NNPH Quarterly Report
FY24

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.1.1.1 Reach at least 3,000 residents and visitors about the impact of secondhand cannabis smoke exposure through communications efforts. (# of residents reached)	Staff developed one (1) social media post on the harms of cannabis secondhand smoke exposure, and resources available for quitting. The post was shared on three social media platforms (Instagram, X, and Facebook), resulting in 493 impressions and 10 engagements. Staff also distributed 100 Need to Know cannabis educational cards to local dispensaries for their clients.	300	2,029	2,590	3,000	3,183	1.1.1.1.1 Provide education about the dangers of secondhand cannabis smoke exposure through distributing Need to Know cards and developing posts to be shared on social media platforms.
(PI) 1.1.1.2 Maintain breastfeeding rates at 80% among WIC clients who report ever breastfeeding.	Breastfeeding rates for those who report ever breastfeeding are at 80% for NNPH WIC clients. This is higher than the State breastfeeding rate, which is 74%.	80.00%	80.00%	80.00%	80.00%	80.00%	1.1.1.2.1 Support staff receiving breastfeeding training. 1.1.1.2.2 Offer clients breastfeeding support and services.
(PI) 1.1.1.3 Increase multi-family housing properties that have smoke free policies by at least 2.	One new property, Dick Scott Manor, opened with a Smoke free/ Vape Free policy in place. This property consists of 12 units, primarily serving low-income veterans.	0	1	3	2	4	1.1.1.3.1 Recruit and provide technical assistance to owners and managers of multi-unit housing properties.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.1.1.4 Reach at least 4 groups or stakeholders with information on how smoke-free workplace policies impact overall community health. (# of partners that receive smoke-free workplace policy information)	Shared information about smokefree workplace policies, including the benefits to businesses and the community, with a group of business leaders at the Young Professionals Network.	2	3	5	4	6	1.1.1.4.1 Provide education and technical assistance to new community partners about smoke-free workplaces.
(PI) 1.1.2.1 Reach seniors with fall prevention messaging at least once per quarter. (# of messaging/ education attempts including events, tabling, and media)	Staff provided senior falls prevention outreach at the Washoe County Senior Services Older Americans Month Resource Fair on 5/1/ 2024. Approximately 118 seniors received information and resources on falls prevention. In addition, staff provided senior falls prevention education at the Family Health Festival 5/22/2024, reaching approximately 123 participants.	1	2	3	4	5	1.1.2.1.1 Provide education, outreach, and support to seniors and senior groups in Washoe County.
(VI) 1.2.1.1a # of WIC participants (quarterly average enrollment, annual average enrollment in Q4)		3,463	3,410	3,342		3,393	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.2.1.1 Maintain at least 95% of enrolled WIC participants as compared to last FY enrollment.	The FY24 average for monthly WIC enrollment (3393) was 0.52% more than the FY23 average monthly enrollment (3375). Changes in data can be attributed to several factors including fluctuations in community demand, changes in staffing, and changes in scope of work/grant deliverables. The WIC program continues functioning strongly and delivering good results.	102.60%	102.10%	100.25%	95.00%	99.47%	1.2.1.1.1 Implement retention efforts and new participant recruitment and enrollment activities. 1.2.1.1.2 Provide outreach to underserved communities.
(VI) 1.2.1.2a # of clients served in the immunization program		1,007	2,396	3,271		4,136	
(VI) 1.2.1.3a # of VFC compliance visits		0	8	17		25	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.2.1.3 Assure 50% of Vaccine for Children (VFC) providers receive a compliance visit yearly.	Immunization Program VFC (Vaccines for Children) Site Visit Reviewers conducted 8 compliance visits with county VFC medical providers during Q4. This activity meets or exceeds FY23-24 goals set forth by the Nevada State Immunization Program and CDC outlining that at least 50% of providers receive this visit every two years. NNPH visited 25 of 43 providers this year (58%).	0%	18.00%	40.00%	50.00%	58.00%	**1.2.1.3.1 Perform compliance visits.**
(VI) 1.2.1.4a # of clients served in the Family Planning and Sexual Health program		1,003	1,951	2,948		3,634	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.2.1.5 Implement 100 community/ provider Sexual Health education and outreach activities.	During FY25, Sexual Health outreach activities consisted of educational sessions, community testing opportunities, and providing the community with information on services provided at NNPH. These activities were provided by the Supervisor, Public Health Investigators, per diem Health Educators and per diem nurses, and Community Health Workers.	21	58	97	100	145	1.2.1.5.1 Provide educational presentations as requested by the community. 1.2.1.5.2 Conduct Academic Detailing to providers addressing sexual health topics. 1.2.1.5.3 Participate in community outreach events. 1.2.1.5.4 Provide offsite testing in partnership with community organizations and businesses.
(VI) 1.2.2.1a # of reported HIV cases investigated		11	27	39		51	
(PI) 1.2.2.1 Initiate investigation of 90% of reported HIV cases within 5 business days of report.	All reported cases of HIV had case investigations initiated within 5 days of the report.	100.00%	100.00%	100.00%	90.00%	100.00%	
(VI) 1.2.2.2a # of primary, secondary syphilis cases investigated		35	60	85		98	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.2.2.2 % of primary, secondary syphilis cases initiated within 5 days.	During the reporting period, 12 of the 13 primary and secondary syphilis cases investigations were initiated within 5 days of report. Cumulatively, 85 out of 98 (86.7%) case investigations were initiated within 5 days during the FY.	68.60%	80.00%	100.00%	90.00%	86.70%	
(VI) 1.2.2.3a # of maternal syphilis cases investigated		4	8	13		18	
(PI) 1.2.2.3 % of maternal syphilis cases initiated within 5 days	During the reporting period, 100% of maternal syphilis case investigations were initiated within 5 days of report.	100.00%	100.00%	100.00%	90.00%	100.00%	
(VI) 1.2.2.4a # of other syphilis cases investigated (early latent, late latent/ unknown duration, biological false positives, old disease)		181	219	505		765	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.2.2.4 % of other syphilis cases initiated within 5 days	During the reporting period, 258 of the 260 other syphilis case investigations were initiated within 5 days of report. Other syphilis cases include early latent, late latent/unknown duration, biological false positives, old disease, and pending cases. Cumulatively, 829 out of 946 (87.6%) case investigations were initiated within 5 days of report during the FY.	76.80%	74.00%	96.00%	90.00%	87.60%	
(VI) 1.2.2.5a # of congenital syphilis cases investigated		6	7	10		18	
(PI) 1.2.2.5 % of congenital syphilis cases initiated within 5 days	During the reporting period, all 8 congenital syphilis case investigations were initiated within 5 days of report.	100.00%	100.00%	100.00%	90.00%	100.00%	
(VI) 1.2.2.6a # of reported gonorrhea cases investigated		126	311	458		579	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.2.2.6 Initiate 90% of prioritized gonorrhea case investigations within 5 business days of report.	Of the 121 gonorrhea cases reported, 117 case investigations were initiated within 5 days of report for the fourth quarter. This is a significant improvement over previous reporting periods due to staff training and diligence, as well as increased staff capacity. For the FY, 488 out of 579 (84.3%) gonorrhea case investigations were initiated within 5 days of report.	60.00%	74.68%	77.51%	90.00%	84.30%	
(VI) 1.2.2.7a # of reporterd chlamydia cases investigated		608	1,156	1,718		2,250	
(PI) 1.2.2.7 Review 90% of chlamydia cases within 5 days of report.	During the reporting period, 522 of the 532 (98%) chlamydia case investigations were initiated within 5 days of report. Case investigations for chlamydia consist mostly of verifying treatment and providing appropriate treatment if needed, through the NNPH Sexual Health Clinic. Cumulatively, 2110 out of 2250 (97.8%) case investigations were initiated within 5 days during the entire FY.	100.00%	89.62%	95.87%	90.00%	98.00%	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 1.2.2.8a # of individuals suspected to have active tuberculosis disease and investigated		5	12	18		21	
(PI) 1.2.2.8 % of all individuals suspected to have active TB status confirmed within 1 business day via Nucleic Acid Amplification Test (NAAT).	For this quarter, 3 out of 4 TB cases were confirmed with a NAAT within 24 hours of sputum collection for the reporting period. These cases were started on standard TB treatment within the same day NAAT confirmation was received. This brings the YTD percentage for NAAT testing to 92%, considering this and previous quarters' data.	100.00%	80.00%	88.00%	100.00%	92.00%	1.2.2.8.3 Collect, review, and process lab and provider reports for suspected or confirmed active TB disease. 1.2.2.8.4 Utilize Directly Observed Therapy (DOT) and virtual DOT to assist with case treatment adherence. 1.2.2.8.5 Establish partnerships with community providers to effectively communicate case management and treatment status. 1.2.2.8.6 Utilize contact tracing for all sputum smear positive disease cases. 1.2.2.8.1 Increase staff who are trained to take select high frequency diseases, in order to reduce burden on any one person or set of staff.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							1.2.2.8.2 Ensure workflows are designed so staff know when a lab is reported so they can begin the investigation as soon as feasible.
(PI) 1.2.2.9 For clients with active tuberculosis, increase the percentage that have sputum culture conversion within 60 days of treatment initiation.	There was 1 case during Q4-24 that was confirmed within the prescribed time frame to have culture converted to no mycobacterium tuberculosis in their sputum within 2 months of treatment. This was the only case that had a pending culture during this time period.	100.00%	100.00%	100.00%	83.00%	100.00%	
(PI) 1.2.2.10 Initiate the index/source case interview and contact investigation for 100% of sputum smear positive tuberculosis cases within 14 days.	For Q4-24 the TB Clinic had one new case diagnosed during this period in which contact investigation was elicited within 14 days. All contacts were negative for TB.	100.00%	100.00%	100.00%	100.00%	100.00%	
(VI) 1.2.2.11a # of foodborne, vector borne, vaccine preventable, disease of unusual occurrence, etc. cases investigated		430	673	1,073		1,216	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.2.2.11 Investigate 100% of foodborne, vector borne, vaccine preventable, disease of unusual occurrence, etc. disease cases within their designated time frame.	Q4 total = 237/280 = 84.6% Same day follow up = 49/61 reported = 80% Within 1 day follow up = 121/142 reported =85% Within 1 week follow up = 57/57 reported = 100% Outbreaks = 10/20 declared = 50% **Total FY24 = 907/ 1071 = 84.7%** **Factors preventing 100% investigations on time: NNPH does not have 24/ 7coverage, cannot pick up calls or labs that come in Friday when staff doesn't get in until Monday.**	85.60%	80.70%	84.70%	100.00%	84.70%	
(VI) 1.2.3.1a # of community-based vaccine provision events		12	26	40		52	1.2.3.1a.1 Provide education at 1 outreach event per quarter.
(VI) 1.3.1.1a # of clients that see the Enrollment Assister annually		37	73	104		110	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.3.1.1 Maintain or increase the number of clients that see the Enrollment Assister annually.	The program reached the target for the fiscal year. Nevertheless, in the last quarter of the year, the Department of Welfare and Social Services management made the decision not to have a worker at NNPH. Thus, the numbers were lower than expected. This is in contrast to when appointments were made onsite, and more clients were able to easily access that service. NNPH staff is also working on an agreement to place a bilingual enrollment assister onsite through Nevada Health Centers, as many clients are Spanish speakers and translations often take a significant amount of additional time for existing staff.	37	73	104	64	110	1.3.1.1.1 Collaborate with State Enrollment Assister onsite to provide assistance, by educating staff, thus increasing education to clients and providing proper paperwork and education to clients prior to appointments. 1.3.1.1.2 Provide reminder calls for scheduled appointments with the Enrollment Assister.
(VI) 1.3.2.1a # of clients and community members provided assistance with navigation of community resources		119	263	524		756	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.3.2.1 Increase the number of clients and community members provided assistance with navigation of community resources. (# provided assistance)	The CHWs provided individual health navigation and resources to 232 clients this past quarter. This is a slight decrease from the prior quarter due to less clients seen in the clinic-based programs. The greatest need for clients continues to be assistance establishing with a primary care provider and insurance assistance.	119	263	524	360	756	1.3.2.1.1 Monitor number of referrals from each CCHS program. 1.3.2.1.2 Evaluate need for standardized referral process. 1.3.2.1.3 Meet with intermittent hourly staff from each program to educate on services provided by CHWs.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 1.3.2.2 Increase community reach through new partnerships and outreach activities. (# of outreach activities)	The CHWs continue to conduct recurring outreach at Eddy House, TMCC, and at multiple Mobile Harvest distribution sites. During the last quarter, CHWs also conducted outreach at TMCC's Take Back the Night event and multiple Family Resource Centers at Sparks and North Valleys schools. Additionally, the CHWs continue to provide Cribs For Kids classes and NNPH resources at the Anthem Wellness Center. * Special note: when this performance measure was created for FY24, it was believed that all outreach activities done by the CHWs would count toward accomplishing this goal. It was later determined that the CHWs could only count outreach activities that were not program-specific, so outreach activities were not being double counted. For example, the outreach at the Eddy House is done by the CHWs but counted in the Sexual Health program as one of	15	22	37	90	46	1.3.2.2.1 Identify 2 new community partners for recurring outreach. 1.3.2.2.2 Identify 2 new community outreach events to table.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
	their outreach activities. The measure has been reevaluated for FY25 to obtain more accurate data.						
(PI) 1.3.3.1 Increase access to programs and services through completing 3 system improvements.	1. CCHS Intranet was implemented this quarter. This SharePoint site allows for one location for staff to visit for most up-to-date policies and procedures, forms, and program information. 2. Teams group chats implemented and refined for quick alerts regarding client needs between front office and back office and between clinical staff. 3. Family Planning Sexual Health clinic workflow changed so that clients do not change exam rooms. Various staff now go to the client instead of the client having to go to them.	0	3	5	3	8	1.3.3.1.1 Establish and evaluate contactless client services. (provider contact, appointments/ self-scheduling, telemedicine, results, payments) 1.3.3.1.2 Implement centralized clerical services.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.1.1 Meet or exceed a 75% data capture rate for ozone.	FY24 Q4 Data Completeness Reports will not be available until September 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the January 1 to March 31, 2024, reporting period. This report summarizes the number of hourly ozone observations as well as data completeness percentages for all ozone monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	98.60%	98.40%	97.90%	75.00%	98.40%	**2.1.1.1.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (ozone)**

