APPROVED BY THE PUBLIC HEALTH ADVISORY BOARD
OCTOBER 12, 2026

MINUTES

SOUTHERN NEVADA DISTRICT BOARD OF HEALTH
PUBLIC HEALTH ADVISORY BOARD MEETING
July 13, 2026 – 8:30 A.M.
Meeting was conducted In-person and via Microsoft Teams
Southern Nevada Health District, 280 S. Decatur Boulevard, Las Vegas, NV 89107
Red Rock Trail Conference Room

MEMBERS PRESENT:	Kenneth Osgood, Chair – At-Large Member, Physician (*in-person*) Paul Klouse – Member, City of Boulder City (*via Teams*) Brian Labus – At-Large Member, Environmental Health (*in-person*) Holly Lyman – Member, City of Henderson (*in-person*) Jennifer Young – Member, City of Las Vegas (*in-person*)
ABSENT:	Susan VanBeuge, Vice-Chair – At-Large Member, Nurse Ronald Kline – Member, City of North Las Vegas
ALSO PRESENT:	Linda Anderson, Maddison Proctor, Ian Russell
LEGAL COUNSEL:	Edward Wynder, Associate General Counsel
EXECUTIVE SECRETARY:	Cassius Lockett, PhD, MS, District Health Officer
STAFF:	Adriana Alvarez, Tawana Bellamy, William Bendik, Haley Blake, Daniel Burns, Joe Cabanban, Andria Cordovez Mulet, Aaron DelCotto, Xavier Gonzales, Danielle Jamerson, Horng-Yuan Kan, Bob Kingston, Josie Llorico, Brian Northam, Zuwen Qiu-Shultz, Larry Rogers, Alexis Romero, Chris Saxton, Randy Smith, Renee Trujillo, Prut Udomwattawee, Sony Varghese

I. CALL TO ORDER AND ROLL CALL

The Chair called the Public Health Advisory Board meeting to order at 8:31 a.m. Andria Cordovez Mulet, Executive Assistant, administered the roll call and confirmed a quorum was present.

II. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was stated by those in attendance.

III. OATH OF OFFICE

Ms. Cordovez Mulet administered the Oath of Office to Member Labus and Chair Osgood.

IV. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda.

Seeing no one, the Chair closed this portion of the meeting.

Member Young joined the meeting at 8:34 a.m.

V. ADOPTION OF THE JULY 13, 2026 MEETING AGENDA *(for possible action)*

A motion was made by Member Kline, seconded by Member Lyman, and carried unanimously to approve the July 13, 2026 Agenda, as presented.

VI. CONSENT AGENDA: Items for action to be considered by the Southern Nevada District Board of Health Public Health Advisory Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES/PUBLIC HEALTH ADVISORY BOARD MEETING**: April 27, 2026 *(for possible action)*

   A motion was made by Member Lyman, seconded by Member Labus, and carried unanimously to approve the July 13, 2026 Consent Agenda, as presented.

VII. REPORT / DISCUSSION / ACTION

1. **Overview on the Preliminary Findings of the Drug Overdose Epi-Aid Project**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Brandon Delise, Senior Epidemiologist, provided an overview of the preliminary findings of the drug overdose epi-aid project.

   Chair Osgood asked whether mental health experts were involved in the survey and whether participants' mental health status was assessed. Mr. Delise stated he would review the survey and provide additional information. Dr. Lockett explained that the Epi-Aid was modeled after similar studies in Pima and Maricopa Counties to allow comparisons and did not specifically involve mental health professionals in the manner described. He added that the mixed-methods study is still being analyzed and that findings related to co-occurring disorders, including among individuals experiencing homelessness, will be presented to the Advisory Board once finalized.

   Member Labus commented on the difference between reported fentanyl use and fentanyl-related death rates and asked about the prevalence of polysubstance involvement in overdose deaths. Mr. Delise responded that polysubstance use is involved in a substantial proportion of overdose deaths, estimating that it accounted for more than half of cases. He noted that the most common combination contributing to overdose deaths is methamphetamine and fentanyl.

   Member Klouse commented that emergency services in Boulder City sometimes has difficulty keeping naloxone in stock due to high demand, indicating that it was being widely distributed in the community. Mr. Delise noted that the Health District provides naloxone free of charge

to both individuals and organizations and emphasized the importance of broad access as an effective way to help prevent fatal overdoses.

Member Young asked whether the survey included questions about naloxone, such as awareness, access, carrying, or use of the medication. Mr. Delise responded that the survey questions focused on participants' awareness of naloxone and their familiarity with it.

2. **Overview of the Healthcare Acquired Infection (HAI) Program**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Danielle Jamerson, Communicable Disease Supervisor; Larry Rogers, Environmental Health Manager; and Will Bendik, Laboratory Manager, presented an overview of the HAI program.

   Member Labus noted similarities between the infection control challenges being discussed and issues previously observed during hotel room inspections, including cleaning and disinfection practices, and asked whether existing hotel inspection resources could help inform the program. Mr. Rogers responded that the program currently relies on guidance from ICAR assessments and CDC resources, which are more specifically tailored to healthcare settings, but agreed to consider whether lessons from hotel inspection processes could strengthen the program. Member Labus added that similar problems had been observed during past outbreak investigations, particularly regarding improper disinfection practices. Mr. Rogers noted that many of the reported issues resemble standard environmental health concerns and suggested there is an opportunity to improve infection prevention practices through education and corrective actions.

   Member Klouse asked how the Health District collaborates with the Nevada Division of Public and Behavioral Health, given that healthcare facilities fall under the state's regulatory authority. Mr. Rogers explained that while the state retains regulatory oversight and provides funding for the program, the Health District has taken primary responsibility for conducting ICAR assessments and outreach activities, with the state serving as a resource when additional support is needed. Ms. Jamerson added that Disease Surveillance and Control maintains a close working relationship with state epidemiology teams through regular collaboration. She noted that the partnership balances the state's regulatory role with the Health District's relationship-based approach, allowing facilities to openly discuss challenges while both agencies work together to meet community needs.

   Dr. Lockett noted that while the Nevada Health Care Quality and Compliance (HCQC) Division has regulatory authority to cite healthcare facilities, the Health District's role is primarily advisory and investigative. He discussed the importance of securing long-term funding and exploring legislative changes that would allow the program to remain sustainable, including the possibility of charging fees for investigations and expanding enforcement capabilities related to infection control measures. Dr. Lockett emphasized that the program, which is currently funded through the state public health fund, serves hundreds of facilities and requires additional resources to meet demand. He also highlighted the value of partnerships with state and federal agencies when addressing issues in higher-risk facilities and requested the Advisory Board's support for future funding and legislative initiatives. Member Klouse expressed support and asked that any proposed legislative changes be brought back to the Advisory Board for consideration.

Chair Osgood asked about trends in hospital-acquired infections, whether local hospitals were being impacted, and whether infection rates affected hospital accreditation. Ms. Jamerson responded that she could not speak about accreditation and noted that the Health District's involvement in this area only began this year. As a result, current data was limited, and the program currently relies on information provided by the state. She added that, over time, the program will collect its own data, which will help guide future prevention and response efforts.

Member Young asked why some healthcare facilities listed were not submitting directly to the Southern Nevada Public Health Laboratory (SNPHL) and whether factors such as cost or private contracts influenced that decision. Mr. Bendik explained that many hospital systems use external reference or contract laboratories, and while their data was still reported to SNPHL, they were not processed directly through the SNPHL. In response to questions about expanding participation, Mr. Bendik noted that integrating systems was often a lengthy process involving information technology departments, funding approvals, and coordination with large healthcare organizations. He shared that one hospital group was beginning implementation and that another large system has been in the process for nearly two years. Chair Osgood asked whether delays were related to decisions being made by corporate leadership outside Nevada. Mr. Bendik agreed that larger organizations typically require more layers of approval, and Dr. Lockett added that navigating regional and corporate healthcare systems can make obtaining approvals particularly challenging.

3. **Update on Data Modernization and Artificial Intelligence**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Prut Udomwattawee, Public Heath Informatics Supervisor, provided an update on data modernization and artificial intelligence.

Further to an inquiry from Member Young, Mr. Udomwattawee explained that Bedrock was currently in pilot testing, while Healow went live that day. Member Young expressed interest in receiving a future update on Healow, particularly regarding the no-show prediction model, including its anticipated benefits, real-world performance, and impact on clinic operations.

Further to an inquiry from Member Labus on a newer version than HL7 version 2 messaging standards, Mr. Udomwattawee responded that HL7 version 2.5.1 remained the current standard in use. Mr. Udomwattawee noted that current industry discussions were increasingly focused on FHIR, which provides more targeted access to needed data.

Member Labus inquired as to whether EpiTrax was developed in-house to replace Trisano. Mr. Udomwattawee explained that EpiTrax originated through the Utah Department of Health and that the Health District migrated from Trisano to EpiTrax. He noted that EpiTrax offers open API capabilities, making system integration and data exchange more efficient and expanding future opportunities. Mr. Udomwattawee also highlighted the adoption of newer EMSA standards, including planned implementation of EMSA 3, which will support electronic case reporting and improve the processing of public health data.

Chair Osgood raised concerns about reports in medical literature describing challenges with AI implementation and asked whether adequate quality control measures were in place to identify and correct errors in AI systems. Mr. Udomwattawee acknowledged that many organizations have struggled with AI projects and explained that the Health District was taking a cautious approach by focusing on practical use cases that can improve staff efficiency and demonstrate measurable value. He noted that early testing has shown promising results, including the use of AI for handwriting recognition and data extraction. Dr. Lockett agreed that concerns about AI accuracy and governance were valid and discussed the Health District's evaluation of ambient scribe technology within its electronic health record system. He explained that while technology showed potential to reduce administrative workload, it can also generate excessive documentation that required provider review and editing. Dr. Lockett emphasized that AI guardrails continue to evolve and that the Health District was carefully assessing how to use these tools while maintaining efficiency and supporting healthcare providers.

VIII. BOARD REPORTS: The Public Health Advisory Board members may identify and comment on Health District related issues. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Public Health Advisory Board unless that subject is on the agenda and scheduled for action. ***(Information Only)***

There were no items raised.

IX. HEALTH OFFICER & STAFF REPORTS *(Information Only)*

- DHO Comments

Dr. Lockett informed the Advisory Board that the Health District was monitoring a multistate cyclospora outbreak affecting 31 states with 843 reported cases as of July 9. He explained that the parasite was primarily transmitted through contaminated food, particularly fresh produce, and causes symptoms including watery diarrhea, nausea, bloating, and gas, typically without vomiting or fever. Dr. Lockett noted that the infection can be diagnosed through stool testing and treated with antibiotics and emphasized that proper hand hygiene remained critical in preventing transmission. He further explained that cyclospora can be difficult to remove from produce because its outer structure allows it to adhere to surfaces, making thorough cooking the most effective method for eliminating the parasite. While no cases had been reported in Nevada at the time of the update, he stated that the Health District continues to closely monitor the ongoing investigation.

Dr. Lockett provided an update on the ongoing Ebola outbreak, noting that it has resulted in a significant number of cases and deaths and was projected to become one of the largest Ebola outbreaks on record. Although the current risk to the United States remained low, Dr. Lockett emphasized that uncertainty remains regarding the outbreak's future trajectory. He noted improvements in treatment capacity and laboratory testing in affected areas but described ongoing challenges related to healthcare capacity, transportation, and outbreak response efforts. Locally, he reported that the Health District was working closely with the CDC, monitoring travelers arriving from Uganda, and coordinating preparedness efforts with emergency management, healthcare facilities, resorts, and airport partners. He added that

response plans have been updated and a standardized process has been developed to guide the identification, evaluation, testing, and management of potential Ebola cases in Southern Nevada.

Dr. Lockett expressed appreciation for the Advisory Board's discussion regarding the HAI program and potential policy recommendations. He stated that staff may develop proposed legislative language related to the program and would welcome the Advisory Board's review and feedback before bringing recommendations forward to the Board of Health.

Dr. Lockett stated that staff will return to the Advisory Board with a more comprehensive analysis of the Epi-Aid findings to help inform future recommendations. He noted that preliminary data identified patterns related to public transportation use, including respondents reporting both substance use and connections to drug suppliers while using transit services. Dr. Lockett also reported that the Health District recently purchased approximately $3 million in naloxone and fentanyl and xylazine test strips for distribution to community partners and organizations serving at-risk populations. In response to a question from Member Young about the longevity of the supply, Dr. Lockett explained that the purchase was made in anticipation of changing federal funding restrictions that may limit future purchases of certain harm-reduction supplies. He added that previous large-scale naloxone distribution efforts reached more than 80,000 two-dose kits and coincided with the first observed decline in overdose deaths in the community, underscoring the importance of continuing these prevention efforts.

