Reporting System

Ms. Peek reported that several years ago Nevada applied for the National Violent Death Reporting System (NVDRS) grant, but did not receive it. Applying again, Nevada received it. This grant complements the work being done on the new opioid grants. She said that, when they talked with CDC, they pointed out and CDC clearly saw the alignment between the two. She stated that the CDC grants could build on the NVDRS.

Mr. Belt explained that the NVDRS was designed to build the capacity in the states and the country to collect and disseminate surveillance data on violent deaths. It was the first system to provide detailed information on circumstances precipitating violent deaths that included brief narratives. By combining information across multiple data sources such as death certificates, coroners' and medical examiners' reports, toxicology, and law enforcement reports, they can comprehensively describe violent deaths and to link multiple deaths that are related to one another—multiple homicides, suicide pacts, and cases of homicide followed by the suicide of the alleged perpetrator. The pilot program was introduced in 13 sites in 2000; data collection began in 2003, with 7 participating state-based systems. Six states were added in 2004, four in 2005, two in 2010. In 2016, CDC received the funding to expand the system to 42 states, including Nevada. The goal is to include all 50 states, all United States territories, and the District of Columbia. He explained that OPHIE captured homicides, suicides, undetermined intent, legal intervention, and unintentional firearm injury, or terrorism. Any deaths not falling into those categories or deaths prior to birth due to violence would not be included. He added that multiple people who were victims or suspects in violent death constituted one incident and deaths that took place within 24 hours of each other that are related would be considered one incident. He said the state scope included residents and occurrent deaths, which are expected to be few. The focus would be to map where violence was occurring, not just where victims of violence lived. For instance, if a victim lived in one state and died in another, he would be a resident and occurrent, the occurrent state would be responsible for collecting the data. The funding Nevada received for this was split among OPHIE, Washoe County Medical Examiner, and Clark County Office of the Coroner/Medical Examiner to hire abstracters to initiate cases and work with law enforcement, toxicology, and child death review. He stated NVDRS was a five-year cooperative agreement. Nevada is concluding its first year. He explained that data going back to January 1, 2017 indicated there are 554 incidents in the system. Ms. Peek added that this will would speak to not only overdose, but also to suicide. She noted it was a great resource with many variables. Mr. Fudenberg reported that his office is currently building the infrastructure to accept the grant money and to get staff in place to do the data collection and input for NVDRS. He added that he hoped they would have something in place in 60 to 90 days and would be doing that work out of their office.

Mr. Belt added that, in looking at the ESOOS grant, he saw the ability in the NVDRS to capture all the information related to those mortalities even if the case is not classified as an NVDRS case. Ms. Peek asked if victims of violent death in the Rurals were transported to an urban facility for autopsy, and if the data would still be captured. Mr. Fudenberg replied that either the Washoe County Medical Examiner's Office or the Clark County Coroner/Medical Examiner's Office did the autopsies for every death that was investigated in the state. Ms. Peek asked if the body of a member of a tribe who died on tribal land would also be sent to a coroner's office. Mr. Fudenberg stated that tribes are not required to do that, but could ask them to investigate the death and invite them onto the reservation, which they would do, but tribes can handle investigations on their own. Mr. Belt pointed out that once a death certificate was generated, OPHIE would see that in their office. For example, if there was a suicide in a rural community, the body would not necessarily be transported for autopsy, but the data would be picked up through the death certificate. The coroner's office would then reach out to that community; it might be that way with the tribes as well.

Dr. Azzam asked for more information about the 24-hour rule. He asked what that meant if he was subject to violence today and died a month later. Mr. Belt replied that OPHIE would still pick that information up. His office would have 180 days from the date of death to initiate a case. Ms. Mburia asked if there was a variable to identify if the death was domestic or intimate partner related. Mr. Belt replied there was. Ms. Mburia mentioned that the CDC approached them about studying a maternal morbidity review. She wondered if NVDRS would report if a woman was pregnant or within a year of delivery at the time of death. Mr. Belt replied that information would be available. Ms. Peek added the NVDRS was great for that information and for the suicide death review as the abstracters would collect as many of those variables as were available. She told the group that she would send out the PowerPoint regarding antibiotics and the variables in NVDRS.

