
















































# NNPH Quarterly Report










FY25














Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <p>(PI) 1.1.1.1 Reach at least 2,000 residents and visitors about the impact of secondhand cannabis smoke exposure through communications efforts. (# of residents reached)</p>	500	0	Staff researched local landscape of fifteen dispensaries and connected with the Northern Nevada Area Director of ayrwellness.com to discuss secondhand smoke exposure education messaging within dispensaries. A Q1 meeting has been re-scheduled to Q2. Ayrwellness.com is a multi-state cannabis operator involved in cultivation and retail consumption. Ayrwellness.com develops products across the spectrum of consumption (beverage, flower, vape, edible, concentrate) with major cannabis brands (Kynd, Canna Punch, Haze, and others). Besides owning major product brands, ayrwellness.com includes retail with two local dispensaries Mynt (two locations in Reno), and The Dispensary (one location Washoe County, three in Clark County), and dispensaries in Connecticut, Florida, Illinois, Massachusetts, New Jersey, Ohio, Pennsylvania. Ayrwellness.com was selected as the largest company with locations in Washoe County and an interest in community partnerships.	 <p>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.</p>
 <p>(PI) 1.1.1.2 Maintain breastfeeding rates at 80% among WIC clients who report ever breastfeeding.</p>	80.00%	80.00%	The breastfeeding rate for clients at NNPH WIC for the year ending September 30, 2024 is 80%.	 <p>1.1.1.2.1 Support staff receiving breastfeeding training.</p>
				 <p>1.1.1.2.2 Offer clients breastfeeding support and services.</p>
 <p>(PI) 1.1.1.3 Increase multi-family housing properties that have smoke free policies by at least 2.</p>	0	0	Staff worked with a new Reno Housing Authority Property (Railyard Flats) on their smokefree and vape free policy. Implementation will begin upon opening their doors in Q2. Staff also ordered policy signage for the new property, which was paid for by a grant.	 <p>1.1.1.3.1 Recruit and provide technical assistance to owners and managers of multi-unit housing properties.</p>
 <p>(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)</p>	1	1	Staff reached decision-makers at Our Center, a local organization serving the LGBTQI+ population in Northern Nevada, with information on how smoke-free workplace policies impact community health. Organization leadership committed to sharing this messaging to their clients and supporting smokefree workplaces.	 <p>1.1.1.4.1 Provide education and technical assistance to new and current community partners about smoke-free workplaces.</p>
 <p>(PI) 1.1.1.5 Reach at least 12 groups (youth, parents, service providers) with e-cigarette prevention messaging among youth and young adults.</p>	3	7	Staff has reached the following organizations/groups to promote e-cigarette prevention messaging among youth and young adults: 211, WCSD (Parent University), High Sierra Area Health Education Center (AHEC), STEP 2, WCSD (Counseling department), Boys and Girls Club, and Safe Talk Teens.	 <p>1.1.1.5.1 Educate youth, parents, service providers, and decision-makers about the dangers of e-cigarette use among youth and young adults and promote available cessation resources.</p>









Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 (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)	1	5	Staff coordinated and performed two paid social media boosts on NNPH sites, targeting older adults in Washoe County with Falls Prevention messages and education during September. These posts were designed to increase awareness around falls prevention, and drive traffic to the Get Healthy Washoe (GHW) web page and resources. Additionally, staff conducted outreach at three senior center locations distributing night lights and educational materials while promoting Enhance Fitness, a new evidence-based group exercise and falls prevention course NNPH is bringing to the senior center.	 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)		3,379		
 (PI) 1.2.1.1 Maintain at least 95% of enrolled WIC participants as compared to last FY enrollment.	95.00%	97.56%	The WIC quarterly average enrollment was 2.44% lower than last FY. This might have been due to a vacancy in the program when a FT WIC clinical staff retired in June of 2024. The position is now filled and once completely trained will be able to help with client visits.  While having a slightly lower enrollment this past quarter, there was still 97.56% enrolled compared to last FY Q1 enrollment.	 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		1,073		
 (VI) 1.2.1.3a # of VFC compliance visits		2		
 (PI) 1.2.1.3 Assure 50% of Vaccine for Children (VFC) providers receive a compliance visit yearly.	0%	9.00%	The Vaccines for Children (VFC) Site Visit reviewers conducted two formal site visits (9%) this quarter with newly enrolled providers in addition to nine follow-up visits with other providers due to past findings and an in-person annual training with Renown Pediatrics. Per the CDC and Nevada state immunization program, VFC providers are required to receive a site visit at least every two years. Grant stipulations also indicate that 50% of Washoe County providers must be visited each grant year. Additional site visits are planned through quarter two and beyond, as 23 VFC Site Visits are to be completed this year.	 1.2.1.3.1 Perform compliance visits.
 (VI) 1.2.1.4a # of clients served in the Family Planning and Sexual Health program		1,110		
 (PI) 1.2.1.5 Implement 100 community/provider Sexual Health education and outreach activities.	25.00	35.00	During the reporting period, 35 community and provider Sexual Health education and outreach activities were provided. Topics included Sexual Health testing, treatment, and prevention, syphilis, congenital syphilis, clinical services, and reporting requirements.	 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.









Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
				 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		8		
 (PI) 1.2.2.1 Initiate investigation of 90% of reported HIV cases within 5 business days of report.	90.00%	100.00%	During the reporting period, eight HIV cases (all stages) were reported with all investigations (100%) initiated within 5 days of report.	
 (VI) 1.2.2.2a # of primary, secondary syphilis cases investigated		19		
 (PI) 1.2.2.2 % of primary, secondary syphilis cases initiated within 5 days.	90.00%	94.70%	During the reporting period, 19 Primary and Secondary stage syphilis cases were reported in Washoe County, with 18 investigations (94.7%) being initiated within 5 days of report.	
 (VI) 1.2.2.3a # of maternal syphilis cases investigated		3		
 (PI) 1.2.2.3 % of maternal syphilis cases initiated within 5 days	90.00%	100.00%	During Q1, of the three (3) maternal syphilis cases reported, all investigations (100%) were initiated within 5 days of report.	
 (VI) 1.2.2.4a # of other syphilis cases investigated (early latent, late latent/unknown duration, biological false positives, old disease)		271		
 (PI) 1.2.2.4 % of other syphilis cases initiated within 5 days	90.00%	93.40%	<p>During Q1, 253 out of the 271 cases had investigations initiated within 5 days of report to NNPH.</p> <p>Staff investigated 271 syphilis cases that were not staged as primary or secondary stages. These include early latent, late latent/unknown duration, cases that are "old disease" (previously infected), biological false positive results, or are pending staging. Due to surveillance case definitions, infectious cases could be included in the late latent/unknown duration category due to lack of syphilis testing history within the year prior to infection, no recall of symptoms or partner symptoms, and no recall of a positive partner. Significant research, interviewing, and problem solving inform a case investigation to determine the case disposition or staging.</p>	
 (VI) 1.2.2.5a # of congenital syphilis cases investigated		4	During the reporting period, four (4) congenital cases were reported to NNPH.	