Member Young asked whether healthcare facilities that do not use SNPHL had access to other local testing options. Dr. Lockett responded that laboratory testing operated through a collaborative partnership among reference laboratories, the state laboratory, and SNPHL.

X. SECOND PUBLIC COMMENT: A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held.

Seeing no one, the Chair closed this portion of the meeting.

XI. ADJOURNMENT

The Chair adjourned the meeting at 9:55 a.m.

Cassius Lockett, PhD, MS
District Health Officer/Executive Secretary

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AGENDA

SOUTHERN NEVADA DISTRICT BOARD OF HEALTH
PUBLIC HEALTH ADVISORY BOARD MEETING
July 13, 2026 – 8:30 a.m.
Meeting will be conducted In-person and via Microsoft Teams
Southern Nevada Health District, 280 S. Decatur Boulevard, Las Vegas, NV 89107
Red Rock Trail Conference Room

NOTICE

Microsoft Teams:
https://events.teams.microsoft.com/event/72ac3a39-fcac-4eff-b089-b24977aca681@1f318e99-9fb1-41b3-8c10-d0cab0e9f859

To call into the meeting, dial (702) 907-7151 and enter Phone Conference ID: 536 265 671#

NOTE:
- Agenda items may be taken out of order at the discretion of the Chair.
- The Board may combine two or more agenda items for consideration.
- The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.

I. CALL TO ORDER AND ROLL CALL

II. PLEDGE OF ALLEGIANCE

III. OATH OF OFFICE

IV. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to two (2) minutes per speaker. Please clearly state your name and spell your last name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chairman or the Board by majority vote. **There will be two public comment periods. To submit public comment on either public comment period on individual agenda items or for general public comments:**

- **By Teams:** Use the meeting controls at the top of the screen and select the Raise Hand icon. When called upon, select the Microphone icon to unmute yourself.
- **By telephone:** Call 702-907-7151 and when prompted to provide the Meeting ID, enter 536 265 671#. Press *5 to raise your hand. When called upon, press *6 on your phone keypad to unmute yourself.
- **By email:** public-comment@snhd.org. For comments submitted prior to and during the live meeting, include your name, zip code, the agenda item number on which you are commenting, and your comment. Please indicate whether you wish your email comment to be read into the record during the meeting or added to the backup materials for the record. If not specified, comments will be added to the backup materials.

V. **ADOPTION OF THE JULY 13, 2026 AGENDA** *(for possible action)*

VI. **CONSENT AGENDA:** Items for action to be considered by the Southern Nevada District Board of Health Public Health Advisory Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES/PUBLIC HEALTH ADVISORY BOARD MEETING:** April 27, 2026 *(for possible action)*

VII. **REPORT / DISCUSSION / ACTION**

1. **Overview on the Preliminary Findings of the Drug Overdose Epi-Aid Project**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

2. **Overview of the Healthcare Acquired Infection (HAI) Program**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

3. **Update on Data Modernization and Artificial Intelligence**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

VIII. **BOARD REPORTS**: The Southern Nevada District Board of Health Public Health Advisory Board members may identify and comment on Health District related issues. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada District Board of Health Public Health Advisory Board unless that subject is on the agenda and scheduled for action. ***(Information Only)***

IX. **HEALTH OFFICER & STAFF REPORTS *(Information Only)***
- DHO Comments

X. **SECOND PUBLIC COMMENT**: A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to two (2) minutes per speaker. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chairman or the Board by majority vote. **See above for instructions for submitting public comment.**

XI. **ADJOURNMENT**

NOTE: Disabled members of the public who require special accommodations or assistance at the meeting are requested to notify the Administration Office at the Southern Nevada Health District by calling (702) 759-1201.

THIS AGENDA HAS BEEN PUBLICLY NOTICED on the Southern Nevada Health District's Website at https://snhd.info/meetings, the Nevada Public Notice website at https://notice.nv.gov, and a copy will be provided to any person who has requested one via U.S mail or electronic mail. All meeting notices include the time of the meeting, access instructions, and the meeting agenda. For copies of agenda backup material, please contact the Administration Office at 280 S. Decatur Blvd., Las Vegas, NV 89107 or (702) 759-1201.

MINUTES

SOUTHERN NEVADA DISTRICT BOARD OF HEALTH
PUBLIC HEALTH ADVISORY BOARD MEETING
April 27, 2026 – 8:30 A.M.
Meeting was conducted In-person and via Microsoft Teams
Southern Nevada Health District, 280 S. Decatur Boulevard, Las Vegas, NV 89107
Red Rock Trail Conference Room

MEMBERS PRESENT:	Kenneth Osgood, Chair – At-Large Member, Physician (*in-person*) Susan VanBeuge, Vice-Chair – At-Large Member, Nurse (*in-person*) Ronald Kline – Member, City of North Las Vegas (*in-person*) Paul Klouse – Member, City of Boulder City (*in-person*) Brian Labus – At-Large Member, Environmental Health (*in-person*) Holly Lyman – Member, City of Henderson (*in-person*) Jennifer Young – Member, City of Las Vegas (*in-person*)
ABSENT:	N/A
ALSO PRESENT:	Maddie Proctor
LEGAL COUNSEL:	Edward Wynder, Associate General Counsel
EXECUTIVE SECRETARY:	Cassius Lockett, PhD, MS, District Health Officer
STAFF:	Emily Anelli, Tawana Bellamy, Daniel Burns, Victoria Burris, Joe Cabanban, Nancy Cadena, Andria Cordovez Mulet, Aaron DelCotto, Xavier Gonzales, Victoria Harding, Carmen Hua, Jessica Johnson, Horng-Yuan Kan, Bob Kingston, Heidi Laird, Anil Mangla, Kimberly Monahan, Brian Northam, Luann Province, Katarina Pulver, Cheryl Radeloff, Larry Rogers, Alexis Romero, Chris Saxton, Randy Smith, Laura Valentino, Lourdes Yapjoco, Lei Zhang

I. CALL TO ORDER AND ROLL CALL

The Chair called the Public Health Advisory Board meeting to order at 8:31 a.m. Andria Cordovez Mulet, Executive Assistant, administered the roll call and confirmed a quorum was present.

II. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was stated by those in attendance.

III. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda.

Seeing no one, the Chair closed this portion of the meeting.

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IV. ADOPTION OF THE APRIL 27, 2026 MEETING AGENDA *(for possible action)*

A motion was made by Member Kline, seconded by Member Klouse, and carried unanimously to approve the April 27, 2026 Agenda, as presented.

V. CONSENT AGENDA:

Items for action to be considered by the Southern Nevada District Board of Health Public Health Advisory Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES/PUBLIC HEALTH ADVISORY BOARD MEETING**: January 12, 2026 *(for possible action)*

   A motion was made by Member Lyman, seconded by Vice-Chair VanBeuge, and carried unanimously to approve the April 27, 2026 Consent Agenda, as presented.

VI. REPORT / DISCUSSION / ACTION

1. **Update on the Health District After Dark**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Laura Valentino, Senior Human Resources Specialist responsible for Academic Affairs, provided an update on the Health District After Dark.

   Member Lyman asked whether CEUs could be requested for community health workers. Ms. Valentino said it hadn't been done before but expressed interest in discussing it. Member Lyman noted they have about 50 community health workers who would benefit from the topics and offered to share more information.

   Vice-Chair VanBeuge praised the presentation and program, noting its long-term impact, engaging discussions, and relevance to both practice and everyday life. She emphasized the program's value to the community, encouraged broader outreach to increase attendance, and expressed strong support for its continued growth and success.

2. **Update on the Community Health Improvement Plan**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Carmen Hua, Health Educator and CHIP Coordinator, presented an update on the Community Health Improvement Plan (CHIP).

   Member Labus asked how the Advisory Board could support implementation efforts. Dr. Lockett advised that members can assist by engaging in updates on key indicators and providing guidance, particularly in addressing chronic disease, which he identified as a priority requiring policy, systems, and environmental changes. He encouraged members to

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review related objectives and contribute ideas, highlighting examples such as beverage-neutral ordinances that promote healthier default drink options, integrating fruit and vegetable or park prescriptions into electronic health records, and better leveraging community assets like local parks to increase physical activity. While noting that some initiatives were already in place, including healthy vending policies and public health campaigns, Dr. Lockett emphasized the need to expand these efforts for greater community impact.

The Chair referenced the 2017 Health Care Summit report and encouraged members to read the report.

Member VanBeuge expressed appreciation for the report. She emphasized the importance of Board member engagement, encouraging collaboration through outreach to community partners, advocacy, and active participation.

Member Lyman thanked the team for their work and highlighted Dignity Health's ongoing practice of adopting the Health District's priorities every three years to ensure alignment and collaboration across the community, avoiding duplication and focusing on shared implementation strategies.

VII. BOARD REPORTS: The Public Health Advisory Board members may identify and comment on Health District related issues. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Public Health Advisory Board unless that subject is on the agenda and scheduled for action. ***(Information Only)***

Member Young expressed interest in exploring a beverage-neutral ordinance and requested information on the feasibility of such an approach. Dr. Lockett agreed to look into this. Member Young also inquired about integrating "food as health" concepts and park prescriptions. Dr. Lockett explained that implementation would be complex, likely requiring partnerships with integrated healthcare networks using platforms such as EPIC, which already offers a park prescription module, along with local coordination, clear guidelines, and identification of a physician or provider champion to lead a pilot effort. Member VanBeuge supported the concept, sharing her own experience prescribing activities to patients and emphasizing the value of learning from best practices in other communities to guide implementation. She also raised questions about the Advisory Board's process for making formal recommendations to the Board of Health.

VIII. HEALTH OFFICER & STAFF REPORTS *(Information Only)*

- DHO Comments

  Dr. Lockett reminded members that as an Advisory Body, they are encouraged to provide formal recommendations to the Board of Health, particularly following presentations or reports.

  Dr. Lockett highlighted key updates from the Health District's State of Public Health held on April 7, 2026, including the successful launch of the Street Medicine Program in November

2025, which had already served 107 unduplicated, unhoused individuals within five months—exceeding initial expectations. The program, developed through extensive community listening sessions, focused on addressing primary care gaps and has secured additional funding through Clark County Social Services to expand services and address heat mitigation for vulnerable populations.

Dr. Lockett also addressed ongoing concerns related to substance use, noting that despite a national decline, overdose deaths in the region had previously increased; however, a 23% reduction was observed in 2025 due to multi-pronged prevention efforts, including widespread naloxone distribution. He emphasized that continued work was needed and shared plans to collaborate with the CDC on an Epi-Aid project to better understand local drug use patterns and inform future strategies.

IX. SECOND PUBLIC COMMENT: A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held.

Victoria Harding, a Health District employee, shared her perspective as a long-time staff member, expressing pride in the Health District's current direction and progress. She noted that despite a workforce of over 800 employees, there were limited opportunities to share ideas or stay informed about broader public health initiatives. Ms. Harding highlighted personal interest in priorities such as nutrition and exercise and expressed a desire to play a more active role in supporting these efforts, even at the community level. Ms. Harding suggested the creation of a formal mechanism, such as a suggestion box, to capture ideas and feedback from staff, emphasizing that employees could provide valuable insights to support public health strategies and advance organizational goals.

Seeing no one further, the Chair closed this portion of the meeting.

X. ADJOURNMENT

The Chair adjourned the meeting at 9:33 a.m.