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.1.2 Meet or exceed a 75% data capture rate for PM2.5.	FY24 Q4 Data Completeness Reports will not be available until September 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the January 1 to March 31, 2024, reporting period. This report summarizes the number of hourly PM2.5 observations as well as data completeness percentages for all PM2.5 monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	98.40%	98.80%	99.60%	75.00%	98.20%	2.1.1.2.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (PM2.5)

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.1.3 Meet or exceed a 75% data capture rate for PM10.	FY24 Q4 Data Completeness Reports will not be available until September 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the January 1 to March 31, 2024, reporting period. This report summarizes the number of hourly PM10 observations as well as data completeness percentages for all PM10 monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	98.40%	98.50%	98.20%	75.00%	98.00%	**2.1.1.3.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (PM10)**

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.1.4 Meet or exceed a 75% data capture rate for carbon monoxide.	FY24 Q4 Data Completeness Reports will not be available until September 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the January 1 to March 31, 2024, reporting period. This report summarizes the number of hourly CO observations as well as data completeness percentages for all CO monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	98.50%	97.00%	96.00%	75.00%	98.00%	2.1.1.4.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (carbon monoxide)
(PI) 2.1.1.5 Meet or exceed a 75% data capture rate for nitrogen dioxide.	FY24 Q4 Data Completeness Reports will not be available until September 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the January 1 to March 31, 2024, reporting period. This report summarizes the number of hourly NO2 observations as well as data completeness percentages for all NO2 monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	97.00%	98.00%	98.00%	75.00%	97.00%	2.1.1.5.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (nitrogen dioxide)

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.1.6 Meet or exceed a 75% data capture rate for sulfur dioxide.	FY24 Q4 Data Completeness Reports will not be available until September 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the January 1 to March 31, 2024, reporting period. This report summarizes the number of hourly SO2 observations as well as data completeness percentages for all SO2 monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	96.00%	96.00%	95.50%	75.00%	96.00%	2.1.1.6.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (sulfur dioxide)
(VI) 2.1.2.1a # of air quality plans and reports worked on during this period.		8	15	21		25	2.1.2.1a.1 Develop Ozone Mitigation Plan and submit to EPA for approval. 2.1.2.1a.2 Complete Dixie/ Antelope Exceptional Event demonstration and submit to EPA for concurrence. 2.1.2.1a.3 Complete Dixie/ Caldor Exceptional Event demonstraion and submit to EPA for concurrence.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							2.1.2.1a.4 Complete Dixie/ Tamarack Exceptional Event demonstration and submit to EPA for concurrence.
							2.1.2.1a.5 Complete Mosquito Exceptional Event demonstraion and submit to EPA for approval.
							2.1.2.1a.6 Develop Second 10-Year PM10 Maintenance Plan and submit to EPA for approval.
							2.1.2.1a.7 Update 2024 Ambient Air Monitoring Network Plan and submit to EPA for approval.
							2.1.2.1a.8 Update 2014-2023 Air Quality Trends Report and present to DBOH for acceptance.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.2.1 Educate and empower leaders, decision makers and regulated entities through a minimum of 3 AQ outreach opportunities. (# of outreach events)	Outreach opportunities completed by AQMD staff during the April 1 to June 30, 2024, reporting period include: 1. Health Equity Initiatives Presentation at NNPH General Staff Meeting – Craig Petersen, April 3, 2024. 2. Air Quality Management in Washoe County Presentation to the NRS 433/633 Fate and Transport Class at the University of Nevada, Reno – Brendan Schnieder and Genine Rosa, April 3, 2024. 3. Street Sanding, Salting, and Sweeping Working Group Meeting Presentation – Brendan Schnieder, June 18, 2024. 4. Second 10-Year Maintenance Plan for the Truckee Meadows 24-Hour PM10 Attainment Area Presentation to the DBOH – Brendan Schnieder, June 27, 2024. 5. 2014-2023 Washoe County, Nevada Air Quality Trends Report Presentation to the DBOH – Ben	8	12	13	3	18	**2.1.2.1.1 Identify and contact community groups and partners.**

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
	McMullen, June 27, 2024 The total number of outreach opportunities completed by AQMD staff in FY2024 is 18.						
(VI) 2.1.2.2a # of community planning efforts where AQMD commented.		2	4	14		24	
(VI) 2.1.2.2b # of community planning efforts where AQMD participated as a technical advisor.		5	13	26		44	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.2.3 Complete updates of 11 parts of regulation chapters.	There were no Updates to regulation parts completed by AQMD staff during the April 1 to June 30, 2024. Updates worked on by AQMD staff during the reporting period, but not completed include: 1. 030.000 – Source Permitting 2. 030.100 – General Permitting 3. 030.200 – Minor Source Permitting 4. 030.300 – Nonattainment New Source Review 5. 030.400 – Prevention of Significant Deterioration 6. 030.500 – Permit to Construct Requirements for Part 70 Sources This project is not limited to one fiscal year. AQMD is constantly revising regulations, and they are not on any set schedule. With reviews from internal staff, EPA, and the regulated community, the revisions are continual and can only go as fast as the processes governing each of these stakeholder groups.	0	4	4	11	4	2.1.2.3.1 Update Chapter 020 – Parts 020.000 – 020.200 (3 parts) 2.1.2.3.2 Update Chapter 030 – Parts 030.000 – 030.500 (6 parts) 2.1.2.3.3 Update Chapter 040 – Asbestos Control Standards and Asbestos Acknowledgements (2 parts)

