

**STATEWIDE EPIDEMIOLOGY WORKGROUP (SEW)  
MULTIDISCIPLINARY PREVENTION ADVISORY COMMITTEE (MPAC)  
COMBINED MEETING  
APPROVED MINUTES**

**DATE:** July 17, 2013  
**TIME:** 9:30 a.m.  
**LOCATION:** Truckee Meadows College  
Redfield Campus

**Video-Conference**  
College of Southern Nevada  
Cheyenne Campus

**SEW Committee Members Present**

Alicia Hansen \*  
Angel Stachnik  
Brad Towle  
Debbie Gant-Reed (Linda Septien, Proxy)  
Deborah McBride  
Julia Peek  
John Johansen  
Kevin Quint (Eric Ohlson, Proxy)  
Misty Allen (Richard Egan, Proxy)  
Pauline Salla  
Ron Pierini (John Milby, Proxy)  
Tony Fredrick  
Wei Yang

Public Member  
Disease Control Specialist, HSPER-OPHIE  
NSHD- Health Statistics, Planning, Epidemiology, & Response  
Crisis Call Center  
Agency Director, SAPTA  
Office of Public Health Informatics and Epidemiology, HSPER  
Impaired Driving Program Manager, Nevada OTS  
Join Together Northern Nevada  
Office of Suicide Prevention, DPBH  
DCFS- JJPO  
Douglas County Sheriff  
Southern Nevada Health District  
Nevada Center for Health Statistics and Informatics, UNR

**MPAC Committee Members Present**

Brad Greenstein\*  
Deborah McBride  
Elizabeth Fildes\*  
John Johansen  
Judge Cedric Kerns (Brad Greenstein, Proxy)  
Monty Williams – Chair  
Susan Mears

Foundation for Recovery  
Agency Director, SAPTA  
Director of Clinical Services, Nevada Tobacco Users' Helpline  
Impaired Driving Program Manager, Nevada OTS  
Las Vegas Municipal Court, Regional Justice Center  
Statewide Native American Coalition, Intertribal Council of NV  
Planning & Evaluation Unit, DCFS

**SEW Committee Members Absent**

Sue Meuschke  
William Gazza – Committee Chair

Nevada Network Against Domestic Violence  
Clark County Coroner's Office

**MPAC Committee Members Absent**

Scott Shick – Co-Chair

Chief Juvenile Probation Officer, Douglas County

**Others Present**

Aliya Buttar  
David Frankenberger  
Kristen Clements-Nolle – Ex-Officio  
Michael Coop – Consultant  
Michelle Frye-Spray – Ex-Officio  
Stephanie Asteriadis – Ex-Officio  
Yvonne Hart  
Erin Hasty  
Sandi Larson  
Brian Parrish

DPBH  
Masters of Public Health Student, UNR  
Epidemiology, UNR / CAPT  
Coop Consulting  
T/TA Specialist, CSAP CAPT West RET, CASAT, UNR  
Nevada Prevention Resource Center / UNR  
DCFS  
Office of the Governor  
OPHIE  
OPHIE

**SAPTA Staff Present**

Bill Kirby  
Charlene Herst  
Charlene Howard  
Kim Davis  
Linda Kreeger  
Meg Matta – Recorder  
Nan Kreher

SAPTA Health Program Specialist  
SAPTA Prevention Team Supervisor  
SAPTA Health Program Specialist  
SAPTA Administrative Assistant  
SAPTA Health Program Specialist  
SAPTA Administrative Assistant  
SAPTA Health Program Specialist

\* Attended Telephonically

1. **Welcome and Introductions**

A quorum was established and introductions were made. MPAC Chair Monty Williams opened the meeting in due form at 9:15 a.m.

2. **Public Comment**

There was no public comment.

3. **Discussion and approval of the Report on Clark County Substance Related Deaths, 2011 (The Coroner's Report)**

Michael Coop discussed the final version of the report. He believes it incorporates all the suggestions and additional data that were requested previously, and walked the members through the explanation of changes. Michael announced that the 2012 data has been received and they have already begun to look at it. When the 2012 report is finished, it will begin to establish trends. He hopes to have a first draft of the 2012 data at the next quarterly meeting. After review, there were no further comments on the report. It was moved to approve the report by Eric Ohlson and seconded by Wei Yang. The motion carried and the report was approved.