Cassius Lockett, PhD, MS
District Health Officer/Executive Secretary

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Preliminary Findings: Overdoses in Clark County, NV (Epi Aid)

Public Health Advisory Board

July 13, 2026

Brandon Delise, MPH, CIC

Senior Epidemiologist

Epi Aid Project Overview (5/18-29/2026)

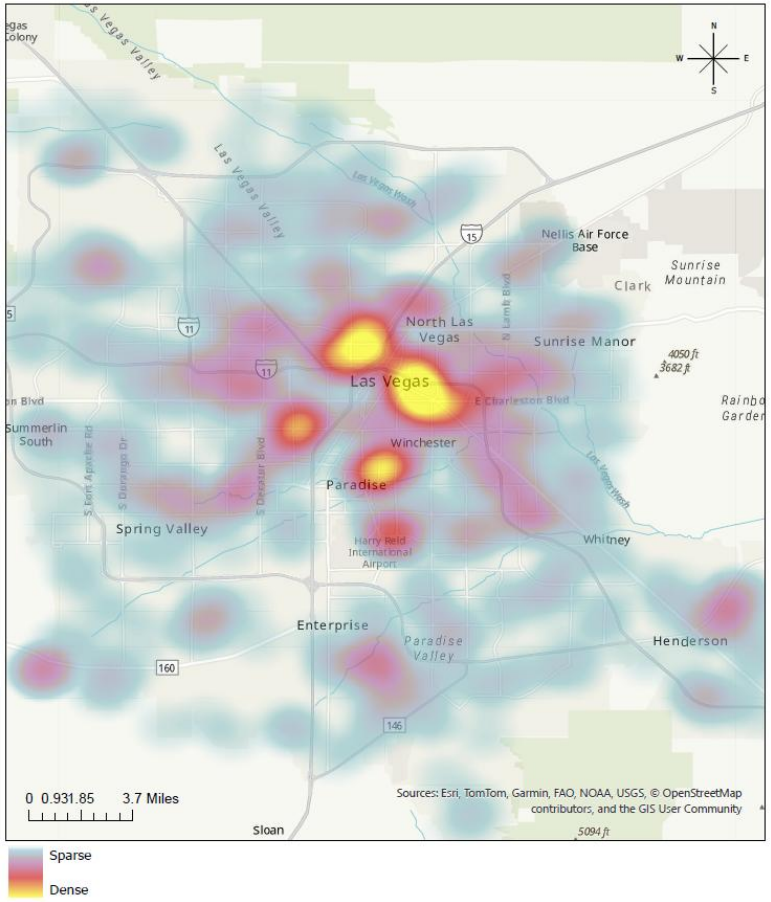
- **Overdose deaths** have been **declining nationally**
- **Nevada overdose deaths are not declining at the same rate** as the rest of the US (2.2% in Nevada vs. 15.9% reduction nationally)
- Findings from this project will inform prevention and response activities to best suit Clark County



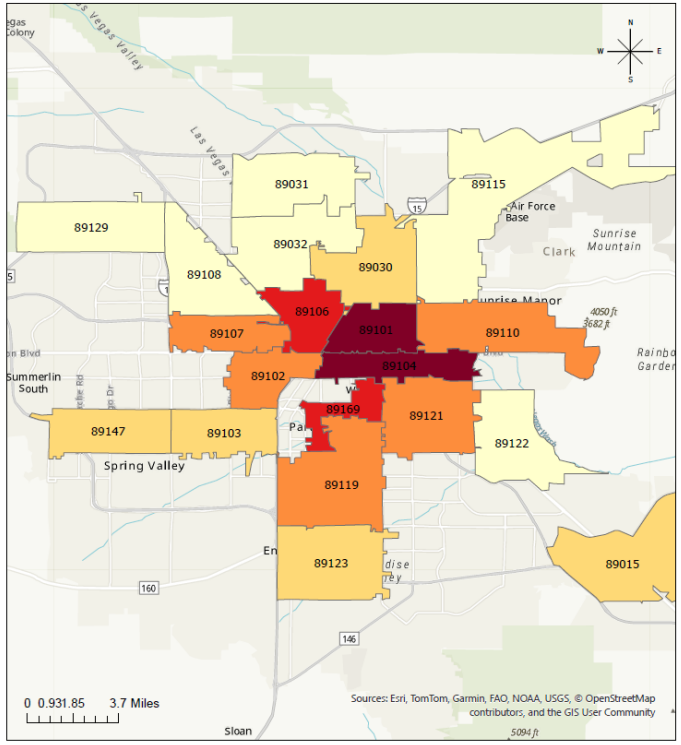


Resident Overdose Deaths by ZIP Code, 2025

Resident Overdose Death Heat Map, 2025



All ZIP Code Death Rates With Numerator >=12



Resident ZIP Death Rate selection

rate_current

- 22.269511 - 28.715004
- 28.715005 - 38.623460
- 38.623461 - 60.199864
- 60.199865 - 86.124402
- 86.124403 - 115.047780

Data Source: SNHD EDRS

Study Objectives and Methods

Primary Objectives

1. **Develop novel interventions** for people at risk of overdose
2. **Characterize** fatal and nonfatal overdose trends in Clark County, NV
3. **Evaluate** knowledge, beliefs, and behaviors among those at risk of overdose
4. **Identify** barriers and facilitators among those who provide services to people at risk of overdose

Investigation Methodology

- Respondents had to **have used a substance other than alcohol or marijuana in the past 6 months**
- **Semi-structured interviews** with people at risk of overdose and service providers
  - Interviews lasted 30-60 minutes per session
  - **Quantitative and qualitative data** collected via survey instrument and transcribed voice recordings
  - Data collected via REDCap

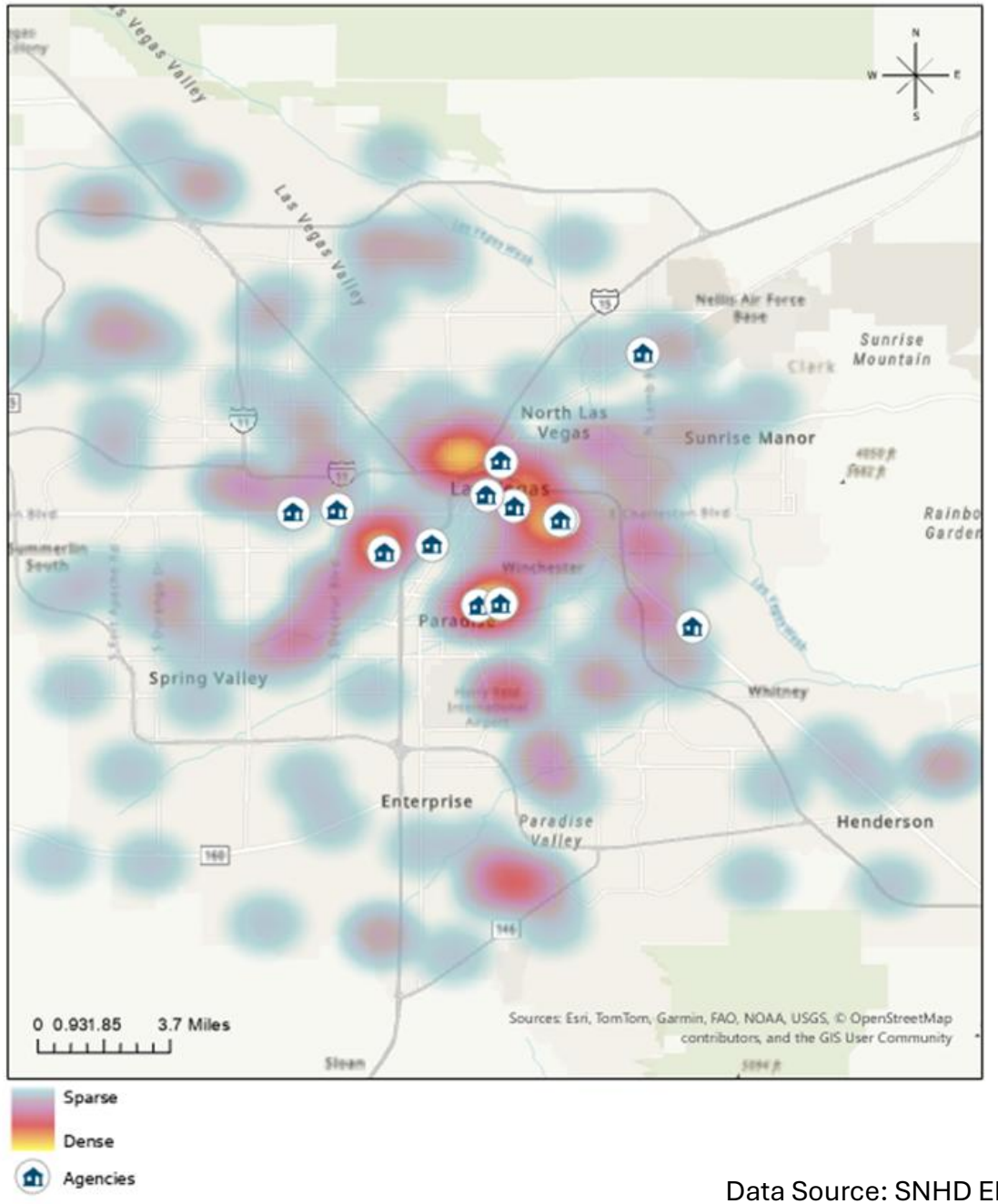
Southern Nevada Health District

Investigation Methodology (continued)

- **Sampling based on housing status** of community member respondents (housed vs. unhoused)
  - Unhoused = lived for any amount of time in the past month:
    - With multiple friends or family for short periods (“couch surfing”)
    - In a vehicle
    - On a street, park, alley, or tunnel
    - In a shelter
    - In any other location not suitable for human habitation
- Community member respondents **recruited from local fatal overdose hotspots** and by community partner organizations
- **Goal of at least 60** interviews → **69 interviews completed** as of 5/28/2026

Southern Nevada Health District

Spatial Overlay of Participant Recruitment Zones and Resident Overdose Fatalities, Winter 2025



Data Source: SNHD EDRS

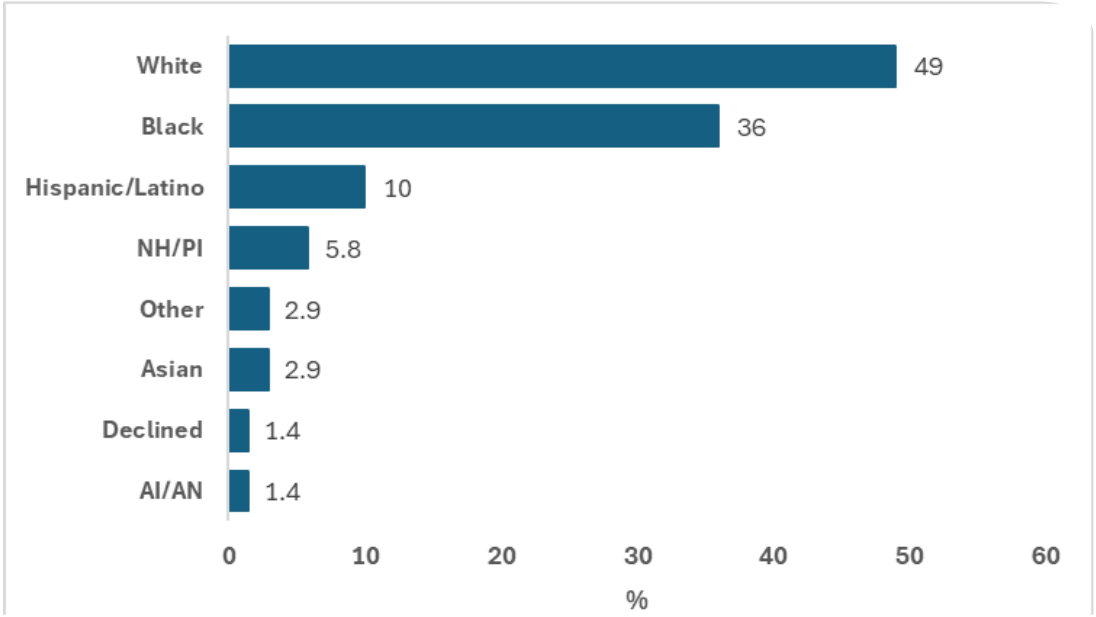
Respondent Demographics (n = 69)

Assorted Demographics

- 55% male / 45% female
- Median age: 42 years
  - IQR 31-51 years
- 46% unhoused / 52% housed*
  - **85% indicated not having a regular place to stay** in the past year