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 2.1.3.1a # of wood-burning devices inspections completed		88	164	231		322	2.1.3.1a.1 Inspect properties which have removed a wood-burning device prior to the close of escrow.
(PI) 2.1.3.1 % wood-burning permits managed within internal best practice standard (NOE 2 business days, COC 10 business days)	The AQMD developed a system to track this best practice standard during Quarter 4 of FY24 and will be able to report out during Q1 of FY25.				100.00%		
(VI) 2.1.3.1b # of wood-burning device registrations		2,129	3,744	5,281		7,272	2.1.3.1b.1 Process and issue Notice of Exemption Registrations submitted to the Air Quality Management Division. 2.1.3.1b.2 Process and issue Certificate of Compliance Registrations submitted to the Air Quality Management Division. 2.1.3.1b.3 Process and issue Dealers Affidavit of Sale Registrations submitted to the Air Quality Management Division.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 2.1.3.2a # of dust control permit inspections completed		117	251	396		539	2.1.3.2a.1 Complete dust control inspections to determine compliance with dust control permit requirements.
(VI) 2.1.3.2b # of dust control permits		45	100	146		196	2.1.3.2b.1 Process and issue Dust Control Permit applications submitted to the Air Quality Management Division.
(PI) 2.1.3.2 % of dust permits managed within 10 business days.	The AQMD developed a system to track this best practice standard during Quarter 4 of FY24 and will be able to report out during Q1 of FY25.				100.00%		
(VI) 2.1.3.2c Total acreage disturbed by dust permits		443	1,246	2,022		2,523	
(VI) 2.1.3.3a # of asbestos renovation and demolition inspections completed		37	70	105		135	2.1.3.3a.1 Complete inspections of asbestos notifications for demolitions and renovations to determine compliance with asbestos NESHAP standards.
(VI) 2.1.3.3b # of asbestos renovation and demolition notifications		37	77	119		154	2.1.3.3b.1 Process asbestos NESHAP notifications for demolition and renovation activities.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 2.1.3.3c Total square feet of asbestos materials		78,300	185,464	302,091		393,182	
(VI) 2.1.3.3d Total linear feet of asbestos materials		5,948	6,371	6,410		8,263	
(PI) 2.1.3.3 % of asbestos permits managed within internal best practice standard.	The AQMD developed a system to track this best practice standard during Quarter 4 of FY24 and will be able to report out during Q1 of FY25.				100.00%		
(VI) 2.1.3.3e Total cubic feet of asbestos materials		0	0	0		0	
(VI) 2.1.3.4a # of complaint inspection/ investigations		47	84	111		158	
(VI) 2.1.3.5a # of warnings and notices of violations issued		13	19	42		63	
(VI) 2.1.3.6a # of stationary source inspections assigned		153	263	385		532	
(PI) 2.1.3.6 Complete 100% of stationary source inspections assigned.	Of (147) Stationary Source inspections assigned in Quarter 4 of FY24, (147) were completed, for a completion rate of 100%.	100.00%	100.00%	100.00%	100.00%	100.00%	2.1.3.6.1 Complete inspections of stationary sources to determine compliance with permit and regulatory requirements.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 2.1.3.7a # of stationary source authority to construct/ permit to operate permits issued		15	31	44		59	
(PI) 2.1.3.7 100% of stationary source authority to construct/ permit to operate permits are issued within 180 days.	Of the (15) Stationary Source Authority to Construct permits issued in Quarter 4 of FY24, (15) Stationary Source Authority to Construct permits were issued within 180 days. Times throughout the year when AQMD fell slightly behind goal deadlines regarding Permits to Operate for Stationary Sources or completing Plan Reviews were attributable to staffing shortages and building new staff members' knowledge/expertise. As the division builds staffing and experience, AQMD is increasingly on track meeting all deadlines.	93.00%	90.00%	93.00%	100.00%	95.00%	2.1.3.7.1 Issue authorities to construct to new sources of regulated air pollutants in Washoe County. 2.1.3.7.2 Reissue permits to operate on an annual basis to sources of regulated air pollutants in Washoe County.
(VI) 2.1.4.1a # of inspections completed at permitted waste management facilities per year.		52	111	200		270	
(VI) 2.1.4.1b # of waste management facility permits		307	299	302		308	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 2.1.4.1c # of waste related complaints		59	95	125		177	
(PI) 2.1.4.1 Complete 100% of inspections at permitted waste management facilities per year.	During the fourth quarter of FY24, 23% of permitted waste management facilities were inspected. This meets the target of approximately 25% per quarter. Due to the fact that the target of 100% of inspections is calculated on the calendar year, rather than the fiscal year, the percentages below do not add up to 100% (different quarters in different years will naturally fluctuate). However, with the exception of 6 permits that were overlooked, all permitted waste management facilities were inspected in CY23, yielding a percentage completion of 98% for CY23.	14.00%	34.00%	63.00%	100.00%	86.00%	2.1.4.1.1 Develop an audit system and conduct a minimum of 3 audits per staff member. 2.1.4.1.2 Update SOPs and develop standardized processes for solid waste complaints.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.4.2 Partner with a minimum of 3 outside agencies to assist in waste reduction/clean up initiatives.	Over the fourth quarter of FY24, EHS partnered with the County Manager's office and Commissioner Garcia to put together a large clean up in Sun Valley. EHS utilized the Tire Fund, a restricted funding source from the State for assisting in the waste management activities of NNPH, to pay for the dumpsters used in the cleanup.	1	1	2	3	3	2.1.4.2.1 Collaborate with KTMB on community engagement regarding reduced waste initiatives. 2.1.4.2.2 Utilize tire funds to create grant program to assist local groups with clean up and sustainability efforts in the community.
(VI) 2.1.5.1a # of first review plans reviewed for compliance with AQ regulations and processed (AQM)		293	460	596		763	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.5.1 Ensure 90% of first review plans for compliance with AQ regulations meet jurisdictional timeframes. (AQM)	Of the (167) plans assigned for AQM review in Quarter 4 of FY24, (167) met jurisdictional timeframes for a rate of 100%. It should be noted, (3) additional plans were received by the AQMD after the due date for that plan review, however those plans were reviewed on the date of receipt. Times throughout the year when AQMD fell slightly behind goal deadlines were attributable to staffing shortages and building new staff members' knowledge/expertise. As the division builds staffing and experience, AQMD is increasingly on track meeting all deadlines.	90.00%	92.00%	94.00%	90.00%	95.00%	
(VI) 2.1.5.2a # of residential septic and well plans reviewed and processed		200	362	600		852	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.5.2 Ensure 90% of residential septic and well plan reviews meet jurisdictional timeframe. (EHS)	Of the 252 plans that the program took in the fourth quarter of FY24, 247, or 97%, met the desired outcome of meeting the jurisdictional time frame for review. Cumulatively for the full FY24, the team is at 796 on time out of 852, or 93%.	92.00%	91.00%	92.00%	90.00%	93.00%	2.1.5.2.1 Build record types for Land Development Program in Accela by the end of FY24. 2.1.5.2.2 Update Land Development regulations and set a schedule for updating by the end of FY24. 2.1.5.2.3 Update SOPs and develop standardized comments by the end of FY24. 2.1.5.2.4 Develop an audit system and conduct a minimum of 3 audits per staff member. 2.1.5.2.5 Establish training requirements for programs and provide staff the opportunity to attend. 2.1.5.2.6 Update Land Development electronic stamps and plan review process.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.1.5.3 Conduct a minimum of 4 outreach events to inform interested stakeholders on residential septics and wells. (# of outreach events)	No outreach event occurred for residential septic and wells over the course of the 4th quarter of FY24. Outreach did occur for public water systems in regard to the revised Lead and Copper rule. 4 outreach events a year may be a bit too high - 3 is a more realistic goal that EHS will set for FY25.	1	2	3	4	3	2.1.5.3.1 Conduct social media campaigns in collaboration with partners. 2.1.5.3.2 Track number of event attendees.
(VI) 2.1.5.4a # of UST inspections		61	101	152		207	
(VI) 2.1.5.4b # of UST permits		211	212	212		212	
(PI) 2.1.5.4 Complete 100% of inspections at UST permitted facilities per year.	Over the fourth quarter of FY24, the team has inspected 26% of the 212 UST permits. This meets the target of completing approximately 25% each quarter. In CY23, all permits were inspected.	28.00%	47.00%	72.00%	100.00%	98.00%	2.1.5.4.1 Establish training requirements for programs and provide staff the opportunity to attend. 2.1.5.4.2 Develop an audit system and conduct a minimum of 3 audits per staff member. 2.1.5.4.3 Create checklist/tools to assist permit holders with compliance.
(PI) 2.2.1.1 Set a baseline for the occurrence of foodborne illness risk factors in inspected facilities.	Waiting on completion of VIP Accela project - project delayed. Risk Factor Study complete.	0%	0%	0%	0%	0%	2.2.1.1.3 Create system to track food related complaints for surveillance purposes.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							2.2.1.1.1 Develop a system to track occurence of foodborne illness risk factors in inspected facilities.
							2.2.1.1.2 Comlete the 2023 Food Safety Risk Factor Assessment
(VI) 2.2.1.2a # of foodborne illness assessments.		2	3	7		3	
(VI) 2.2.1.2b # of inspections for food establishments.		558	1,259	2,047		2,909	
(VI) 2.2.1.2c # of temporary food event inspections.		637	889	939		1,392	
(VI) 2.2.1.2d # of permitted food establishments		4,033	4,036	3,994		4,099	
(VI) 2.2.1.2e # of temporary food permits		968	1,118	1,177		1,510	
(VI) 2.2.1.2f # of complaints responded to.		60	121	183		264	
(VI) 2.2.1.2g 1# of other permitted facilities		1,193	1,179	1,208		1,209	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.2.1.2 Complete at least 4 components of standards to make progress toward conformance with FDA retail food program standards. (# of components completed)	Currently meet 4 of 9 standards and are working toward meeting additional criteria for each standard not currently met, with a goal of meeting 2 additional standards by FY25 Q2. 1. Regulatory Foundation - Fully met 2. Trained Regulatory Staff - 90% met 3. Inspection Program Based on Hazard Analysis and Critical Control Point (HACCP) Principles - Fully met 4. Uniform Inspection Program - 93.8% met 5. Foodborne Illness and Food Defense Preparedness and Response - Fully met 6. Compliance and Enforcement - 85% met 7. Industry and Community Relations - Fully met 8. Program Support and Resources - 61.5% met 9. Program Assessment - 90%	1	1	2	4	2	2.2.1.2.1 Standard 2- Complete initial training for all employees. 2.2.1.2.2 Standard 2- Maintain CEUs. 2.2.1.2.3 Standard 2- Complete initial standardization for all employees. 2.2.1.2.4 Standard 3- Develop and implement annual permit for temporary food vendors. 2.2.1.2.5 Standard 3- Develop assessment documents for change of ownership and new facilities. 2.2.1.2.6 Standard 4- Develop schedule for process to review inspection reports and conduct field evaluations of assigned staff. 2.2.1.2.7 Standard 4- Transition opening inspection report review. 2.2.1.2.8 Standard 5- Revise Outbreak Response Plan with CD.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							2.2.1.2.9 Standard 6- Implement active managerial control (AMC) program.
							2.2.1.2.10 Standard 6- Develop a new compliance and enforcement branch.
							2.2.1.2.11 Standard 7- Increase outreach and education opportunities through social media, public workshops, videos, handouts, and newsletter.
							2.2.1.2.12 Standard 7- Identify barriers to language accessibility.
							2.2.1.2.13 Standard 8- Develop a plan to ensure adequete inspection staff to complete inspections and increase conformance with program standards.
							2.2.1.2.14 Standard 9- Meet Standard 9 and demonstrate status of foodborne illness risk factors over the last 5 years.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							2.2.1.2.15 Standard 9- Develop intervention strategies to address the foodborne illness risk factors identified as needing priority attention.
(PI) 2.2.1.3 Percentage of required inspections of food establishments completed.	Percent of routine inspections conducted is off target due to lack of staffing resources and trained staff to complete inspections.	11.00%	24.00%	40.00%	100.00%	60.53%	
(PI) 2.2.1.4 Number of permitted facility (non-food based) programs with the foundation necessary to complete risk-based inspections from 0 to 1. (programs developed)	Accela VIP project has allowed some progress to be made in transitioning into a risk-based program model. Staff were able to create a new checklist and update checklists in the inspection software to better align with a risk-based inspection program.	0	0	0	1	0	2.2.1.4.1 Pool & Spa program finalized in Acella and in use (complete draft review of pool regulations, finalize working drafts of pool regulations, provide outreach, draft field guide, host public workshops, boards for approval, finalize working drafts of pool regulations).
							2.2.1.4.2 PACC program finalized in Acella and in use (finalize inspection form, upload form into Accela, finalize field guide, develop guidance documents).