7. Highlights of Strategic Plan

Mr. Erickson gave a basic overview of the strategic plan. He stated that they put together a steering committee in January that was to be neutral, not grand-focused at all. It was comprised of people who were not affected by grants. He added that they focused quite heavily on SAPTA's core concepts:

- Behavioral health is essential to health.
- Prevention does work.
- Treatment is effective.
- People recover from mental and substance use disorders.

The committee also talked about data-driven decision-making and what was important there; comprehensive, coordinated, integrated services; portable and timely care that met state quality assurance standards; the Culturally and Linguistically Appropriate Services (CLAS) standard; well trained and incentivized workforce sufficient to meet community needs; and accountability to the people served. With that, the committee created five goals because of focused strategic thinking, bringing in many providers and people who contributed ideas. He stated they would be constantly monitoring each goal and presenting them to the various councils that they serve on, including the Behavioral Health Planning and Advisory Council (BHPAC), on almost a quarterly basis. The results are to be in place from 2017 to 2020:

- Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies—the internal ability to manage all the products we put out by reviewing and improving them.
- Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities. With that, they wanted to reduce the service gaps in the state and to increase the capacity of local communities to do that. He stated that, especially in the rural areas, this would be done in the block grant application.
- Sustain and strengthen evidence-based practices and promote a competent workforce. They would like to increase the use of evidence-based practices across the state, including the workgroups that report to SEW regularly. They would also like to increase the competency of the workforce, developing online modules or whatever it takes to increase competency and to make it easier for the professionals out there.
- Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information. This should improve the accessibility and dissemination of prevention, outreach, intervention, treatment, and recovery information. He stated they wanted to be able to tell the story better. They also wanted to improve communication between the Bureau, the public, and its partners. That should result in more information being available on the website. He added that the block grant application would be on the website so that the Bureau could receive more public comment that could drive priorities in the proper manner.
- Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services. He reported the Bureau wanted to

improve access to timely and appropriate treatment and care and to increase collaboration among funded providers so that they could make referrals to each other, and referring to the Bureau when it was not possible to place a person for treatment.

Mr. Erickson noted they would be creating their own little goals inside each of those goals, creating their operational plans on how they can move the work forward and monitor themselves regularly. Ms. Peek added that data was core to most of those goals. Understanding what was needed at the community level depended on data. Tracking of what services were being provided in prevention and treatment had been a challenge as related to Treatment Episodic Data Set (TEDS). She stated that, as part of the Opioid STR Grant they would use an electronic reporting system called Web Infrastructure for Treatment Services (WITS) that would deliver much better data related to TEDS that OPHIE will analyze and distribute to this group and to communities to understand what was happening in treatment. The information would also be provided to the other advisory bodies so that they could direct resources appropriately. She summarized that many of the things relate to how the Bureau moved forward would depend on what analytics were provided to SEW.

8. Nominate and Appoint Coroner John Fudenburg, Clark County, to the Workgroup

Ms. Peek stated that Mr. William Gazza, having served on or chaired SEW for many years, nominated Mr. Fudenberg to represent the Clark County Coroner's Office. She stated that his office provided data that was an integral part of what this group looked at in relation to opioids and all drug overdoses to understand what was happening in the population. She added that she spoke to him earlier in the week to explain what SEW does.

Mr. Fudenberg stated that he was honored to be a part of this group and, even though he was not familiar with the epidemiology world well, he was excited and interested in analyzing the data that was in his office. He was under the impression that a lot more could be done with that information than was currently being done. He reviewed his résumé, which can be found here. Ms. Peek pointed out that Mr. Fudenberg has also participated in the legislative process, which was an asset.

Ms. Barker moved to approve Mr. Fudenberg as a member of SEW. Dr. Azzam seconded the motion. The motion passed with no opposition and no abstentions.

Mr. Fudenberg added that during the last two legislative sessions, he served as a lobbyist for Clark County. He wanted the group to know that if there was anything he could do to help SEW he would be happy to do it.