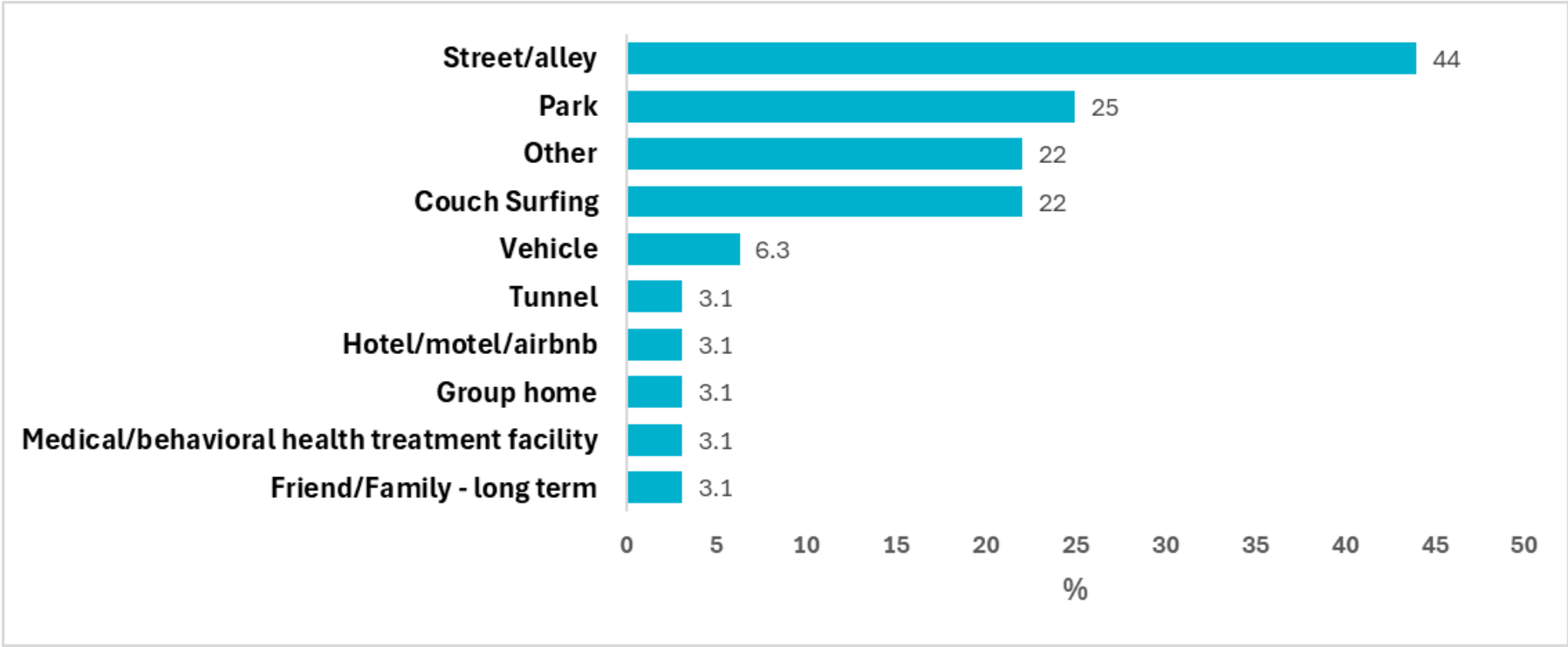
*Housing status not determined for 1 respondent

Respondent Race/Ethnicity*



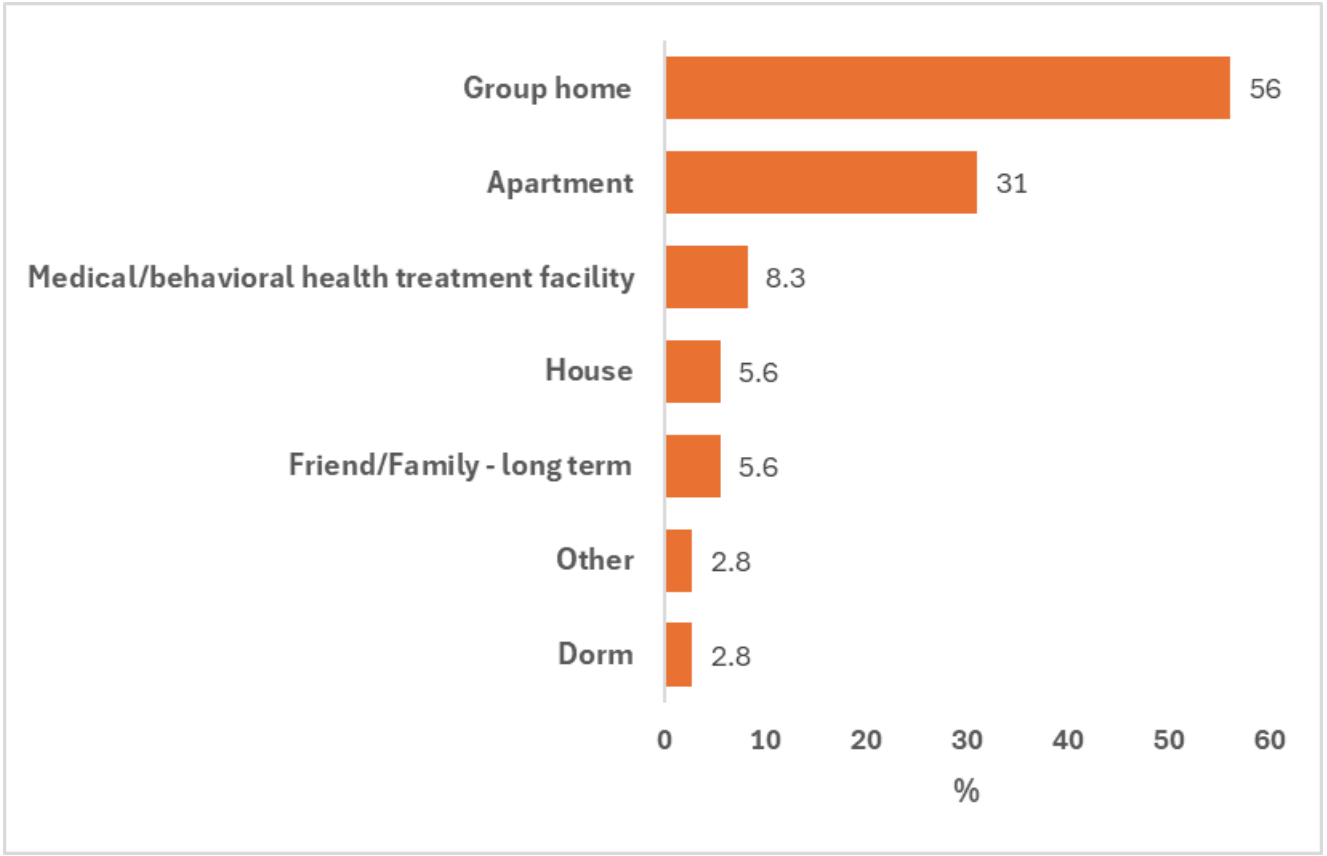
*Categories are not mutually exclusive

Unhoused Respondent Living Situations* (n = 32)



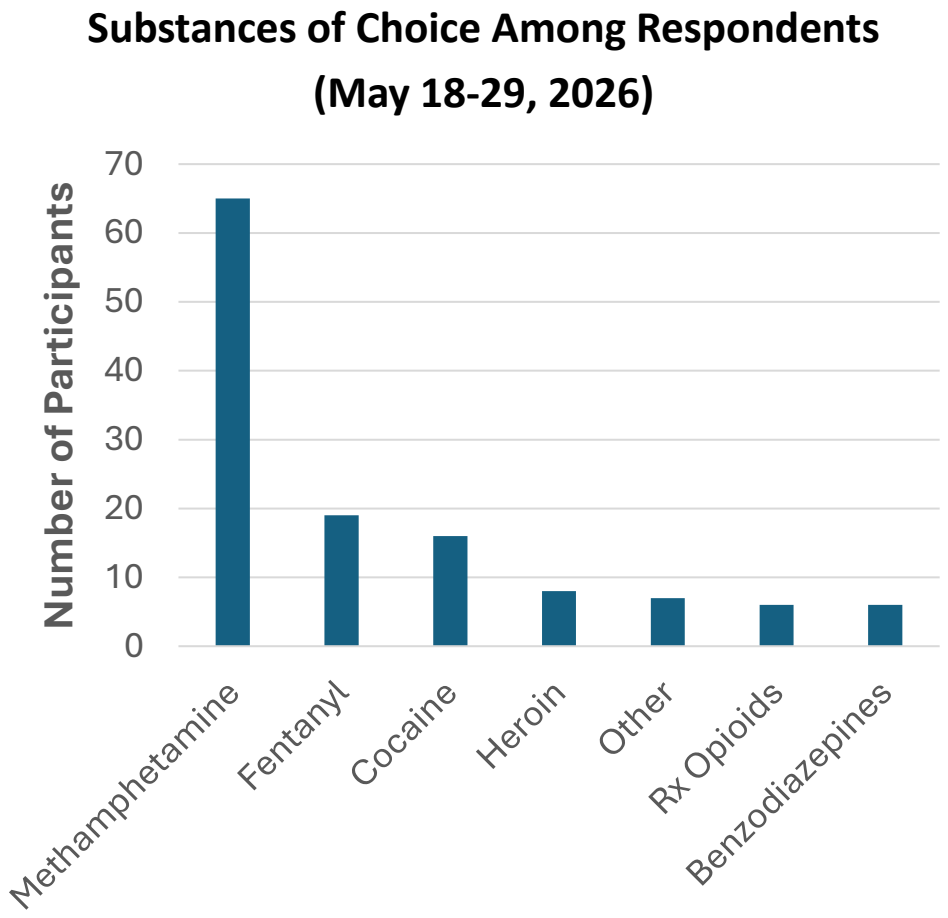
*Categories are not mutually exclusive

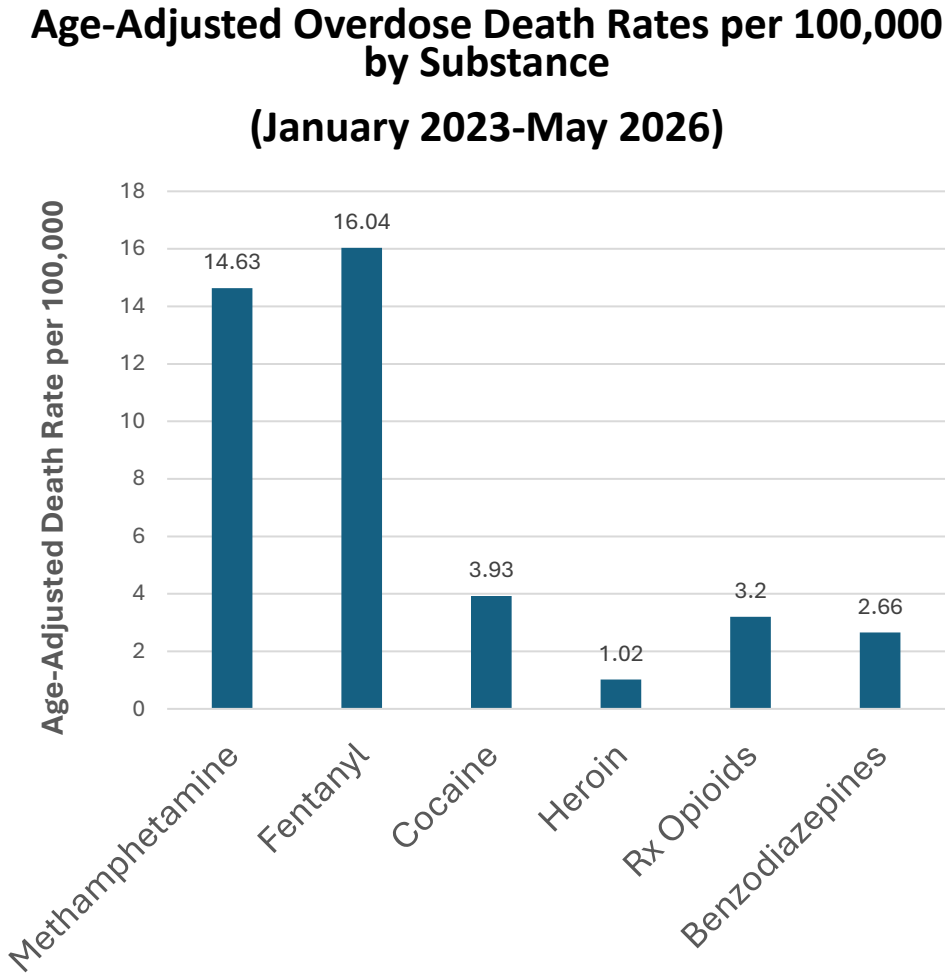
Housed Respondent Living Situations* (n = 36)



*Categories are not mutually exclusive

Substances of Choice





Reported Polysubstance Use

- 95% of respondents **who use fentanyl also reported using methamphetamine (n = 19)**
- About 67% of respondents believed that **drugs are being cut with fentanyl more often**
- About 50% of respondents reported **using more than one substance** and reported a **preference to use alone**



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Overdose Awareness and Response

- About **70% of respondents reported witnessing an overdose** in the past year
  - **85% reported that naloxone was administered**
  - 73% reported that 911 was called to respond
- **60% of respondents reported awareness of Nevada's Good Samaritan Law** (NRS 453C.150)
  - 52% of respondents indicated trust in this law





Perceptions of Risk (Qualitative Findings)

- Respondents who use methamphetamine **perceived a lower overdose risk** compared to those who use fentanyl
- Internal tension between **knowing that drugs are cut with fentanyl** vs. assumption of personal risk
- **Methamphetamine is widely available but considered cheap and weak**
- **Drug supply is cyclical** (e.g., strength/potency)
- Respondents are aware of overdose risk and are **prepared to help other community members**
  - **Aware that naloxone is widely available** and administration is generally understood

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Barriers and Facilitators to Service Provision (Qualitative Findings)

- Respondents indicated a **need for wraparound services**
  - Service providers are navigating and using available resources to help clients as best they can
  - **Housing resources for clients should be prioritized**
- Federal and state **policies create barriers** to service provision (i.e., Medicaid, SNAP)
- **Perception that overdose prevention funding is "drying up"**
- Many respondents were **people with lived experience**
  - **Impact of peer support services**

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Next Steps

- Quantitative and qualitative **analyses are underway**
- **Full report** with quantitative findings and salient themes **expected in 4-6 months**
- Finalized data will be presented to the Board once available
- **Detailed findings will guide further SNHD interventions**
  - Develop novel interventions and refine existing interventions

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Thank you to our community partners and CDC colleagues!