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 2.2.1.5a # of total inspections of non-food based permitted facilities including other elements (reinspections etc).		226	408	726		1,667	
(VI) 2.2.1.5b # of non food-based facility permits		1,193	1,179	1,208		1,209	
(VI) 2.2.1.6a # of other permitted facility complaints		19	27	40		47	
(VI) 2.2.1.7a # of sanitary surveys of public water systems		9	23	25		30	
(VI) 2.2.1.7b # of public water system permits		75	76	75		77	
(PI) 2.2.1.7 Complete 100% of required sanitary surveys of public water systems to help ensure proper public health protection.	Over the fourth quarter of FY24, the team conducted 25 surveys out of a total of 77 water systems, or 32%. This exceeds the target of completing approximately 25% each quarter. In CY23, all required surveys were completed.	25.00%	30.00%	76.00%	100.00%	100.00%	2.2.1.7.1 Establish training requirements for programs and provide staff the opportunity to attend. 2.2.1.7.2 Update chemical compliance templates and SOPs. 2.2.1.7.3 Implement continuous verification process for possible water systems.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							2.2.1.7.4 Conduct outreach to public water systems on upcoming lead and copper rule revisions.
(VI) 2.2.2.2a # of New Jersey daily trap counts that contain more than 10 mosquitos from May to October	Three New Jersey traps have counts that have been above 10 mosquitos per day.	80	80	80		83	2.2.2.2a.1 Transition to drone treatment.
(VI) 2.2.2.3a # of mosquito pools submitted for testing.		742	742	742		839	
(VI) 2.2.2.4a # of mosquito pools positive for arbovirus (West Nile/St. Louis Encephalitis/ Western Equine virus).		0	0	0		0	
(VI) 2.2.3.1a # of commercial plans reviewed for health standards (Including food establishments)		469	862	1,281		1,791	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 2.2.3.1 Ensure 90% of first review for commericial plans meet jurisdictional deadlines.	For the 4th quarter, 66% of plans were reviewed within the jurisdictional goal. For the entire reporting period, EHS reviewed 75% of plans within the jurisdictional goal of 10 business days. As a note, the health department has a goal to review all plans (including revisions) within the jurisdictional goal. At this time, EHS does not have the staffing resources to consistently meet this goal. Staff are required to complete routine inspections, pool openings, complaints, and construction inspections, and with the increase in plan submittals, the division does not have the capacity to review all commercial plans within the time frame.	77.39%	81.17%	81.34%	90.00%	75.15%	2.2.3.1.1 Test an updated workflow into Accela for each jurisdiction to create a uniform plan review mechanism.
(VI) 3.1.1.1a # total social media posts		384	898	1,445		1,987	
(VI) 3.1.1.1b # of culturally relevant or health equity social media posts		106	191	368		539	3.1.1.1b.1 Work with community members or organizations to create culturally relevant content.
(VI) 3.1.1.1c # of social media followers		11,094	11,518	11,868		12,117	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 3.1.1.1d # of web hits		76,102	182,812	322,590		468,625	
(PI) 3.1.1.2 Increase audience growth on all platforms by 10%. (followers)	With a 4.1% increase in NNPH's social media audience in Q4, this goal was exceeded with a 12% mark.	2.00%	4.90%	7.90%	10.00%	12.00%	3.1.1.2.1 Launch LinkedIn profile.
(PI) 3.1.1.3 Increase engagement on all social media posts by 10%. (comments, shares, link, clinks and more)	NNPH social media posts had a 32 percent increase in Q4, far exceeding what the comms team projected as a target not only for Q4, but for the entire fiscal year.	20.00%	41.10%	114.80%	10.00%	146.80%	3.1.1.3.1 Create and post videos and graphic design content to drive engagement.
(PI) 3.1.2.1 Garner 1 million impressions through rebranding effort. (# of rebranding effort impressions)	NNPH had more than 4.1 million impressions in April alone. May and June data has yet to be returned to the health district by the Abbi Agency, which is the group responsible for the rebrand from WCHD to NNPH and tracks these numbers. Despite this, NNPH exceeded its end-of-year goal by more than 25 million impressions.	1,500,000	8,930,000	26,206,506	4,000,000	30,306,506	3.1.2.1.1 Launch new website. 3.1.2.1.2 Execute outreach plan. 3.1.2.1.3 Implement outdoor signage. 3.1.2.1.4 Advertise buy. 3.1.2.1.5 Update style guide. 3.1.2.1.6 Maintain brand standards internally.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 3.1.2.2 Reach at least 10,000 people per quarter through paid media featuring equity content promoted by WCHD. (# of people reached through paid media featuring equity content)	NNPH slowed down the paid media strategy as expected due to lower funding allotment; however, there were still 67,872 impressions in Q4 from paid media on the "NNPH en Espanol" Facebook page from COVID-19 ads.	60,500	320,284	353,221	40,000	421,093	3.1.2.2.1 Maintain and increase Spanish language presence on live media and on Spanish-language radio. (HE Plan Goal 4, Initiative 2) 3.1.2.2.2 Implement public information campaigns designed to promote health equity and reduce health disparities. Include 5210 Healthy Washoe and other campaigns targeting co-morbidities of COVID. (HE Plan Goal 4, Initiative 1)
(VI) 3.1.2.3a # of public records request fulfilled (ODHO)		0	0	0		0	
(VI) 3.1.2.3b # of public records request fulfilled (AQM)		14	23	38		65	
(VI) 3.1.2.3c # of public records request fulfilled (CCHS)		0	0	1		2	
(VI) 3.1.2.3d # of public records request fulfilled (EPHP)		11	30	48		59	
(VI) 3.1.2.3e # of public records request fulfilled (EHS)		1,656	2,951	4,023		4,883	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 3.1.2.4a # of press releases, media alerts, media availability.		23	70	91		111	
(VI) 3.1.2.5a # of community presentations (ODHO)			10	19		25	
(VI) 3.1.2.5b # of community presentations (AQM)		8	12	13		7	
(VI) 3.1.2.5c # of community presentations (CCHS)		9	31	39		56	
(VI) 3.1.2.5d # of community presentations (EPHP)		11	18	24		32	
(VI) 3.1.2.5e # of community presentations (EHS)		7	11	15		23	
(VI) 3.2.1.1a # of vital records requests and services		13,538	25,454	39,221		52,294	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 3.2.1.1 Process 90% of vital records requests and services within 96 hours.	**Death Requests** **Number of Request** **July 2023** 2037 **August 2023** 2356 **September 2023** 1937 **October 2023** 1895 **November 2023** 2169 **December 2023** 1962 **January 2024** 2364 **February 2024** 2153 **March 2024** 2018 **April 2024** 2113 **May 2024** 2382 **June 2024** 1860 **Birth Requests** **Number of Request**	100.00%	100.00%	100.00%	90.00%	100.00%	3.2.1.1.1 Assist the state by testing and implementing the NETSMART system and providing feedback. 3.2.1.1.2 Improve communications with other Nevada vital statistics jurisdictions through monthly meetings. 3.2.1.1.3 Identify gaps to improve procedures and processing time with funeral homes. 3.2.1.1.4 Identify gaps to improve procedures and processing time with physicians and medical examiner's office

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
	July 2023 1397 **August 2023** 1790 **September 2023** 1068 **October 2023** 1055 **November 2023** 958 **December 2023** 901 **January 2024** 1389 **February 2024** 1389 **March 2024** 1274 **April 2024** 1218 **May 2024** 1225 **June 2024** 1072 In addition to this, there were 207 internal county requests of birth and death certificates sold and 11,335 registrations with 770 corrections. All of these were completed within 96hrs.						