4. **Approval of Meeting Minutes of SEW and MPAC of April 17, 2013**

It was moved to approve the SEW minutes with corrections by Eric Ohlson and seconded by John Johansen. The motion carried and the SEW minutes were approved.

It was moved to approve the MPAC minutes with corrections by Deborah McBride and seconded by John Johansen. The motion carried and the MPAC minutes were approved.

5. **Presentation and Training on the Adverse Childhood Experience Survey (ACES)**

Michelle Frye-Spray explained that SAMHSA has identified eight Strategic Initiatives to focus on improving lives. ACES falls under SAMSHA's Strategic Initiatives I, which is aimed at promoting emotional health and substance abuse prevention through the creation of supportive communities. SAMSHA's Strategic Prevention Framework or SPF is comprised of five steps to help states become better at using data in their prevention planning efforts. The first step of the SPF is a thorough assessment of the substance abuse problem and conditions contributing to it. Today we are specifically looking at how Adverse Childhood Experiences are a risk factor for substance abuse. We will present a common language with regard to adverse childhood experiences and the role of the ACES in prevention planning and identify the mechanisms by which ACEs influence substance abuse and related health problems.

In the CDC Kaiser Permanente study, the focus was placed on a specific set of risk factors that occur in a household which are ongoing, chronic and persistent; and that subsequently impact an individual over a lifetime. These are defined as stressful or traumatic experiences including abuse, neglect, substance abuse, incarceration, mental health issues, divorce, and parental battery. Depending on when the adverse experience occurs, it impacts brain development and changes an individual's brain chemistry and adaptive processes not just for the moment but for their lifetime. These patterns impact a person's behaviors, relationships, morbidity and mortality.

While there are other factors which may have a negative impact on an individual, such as historical trauma, this study narrows its focus on household risk factors. If ACES are not conscientiously and systematically addressed, they will continue into the next generation.

She turned the presentation over to Kristen Clements-Nolle to demonstrate the epidemiologic evidence demonstrating a strong dose/response relationship between ACES and substance abuse, and between ACES and mental and behavioral health outcomes. Kristen said that the ACES is being studied by a range of agencies, including the CDC and Native American entities, and that it can prove to have an impact on health outcomes across all the systems including chronic disease, sexual risk, etc. The base of the research was derived from the Kaiser Permanente study where they had vast electronic records on a very stable, middle class population. It began in the mid 1990s, when the question of the day was what factors were contributing to increases in obesity and chronic diseases. They thought that perhaps adverse experiences in the home were contributing to behaviors that were causing the increase in the numbers; and they devised a survey to send to their clients. Their first survey received an astonishing 85% return – approximately 90,000 survey responses. These could be cross referenced with medical records, pharmacy records, and emergency room data. Subsequent surveys enriched the data, and because most Kaiser Permanente patients are stable, the data was able to follow health patterns in their patients as they aged. The Kaiser data proves to be very consistent with what is now being seen in the data in Nevada and other states. About a third of the population self-reports to have no adverse childhood experiences, and about two-thirds self report to have one to four or more experiences. The importance of this finding is that there is a sufficient number in the population who experience adverse childhood experiences to indicate a need for screening and intervention measures. The earlier the intervention, the more profound the impact.

Data shows that adverse childhood experiences tend to cluster. Historically, focus has been on a single adverse experience, such as sexual abuse, as an independent predictor of the outcome. However, data shows that a child who has been sexually abused may also live in a household where there is also verbal abuse, substance abuse, incarceration, etc. The ACE study shows that the independent experiences that have the most profound adverse affects on a child are not necessarily the most traumatic incident, but the ongoing and persistent chronic stressors, or toxic stress. Surprisingly, studies show that an incident of sexual abuse may not be as toxic in the development of a child as the ongoing verbal abuse that exists in the household. The findings show that adverse experiences cannot be viewed in isolation, but as a whole. It is the overall ACE score that is more important. Whatever those repeated stresses are, the body and chemistry changes to it over time.

The Kaiser studies show a strong relationship between the ACE score and a host of health outcomes: all the chronic diseases, autoimmune disease, frequent headaches, quality of life, heart disease, liver disease, COPD, alcohol and drug misuse, sexual health, mental health, and a variety of other social conditions. Kristen emphasized that because an individual has a high ACE score, it does not mean that they are not able to find other ways of coping – some may have done very well. There are also people who may not have any ACEs but who suffer from the above mentioned health issues. It is important to remember that these studies look at the epidemiology at the population level rather than the individual level.