- Foundation for Recovery
  - Sean O'Donnell
  - Sherra McGowan
- There Is No Hero In Heroin (TINHIH)
  - Rhonda Fairchild
- Trac B Exchange
  - Kat Reich
  - Lacey Kennedy
  - Rick Reich
- The Center
  - Ron Schnese
- Clean the World
  - Will Allphin
- Vegas Stronger
  - Nathalie Barki Delice
  - Brandon Lite
- PACT Coalition
  - Jamie Ross
- Shine-A-Light
  - Brent Nowak
  - Rob Banghart
- LVMPD LIMA Program
  - Angel Lash
  - Joseph Enez
- Everybody Is Somebody
  - Ashely Carr
- Partida Corona Medical Clinic
  - Dr. Jose Partida Corona
- HELP of Southern Nevada
  - Jaqualyne Peeples



Centers for Disease Control and Prevention EIS Officers:

- Geoff Melly
- Joy Ortega
- Chelsea McCullough
- Irina Kasarskis
- Halley Riley
- Domonique Hargrave

Southern Nevada Health District

Healthcare Associated Infections Program Overview

Public Health Advisory Board
July 13, 2026

Danielle Jamerson, MS, CIC
Larry Rogers, REHS
William Bendik, MPH, MLS (ASCP)cm

Healthcare Associated Infections (HAI)

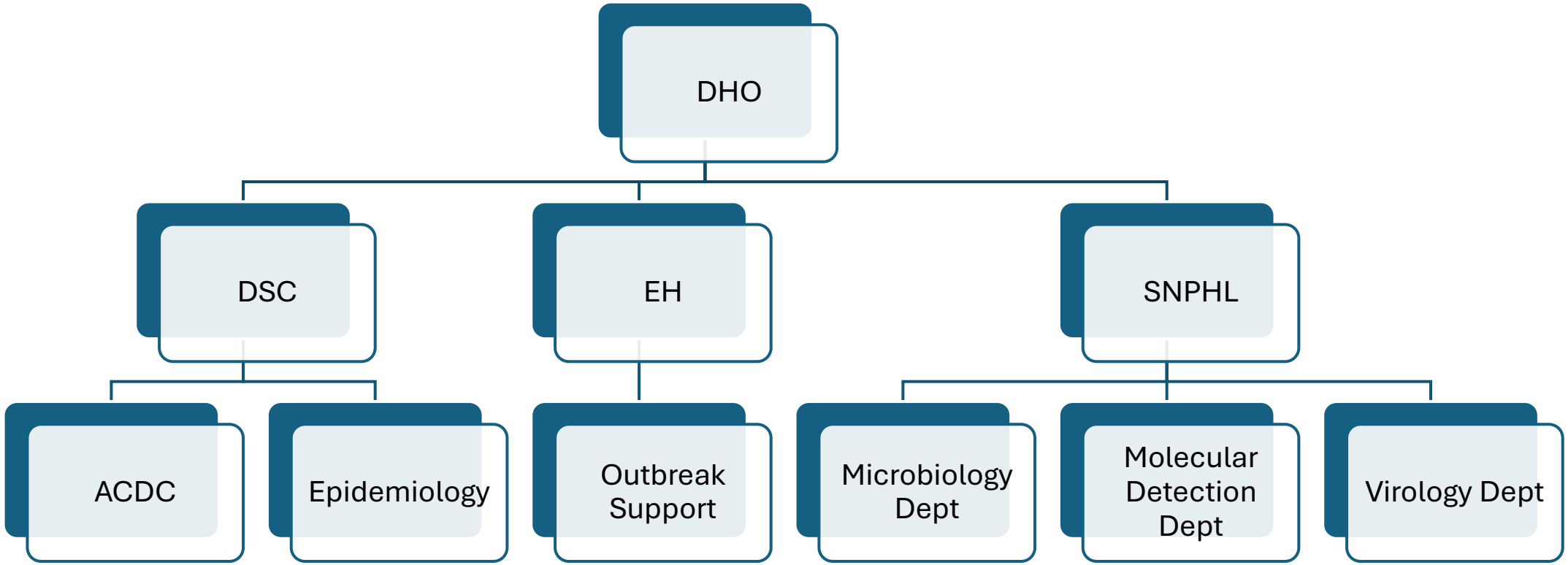
- The Southern Nevada Health District (SNHD) assumed primary responsibility for Healthcare Associated Infections (HAI) prevention and control activities in Clark County beginning January 1, 2026.

- SNHD responds to reports of HAIs, suspected clusters, and outbreaks in acute care, long-term, and other medical facilities including outpatient settings.

- The HAI team also provides support through the Infection Control Assessment and Response (ICAR) framework, offering recommendations, training, and resources upon request. Facilities are encouraged to contact SNHD whenever assistance is needed.

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Who are we?



Southern Nevada Health District

HAI Responsibilities and Activities

- HAI surveillance and response activities are initiated in the Division of Disease Surveillance & Control when a report is submitted by a medical provider or a laboratory.
- **Disease Surveillance**
  - ACDC receives reports of all reportable diseases and obtains data on reportable diseases
  - https://www.southernnevadahealthdistrict.org/healthcare-associated-infections-program/
  - Additional reports (not reportable in NV) are received and monitored
- **Disease Investigations**
- **Outbreak investigations-** (Multidivisional and program response: DSC, EH, SNPHL)
- **Data collection and analysis-** (Monitoring disease and trends)
  - Epidemiology team uses *C. auris* data to prioritize outreach efforts- Data driven efforts
  - Variables of analysis include: Clinical and Colonized cases, magnitude, severity, imbalance, and signal or positivity
- **Training and education**
  - Identify areas of need and offer training to healthcare facilities
  - Conduct assessments

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What do we investigate?

Priority Group	Organism Description
OUTBREAKS	• ALL (examples include COVID-19, foodborne illnesses, *Candida Auris, C. difficile*, Norovirus)
Tier 1	• VRSA/VISA (Vancomycin-resistant *Staphylococcus aureus/Vancomycin Intermediate Staphylococcus aureus)* • Novel Diseases or New or Rare Resistance Mechanisms
Tier 2	• PAN-Resistant and Echinocandin resistant *Candida Auris* • All PAN-Resistant Carbapenem Resistant Organisms (CRO) (except non-OXA Carbapenem Resistant *Aeruginosa baumannii [CRAB]*) • OXA PAN-Resistant CRAB • KPC-producing CRO (other than *Enterobacteriaceae*) • Non-KPC Carbapenemase Producing Organisms
Tier 3	• Pan-resistant non-OXA CRAB
Tier 4	• *Candida Auris* • KPC-producing carbapenem-resistant *Enterobacteriaceae* (KPC-CRE)

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Infection Control Assessment and Response a.k.a ICAR

- This comprehensive tool is intended to help assess IPC practices in acute care, long-term care, and outpatient settings
- Systematic assessment, comprised of interviews and observations
  - Collaboration with Acute Communicable Disease Control Program, Epidemiology, Environmental Health and SNPHL
- This is a *quality improvement* tool and facilitators may modify it and/or prioritize certain sections and questions:
  - Tailoring it to the needs of the facility
  - Tailoring it based on the pathogen or concerns identified within the facility
  - Focusing on topics that are priority within the jurisdiction
  - Ensuring alignment and adherence to State and Local regulations

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Goal of ICAR

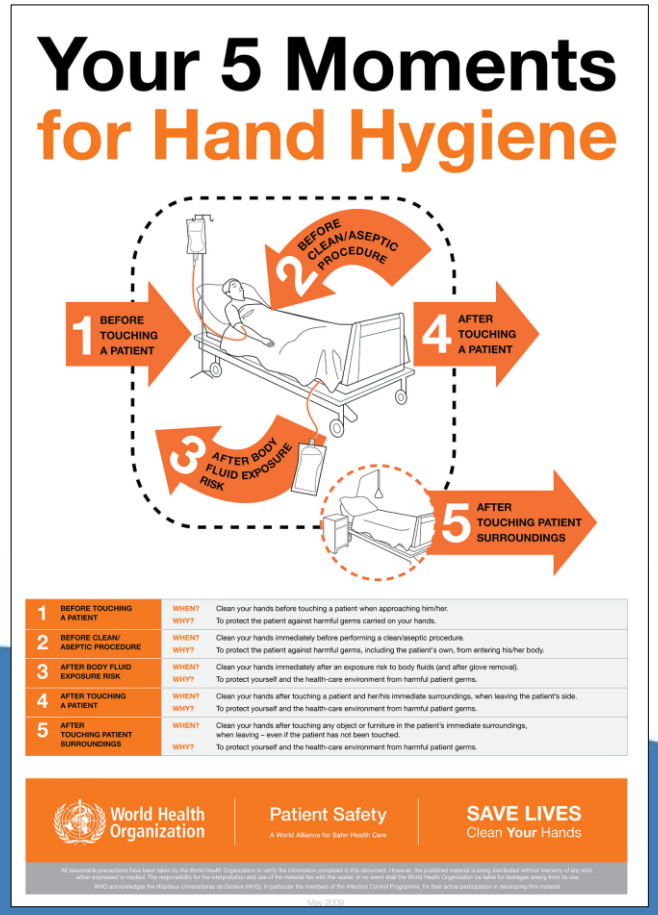
- Partner with facility to make it as safe as possible for patients and staff
- Understand facility practices related to the case(s) exposure, through discussion and observations
- Identify potential risks for illness transmission
- Help implement safer practices where gaps are identified



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ICAR modules- Assessments and Observations