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 3.2.2.1a # of reports (Communicable Disease Annual; CPO Quarterly; COVID-Bi-Weekly; ILI Weekly) provided to the community		4	19	38		50	
(PI) 3.2.2.1 Publish 100% of reports (Communicable Disease Annual; CPO Quarterly; Covid-Bi-Weekly; ILI Weekly) provided to the community based on designated time frame.	Q1 4/6 = 66.6% out on time Q2 15/15 = 100% out on time Q3 16/17 = 94.1% out on time Q4 12/13 = 92.3% out on time Total = 92.1% out on time	66.00%	90.50%	92.10%	100.00%	92.10%	3.2.2.1.1 Build a tracking mechanism to know which reports were released on which dates. 3.2.2.1.2 Increase staff who are trained to take select high frequency diseases, in order to reduce burden on any one person or set of staff.
(VI) 3.2.3.1a # of statistical analysis requests met.		13	30	33		37	
(PI) 3.2.3.1 Deliver on 95% of requests for statistical analysis. (# of requests)	In Q4, there were three public records and external partner requests, and all were met. One record request asked for information on COVID-related hospitalizations and deaths. The other two requests were for Fire Agencies to pull EMS data to help support decision making.	100.00%	100.00%	100.00%	95.00%	100.00%	3.2.3.1.1 Capture measurable outcomes for all programs. 3.2.3.1.2 Maintain statistical capacity to serve EPHP and the WCHD.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 3.3.1.1a # of interim committee meetings, public workshops, and coalition meetings attended/ monitored.		17	43	65		114	3.3.1.1a.1 Generate a list of potential 2025 legislative priorities.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 3.3.1.1 Pursue and achieve 2 local government health in all policies initiatives.	There were two policy initiatives pursued during this quarter as follows: 5/30/24- Discussion with NNPH Health Equity Team and the Chronic Disease and Injury Prevention team members to discuss policy tobacco-reduction strategy at a local level. For various political reasons, there is currently not a lot of local energy or appetite to pursue local smoke-free policy. 6/3/24- Discussion with engineering consultant working on a local roadway project to discuss policy and project changes for roadway design. The discussions centered around answering the question: How can public health have more impact related to promoting public transit, carpooling, and otherwise reducing vehicular traffic? At this time, conversations surrounding both of these initiatives did not yield immediate results and are simply	0	0	0	2	2	**3.3.1.1.1 Generate a list and identify local government priority initiatives to pursue.**

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
	in the discussion/ exploratory phase.						
(PI) 4.1.1.1 Residents have access to multiple elements of a best practice crisis response system.	Efforts continue to be made to build out a best practice crisis response system.	1	1	1	2	2	4.1.1.1.1 Work with community partners and the state to implement additional elements of the behavioral health crisis system.
(PI) 4.1.2.1 Pilot the Zero Suicide Program in 2 CCHS clinic programs.	Implementation of the Zero Suicide program in clinics program is on hold. CCHS leadership is currently exploring moving this activity to a supervisor within the clinics, as opposed to the non-clinic staff member that the ZS program has lived with. Since clinicians are the ones actually implementing ZS, they should be in charge of the program's daily implementation.	0	0	1	2	1	4.1.2.1.1 Facilitate at least 2 suicide prevention training opportunities and assist with the creation and implementation of program-specific suicide prevention internal procedures.
							4.1.2.1.2 Identify at least one community partner to accept warm hand-offs for Community and Clinical Health Services clients determined at-risk of suicide.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.1.2.2 Implement at least one lethal means reduction strategy in coordination with the Washoe County Lethal Means Coalition.	Staff continued facilitating regular Washoe Suicide Prevention Alliance (WSPA) meetings and activities. Staff also led the coordination of the design and content for the WSPA social media platforms and developed a strategy for sharing messages regularly. Finally, staff led the design and purchase of WSPA branded outreach and educational materials. These activities were all done to further the overall initiative's goal/ reduction strategy.	1	1	1	1	1	4.1.2.2.1 Facilitate the formation and operation of a Lethal Means Coalition in Washoe County, and collaborate with local and state stakeholders.
(PI) 4.1.3.1 90% of applicable WIC participant interactions will receive substance abuse screening, education and referrals.	Chart audits indicate that staff need reminders to provide substance abuse screening, education, and referrals, and also to document in the clients' charts that this was done. Only 81.1% of randomly selected chart audits shows that clients were receiving this screening, education and referral.	100.00%	92.00%	87.00%	90.00%	81.10%	4.1.3.1.1 Provide staff with training refreshers on substance abuse screening, education and referrals. 4.1.3.1.2 Complete chart audits for compliance with substance abuse screening, education and referrals.
(VI) 4.1.3.2a # of organizations participating in the substance abuse task force		26	14	25		28	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.1.3.2 Reach at least 4 additional local organizations to participate in quarterly Washoe County Substance Abuse Task Force partner meetings focusing on reducing drug-related overdoses in Washoe County.	Staff reached three (3) new local organizations to participate in the Washoe County SATF. These include Reno Behavioral Healthcare Hospital, Catholic Charities of Northern Nevada, and Washoe County Specialty Courts.	0	2	4	4	7	4.1.3.2.1 Coordinate and schedule at least 6 presentations during SATF meetings of exemplary strategies and emerging best practices in the field of SUD and drug-related overdose prevention. 4.1.3.2.2 Coordinate sharing of local drug-related overdose statistics, trends and prevention activities and initiative updates in at least 6 instances among SATF participants.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.2.1.1 Increase the number of corner stores engaged in offering healthy food with the addition of 3 new stores.	The store that was recruited in Quarter 3 decided not to move forward with being part of the program. The store owner would like to try at a different time. Staff will keep this store in mind and will reassess for future recruitment. Staff met with the store owner of Ballpark Market and had great discussion on potentially becoming a Healthy Corner Store. The store owner would like to have another formal meeting to discuss program further. Staff has reached out to set a time to touch base again. Although the target of three stores was not met this fiscal year, staff will continue the HCS recruitment into fiscal year 2025. Staff are working on re-structuring recruitment guidelines and strategies with hopes to get more interest and buy-in.	0	0	0	3	0	4.2.1.1.1 Provide education and technical assistance to store owners/ managers on store conversion process to connect community to healthier food options.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.2.1.2 Expand the number of sites that are implementing the 5210 Healthy Washoe program from 5 to 10 elementary schools.	Two additional sites were recruited at the end of SY23/24 and the team modified the number of sites recruited to 5 instead of 10 as they need additional capacity to provide more technical assistance. Additionally, the team applied for a grant with the Robert Wood Johnson Foundation to expand the team's capacity to take on more school sites implementing the program.	0	0	2	10	2	4.2.1.2.1 Provide technical assistance to partner sites.
(VI) 4.3.1.1a # of FHF attendees		397	550	550		803	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.3.1.1 At least 80% of FHF participants will recieve the services needed.	There was one Family Health Festival held at the Neil Road Recreation Center in late May 2024. 208 families representing a total of 803 individual people attended and received a variety of services, including blood pressure checks, vaccinations, a fresh food distribution, and the ability to apply for energy assistance and SNAP benefits. Participants filled out a brief survey as they exited the festival, and 98% indicated that they received the services and information they needed onsite.	96.00%	95.00%	95.00%	80.00%	98.00%	4.3.1.1.1 Screen 100% of FHF attendees during intake for primary care homes and insurance. 4.3.1.1.2 Conduct outreach for partners and community-based organization's to participate in FHF's and promote events to underserved communtties. 4.3.1.1.3 Secure partnerships with healthcare providers and Managed Care Organizations.
(PI) 4.3.1.2 Create 1 new coalition to increase the number of individuals in Washoe County covered by health insurance.	Efforts were redirected to increase access to health care. This item is completed.	0	0	0	1	0	4.3.1.2.1 Facilitate coalition convenings and identify strategies and actions to be implemented. 4.3.1.2.2 Complete 2023 health insurance enrollment campaign.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.3.1.3 Implement at least three initiatives designed to improve access to care.	The CHIP includes efforts to improve access to primary care homes through the FHF events. Additionally, efforts were implemented to convene emergency responders to address pathways to the right care, and NNPH conducted a statewide assessment of access to health care services to better understand the barriers to receiving care services.	3	3	3	3	3	**4.3.1.3.1 Convene community health care stakeholders at least four times to identify strategies and actions Washoe County as a community can implement to increase access to quality care in an appropriate care setting and decrease utilization of emergency resources.**
(PI) 4.4.1.1 Serve an average of 500 seniors monthly through all Golden Groceries pantries in Washoe County.	About 650 clients are accessing Golden Grocery pantries each month. Alternative efforts to improve access to fresh produce will be underway starting in FY25. As a result, NNPH's role with the Golden Groceries will transition, although the pantries will continue being promoted in other CHIP programs.	0	1,328	3,273	500	3,923	**4.4.1.1.1 Promote access to existing Golden Grocery Client Choice pantries in Washoe County.**