The relationship between the ACE score and health outcomes is referred to as the dose-

response relationship. As the score increases, the probability of the population as a whole having the different health outcomes also increases. This strong dose-response relationship is not seen often, which adds special importance to this research.

Kristen went on to focus on substance abuse and mental health, beginning with early initiation of alcohol use before the age of fourteen. Only 4% of those with zero ACE scores initiated alcohol use before the age of fourteen as compared to 17% of those with a score of four or more. The data is controlled for all socio-demographics. The same dose-response relationship that is seen with the under-fourteen age group is also seen with the fourteen to seventeen age group. The same strong dose-response relationship is shown in the underage smokers and early initiation of illicit drug use.

The Ten Tribe Study of adolescents and young adults among Native Americans looks at a broader range of severe traumatic events than the household adversity in the ACES, which are more specific to the population. An example of a chronic stressor in this study may be the forced removal to boarding school or other forms of historical trauma. This study found that compared to people with zero ACEs, the odds of people with a diagnosed alcohol disorder and one ACE was 2 times higher; with two ACEs they were 4 times higher; and with three or more they were 4.6 times higher.

As these ACE scores affect the health outcomes of individual lifetimes, adults are also studied. In one study of Native Americans who were self-reported alcoholics, it showed high ACE scores contributed to their alcoholism or to the fact that they married alcoholics, which was particularly high in women. The report indicates intergenerational transmission and a high dose-response. Those adults with an ACE score of four or more are 7 times more likely to have alcohol dependency, as compared to those with zero scores.

The American Academy of Pediatrics just published a policy brief on ACES. They are extremely motivated to move in a different direction as pediatricians. As an organization, they have been influenced by the neuro-biological information that is coming out, as well as the epidemiology. They are proposing that pediatricians have an ethical duty to play a larger role in addressing this by screening kids during their pediatric appointments, equipping themselves with appropriate referrals that will help the whole family, and integrating the information into the medical educational system. Their eco-biological framework promotes outcomes of lifelong well-being, and presents research showing that chronic and toxic stress influences the genes and brain biochemistry of certain individuals and causes disruption to adaptations over time. Programs from public health, primary health care, community services, private sector, child welfare, early intervention and others across the spectrum need to come together to see what can be done to influence the community structures and prepare them to build resiliency.

The dose-response relationship continues to be consistent across populations, and across the behavioral health issues, including suicide. Assuming a causal relationship, the next step is to ask what we, as a system or as a state, are going to do about this at the policy level. What is predictable is preventable.

The SEW's primary role is to interpret the data, and the MPAC's primary role is to work on policy. Within the State, there are agencies that work with specific populations, such as

Division of Child and Family Services (DCFS) and Nevada Early Intervention Services (NEIS). However, the ability to share the data with various direct providers can have a dynamic impact. Eric Ohlson commented that a natural fit is with regard to the statewide gap on protocols regarding drug endangered children. There are vastly different degrees of success among the communities in their implementation of protocols. Some communities are not moving quickly enough to enable intervention with a child at an early age.

Monty Williams commented that historical trauma in the tribal community compounds over generations and has an adverse affect on adolescents and their sense of identity. He asked how historical trauma could be worked into the process. Kristen replied that in the Ten Tribe study, some of the more complicated cultural aspects were incorporated. Michelle Frye-Spray added that as Monty implements his programs he can work on the assumption that the adolescents have high ACE scores, based on the body of evidence. He can implement programs that will be both ACE-informed and holistic. With the incorporation of ceremonies such as sweat lodges, which provide opportunities for intervention at the individual level, the individual's chemistry, parasympathetic and sympathetic nerve systems and the response to stress are actually getting retrained, which is the goal.

Kristen said she has a video of a high school in Walla Walla Washington that adopted ACE-informed education approach and has coordinated with a nearby clinic, trained the parents, teachers and students, and has already seen their graduation rate increase and their suspension level drop. She will provide the video to Charlene to show the group.

Ihsan pointed out that when ACES is conducted in a school system, any parent who gives consent probably has little to fear from the findings, and therefore results may not be true. He affirmed that the existing procedures utilized by Child Protective Services are not working, and with all the data the ACES needs to be accepted as a fact.