Mr. Erickson wanted to know if Mr. Fudenberg would be involved in creating the Clark County Coroner's Report He also wanted to know if it was written on a biennial or an annual basis. Mr. Fudenberg replied that the report Mr. Erickson referred to was only created one time. He had understood that the report had been created by SEW, using Clark County data. As he was not the coroner at that time so was not sure who developed it. Ms. Peek stated that SEW reviewed and approved it. She thought it could be given to the analytics team and to Mr. Kuzhippala to duplicate the work and that they duplicated it for the other counties. Ms. Snyder reported that the report was paid for by SAPTA and was put together by people outside the state. She added that Washoe County showed the report to the Medical Examiner's Office and JTNN would be funding a similar report for Washoe County and the Rurals. She understood that the PACT coalition was working with the Southern Nevada Health District to replicate the report. Dr. Azzam added that SEW reviewed the draft report several times. Ms. Peek stated that she preferred not to invest SAPTA funds into something that could be done by what was already being funded so that SAPTA could be freed up to work on treatment or other primary prevention activities. She suggested they discuss offline what the report was, who was doing it, and what money was being invested and if it could be duplicated at the state level. She also mentioned that there was data that was only available for Mr. Fudenberg's staff and was not transmitted to the state, so that they did not have access to it even if they wanted it. Mr. Fudenberg did not anticipate that his office would need SAPTA funding to generate the report, as there were grants they were awarded that would allow them to put staff in place to put together robust reports that would be shared with SEW. Ms. Snyder added that the initial cost of the original report was high because the system was new, so they

were creating all the data fields. Ms. Peek stated that she would send out that report from 2013 for the group to review before another meeting at which the format and content could be discussed. Mr. Egan explained that, when they were working on the report, they requested to have consistent reports from year to year so reports could be compared. He encouraged the group to look at the report to see if that consistency existed. He did not think the reports were related to each other so that it was difficult to quantify what was changing. He said they wanted things that brought continuity across the state in the different entities that do these reports. Ms. Peek reminded them that Ms. Snyder said they made sure that their variables were the same and that they were collected in the same manner so that they could compare apples to apples. She pointed out that one of the benefits of NVDRS is that it required apples to apples. She wanted to know if SEW thought there would be benefit in doing these hard reports again. She wondered where it was on the website and how many hits it got. She asked if they want to continue doing big reports or should they purchase an intelligence dashboard—a tool that can dashboard information very quickly, giving drill down capability. She mentioned they would be using that for OPHIE, as it allowed them to feed in more real-time data as it became available to them. She stated that they would like to show it to SEW, then allow the group to decide what topics they would like more epidemiological analysis on that should be in a physical document rather than just looking at overdose statistics regarding how the state of Nevada is doing at a point in time.

9. Remove Brad Towle as a Member

Ms. Peek reminded SEW that Brad Towle had been a member of SEW for many years. He retired from his job and needed to be removed from SEW's membership. The vote was unanimous among members present to remove him from membership.

10. Overview of Center for the Application of Prevention Technologies (CAPT) Resources and Tools

Ms. Frye-Spray stated that CAPT had a national contract through SAMHSA's Center for Substance Abuse Prevention (CSAP), working with grantees who have discretionary funds to implement substance misuse prevention efforts. She said that grantees—such as the Partnership for Success, grantees doing the prevention set aside for the STR grants, the prevention set aside for the block grant, grants to prevent Prevention Drug/Opioid Overdose-Related Deaths (PDO), or Strategic Prevention Framework for Prescription Drugs (SPF Rx) at the state level—were their first clients. She explained that many years ago there were three groups, the evidence-based workgroup, an advisory council, and the epidemiology workgroup, to help states be data-informed and then to bring a data-informed prevention planning process to local level coalitions that were funded to implement prevention. She stated they have worked around the strategic prevention framework for many years and have numerous resources, including an online tool called the Substance Abuse Prevention Planning and Epidemiology Tool (SAPPET) that brought together ten national data sources that can be searched by state. She explained that CAPT offered training and technical assistance (TA) tailored to where they are. With Nevada having multiple grants coming in that address opioids, one of the key aspects with the STR prevention set aside would be to begin to build the strategic plan and to look at all the opioid grants that are coming in. She commended them for bringing up many key points that epi workgroups in other states were looking at. She stated that CAPT provided added value, setting aside significant resources to support the work, particularly now between now and the end of October—there could be consultation, training for grantees, and/or training for the epi workgroup, peer-sharing calls if any wanted to connect with a different state to find out how they track some things. They could meet the training and TA needs and offer resources. Ms. Peek said she would link the website samsha.gov/capt so that members of SEW could see the resources available. She stated that she previously worked on HIV/AIDS planning councils, where they annually did an "Epi 101" for providers, like how a coalition was structured with membership. She asked the group if they saw a benefit in reaching out to the coalitions to see if they would find value in doing such a class about how to look at data and how to interpret it, asking if CAPT could do that. Ms. Frye-Spray replied that they could. She suggested they look at who the audience would be for determining, for example, whether to provide a hard-copy report of the coroners' report. If you were trying to do infographics, there would be value in doing an online version that communities could use to download information and manipulate it to create their own infographics, but