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.5.1.1 Implement/ execute 4 strategies in the EMS Strategic Plan FY24-29.	In Q4, EPHP personnel conducted a full-Scale MCI Exercise, which was held on May 14th with involvement from hospitals, fire and EMS agencies, and emergency management. Lessons learned from the exercise were incorporated into the MCI Plan. The MCI Plan was reviewed and approved by the coalition on June 14, 2024. A timeline is currently being developed for MCI/MAEA plan updates.	1	1	1	4	1	4.5.1.1.1 Reduce EMS practitioner exposures to infectious illnesses. 4.5.1.1.2 Decrease EMS practitioner physical and psychological injuries due to active shooter and civil unrest. 4.5.1.1.3 Increase EMS practitioner driver safety. 4.5.1.1.4 Create and implement a CQI process for pre-hospital treatment/ patient outcome.
(PI) 4.6.1.1 Increase community access to CHA data via online dashboard from 0 to 500. (# of web visits)	Q1 - 0 Q2 - 0 Q3 - 353 visits, 185 new users Online dashboard just launched near the end of Q3. **Q4 - 128 visits, 17 new users.** Sessions: 160 **Total Users: 128** New Users: 17 Engagement rate: 46.25% Average session duration: 00:01:46 **Cumulative - 481 visits, 202 users**	0	0	353	500	481	4.6.1.1.1 Work with TMT to develop a dashboard. 4.6.1.1.2 Maintain a dashboard with CHA indicators as data.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 4.6.2.1a # of collaborative initiatives in the CHIP		19	19	23		23	
(PI) 4.6.2.1 Complete at least 60% of activities planned in the CHIP.	71% of CHIP Activities were achieved as planned in year 1 of implementation. Included in the 2023 CHIP Annual Report are the details about year 1 activities and updates going into year 2 of implementation. Efforts to measure progress of CHIP year 2 implementation will occur again at the end of the calendar year.	59.00%	60.00%	71.00%	60.00%	71.00%	4.6.2.1.1 Invest in community partners to improve community health improvement outcomes.
(PI) 4.6.2.2 Maintain the number of organizations leading CHIP initiatives	Our partnerships have continued with existing organizations, and the team continues to explore opportunities for additional partnerships.	27	27	31	30	31	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.6.2.3 Implement at least 2 CHIP initiatives focused on policy changes that alleviate causes of health inequities.	Aca Entre Nos targeting Spanish Speaking communities is underway in the community to improve access to mental health services and to reduce stigma about the topic. Expansion efforts are being explored with Clayton Middle School to offer students and their families 4 sessions that build on the topic. Additionally, Hello Real Estate and NNPH continue to provide financial literacy to the Spanish Speaking community to improve social determinants of health/financial stability. 7 classes have been provided and have been well attended.	0	3	3	2	5	4.6.2.3.1 Review policies or laws that have a disproportionate effect on one or more subpopulations in Washoe County; impact CHIP focus areas or the Health District's legislative priority areas. 4.6.2.3.2 Gather input from stakeholders about policies under review and collaborate with stakeholders to share findings of the review.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.6.2.4 Increase the number of partners representing underserved parts of our community participating in CHIP initiatives from 2 to 8.	The financial literacy CHIP initiative partnered with Sierra Pacific Federal Credit Union to deliver presentations in Spanish to Spanish-speaking communities about the importance of having a checking account. They further discussed how families can set up checking accounts for children aged 11 and older to start discussing financial literacy in their households. Also, the 5210 CHIP initiative partnered with Glenn Duncan Elementary to develop an access map for their community along the Oddie corridor including information about the Summer Café Program, parks for physical activity, healthy corner stores, and libraries in the area. Lastly, the Aca Entre Nos CHIP initiative initiated a partnership with the Clayton Middle School Counseling Department to collaborate in the 2024-2025 school year on a 4-part bilingual mental health series.	3	5	10	8	13	4.6.2.4.1 Build partnerships through community based meetings, discussions with community leaders and events. (HE Plan Goal 3, Initiative 1)

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.6.2.5 Maintain the number of individuals who provide input to the CHIP. (# of people at Steering Commitee, subcommittee meetings, and plannings meetings)	The planning process for the CHIP wrapped up earlier this year and efforts are being explored to build out CHIP year 3. As such, the project committees have met outside of the larger convenings. CHIP Focus Area Subcommittee meetings will be scheduled in the fall 2024.	0	198	229	350	229	4.6.2.5.1 Engage community members in the decision making process to update initiatives for year 2. 4.6.2.5.2 Complete CHIP Annual Report.
(PI) 4.6.2.6 Recruit at least 10 community representatives to establish 1 cross-sector health coalition. (# of committee members)	The CHIP Steering Committee continues to serve as the body representing a cross-sector coalition. Other discussions are in progress to explore the potential of expanding the coalition to include pillars that uplift the diversity of our community on a larger scale with more subject matter experts.	0	16	16	10	16	4.6.2.6.1 Develop a process to respond to community me mbers and organizations on commitments.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.6.2.7 Maintain a network of relationships with key organizations and leaders, and address at least 3 gaps in relationships to address disparate health outcomes.	The health equity team is beginning to maintain a network of relationships in a better way through their relationship management software pilot project. A new partner the HET has connected with is One APIA Nevada (OAN). OAN is a grassroots organization that advocates for policies that empower Asian American, Native Hawaiian, and Pacific Islander (AANHPI) Nevadans. An area to strengthen relationships is with the faith-based community. A HET representative is attending recurring law enforcement and faith-based community meetings and has reached out to another partner, ACDC, to help facilitate introductions to other faith-based leaders.	2	4	8	3	9	4.6.2.7.1 Identify, pilot and implement a system to track health equity relationships with key community partners and leaders. 4.6.2.7.2 Establish participatory leadership opportunities for community members to influence public health through the CHIP Steering Committee, CHIP initiative subcommittees, Health District Advisory Boards, and/or Health District Hearing Boards or other opportunities.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.6.3.1 Identify at least 3 initiatives or projects for divisions to work with community-based partners to impact health disparities.	The Health Equity Team (HET) collaborated with the Food Safety and Communications Team along with community partners such as Make the Road Nevada and IC Media Strategies to assist with the Food Vendor Resource Fair. Additionally, a representative from the HET met with the Washoe County Green Team to discuss strategies to incorporate community feedback into their first ever County Climate Action Plan. The HET connected the Green Team to local CBOs and community leaders such as the Latino Stakeholder Council, the Asian Community Development Council, and the Nevada Office of Minority Health and Equity to discuss the action plan and collect their feedback.	1	1	2	3	4	**4.6.3.1.1 Apply community organizing principles and health equity best practices among Health District programs to address health disparities. (HE Plan Goal 3, Initiative 2)**