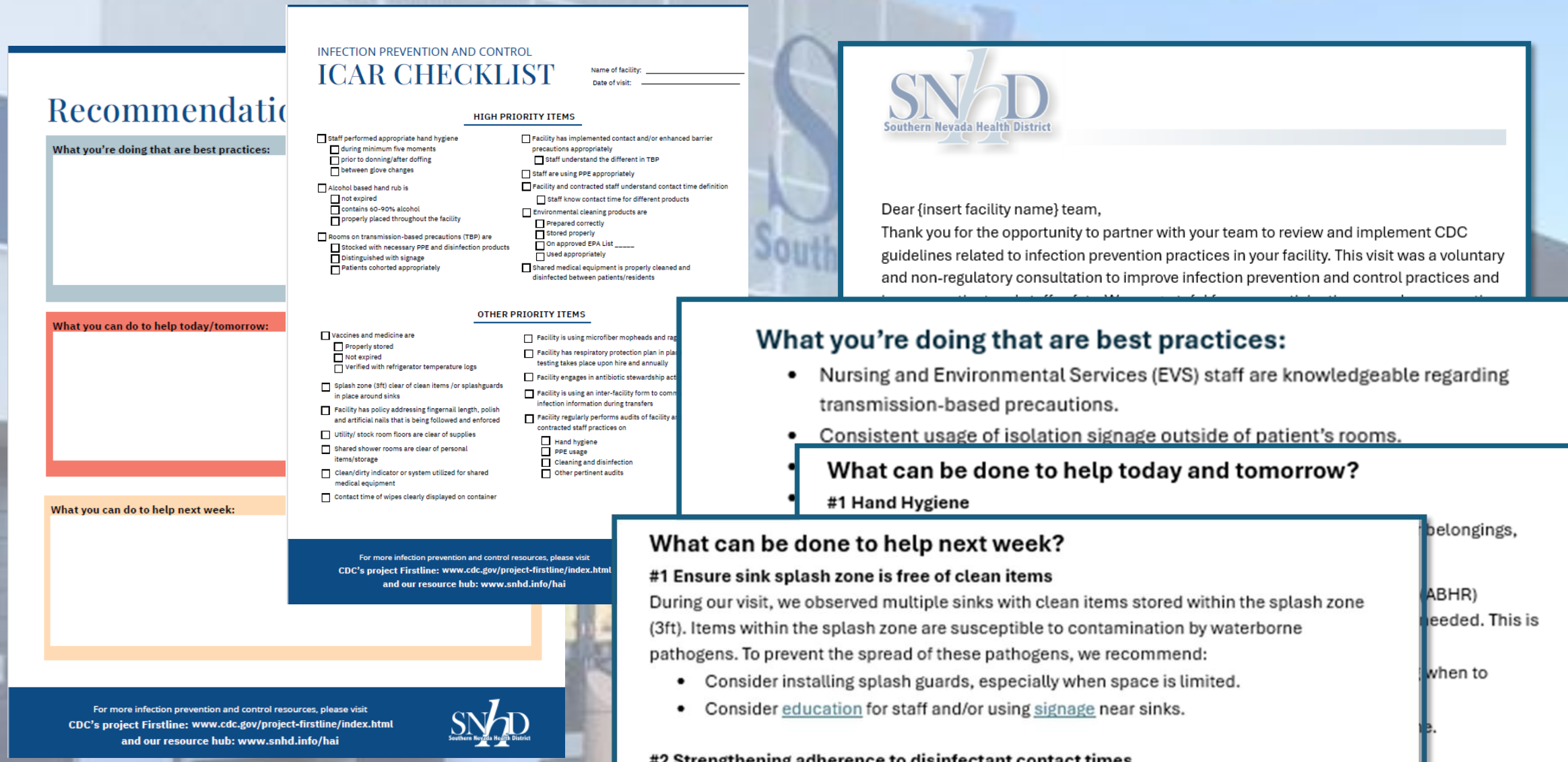
- Module 1 - Training, Audits, Feedback
- Module 2 - Hand Hygiene
- Module 3 - Transmission-Based Precautions
- Module 4 - Environmental Services
- Module 5 - High-level Disinfection and Sterilization
- Module 6 - Injection Safety
- Module 7 - Point of Care (POC) Blood Testing
- Module 8 - Wound Care
- Module 9 - Healthcare Laundry
- Module 10 - Antibiotic Stewardship
- Module 11 - Water Exposure

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Feedback and Summary of Recommendations

Non-regulatory, non-punitive, support driven, a public health approach

Immediate feedback provided



Recommendati

What you're doing that are best practices:

What you can do to help today/tomorrow:

What you can do to help next week:

For more infection prevention and control resources, please visit
CDC's project Firstline: www.cdc.gov/project-firstline/index.html
and our resource hub: www.snhd.info/hai

INFECTION PREVENTION AND CONTROL

ICAR CHECKLIST

Name of facility: _____

Date of visit: _____

HIGH PRIORITY ITEMS

- ☐ Staff performed appropriate hand hygiene
  - ☐ during minimum five moments
  - ☐ prior to donning/after doffing
  - ☐ between glove changes
- ☐ Alcohol based hand rub is
  - ☐ not expired
  - ☐ contains 60-90% alcohol
  - ☐ properly placed throughout the facility
- ☐ Rooms on transmission-based precautions (TBP) are
  - ☐ Stocked with necessary PPE and disinfection products
  - ☐ Distinguished with signage
  - ☐ Patients cohorted appropriately
- ☐ Facility has implemented contact and/or enhanced barrier precautions appropriately
  - ☐ Staff understand the different in TBP
- ☐ Staff are using PPE appropriately
- ☐ Facility and contracted staff understand contact time definition
  - ☐ Staff know contact time for different products
- ☐ Environmental cleaning products are
  - ☐ Prepared correctly
  - ☐ Stored properly
  - ☐ On approved EPA List _____
  - ☐ Used appropriately
- ☐ Shared medical equipment is properly cleaned and disinfected between patients/residents

OTHER PRIORITY ITEMS

- ☐ Vaccines and medicine are
  - ☐ Properly stored
  - ☐ Not expired
  - ☐ Verified with refrigerator temperature logs
- ☐ Splash zone (3ft) clear of clean items /or splashguards in place around sinks
- ☐ Facility has policy addressing fingernail length, polish and artificial nails that is being followed and enforced
- ☐ Utility/ stock room floors are clear of supplies
- ☐ Shared shower rooms are clear of personal items/storage
- ☐ Clean/dirty indicator or system utilized for shared medical equipment
- ☐ Contact time of wipes clearly displayed on container
- ☐ Facility is using microfiber mopheads and rag
- ☐ Facility has respiratory protection plan in pla
  testing takes place upon hire and annually
- ☐ Facility engages in antibiotic stewardship act
- ☐ Facility is using an inter-facility form to comm
  infection information during transfers
- ☐ Facility regularly performs audits of facility a
  contracted staff practices on
  - ☐ Hand hygiene
  - ☐ PPE usage
  - ☐ Cleaning and disinfection
  - ☐ Other pertinent audits

For more infection prevention and control resources, please visit
CDC's project Firstline: www.cdc.gov/project-firstline/index.html
and our resource hub: www.snhd.info/hai

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Dear {insert facility name} team,

Thank you for the opportunity to partner with your team to review and implement CDC guidelines related to infection prevention practices in your facility. This visit was a voluntary and non-regulatory consultation to improve infection prevention and control practices and

What you're doing that are best practices:

- Nursing and Environmental Services (EVS) staff are knowledgeable regarding transmission-based precautions.
- Consistent usage of isolation signage outside of patient's rooms.

What can be done to help today and tomorrow?

#1 Hand Hygiene

belongings,

ABHR)

needed. This is

when to

e.

What can be done to help next week?

#1 Ensure sink splash zone is free of clean items

During our visit, we observed multiple sinks with clean items stored within the splash zone (3ft). Items within the splash zone are susceptible to contamination by waterborne pathogens. To prevent the spread of these pathogens, we recommend:

- Consider installing splash guards, especially when space is limited.
- Consider education for staff and/or using signage near sinks.

#2 Strengthening adherence to disinfectant contact times

During interviews with EVS staff, knowledge gaps were identified regarding required disinfectant contact times. The facility maintains a wide range of disinfectants with varying contact times, from 1 minute to 10 minutes, that differ by product and pathogen. Managing

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Outcomes

36 Assessments using ICAR tool

34 introductory visits to medical facilities

70 on-site visits to facilities

8 outbreaks

4200+ reports received from approximately 250 healthcare providers/ facilities.



ICARs (36)	Meet and Greets (34)
Acute Care Hospital - 11	Acute Care Hospital – 9
Long-Term Acute Care Hospital – 5	Long-Term Acute Care Hospital - 2
SNF/NH/LTC - 20	SNF/NH/LTC - 23

Themes and Observations

1 Hand hygiene

- Lack of hand hygiene, primary observed in repeated populations: providers and contracted staff
  - Sometimes related to lack of availability of ABHR
- Key findings: Not performing hand hygiene prior to putting on gloves or after removing and cross-contamination when using gloves. Example; using dirty gloves to touch clean surfaces
- Good hand hygiene practices among nursing staff at facilities

#2 Trends by position

- Providers in acute care settings are consistently non-compliant with proper hand hygiene and proper PPE use
- IPs in acute care settings have been observed attempting to educate/correct providers in these instances. IP recommendations are not received well by providers.
- Nurses and EVS staff do a great job utilizing PPE; PPE is adequately stocked and available

#3 Interfacility Infection Control Transfer forms

- Some facilities reported they use a transfer form for outgoing patients. However, we receive consistent reports from facilities that they are not receiving the transfer form
- Facilities report they provide infection information during verbal nurse-to-nurse report rather than using the transfer form

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Themes and Observations

Approach/Survey Results

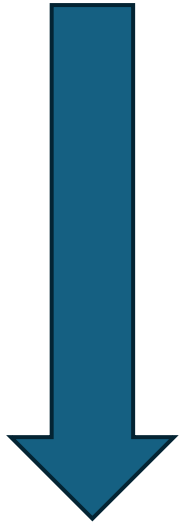
- Facilities have been responsive to our approach. We've received feedback that they enjoy the style/joint effort approach we take.
- Due to feedback we received, we have updated our HAI reporting form to reduce IP burden.

Healthcare Facilities-IP staff

- The acute care hospitals typically have robust, evidence-based infection control protocols that staff are expected to follow
- We have existing positive relationships and partnerships with IP's from acute care facilities that carry into this new program area.
- IP's have been very knowledgeable about their facility specific IPC practices/policies
- Facilities are often conducting audits and providing just in time corrective action to staff.
- IPs have been quick at providing the additional information we need for investigations (medication list, bed trace, etc.)

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Common Gaps Identified



1. **Unfamiliar with and/or improper adherence to disinfectant concentration and/or contact/dwell times**
   - Staff using disinfecting wipes that dry before the reaching the effective contact time
2. **Deviation from proper cleaning sequence for patient rooms**
   - Staff using the same wiping cloth to clean a bed rail immediately after a dirty sink.
3. **No system in place or incomplete system in place to indicate clean/soiled status of shared equipment**
   - No tags, signage, or designated areas established for clean and dirty equipment.
4. **Inadequate cleaning of patient rooms**
   - High touch surfaces tagged with fluorescent markers remain after cleaning.
5. **Clean items stored within sink splash zone**
   - Medications and other sterile supplies being stored within 3 ft. of a sink.
6. **Nonpatient rooms soiled**
   - Soiled equipment and personnel items stored among clean equipment in storage rooms and showers

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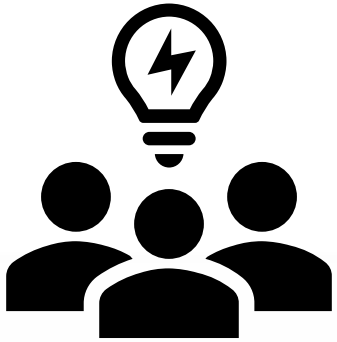
Addressing the Gaps

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1. Education

On site education and discussion

- Help brainstorming corrective actions that will work for individual facility

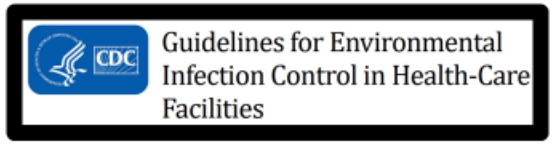


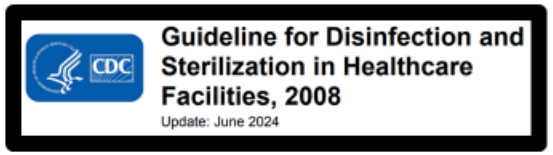
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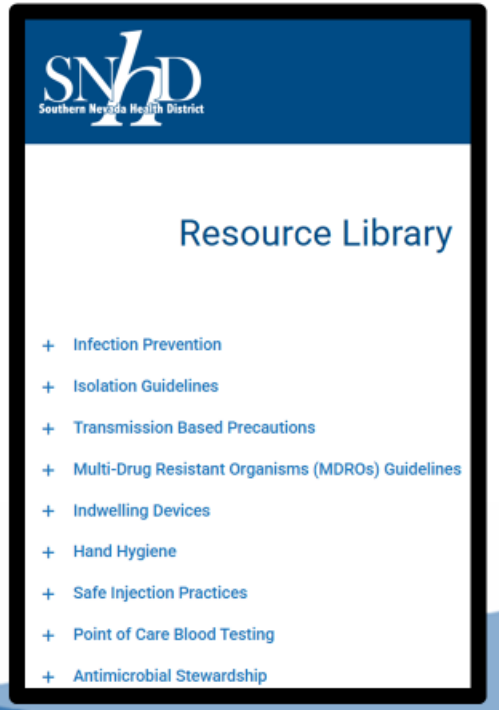
2. Sharing Resources