they must have that capacity. She said CAPT could help them think through what they would like to do with the data. Ms. Peek asked Ms. Snyder, as representing the coalitions, what she thought of an Epi 101 training. Ms. Snyder thought it would be valuable, even though the statewide epi goals were different than the communities' goal. Ms. Peek stated they developed coalition-level behavioral health reports, but she did not know how much that was being used. It was sent out to all the coalitions, but she did not know if the data was presented to the coalitions to help them make decisions. Ms. Snyder replied that it was very helpful; the coalitions liked having as much data as possible. Ms. Peek pointed out that it was almost time to do an annual update on that information and suggested that someone from CAPT could go out to the coalitions and talk about Epi 101 and how to interpret data while someone from her unit could provide the individualized data. Ms. Frye-Spray pointed out they probably could not meet with coalitions one-on-one; it would be better to provide a training for the coalitions together and do some virtual follow-up TA and coaching what they could do with the data, in partnership with the state as liaisons to make sure that there was follow-up, sustainability, and a good connection between the state and county level coalitions. Ms. Snyder thought this could go beyond coalitions to include prevention partners because while some of the bigger organizations understood the value of the epi information, the pre- and post-tests, and what is being done in the programs, there were others that did not understand. Ms. Frye-Spray added opioid overdose and opioid misuse in frontier or rural areas present different concerns. She could help partners look at how the issue was framed for their community and how to tell the story of prevention. She stated they were doing a lot of work on how to tell the story to show there is power in primary prevention—the issue was not overdose, it involved getting upstream. They needed to articulate the power of getting upstream. Dr. Yang commented that many are not only providers, but are also the providers of data to the epi team. He stated that a good example of this was the Youth Risk Behavior Surveillance System (YRBSS). If all districts required passive parental permission, it would be better for them. This survey presented an opportunity for the community to understand how important the data was. Ms. Richardson suggested that SAMHSA could put together a plan to target all the key components and do it in phases, so that Nevada could reach all the regions systematically. Ms. Peek shared that a concern they have heard is that they had a lot of data, but lacked interpretation of the data, and that analysts who are not in the field made assumptions. She said she was working on a project related to the plan of safe care with the Comprehensive Addiction and Recovery Act (CARA) that has them focusing on how to deliver the data from reporting and recording the cases. She explained that as part of her outreach to the hospitals, she used hospital discharge billing data of infants to get a proxy of how many cases would be reported. She spoke to someone at a rural hospital that had only reported one case over the last five years and was told that information was incorrect. She pointed out they need to understand the whole spectrum and can speak well about the data and limitations as they could misinterpret the issue in the community based on the best information that was available to us. She added that they would look at a data reporting system that would modify the birth record to include a few extra variables related to whether a baby fell under CARA, was a plan of safe care created, and was the family referred to treatment services. Ms. Mburia asked if they could create a field to collect the telephone number of the mother for follow-up. Ms. Peek replied that they were planning on adding that field to birth certificates.