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.7.1.1 Execute a Chemical Surge Exercise with regional healthcare partners and finalize After Action Report within 90 days following.	The chemical exercise was conducted on April 9 and 10. The after-action report/ improvement plan was also completed on time.	25.00%	50.00%	75.00%	100.00%	100.00%	4.7.1.1.1 Develop a MOU for partner utilization of the mobile medical/ command post vehicle. 4.7.1.1.2 Participate in 90% of requested school EOP meetings. 4.7.1.1.3 Produce an after action/ improvement plan within 90 days following the exercise. 4.7.1.1.4 Conduct HSEEP planning meetings.
(PI) 4.7.2.1 Complete 75% of planned activities identified by the IHCC.	IHCC completed 100% of the planned activities.	10.00%	40.00%	75.00%	75.00%	100.00%	4.7.2.1.1 Update IHCC guidelines annually. 4.7.2.1.2 Complete Resource and Gap Analysis annually. 4.7.2.1.3 EMS/ FIRE Planned Activities: MCI Plan Updates and Interagency training with law enforcement. 4.7.2.1.4 Hospital Planned Activities: Training and Exercising the MAEA and MCI plans.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							4.7.2.1.5 Skilled Nursing/ Memory Care/ Assisted Living PLanned Activities: Evacuation planning/ training and staff and resource sharing plan.
							4.7.2.1.6 Clinic/ Ambulatory Surgery Center Planned Activities: COOP, Recovery/ Business Continuity Planning; Staff and Resource Sharing Plan; Emergency Operations Planning; Staff and Resource Sharing Planning.
							4.7.2.1.7 Home Health/Hospice Planned Activities: Informaiton Sharing/ Communications Plan and Exercise Plan.
							4.7.2.1.8 Public Health Planned Activities: MCI/ MAEA Plan updates and Shelter Support Plan.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.8.1.1 Initiate at least one new project collaboration with UNR per year. (# project collaborations)	The new project initiated this year with UNR is the asynchronous training course for public health professionals who have not received formal public health degree training. UNR has been updating and improving this comprehensive online overview course. It has received several rounds of feedback and is being updated to reflect the desired changes. The course is being finalized, but specifics on how to offer it to public health staff are still being worked out, pending logistical details on UNR's side being finalized.	0	0	0	1	1	4.8.1.1.1 Maintain regular communications through a joint advisory committee for new research and developments. 4.8.1.1.2 Participate on UNR's graduate committee. 4.8.1.1.3 Increase research resources through identifying shared resources. 4.8.1.1.4 Identify joint research opportunities and joint grant funding resources. 4.8.1.1.5 Identify training opportunities for WCHD staff through UNR. 4.8.1.1.6 Maintain the continunity of and improve joint course on real world public health applications.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 4.8.1.2 Ensure standardized, recurring intership opportunities. (# of recurring internship opportunities) (maintain minimum of 3 per year)	Recurring internship opportunities are continuously being discussed with programs, and staff is always working to implement them. Currently, two internship projects that can be recurring are being discussed and are looking for MPH students, one being in government affairs and another in EMS data-cleaning and reporting. The one in EMS statistics has been implemented and is receiving great feedback. Future opportunities continue to be discussed and methods are being put forward for streamlined internship opportunities.	0	0	0	3	1	4.8.1.2.1 Improve the quality of internship opportunities for UNR students in all disciplines.
(VI) 5.1.1.1a # of retirements.		1	1	0		2	
(VI) 5.1.1.1b # of non-retirements, promotion or transfer departures		10	17	28		32	5.1.1.1b.1 Conduct exit interviews with all departing staff via online survey.
(VI) 5.1.1.1c # of promotions/ transfers.		5	7	8		11	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.1.1.1 Maintain 5% or less employee vacancy rate (vacancy rate= average monthly vacancy rate including all employees).	As NNPH transitions from COVID activities, positions that will ultimately be eliminated are currently reflected as vacant, thus leading to artificially high vacancy numbers. This trend will likely continue through FY 26.	11.00%	13.64%	7.94%	5.00%	9.83%	5.1.1.1.1 Provide monthly vacancy report to include insights/trends on hard to fill positions. 5.1.1.1.2 Recruit and promote career opportunities via social media out lets and other direct channels that reach individuals within the community.
(PI) 5.1.1.2 Increase mandatory training completion rate from 96% to 98%.	Staff ultimately are accomplishing all required training; however, sometimes it doesn't get done within the target time frame due to staff needing to balance training on the job requirements of their positions alongside the mandatory County and NNPH trainings.	0%	91.38%	96.41%	98.00%	96.00%	5.1.1.2.1 Remind staff of mandatory trainings via email. 5.1.1.2.2 Track mandatory training completion rate to present to DDs and Supervisors.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.1.1.3 Increase probationary/ annual evaluation completion rate from 80% to 85%.	Supervisors required to perform staff performance evaluations are sometimes stretched thin in terms of workloads and existing priorities. Unfortunately, yearly staff evaluations can sometimes fall through the cracks because of this. NNPH is mindful of this and trying to get back on track, but staff turnover and new supervisors have also played a role in why staff can fall behind.	79.00%	75.55%	68.20%	85.00%	69.57%	5.1.1.3.1 Generate monthly communication to DDs and supervisors to keep them informed of schedule. 5.1.1.3.2 Provide training related to running effective and meaningful evaluations.
(PI) 5.1.1.4 Increase percentage of employees who recommend WCHD as a good place to work from 76% to 78%.	Survey results for each County department are being processed and will be shared in the fall 2024	0%	0%	0%	78.00%	0%	5.1.1.4.1 Continue to provide thoughtful, consistent, optional flex, hybrid, and remote work as appropriate based on position. 5.1.1.4.2 Identify and provide ongoing opportunities for staff to provide input. 5.1.1.4.3 Support and implement an employee recognition program.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							5.1.1.4.4 Create opportunities for staff to work across divisions on projects and task forces.
							5.1.1.4.5 Provide onboarding program to integrate staff into WCHD team.
							5.1.1.4.6 Provide a quarterly orientation about the full organization to new employees.
							5.1.1.4.7 Promote key takeaways activity.
(PI) 5.1.1.5 Increase transparent internal communications from 0 to 4.	The bi-weekly cadence of the employee newsletter, NNPH Buzz, is established moving forward. Noah Glick is doing a great job curating content that is both informational and entertaining.	0	2	9	4	16	5.1.1.5.1 Launch internal newsletter. (promote Tell Kevin, workforce development, budget)
(VI) 5.1.2.1a # of staff participating in district-wide professional development opportunities.		114	239	280		321	5.1.2.1a.1 Provide at least 2 leadership development opportunities to staff.
							5.1.2.1a.2 Identify at least one professional development opportunity as part of each employee goal setting.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							5.1.2.1a.3 Collaborate with DDs and ODHO to identify training challenges.
(PI) 5.1.2.1 At least 50% of of employees will report feeling proficient on targeted core competencies.	Core competencies on health equity are included in the Core Competency training provided through NNPH's Onboarding Program. The structure of the reports are being created to provide data on knowledge increased.	0%	78.00%	78.00%	50.00%	78.00%	5.1.2.1.1 Provide targeted core competency training on areas identified through staff and supervisor input.
							5.1.2.1.2 Identify 1-2 core competencies for trainings to include on pre-post assessments.
							5.1.2.1.3 Evaluate improvement on targeted core competencies as assessed by employees and supervisors.
							5.1.2.1.4 Train DDs and supervisors on the budget process.
							5.1.2.1.5 Provide FAQs for staff on budget process and grants.
							5.1.2.1.6 Build out additional onboarding activities for supervisors over their first year.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.1.3.1 Increase the number of mental health resources provided to staff in the workplace from 2 to 3.	The Calm App continues to be promoted internally through the employee newsletter and on the WFD portal. As more opportunities arise, we will update the platforms to include the information.	0	0	3	3	3	5.1.3.1.1 Provide optional opportunities to learn about wellness techniques and strategies.
(PI) 5.2.1.1 Meet 100% of requirements to maintain accreditation.	The PHAB committee continues to collect information to for NNPH's Reaccreditation application. The application opens on July 1st 2024.	100.00%	100.00%	100.00%	100.00%	100.00%	5.2.1.1.1 Submit annual reports with all required documentation. 5.2.1.1.2 Convene reaccreditation committee. 5.2.1.1.3 Gather at least 50% of documents required for reaccreditation by the end of year.
(PI) 5.2.1.2 Increase the number of QI projects implemented ac ross the HD from 0 to 3.	The QI program is being built out to support continuous improvement efforts across NNPH. Additionally, the ODHO team is working on a QI project to improve the process to translate documents.	0	0	0	3	1	5.2.1.2.1 Establish and convene QI team . 5.2.1.2.2 Develop a QI plan. 5.2.1.2.3 Train staff about QI concepts and internal process. 5.2.1.2.4 Communicate with leadership, governing body, and stakeholders about QI activities.
(VI) 5.3.1.1a # of filled positions		224	227	220		172	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(VI) 5.3.1.1b # of FTE		197	202	202		202	
(VI) 5.3.1.1c # of filled FT/PT employees		172	176	177		172	
(VI) 5.3.1.1d # of internship opportunities at NNPH		9	9	9		6	
(PI) 5.3.1.1 Increase investment in personnel where workforce capacity is a barrier to productivity. (% increase in FTE)	Due to budget issues at the State level. NNPH has had reductions in multiple subawards. In addition, budget concerns at the County level have resulted in Above Base position freezes through December of 2024. Leadership is involved in ongoing budget discussions at the state and county level to address current budget issues and begin long term budget planning.	0%	0%	0%	1.00%	0%	5.3.1.1.1 Update FPHS assessment for FY24 and work statewide to build the case for support for ongoing public health funding.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.3.2.1 Make progess on the health equity plan by completing 8 initiatives.	The health equity team is currently developing the annual report for the second year of the health equity plan. A total of seventeen initiatives are considered complete. Some of the initiatives include strategically participating in community outreach activities to bring public health information directly to communities, implementing language accessibility best practices, promoting job opportunities using methods designed to reach diverse audiences, and annually reviewing how the demographics of the NNPH workforce compare to Washoe County demographics.	0	7	11	8	17	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.3.3.1 Review at least 10 job descriptions to evaluate for systemic barriers to hiring a diverse workforce.	The pilot project around efforts related to recruiting and hiring a diverse workforce is taking longer than expected, so no job descriptions have been evaluated. However, the project team has a plan moving forward and has identified a few job positions and class specifications that will be revised in FY25.	0	0	0	10	0	5.3.3.1.1 Review targeted job descriptions to evaluate for systemic barriers such as language, educational requirements, or other access issues, starting with those positions that have the highest potential to impact health equity (HE Plan Goal 7, Initiative 2) 5.3.3.1.2 Annually review how the demographics of the health district workforce compare to the demographics of the community we serve. (HE Plan Goal 7, Initiative 3) 5.3.3.1.3 Create inclusive job descriptions that attract candidates.
(VI) 5.3.3.2a # of existing staff who complete asynchronous cultural competency training.		0	0	2		7	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.3.3.2 100% of new staff will take asynchronous cultural competeny training as part of the onboarding process.	The online cultural competency training that is part of the onboarding process was put on pause to make modifications to the training. Therefore, staff that joined the organization this quarter have not completed the training.	0%	0%	58.00%	100.00%	58.00%	5.3.3.2.1 In partnership with the Larson Institute build, pilot and launch an asynchronous, online training designed specifically to build health equity competencies from the Council on Linkages and Public Health Practices. Require all new staff to complete within the first 180 days and offer to all existing staff regularly.
(VI) 5.3.3.3a # of staff participating in district offered DEI/cultural competency professional development opportunities.		90	116	160		208	5.3.3.3a.1 Offer district-wide diversity, equity, inlcusion, cultural competency and/or health equity training to health district staff.
(VI) 5.3.3.4a # of staff participating in informal opportuntiies to explore DEI, cultural competency and equity topics		0	0	0		0	5.3.3.4a.1 Continue and expand optional opportunities for staff to participaite in dialogue and reflection on diversity and equity topics. (HE Plan Goal 1, Initiative 3)