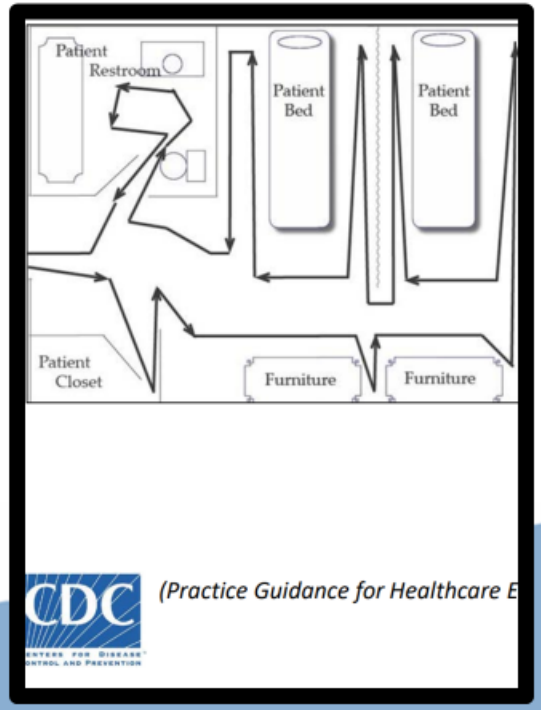
Including links in communications to guidance documents, trainings, posters, and more

www. snhd.info/hai







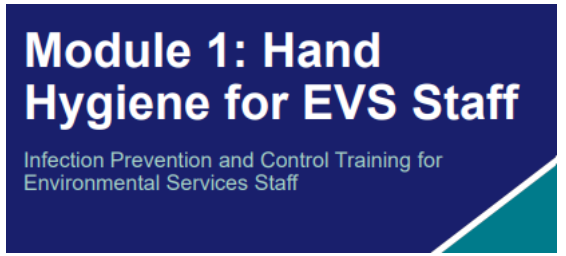


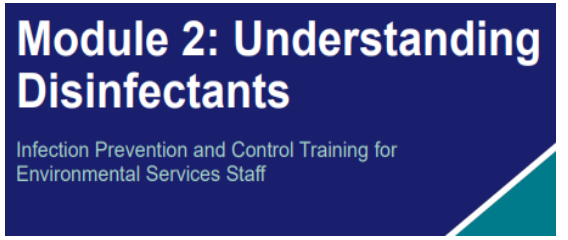
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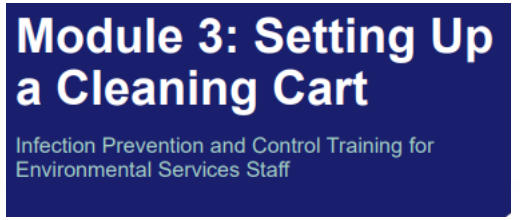
3. Training

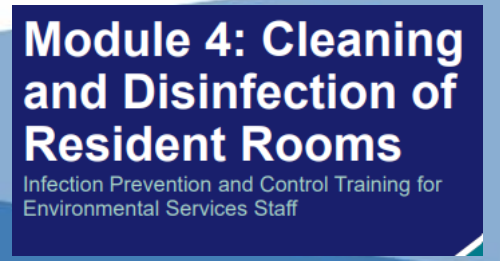
CDC Project Firstline based training recommended to facilities with significant gaps identified

- EVS training
  - Four one-hour modules with interactive components
  - Presented in person, on-site, one per week over 4 weeks
  - Provided in English and Spanish









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HAI Testing: Southern Nevada Public Health Laboratory

Existing Testing Protocols

- *Candida auris* colonization screening by PCR
  - (for Infection Prevention patient cohorting and isolation)
- *Candida auris* antifungal susceptibility testing
  - (for clinical isolates suspected of causing illness)

Facilities Currently Submitting to SNPHL

Sunrise Hospital, Valley Hospital, Summerlin Hospital, Centennial Hills Hospital, Spring Valley Hospital, Henderson Hospital, North Vista Hospital, Desert View Hospital, VA Medical Center, Encompass Health Rehabilitation Hospital, West Henderson Hospital, Horizon Specialty Hospital, Southern Hills Hospital (new as of June 2026)

What is the value of a local Public Health Laboratory HAI Testing program?

Local healthcare facilities that submit samples to SNPHL benefit from:

- Faster turn-around times for HAI pathogen detection and response
- Strengthened community partnerships and laboratory subject matter expertise
- Maintaining a testing support network of partner laboratories for uninterrupted local HAI monitoring
- Direct connections and electronic reporting to SNHD HAI teams



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HAI Testing: Southern Nevada Public Health Laboratory

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Additional Testing Protocols (Expected July 2026)

- Phenotypic confirmation of Carbapenem-Resistant Organisms (CRO) from clinical isolates
- Genotypic detection of carbapenem resistance genes (KPC, NDM, VIM, OXA, IMP) in CRO/CPO isolates
- Expanded antibiotic susceptibility testing for Carbapenem-Resistant Organisms (CRO) using antibiotics commonly used for treatment in Clark County

Next Steps in Laboratory Testing

Electronic Order and Results Delivery Interface

- **Current Challenge**: Reliance on paper requisitions causes demographic errors and operational inefficiencies for both hospital and lab staff.
- **Solution**: Integrate our LIMS with hospital EMRs via HL7 messaging to enable direct ordering and automated result transmission.
- **Key Benefits**: Eliminates manual entry errors, secures patient record management, and accelerates total turnaround time.
- **Contact**: William Bendik, Lab Manager: Bendik@snhd.org

  (702) 759-1026

https://www.southernnevadahealthdistrict.org/programs/southern-nevada-public-health-laboratory/



Southern Nevada Health District

Acknowledgements



- Dr Cassius Lockett, DHO
- Dr. Anil Mangla, Director, DSC
- Dr. Xavier Gonzales, Director, CH
- Dr. Horng-Yuan Kan, Director, SNPHL
- Chris Saxton, Director, EH
- Division and Program Staff
  - SNPHL
  - Environmental Health
  - Disease Surveillance and Control

SNHD Southern Nevada Health District

Questions and Contact Info:

- For questions or concerns:
  - HAI@snhd.org
- For more info on SNHD HAI:
  - https://www.southernnevadahealthdistrict.org/healthcare-associated-infections-program/
- For info on how to report:
  - https://www.southernnevadahealthdistrict.org/news-info/reportable-diseases/

- William Bendik, Laboratory Manager
  - 702-759-1026 bendik@snhd.org
- Lauren DiPrete, Environmental Health Supervisor
  - 702-759-1504 diprete@snhd.org
- Kimberly Franich, Communicable Disease Manager
  - 702-759-0721 franich@snhd.org

Southern Nevada Health District

Data Modernization and Artificial Intelligence Update

Public Health Advisory Board
July 13, 2026

Prut Udomwattawee,
Sony Varghese

Office of Informatics

SNHD
Southern Nevada Health District

Office of Informatics: What We Do

Turning Data Into Action for a Healthier Southern Nevada

The Office of Informatics provides innovative technology, data, and analytical solutions that empower SNHD programs, partners, and the community to prevent disease and promote health.

1 DISEASE SURVEILLANCE SYSTEMS
Collect. Monitor. Protect.

EpiTrax — Disease Surveillance System
EMSA / EMSA2 — Electronic Lab & Case Reporting
Outbreak Management — Investigation & Response

- Monitor reportable diseases and outbreaks
- Receive and process electronic lab & case reports
- Syndromic surveillance and early event detection
- Support investigations and case management
- Maintain master person index (MPI)

2 EHR
Connect. Receive. Integrate.

EHR Support
Electronic Health Record Systems

- Support electronic case reporting (eCR) from healthcare providers
- Integrate clinical data from EHRs
- Improve data completeness and quality
- Reduce provider reporting burden
- Strengthen interoperability using HL7, FHIR, and HIE

3 LAB INFORMATION SYSTEM
Connect. Exchange. Standardize.

LIMS Support
Laboratory Information Management Systems

- Support electronic laboratory reporting (ELR)
- Integrate lab results into EpiTrax
- Standardize lab data using LOINC and SNOMED
- Improve timeliness and data quality
- Enhance lab-to-public health communication

4 DATA INTEGRATION & INTEROPERABILITY
Connect. Exchange. Integrate.

Healthcare Providers · Laboratories · Immunization Registries · Other Partners

HL7 — **HIE / QHIN** — FHIR

SNHD Systems
(EpiTrax, LIMS, Dashboards, Data Warehouse)

- Electronic Lab Reporting (ELR)
- Electronic Case Reporting (eCR)
- HL7 & FHIR standards implementation
- Nevada HIE and QHIN connectivity
- Secure data exchange and integration

5 ANALYTICS & DECISION SUPPORT
Analyze. Visualize. Inform.

Dashboards · GIS & Mapping · Data Warehouse

Actionable Insights for Faster, Smarter Decisions

- Interactive dashboards and reports
- Geospatial analysis and mapping
- Data warehouse and advanced analytics
- Performance measurement and evaluation
- Support leadership and public health action

6 INNOVATION & AI
Automate. Enhance. Advance.

Artificial Intelligence · Workflow Automation · Document Processing

AI-Powered Solutions that Augment Public Health Work

- AI-assisted data extraction and review
- Natural language processing (NLP)
- Data standardization and quality improvement
- Automation of repetitive manual tasks
- Innovation to improve efficiency and impact

FOUNDATIONAL SERVICES WE PROVIDE

Data Security & Privacy
Protecting sensitive health information and ensuring compliance

Data Quality
Accurate, complete, timely, and reliable data for trusted decisions

Infrastructure & Operations
Reliable systems, secure cloud platforms, network, and system administration to support 24/7 operations

Partnerships
Strong collaboration with providers, labs, state, and federal partners

People & Expertise
Skilled informaticians, analysts, developers, and project managers

We transform data and technology into actionable public health solutions that protect and improve the health of our community.

- **Integrity** — We do the right thing.
- **Collaboration** — We achieve more together.
- **Innovation** — We embrace new ideas.
- **Impact** — We make a difference.

Why Data Modernization Matters for Public Health

Modern Data. Connected Systems. Healthier Communities.

1 Increasing Disease Reporting Volume



What's Driving It

- Growing population and more healthcare encounters
- Increased electronic case reporting (eCRs and ELRs)
- More lab results, test orders, and clinical documents

Current Challenges

- Manual processes can't keep up with volume
- Delays in data entry and case creation
- Backlogs impact case investigation and response

Impact

- Slower detection of disease trends
- Delayed interventions and outbreak response
- Strain on public health staff and resources

2 Multiple Healthcare Systems and Data Standards



Different systems. Different formats. Different standards.

What's Driving It

- Diverse EHRs, labs, and information systems
- Varied data formats and coding standards (LOINC, SNOMED, ICD-10, RxNorm, etc.)
- Inconsistent data exchange and interoperability

Current Challenges

- Data silos and fragmented information
- Inconsistent or incomplete data
- Difficult to link and share data across systems

Impact

- Incomplete understanding of patient and community health
- Duplicate data and missed opportunities
- Inefficient workflows and data reconciliation

3 Need for Timely Data & Real-Time Analytics



What's Driving It

- Infectious disease threats can escalate quickly
- Decision-makers need current, actionable information
- Communities expect fast, transparent public health action

Current Challenges

- Delayed data availability and reporting
- Limited real-time visibility into emerging trends
- Complex processes slow down insights

Impact

- Delayed detection of outbreaks and hotspots
- Slower response and communication
- Greater risk to community health

Data Modernization Delivers

- Faster, more accurate disease detection
- Stronger, more coordinated public health response
- Seamless data exchange across partners
- Better insights through data & real-time analytics
- Healthier communities and better outcomes

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Current Data Modernization Progress

Building a Modern, Connected, and Intelligent Public Health Data Ecosystem

1 Disease Surveillance System

- Strengthening EpiTrax and EMSA for electronic case reporting (ELR/eCR)
- Automating lab data processing and workflows
- Enhancing data quality, deduplication, and case management

Key Achievements

- Increased ELR/eCR onboarding and automated processing
- Enhanced data quality rules and standard validations
- New features: eCR viewer, outbreak module, FBI forms

Status: Ongoing

2 Interoperability

- FHIR exchange via eHealth Exchange and IZ Gateway
- SFTP automation and secure data exchange
- Connecting with state systems, labs, hospitals, and providers

Key Achievements

- FHIR server (Facade) and client development underway
- IZ Gateway (NV IIS) integration for immunization data
- SFTP automation with multiple partners and the state

Status: In Progress

3 Master Person Index (MPI)

- Implementing OpenEMPI for enterprise-wide patient matching
- Linking EpiTrax, EMSA, and expanding to other systems
- Improving match accuracy and data consistency

Key Achievements

- OpenEMPI server installed and operational
- Person data import and linkage UAT completed
- EMSA integration testing in progress; expansion planned

Status: In Progress

4 AI Adoption

- Piloting AI for document processing and data extraction
- Exploring AI for clinical data standardization and case intelligence
- Building AI-ready infrastructure

Key Achievements

- AI pipeline design for eCRs and CCDs
- Evaluated tools (e.g., AWS Bedrock) for NLP/LLM
- Use cases identified for automation and insight

Status: In Progress

5 Analytics – Dashboards and GIS

- Expanding Power BI dashboards for surveillance and operations
- GIS mapping for outbreaks and environmental data
- Enabling data-driven decisions and communication

Key Achievements

- Respiratory, wastewater, and claims dashboards live
- Outbreak and facility mapping with GIS
- Enhanced reports for programs and leadership