Charlene Howard shared that in schools in the rurals where they are conducting Teen Screen, the problem is that there are not enough clinical services to refer the high risk students to. Kristen agreed and asked what can be done in grades K through 12 if we are taking a whole system approach. The ACES may identify the problem, but other realms need to contribute support as well. Charlene said the reason for the SEW and MPAC coming together for this meeting was to consider working together on data and policy to make a difference in the community.

Kristen added that the World Health Organization (WHO) is now conducting an ACES surveillance study internationally, but has expanded it to include experiences outside the household. They include external stressors as may be brought on by incessant wars and violence. Kristen said she is now looking at chronic stressors imposed by the neighborhood, community violence and bullying to see if it will help with the juvenile justice population.

## 6. **Discussion and Approval of the Transgender Survey**

Kristen provided an update on the Transgender Survey which is a collaboration of different levels in the Division of Public and Behavioral Health because there is no existing data in Nevada. In the national surveillance systems, there is only data on sexual health; but nothing on those individuals who are transgender or whose gender identification is now different from what is on their original birth certificate. To discover what the issues may be for people

in Nevada, funding was provided by four programs within the Division of Public and Behavior Health; SAPTA, Mental Health, the HIV Prevention Program, and the Ryan White Care Program; to establish a sub-contract with the Nevada Public Health Foundation to hire people from the transgender community to help design the study and do a statewide needs assessment. The local coalitions came up with the name, *Hope Grows for Nevada Trans Health* and on a volunteer basis, have helped with the graphics.

A sexual orientation question was intended to be added to the BRFSS this past year; but due to a mix-up, will be included next year instead. In future, data will be collected from the YRBSS as well. In the absence of a grant, however, the project needs to come together on a volunteer basis. Staff time has been contributed by STD Prevention and Control Program and the Office of Public Health Informatics and Epidemiology (Sandi Larson's group and Julia Peek's group) as well as by UNR. Further collaboration has been provided by the UNR School of Community Health Sciences, Advocates for Trans Health which is a program of gender justice, and the Transgender Allies Group.

The purpose for the project is to fill a data gap. It is an online survey, currently available in English or Spanish, and approved by UNR's Institutional Review Board. The eligibility for participation is self-identification as transgender or gender non-conforming, 18 years of age or older, and if they had resided or worked in Nevada for the past six months. Each of the partners in the study had different validated measures in areas of the survey. There were sections of questions on accessing hormones or other aids in sexual transitions; on abuse, violence and victimization; on health and social services; on substance abuse and mental health; on social support and priority needs. The survey began in January, 2013 and currently has 172 participants statewide, including the rural areas. There still remains a desire to get wider representation of ages and ethnicity in the survey. Kristen reviewed the findings in the survey which provide direction for the needs assessment. The needs assessment is usually a one-time report and limited in its ability to generalize because the population is unknown, and there is no sampling frame. However, many agencies find it useful as they see more of the target population seeking help. She hopes for further development of the website: [nvtranshealth.com](http://nvtranshealth.com). Charlene says that as a baseline in capturing a part of our population we've never been able to capture before, this is an incredible first step.

- 7. Discussion and Approval of the Youth Risk Behavior Surveillance System (YRBSS)**

David Frankenberger is a student at UNR who is currently studying epidemiology. He served this year as the YRBSS coordinator. He presented an overview of the procedures and participants. The incentives were persuasive, every school on their list participated and the response was high. This was the first year that UNR conducted the survey, and they got a late start. Due to the short planning period, the list may not have been as complete as they would have liked. Specifically, the Pyramid Lake High School, which is in the Washoe County School District, was skipped and an opportunity to obtain data on Native Americans was lost. Kristen said that in the next survey there will be more time to plan and she will set up an advisory committee to help select schools for sampling. There was discussion about active and passive parental consent. The schools with passive consent have a better participation rate. They would like to see Clark County School District change to passive consent to increase their participation. It has become a political situation between the superintendents and the school boards, and the best results may be obtained by the

coalitions.

The data from the recent survey will be entered through the summer. They will get data back from the CDC, hopefully in the fall. In the winter they will work to weight the data and will be developing the community and statewide data, and will hopefully have reports to distribute in the spring. They will present their findings in a coalition meeting at that time.