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.4.1.1 Develop and implement a plan to meet the office space needs of the Health District employees. (% of completion)	The ability to develop a plan is contingent upon knowing how much space will be provided to Health District staff. While the Space Plan was presented to the BCC, the space available to NNPH in building C has not been finalized. This is most likely occurring by December 2024.	10.00%	10.00%	10.00%	100.00%	10.00%	5.4.1.1.1 Redesign floor plans to maximize the use of current space and implement changes. 5.4.1.1.2 Develop and implement plan for hybrid/ remote work to address unmet space needs.
(PI) 5.4.2.1 Ensure completion of new TB and expanded office space building. (Complete 3 steps - location identified, building design complete, contractor identified)	The County closed escrow on February 26, 2024, for the West Hills property. The TB Clinic will be located on this property (Step 1). A bid process was conducted for the selection of a contractor with final presentations held on March 5th, and a vendor was selected through this process (Step 3). In addition, multiple building designs have been created, discussed, and edited. A final design is anticipated to be submitted for permitting in August 2024 for ground breaking in December 2024.	1	1	2	3	2	5.4.2.1.1 Confirm final location based on Washoe County Commissioners and County Manager decisions. 5.4.2.1.2 Support CSD in the approval of contractors and building design.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.5.1.1 Increase the percentage of AQMD customers paying through the Accela Customer Access platform to 25%. (estimated average for all programs)	The AQMD has made tremendous strides in improving the customer experience of its self-serve platforms. Many of the programs such as the Asbestos and Dust Control programs have been able to achieve nearly 100% online processing. Unfortunately, the Accela system continues to be a barrier to the organization achieving 100% online processing, given how it is not a system certified by the EPA Cross-Media Electronic Reporting Rule and is unable to become certified. In addition, the wood-burning device program will need significant improvement in order to transition to a more customer self-service process.	15.00%	17.00%	18.00%	25.00%	18.00%	5.5.1.1.1 Work with Technology Services and consultant to streamline Accela Customer Access submittal process.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.5.1.2 Increase payments made via Accela. (EHS)	Accela VIP project is still under way, and this will streamline online renewal process and submittal for all EHS record types. Temporary Food Event permits are currently live, and staff will be requiring electronic submittal for the following Temporary Food Event season, which will improve online payment rates and admin processing.	12.45%	19.00%	20.38%	50.00%	14.25%	5.5.1.2.1 Ensure kiosk is set up and available to customers by August 1, 2023. 5.5.1.2.2 Create written instructions by August 1, 2023. 5.5.1.2.3 Create videos by September 1, 2023. 5.5.1.2.4 Distribute public service announcements. 5.5.1.2.5 Add announcement to website. 5.5.1.2.6 Educate customers to help them understand how to submit payment via Accela by November 1, 2023. 5.5.1.2.7 Revise and communicate instructions with customers by October 1, 2023. 5.5.1.2.8 Communicate November 1, 2023 Accela launch date to customers via distribution lists, press releases, etc. 5.5.1.2.9 Monitor and document lessons learned.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 5.5.2.1 % of new/renewed sources integrated into the software.	The AQMD continues to build out and refine the UNICON Impact software. It is expected that beginning 1/1/25, the AQMD will begin integrating sources into the software. This is timely as it is also the expected implementation date of the new Chapter 030 regulations.	0%	0%	0%	100.00%	0%	5.5.2.1.1 Draft SOP for use of software by January 2024.
(VI) 5.5.3.1a # of all Health IT help desk tickets			683	1,034		1,370	
(VI) 5.5.3.1b # of health desk tickets going through County TS			198	277		319	
(PI) 5.5.3.1 Montior average time (in minutes) to close help desk ticket.	County TS is implementing a new ticketing system that will be implemented through summer 2024. This activity will be completed when the new system is in place.	0	0	0		0	5.5.3.1.1 Establish help desk ticketing system workflow for employees. 5.5.3.1.2 Train employees on the help desk ticketing system workflow. 5.5.3.1.3 Track 100% of IT time by cost allocation. 5.5.3.1.4 Identify TS capacity dedicated to each division and identify workload capacity.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							5.5.3.1.5 Track 100% of projects by category.
							5.5.3.1.6 Work with TS to revamp ticket categories based on type and then track going foward.
							5.5.3.1.7 Categorize help desk tickets to identify problem areas/projects where staff need support.
							5.5.3.1.8 Create training for staff based on challenging areas identified.
(VI) 6.1.1.1a Amount of expenditures.		$ 0.00	$ 16,278,184.00	$ 26,012,232.00		$ 36,309,231.00	
(VI) 6.1.1.1b Amount of income.		$ 0.00	$ 13,495,237.00	$ 22,231,930.00		$ 33,291,267.00	6.1.1.1b.1 Advocate for dedicated public health funding at the federal, state and local level.
(PI) 6.1.2.1 Maintain 100% compliance with purchasing and contract procedures.	As a government agency, NNPH must stay 100% compliant with this measure, so it is a top priority always attended to.	100.00%	100.00%	100.00%	100.00%	100.00%	6.1.2.1.1 Deliver and record 1 staff training on the purchasing and contract process.
							6.1.2.1.2 Provide FAQs for staff.
(PI) 6.1.2.2 Maintain 100% of grant compliance.	As a government agency, NNPH must stay 100% compliant with this measure, so it is a top priority always attended to.	100.00%	100.00%	100.00%	100.00%	100.00%	6.1.2.2.1 Meet with program managers to understand areas of opportunity to learn about grant process

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
							6.1.2.2.2 Standardize training process to ensure staff is clear on grant process and compliance expectations.
							6.1.2.2.3 Provide 1 training on grant compliance to staff.
(VI) 6.1.2.3a Amount of revenue generated by grants and relief funding		$ 0.00		$ 8,056,904.00		$ 14,635,082.00	
(VI) 6.1.2.3b # of grants received		0		53		53	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 6.1.3.1 Set a baseline for % of costs recovered for clinic services through client and third-party payer payments.	The goal for FY24 was just to set a percentage, but after reviewing it with AHS leadership and the DDHO, CCHS is not going to move forward in FY25 with this as a goal. Instead, the intention will be to just report the percentage of costs recovered annually. CCHS is different from divisions such as EHS and AQM because it can raise its fees as high as desired, but it does not impact the division's revenue. This is because Medicaid has set reimbursement rates, so they do not pay CCHS more just because the fees set internally are higher. CCHS personnel mainly bill Medicaid, and they also have a sliding fee scale since the NNPH clinic is here to serve clients that do not have insurance or a medical home, so clients often slide to "0 pay." Given these factors, this goal is being reevaluated/ restructured for FY25, and no consistent or meaningful data could			100.98%		0%	

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
	be derived for this measure in FY24.						
(PI) 6.1.3.2 Maintain or increase access to services and revenue through billable services. (# of contracted insurance companies) (10 to 12)	During this last quarter, CCHS was able to secure a contract with Silver Summit, bringing the total to 12 contracted insurance companies. At this point, CCHS is able to bill most insurance companies, creating greater access for community members and revenue for the division's programs.	10	11	11	12	12	6.1.3.2.1 Review error and rejection report daily to minimize inaccurate claim submission. 6.1.3.2.2 Submit clean claims to insurance companies the first time to eliminate costly appeals and ensure maximum reimbursement for services.
(PI) 6.1.3.3 Maintain 100% cost recovery for AQM permitting and compliance programs.	Over the last six (6) fiscal years, the AQMD has been able to cover both direct and indirect expenses. Moreover, during this period of time, the AQMD has contributed nearly $2 million dollars to the Health Fund. Due to forgoing of the CPI increase to our fees and the 35% increase in salaries and benefits from the Korn Ferry study, with FY23-24, the AQMD has only been able to cover direct expenses. It is expected that the AQMD will be returning to covering both direct and indirect expenses with FY24-25.	0%	0%	0%	100.00%	100.00%	6.1.3.3.1 Work with DDHO and AHS staff to assess current fee structure and develop new methodology. 6.1.3.3.2 Present new fee methodology to regulated community, stakeholders and DBOH.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
(PI) 6.1.3.4 Increase the percent of costs recovered through EHS fees.	The cost recovery is higher than anticipated (55%) due to revenues coming in higher than projected but still under the target of 100% cost recovery. The increases were in temp food events, which doubled their projected revenue, and increases in new applications and food permit fees. Additionally, costs were surprisingly lower than projected due to turnover and vacancies in staffing. These netted 10% savings when comparing actuals to budgeted values, along with some minor savings in operating expenses. These savings came despite the recent implementation of the Korn Ferry classification and compensation study. The current fiscal year is still in the process, and there is potential for decrease in the cost recovery percentage as final costs are processed with the end of year closeout. Additionally, this number reflects restricted grant funds	0%	0%	0%	100.00%	73.24%	6.1.3.4.1 Meet with admin staff at least quarterly to monitor fee trends.

Outcome	Analysis	Q1-24 Actual	Q2-24 Actual	Q3-24 Actual	Q4-24 Target	Q4-24 Actual	Initiative
	that are not used in daily operation. Under the current fee structure, EHS is unlikely to ever recover 100% of costs via fees. While the fees cover many costs associated with inspections, they do not account for administrative support or the time staff spends giving extra help and follow-up assistance to certain establishments and individuals in the community who need more support.						
(PI) 6.1.3.5 Maintain 100% cost recovery for vital records services.	EPHP has exceeded 100% cost recovery for vital records services, with revenues and expenses as follows: Revenue= 702,565 Expenditures= 504,061	0%	0%	0%	100.00%	139.00%	
(PI) 6.1.4.1 Make progress toward maintaining an ending fund balance of 10-17%.	AHS books close around September 2024. However, expenses have been tracked consistently throughout the year and appear to be in order. Based on current projections, NNPH is expected to be within the 10-17% range within the next 24 months.				30.00%	0%	**6.1.4.1.1 Provide monthly financial review to the Board.**