Status: Ongoing

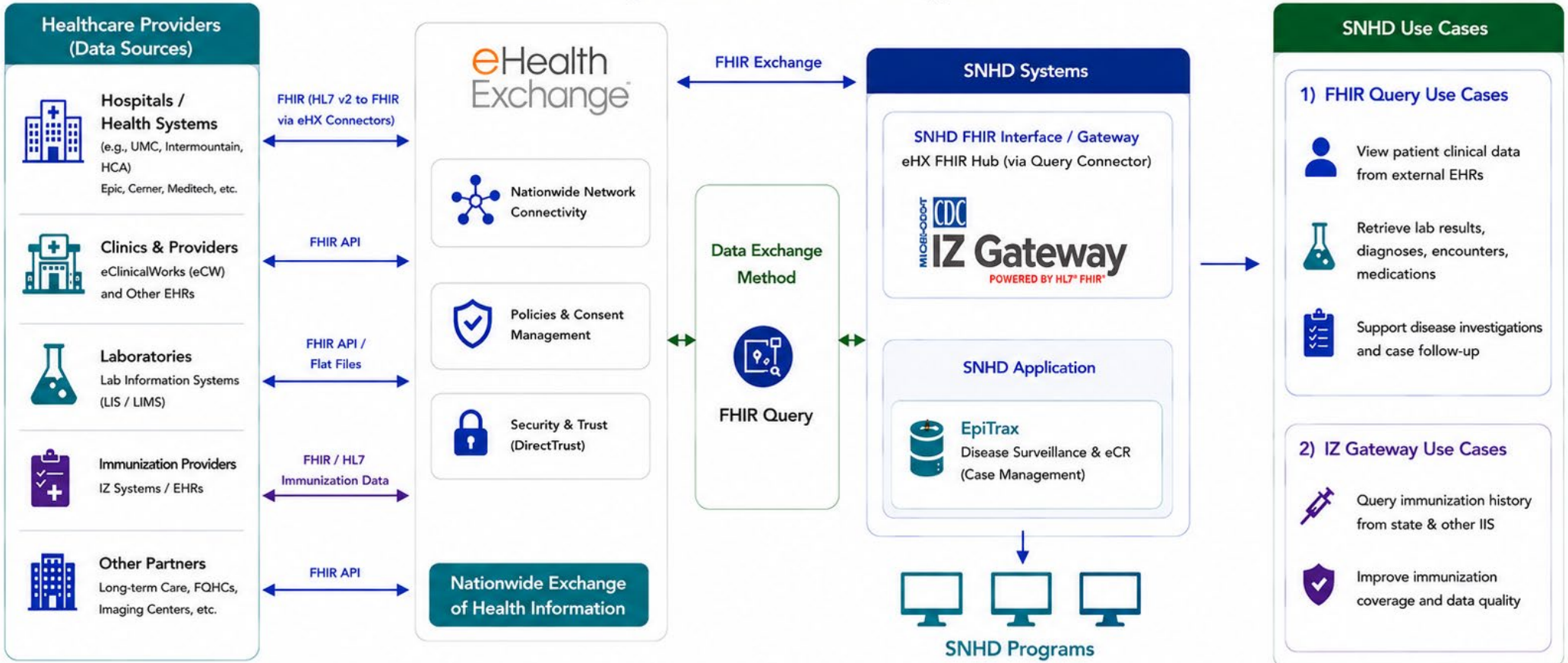
Driving Impact for SNHD & Our Community

- Better Data Quality and Completeness
- Faster Disease Detection and Response
- Stronger System Integration and Data Sharing
- Data-Driven Decisions and Resource Allocation
- Healthier Communities and Better Outcomes

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FHIR Exchange and IZ Gateway Use Cases

Connecting Healthcare Partners to Support Public Health



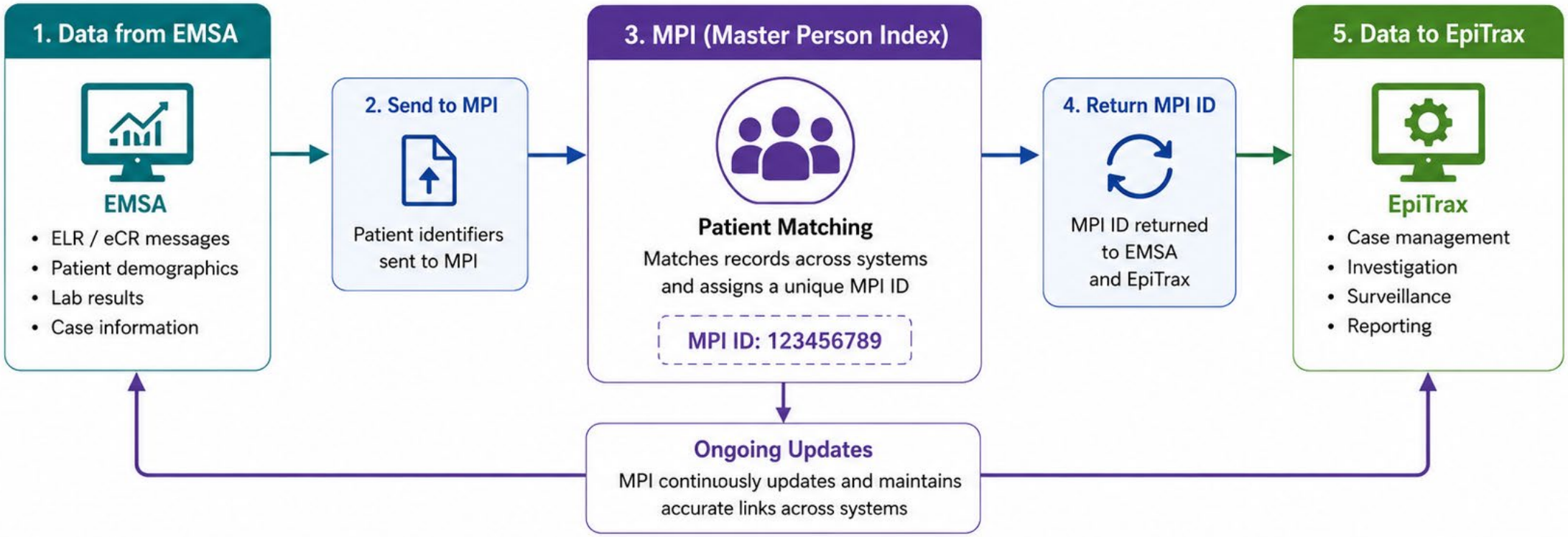
Key Benefits for SNHD & Community

- **Secure Nationwide Access** to clinical and immunization data when and where needed
- **Faster Disease Detection** and Timely Public Health Response
- **Improved Data Quality** and More Complete Patient Records
- **Operational Efficiency** and Reduced Manual Requests
- **Stronger Collaboration** with Providers and Public Health Partners

FHIR / API Connection
Immunization Data Flow
Data Exchange / Query

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MPI Implementation: Connecting EpiTrax and EMSA



Benefits

- Improved patient matching across systems
- More complete patient history for investigations
- Better data quality and fewer duplicates
- Faster case finding and response
- Consistent, secure, and trusted data

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SNHD eCR AI Workflow

Using AWS Bedrock AI to extract, standardize, and integrate eCR data into EpiTrax

1 eCR Data Sources

Nevada HIE
(Health Information Exchange)
eCR submissions from healthcare providers

AIMS
(APHL Informatics Messaging Services)
eCR submissions from healthcare providers

2 Ingest & Secure Transfer

Secure Transfer
(FHIR API via SFTP)

Download raw eCRs to SNHD Local Servers
(No raw eCRs stored in Cloud)

3 AI Analysis with AWS Bedrock

AWS Bedrock (LLM)

Extract Key Data Elements

- **Clinical Data** (Symptoms, Diagnoses, Lab Results, Medications, Procedures, etc.)
- **Social & History Data** (Travel History, Pregnancy Status, Vaccinations, SOGI, etc.)
- **Other Context** (Encounters, Risk Factors, Insurance, etc.)

AI extracts key data elements from raw eCRs using NLP and information extraction

4 Standardization & Mapping

Standardize Clinical Data

- Laboratory Results (LOINC & SNOMED)
- Diagnoses (ICD-10)
- Medications (RxNorm)
- Social History

Human Validation & Quality Checks

5 Standardized eCR Data Integration

Standardized eCR Data Validated & Structured

Integrated into EpiTrax

Key Outcomes

Improved Data Accuracy
Consistent, complete and high-quality data

Reduced Manual Work
Automated extraction and standardization

Faster Public Health Response
Timely insights for investigations and outbreak detection

Interoperable & Scalable
Standards-based data integrated across systems

Enhanced Reporting
Better data for state, CDC and public health reporting

AI-powered eCR processing enables SNHD to turn unstructured clinical data into actionable public health intelligence.

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AI in eCW: Healow No-Show AI Prediction Model

Machine learning predicts the likelihood of patient no-shows and empowers staff to take proactive action.

1. Data Inputs

The AI model analyzes patient scheduling history and related patterns.

- Past appointment history (kept, canceled, no-show)
- Days / times of previous appointments
- Demographics
- Visit type / provider
- Communication history (reminders, calls, texts)
- Other relevant factors

2. AI Prediction Engine

Healow No-Show AI Prediction Model



Machine Learning Model

Forecasts the likelihood that a patient will miss their upcoming appointment.

Up to 90% Accuracy

3. Results in eCW

The no-show probability score is displayed where staff work every day.

eCW Schedule View

Time	Patient	Appt. Type	No-Show Probability
9:00 AM	John Smith	OV	65%
9:20 AM	Maria Garcia	OV	25%
9:40 AM	David Lee	FU	72%
10:00 AM	Sarah Johnson	OV	15%
10:20 AM	Michael Brown	OV	55%

No-Show Dashboard



High Probability

High-Probability Appointments (50% or Higher)

Today	18
This Week	87
This Month	312

Probability Score Categories

- Low Probability (< 30%)
- Moderate Probability (30% – 49%)
- High Probability (≥ 50%)

4. Actionable Workflows

Staff can take proactive steps for high-risk patients.

- Identify high-risk patients (≥ 50% probability)
- Contact patients to confirm attendance, offer transportation, or reschedule if needed
- Use custom visit status (e.g., "Confirmed Live") to track confirmed appointments
- Optimize provider schedules and consider strategic double-booking where appropriate

Key Benefits

Revenue Protection
Reduces lost revenue from no-shows, late cancellations, and reschedules.

Time Efficiency
Saves staff time by focusing outreach on patients most likely to no-show.

Better Utilization
Helps ensure provider time is used effectively and schedules stay productive.

Improved Patient Experience
Proactive outreach improves communication and patient engagement.

AI-powered predictions. Human-powered action. Better outcomes.

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SNHD Next Steps: Data Modernization & AI Advancement

Building an Integrated, Intelligent, and Interoperable Public Health Data Ecosystem

1 Expand Enterprise Master Person Index (MPI)

Complete MPI between EpiTrax and EMSA

Strengthen and finalize person matching across both systems.

Expand to Other Systems

Extend MPI to additional systems such as Vital Records and eClinicalWorks (eCW).

Improve Patient Matching

Increase accuracy and reduce duplicates to ensure one person rrecord across systems.

Better Data Quality & Efficiency

Enhance data quality, streamline investigations, and enable better public health outcomes.



2 Expand AI Applications

Focus on eCRs and CCDs

eCR
CCD

Use AI to process electronic case reports (eCRs) and Continuity of Care Documents (CCDs).

Document Processing and Case Extraction

Leverage AI to extract key clinical information, identify case details, and support faster investigations.

Clinical Data Standardization

Standardize clinical data using terminologies (LOINC, SNOMED, ICD-10, RxNorm) to improve consistency and usability.

Outcome

Reduced manual workload, faster disease detection, and improved data accuracy for public health action.

3 Advance National Health Information Exchange

Connect through QHIN (Qualified Health Information Network)

Leverage QHIN to enable secure, trusted exchange of clinical data with partners across the country.

Participate in TEFCA

Engage in the Trusted Exchange Framework and Common Agreement (TEFCA) to exchange data nationwide.

Improve Access to Timely Clinical Data

Gain timely access to clinical information from external sources to support accurate and rapid disease investigations.

Outcome

Stronger interoperability, broader data access, and better public health response across jurisdictions.

Collective Impact for SNHD & Community

- More Complete Patient Information
- Faster & Smarter Disease Investigations
- Data-Driven Decision Making
- Stronger Partnerships & Collaboration
- Better Health Outcomes for Our Community

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Questions?

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