Kristen also wants to start the advisory group now to make a plan for the next survey in 2015. A head start will be needed to establish relationships and work on getting better participation from Clark County. The CDC support is very limited, and will fund only the core questions; but it has added a new core question on sexual orientation and provided another YRBSS grant for the next five years. The advisory group will decide what additional items will be added to the survey and why they need to be added. Stakeholders need to be identified and funding sources established for the statewide questions that are in addition to the core.

Wei expressed appreciation to contributors to the YRBSS. SAPTA supported the incentives; and the programs on tobacco control and STDs have been funded as well. He hopes more people will use the data and join support of the project. Eric Ohlson added that the coalitions have a potential funding source called Drug Free Communities Coalition. In order to be eligible for that funding, the coalitions have to answer about 16 questions on core measures. He stated this is the best opportunity to get that data. Kristen added that it is important to have coalitions included in the advisory group.

On the off years, Nevada has been conducting another survey called a Profile Survey which collects data at the school level from principals and health teachers. It gathers information on policies and programs centered on health issues such as sexual health, obesity and chronic disease. Nevada has had a good response rate and has been included in the weighted data, and the plan is to be involved with that survey as well.

Charlene Howard said that Washoe County does a Student Climate Survey that is excellent. Kristen said that students have provided important variables about mental health and substance abuse and how they feel or perceive it, that could be valuable to the SEW and MPAC. She suggested it would be of interest if they could present their findings to the group in the future. Kristen also commended Washoe County on their quick dissemination of the data.

#### 8. **Discussion and Approval of the Behavioral Risk Factor Surveillance System (BRFSS)**

In 2009 an ACE module, developed in part by the Kaiser investigators, was added to the BRFSS. The main adaptation was to develop protocols to accommodate a phone survey as opposed to a mail-in survey. There were five states, mostly in the West, which participated in 2009. The researchers are able to look at smoking and sleep problems, among other behaviors, and discover how they related to the ACE score. When the states studied their own scores, there was a strong consistency among their scores.

Washington decided to include the ACE module every year for three years so they could have a big enough sample size to get down to the local level. Then they plan to stop the ACE module for five years to do intense intervention in the communities with high scores,

after which they will continue surveillance for another three years to verify the trends. Beyond the surveillance perspective there is the screening, which is useful not only for research but to indicate when intervention is necessary. At some point the dose-response will be accepted as fact and further research is no longer necessary.

In the 2010 survey in Nevada, 36% did not have any self reported ACES; 22% scored 1; 14% scored 2; 10% scored 3. The impact begins to be apparent across the outcomes in those scoring 4 and above when compared to those who reported 0 ACES. The dose-response relationship remains constant across outcomes and across populations and demographics, where the group scoring 8 has 10 times the occurrence of smoking, drinking, drug use, and suicide ideation.

Kristen said that if Nevada is going to commit to the ACES module in the BRFSS, it has to be decided who they are trying to reach, what modules should be included, and can they find the funding to remain committed for three years. John Johansen pointed out that ACES contributed to some behaviors at a higher rate than to other behaviors, and asks which focuses will give the highest return for dollars spent. Using the data, find the low-hanging fruit and make sure a consistent message gets out statewide. For example, in traffic safety one message will be uniform across the state at any given time; whether for seatbelts or drunk driving. There isn't enough money to do five or seven messages, and if more than one is done at a time it will confuse the community.

Kristen said the place to begin is gathering good data, and then getting the data disseminated throughout the state agencies so that there is an understanding of its purpose, followed by a sort of buy-in. Some of the states that are a little further ahead of Nevada already have legislation at the state level where ACES is the unifying theme across all systems. The next step is bringing the systems together and framing a message to roll out to the community.

The discussion moved to issues around the marijuana initiative. Charlene Herst mentioned that it will be interesting to see any changes in the BRFSS data from Washington state now that they have legalized marijuana. John Johansen said they are now seeing an increase in California traffic fatalities related to marijuana use. Having information comparing those states which have legalized marijuana use to states which have not will be useful data when the issue comes before the Nevada legislature.

9. **Discussion and Approval of Agenda Items for SEW and MPAC Meetings of October 16, 2013**

In the interest of time, approvals of items for the agendas for the October 16th meetings were tabled. Charlene Herst will email members individually for their agenda requests.

10. **Public Comment**

There was no public comment.

11. **Adjournment**

Ihsan Azzam moved for the meeting to be adjourned and John Johansen seconded. The meeting was adjourned at 1:05 p.m.