Mr. Delap agreed with what was said about the value of the data. He expressed that the data was helpful and that the audiences were important, too. He stated that the coalition-level reports were extremely valuable, as were those that were broken down by legislative district. He would like to have people think of the data as a public resource as there has been a substantial public investment into getting the data and analyzing it. He thought it would be helpful to many of the partners the coalitions work with. He reminded them that the coalition structure was intended to represent community needs and have a way to distribute resources to the community. Data-driven decision-making could change the paradigm by making programs stronger, identifying weaknesses, and providing public access to information that was available. He added that dashboards were awesome because people could pull different pieces of information that they wanted. He thought that, in odd-numbered years, they should do some of the aggregated hard reports so that they are available, pointing out that in odd-numbered years, the state needed lots of data that has been distilled effectively. He thought it would be great to have emerging potential program partners for coalitions. They

did not know where to start, how to use data in anything they were doing, and they did not know evaluations—which could be frustrating for grantees and all the way up. Even at the municipal level, city council members and counties would benefit from neighborhood level information. This could create a standard so that everyone would be making decisions off the same data set.

Ms. Frye-Spray added that her focus was on SAMHSA grantees that are PFS and PDO, but the value of working with the grantees was that they could do some things with them and then scale some of those successes up to the larger system or to other grantees outside of their focus. Ms. Lang commented that the Statewide Coalition Partnership was incorporating into new grants for the next fiscal year a very detailed comprehensive evaluation plan that they would all be doing together so that they had true coalition-backed data and that the SAPTA staff would attend this. She thought any epi workshop or training should come before that meeting. She said they were looking at getting this three-step process started in November. One of the first steps would be utilization, data, and establishing an evaluation model for the state. Ms. Peek said the one of the key things they were trying to educate folks on was what data sets were available and whether they could be used to evaluate programs or not. She added that in many cases they had population health level data, so if someone was doing a project specific in scope and using BRFSS or YRBSS, population health, they might not see the needle move fast enough. In addition, she pointed out there were questions in the surveys that she did not like because they were so specific that, if an intervention was done, it might not be seen. She said they needed to evaluate very specific programs to determine what data needed to be collected for that. Ms. Frye-Spray said that was where having identified risk and protective factors to address would give a greater capacity to evaluate changes regarding consumption or consequent behavior. Ms. Peek stated that in DPBH, they were working hard to get personal identifiers for the data sets that get—law enforcement partners, death information, hospital discharge billing data, overdose, and PDMP. Linking all these systems and seeing how the individual interacted with the system might help with evaluation, but with a different scope than BRFSS and YRBSS, reflecting population health, generalized to whatever geographic area was the focus.

11. Behavioral Risk Factor Surveillance System and Youth Risk Behavior Surveillance System Questions

Ms. Peek pointed out that BRFSS and YRBSS have been the core data sets used in substance use for many years. They have received a good investment of funds from the substance use side. They wanted to look at what data they were getting, the questions, and if there questions they would prefer. She reminded the group that at their last meeting they talked about SB 166 which proposed $1 million to do a school survey. That bill did not pass, but there was interest to drill down on data. She said they needed to figure out if that would compromise other data sets and how that would meet the need of the community. Others were saying they really wanted to drill down on this with questions like, "How did you get access to the drug?" She wondered if there would be a benefit to adding a few more questions to meet the need of what was presented to the Legislature.

Mr. Kuzhippala said that Mr. Agbewali put together the state-added BRFSS questions that were asked 2011 to 2016 and the BRFSS core questions that related to behavioral health. Dr. Yang explained that the BRFSS is a random digit telephone survey. Typically, there were between 4,000 and 5,000 completed surveys each year, but the past two years the sample size was decreased to 2,000 to 3,000 due to less funding. They separated to four strata—Washoe County, Clark County, the rest of the state, and cell phones across the state. Interviewers, trained not to feel rejected, tried up to 15 times to contact a phone number. It has been harder to get responses each year. He stated that not only was SEW using the indicators, but some in the public health field believed this it was the most important data source for public health indicators. He explained that the core was made up of 10 different areas, with 25 to 30 modules specially designed for each topic. For instance, for the diabetes module, there were 11 questions that asked whether a person had diabetes and how they planned to take care of themselves long-term. He said that the modules were optional; as they had the funding, they used the modules. He added that they then used the state-added questions. Usually the CDS did not paid much attention to the state-added questions, so there was more flexibility in language compared to other tests where not even a period can be changed. He said CDC usually asked states to do cognitive tests to test among ourselves. Dr. Azzam pointed out that the state-added questions

prevent you from comparing with other states as the YRBSS was a national survey and, to provide valid comparison criteria, the questions should be asked in every state in the same way. Dr. Yang explained that the core questions are comparable, the module questions are comparable, but the state-added questions are not comparable. Ms. Peek mentioned that she needed SEW to help better address SAPTA with their funding by looking at the questions. She explained that she wanted members to see if there were state-added questions that would help them figure out what prevention and treatment resources were needed in local communities. She added that she wanted them to consider if it was more important to direct resources to oversampling so that they had more granular data locally, since they had a limited amount of funds and needed to find the best direction to take going forward. Members also needed to consider if they should redirect some funds that were being spent in other areas for data and analytics and how to justify that. They could discuss this at ongoing meetings because these were two key data sets they used.
Ms. Peek asked if the BRSFS questions were already prepared for next year. Dr. Yang replied they were not so that now would be the perfect time to review them. Ms. Peek asked for clarification that the questions needed to be finalized by November 1. He agreed. Ms. Peek suggested that feedback be sent to her so she could share it with Dr. Yang and SAPTA. She also said that if SEW preferred oversampling, SAPTA needed to know. Dr. Yang stated that BRSFS was basically in-house and very flexible. Oversampling could be focused on youth or be done in multiple modes—phone call, website, email. Ms. Peek pointed out that the benefit would be that they could cross-tab the data—they could see if someone in an age group said yes to alcohol, but no to marijuana. She said there were opportunities to do that again, but the more granular the data, the less the ability to get that data out because it could be identifiable unless there was an oversample. Tying all this together, she stated they would like SEW's guidance on how to direct funds and what specific questions for oversampling they recommended. Dr. Azzam asked what the reason was for using the BRSFS when evaluating the prevalence and the burden—how big or how small the problem—by age, by gender, by location. He thought that for evaluating the risk, the BRSFS was not the best tool. He added that they needed to evaluate burden and risk and to measure how big the problem was. Ms. Peek said they could consider not having to ask about overdose or bad experience because those are reportable conditions, or they might not need to ask about prescriptions because of access to the PDMP. She stated there might be a better data set for specific issues they wanted to understand and data that could not be captured another way might be revealed by questions on some sort of survey so they could limit the resources for BRSFS to areas that cannot be analyzed elsewhere. Ms. Pyle asked what the best uses for this data set are. She wondered if they could look at things like co-occurring disorders or get indications of that from the responses to the survey. Dr. Yang replied that many of the indicators were created for programs that need the surveillance data to apply for block grants. He explained that they watched prevalence and have the chance to look at the trend, not real incidents.

Ms. Pyle stated that, since the state funded gambling treatment, she has encouraged SEW to add questions about gambling. She suggested that if they were looking at trends, problem gambling could be an indicator to address with state-added questions. She said that casino workers are at higher risk for problem gambling, so questions could be asked in the hospitality and service category. There are extensive questions about specific types of drugs, drugs with different treatment modalities. She thought it would be nice to know if a gambling disorder existed or if there was some evidence to find out what the issue is. She reported that it is known that in the general population the prevalence is 2 percent, but some populations—teens, college students, and seniors—are at higher risk. Those issues can have a huge impact at those ages. Dr. Azzam said that a repeated survey was necessary to see if the problem increased or decreased, or if the interventions are working. In his opinion, the first survey just told you how much trouble you were in, how big the problem was, and what resources there were for that. Prevalence surveys are very powerful in showing the problem. Ms. Peek stated that gambling was an area they do not have a survey on, so she would look up in BRSFS to see if states have asked questions related to problem gambling, and what those questions are. Dr. Yang stated that BRSFS has never had questions about gambling. He asked for examples of questions that could be added. Ms. Pyle said she would get them.

Ms. Peek reported that the SAMHSA PSF grant for YRBSS was ending. She stated that now would be the time, with the limited number of resources in other SAPTA grants, to see if SAPTA would like to continue to pursue the questions and efforts related to YRBSS, the only data set for youth. Dr. Yang said CDC funding has been limited funding, approximately $65,000 per year. The CDC only supports data collection in the 30 schools they have randomly selected for the state, 70 to 80 percent of which are in Clark County. The information generated is for the state as whole, so is hard to use locally. He reported that Ms. Peek put together funding support for the survey, which covered every high school and that Nevada also added middle schools. It is done every other year, surveying 260 middle and high schools. He said the strata is based on coalitions, with every coalition being a sample frame. He said it was designed specifically for coalitions, with six different sections of questions. Substance abuse includes tobacco use, drug use, and drinking. They have added five specific marijuana questions, which ask about perceptions, current use, lifetime use, and the amount used and if the youth rode in a car with a driver that had used marijuana. That was their baseline, before the session. In the next survey, he said they will ask the same questions, but should able to see differences. They do ask about perceptions five other drugs. Ms. Peek added that in the off year, they ask questions of school principals and health teachers to find out what health education was being provided to students so the relation between education and health behaviors can be seen. She stated they will have to make hard decisions about how to fund this.

Mr. Erickson asked how the amount time it takes to administer the test. Ms. Peek replied that it took about one class period, about one hour. Dr. Yang said the test was limited to 99 questions for high school, some of which are core questions, with 10 to 15 state-created questions allowed. Some core questions can be modified. He clarified that this was a Scantron test, as students trust Scantron more thinking that the computers can track them, so they may not answer honestly. Ms. Peek pointed out that the school climate survey in Washoe County asked questions very similar to the YRBS and the two data sets showed different results. Dr. Yang stated that students tell more with a pencil and bubble because they cannot be tracked. Mr. Erickson added that some schools had students do another log on and switch computers. Dr. Yang said that another issue they faced was that participation in the survey required parental permission. Eight districts, including Clark County, require active permission—meaning every high schooler must bring a parent's signature to participate in the survey. Mr. Erickson noted a trend he saw in the last report that the counties with a grant-funded professional in its schools, such as Nye County, had a higher increase in parent permission slips because they were a person who could get permissions slips on back-to-school nights. In the survey results you could see a higher number of participants than in the past. In active permission districts, he said it is interesting to see how having one staff member who understood the need for data could educate parents, getting more signatures and more results. Dr. Azzam said they should examine the response rate for the two subsets so they could see why there was such a difference in data for the same people, which he found rather puzzling. Mr. Erickson said he attributed it to the funded individuals' actively pursuing permission and that you could see a direct correlation in the additional data gathered in those communities. Ms. Peek stated that one of the criticisms of YRBSS has been that it is still paper-based. She said that CDC enforced paper-based testing for a long time, but is now considering electronic. She thought that if Nevada chose to go that route, the data would vary and there would be issues looking back in time. These are all things to consider for the future.

12. Discussion of Agenda Items for Next Meeting.

Ms. Peek stated that the agenda items she noted for the next meeting include:

- Understanding what is reported through EMS related to drug overdose
- Having a draft ready for review regarding NRS 441A regulations for overdose reporting
- Better establishing a plan for what needs to available on a dashboard versus in a larger hard report, infographics, etcetera. Options will be provided. There will be discussion about the audiences being informed.
- Looking at the questions on BRFSS and YRBSS and to figure out next year's questions and funding.

Mr. Egan asked if something could be presented about the NVDRS—what benefits are received from it and what kind of data it includes—so that SEW can understand what this system will bring to us.
Mr. Erickson asked if the group would be interested in learning more about the school climate survey. He understood they have been publishing the results so communities can see their schools and that next year results will be compared to national norms. Some communities need specific data related to adolescents in order to understand youth perception of their schools.
Dr. Yang said they have one statewide report based on the YRBSS. Fourteen analysis reports are available on the UNR website, including correlation reports, Native American reports, a Lesbian Gay, Bisexual, and Transgender (LGBT) report, and a specific report for the big counties.

13. Public Comment
There was no public comment.

14. Adjournment
The meeting adjourned at 3:50 P.M.