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 (PI) 1.2.2.5 % of congenital syphilis cases initiated within 5 days	90.00%	100.00%	During the reporting period, 100% (4/4) congenital syphilis case investigations were initiated within 5 days of report.	
 (VI) 1.2.2.6a # of reported gonorrhea cases investigated		163		
 (PI) 1.2.2.6 Initiate 90% of prioritized gonorrhea case investigations within 5 business days of report.	90.00%	90.80%	During the reporting period, 148 of the 163 case investigations (90.8%) were initiated within 5 days of report.	
 (VI) 1.2.2.7a # of reported chlamydia cases investigated		598		
 (PI) 1.2.2.7 Review 90% of chlamydia cases within 5 days of report.	90.00%	98.30%	During the reporting period, 588 out of the 598 (98.3%) chlamydia cases reported had investigations initiated within 5 days of report. Investigations for chlamydia are limited to verifying appropriate treatment and arranging for treatment if needed. Partner Services, or contact tracing, are not provided for chlamydia cases due to the volume and lower priority of intervention compared to STIs with more serious consequences.	
 (VI) 1.2.2.8a # of individuals suspected to have active tuberculosis disease and investigated		3		
 (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).	100.00%	0%	None of the cases that were confirmed to have active TB were confirmed via NAAT testing for this reporting period. This was due to low to no bacterial load in the specimen provided. Therefore, the confirmed cases during this period were diagnosed based on clinical presentation, therapeutic drug response, and improvement via imaging.	 1.2.2.8.1 Collect, review, and process lab and provider reports for suspected or confirmed active TB disease.  1.2.2.8.2 Utilize Directly Observed Therapy (DOT) and virtual DOT to assist with case treatment adherence.  1.2.2.8.3 Establish partnerships with community providers to effectively communicate case management and treatment status.  1.2.2.8.4 Utilize contact tracing for all sputum smear positive disease cases.











Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 (PI) 1.2.2.9 For clients with active tuberculosis, increase the percentage that have sputum culture conversion within 60 days of treatment initiation.	83.00%	0%	There were no cases that were sputum culture positive during this period, therefore no cases that were awaiting culture conversion.	
 (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.	100.00%	100.00%	For Q1 FY25, the TB Clinic had two new cases diagnosed during this period in which contacts were elicited within 14 days. Both of these cases had source investigations conducted. Of the contacts tested, two tested positive and are being treated for LTBI.	
 (VI) 1.2.2.11a # of foodborne, vector borne, vaccine preventable, disease of unusual occurrence, etc. cases investigated		339		
 (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.	100.00%	91.15%	<p>There were 309 cases investigated within their designated time frame (e.g. same day, next day, or within the week) out of 339 total number of reportable cases requiring follow-up via a case investigation by phone. This is a total of 91.15%. The calculation of this percentage utilized adjusted dates for those cases reported on the weekends or NNPH holidays.</p> <ul style="list-style-type: none"> <li>For conditions requiring same-day follow-up/investigation <ul style="list-style-type: none"> <li>83/106 = 78% on time</li> </ul> </li> <li>For conditions requiring next-day follow-up/investigation <ul style="list-style-type: none"> <li>159/166 = 96% on time</li> </ul> </li> <li>For conditions requiring follow-up/investigation within the week <ul style="list-style-type: none"> <li>All 67, 100% on time</li> </ul> </li> </ul> <p>Disease reports and laboratory reports can come in after standard office hours (5 PM). These are investigated ASAP the next morning. Accordingly, same-day follow-up cannot be captured as accurately because of this. Additionally, ongoing staffing shortages is another factor.</p>	 1.2.2.11.1 Complete update of the GCD manual chapters to support investigation process   1.2.2.11.2 Ensure workflows are designed so staff know when a lab is reported so they can begin the investigation as soon as feasible.
 (VI) 1.2.3.1a # of community-based vaccine provision events		6		 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		3		












Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 (PI) 1.3.1.1 Maintain or increase the number of clients that see the Enrollment Assister annually.	16	3	The new enrollment assister's first day in the office was September 3, 2024. Arrangements were not finalized by the state office until 09/02/2024. The new enrollment assister was in the clinic three Tuesdays in September and saw three clients. The enrollment assister also had one sick day during the month of September.	 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.
 (VI) 1.3.2.1a # of clients and community members provided assistance with navigation of community resources		250		
 (PI) 1.3.2.1 Increase the number of clients and community members provided assistance with navigation of community resources. (# provided assistance)	100	250	The CHWs provided services to 250 clients in Quarter 1. Services provided included transportation services, PrEP navigation for HIV prevention, assistance with finding a primary care provider and insurance enrollment, safe sleep education, and food and housing resources. Additionally, the CHWs began billing Medicaid for services in the Family Planning Sexual Health Clinic.	 1.3.2.1.1 Monitor number of referrals from each CCHS program.  1.3.2.1.2 Create a policy and procedure for referrals to the Community Health Worker.  1.3.2.1.3 Create a SharePoint document accessible to all CCHS staff that describes the services the CHW can provide.
 (PI) 1.3.2.2 Increase community reach through new partnerships and outreach activities (# of outreach activities)	10	16	The CHW team participated in 16 outreach activities this quarter: 4 in July, 7 in August, and 5 in September. The NNPH Mobile Harvest continues monthly with a total of 228 families served during the quarter. Additional outreach activities included participating in a community baby shower hosted by Anthem Medicaid and multiple community resource fairs at local elementary and middle schools. New outreach events included providing resources at an event for foster parents hosted by Human Services Agency and providing resources for families new to Washoe County School District.	 1.3.2.2.1 Identify 2 new community partners for recurring outreach.  1.3.2.2.2 Conduct 4 outreach activities per month that promote services provided by CCHS to underserved communities.
 (PI) 1.3.3.1 Increase access to programs and services through completing 3 system improvements.	0	2	<ol style="list-style-type: none"> <li>On July 1, 2024, WIC implemented night clinic on the first, third, and fifth Wednesday of every month. WIC was not doing night clinic hours like the rest of our clinics before July 1st. They now have appointments until 6:30pm on the 1st, 3rd, and 5th Wednesdays of the month. Staff is hearing that these appointments are being filled, and that the clients are happy with the expanded access.</li> <li>Implemented Wordly at the front counter and in the clinics to assist with translation between clients and staff.</li> </ol>	 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.

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <p><b>(PI) 2.1.1.1 Meet or exceed a 75% data capture rate for ozone.</b></p>	75.00%	98.70%	<p>FY25 Q1 Data Completeness Reports will not be available until December 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 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.</p> <p>These quality metrics are largely the result of the care that AQMD's experienced field staff put into running, maintaining, and calibrating the analyzers, monitors, and samplers. Additionally, the expertise of the Data Manager in managing, editing, and submitting this data to EPA through AirNow and AQS plays a significant role.</p>	 <p><b>2.1.1.1.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (ozone)</b></p>
 <p><b>(PI) 2.1.1.2 Meet or exceed a 75% data capture rate for PM2.5.</b></p>	75.00%	98.40%	<p>FY25 Q1 Data Completeness Reports will not be available until December 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 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.</p> <p>These quality metrics are largely the result of the care that AQMD's experienced field staff put into running, maintaining, and calibrating the analyzers, monitors, and samplers. Additionally, the expertise of the Data Manager in managing, editing, and submitting this data to EPA through AirNow and AQS plays a significant role.</p>	 <p><b>2.1.1.2.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (PM2.5)</b></p>
 <p><b>(PI) 2.1.1.3 Meet or exceed a 75% data capture rate for PM10.</b></p>	75.00%	98.20%	<p>FY25 Q1 Data Completeness Reports will not be available until December 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 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.</p> <p>These quality metrics are largely the result of the care that AQMD's experienced field staff put into running, maintaining, and calibrating the analyzers, monitors, and samplers. Additionally, the expertise of the Data Manager in managing, editing, and submitting this data to EPA through AirNow and AQS plays a significant role.</p>	 <p><b>2.1.1.3.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (PM10)</b></p>
 <p><b>(PI) 2.1.1.4 Meet or exceed a 75% data capture rate for carbon monoxide.</b></p>	75.00%	96.00%	<p>FY25 Q1 Data Completeness Reports will not be available until December 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 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.</p> <p>These quality metrics are largely the result of the care that AQMD's experienced field staff put into running, maintaining, and calibrating the analyzers, monitors, and samplers. Additionally, the expertise of the Data Manager in managing, editing, and submitting this data to EPA through AirNow and AQS plays a significant role.</p>	 <p><b>2.1.1.4.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (carbon monoxide)</b></p>














Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 2.1.1.5 Meet or exceed a 75% data capture rate for nitrogen dioxide.</b>	75.00%	97.00%	<p>FY25 Q1 Data Completeness Reports will not be available until December 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 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.</p> <p>These quality metrics are largely the result of the care that AQMD's experienced field staff put into running, maintaining, and calibrating the analyzers, monitors, and samplers. Additionally, the expertise of the Data Manager in managing, editing, and submitting this data to EPA through AirNow and AQS plays a significant role.</p>	 <b>2.1.1.5.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (nitrogen dioxide)</b>
 <b>(PI) 2.1.1.6 Meet or exceed a 75% data capture rate for sulfur dioxide.</b>	75.00%	95.00%	<p>FY25 Q1 Data Completeness Reports will not be available until December 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 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.</p> <p>These quality metrics are largely the result of the care that AQMD's experienced field staff put into running, maintaining, and calibrating the analyzers, monitors, and samplers. Additionally, the expertise of the Data Manager in managing, editing, and submitting this data to EPA through AirNow and AQS plays a significant role.</p>	 <b>2.1.1.6.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (sulfur dioxide)</b>
 <b>(VI) 2.1.2.1a # of air quality plans and reports worked on during this period.</b>		7		 <b>2.1.2.1a.1 Develop and complete 2023 triennial Emissions Inventory and submit to EPA</b>
				 <b>2.1.2.1a.2 Update 2025 Ambient Air Monitoring Network Plan and submit to EPA for approval.</b>
				 <b>2.1.2.1a.3 Update 2015-2024 Air Quality Trends Report and present to DBOH for acceptance.</b>





























Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(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)</b>	0	5	Outreach opportunities completed by AQMD staff during the July 1 to September 30, 2024, reporting period include: <ol style="list-style-type: none"> <li>1. Reno Gazette Journal Weekend Wildfire Smoke Forecast Interview – Ben McMullen, July 26, 2024.</li> <li>2. 2 News Nevada Air Quality, Health, and Wildfire Smoke Interview – Ben McMullen, July 29, 2024.</li> <li>3. KOLO Wildfire Smoke and Ozone Interview with Colin Jackson – Craig Petersen, August 13, 2024.</li> <li>4. KOLO Weekend Air Quality Forecast Interview with Valerie Bishop – Brendan Schnieder, August 30, 2024.</li> <li>5. News4/FOX11 Air Quality Advisory Interview – Brendan Schnieder, September 5, 2024.</li> </ol>	 <b>2.1.2.1.1 Identify and contact community groups and partners.</b>
 <b>(VI) 2.1.2.2a # of community planning efforts where AQMD commented.</b>		6		
 <b>(VI) 2.1.2.2b # of community planning efforts where AQMD participated as a technical advisor.</b>		10		
 <b>(PI) 2.1.2.3 Complete all necessary reviews and any associated updates to air quality regulations.</b>	0	0	AQMD has goals to revise and update regulations based on priorities identified by the permitting and compliance programs. With implementation of the newly adopted source permitting rule beginning January 1, 2025, and the priority to finish the revision and adoption of our asbestos regulations, no other rule revision priorities have been set at this time.	 <b>2.1.2.3.1 Update Chapter 030 – Parts 030.000 – 030.500 (6 parts)</b>  <b>2.1.2.3.2 Update Chapter 040 – Asbestos Control Standards and Acknowledgement of Asbestos Assessment (2 parts)</b>
 <b>(VI) 2.1.2.4 Number of regulations reviewed</b>		0		
 <b>(VI) 2.1.3.1a # of wood-burning devices inspections completed</b>		79	The following Wood-burning device inspections were completed in Q1 of FY2025.  Notice of Exemption Subprogram - (1,780) Notices of Exemption registrations were filed with the AQMD, of which (15) of those properties indicated the removal of an uncertified Wood-burning device which required an inspection of the property to confirm removal.  Certificate of Compliance Subprogram - (64) properties were inspected by a certified Wood-burning device inspector. (19) of those properties required the Wood-burning device be removed or exempted prior to the transfer of ownership.	 <b>2.1.3.1a.1 Inspect properties which have removed a wood-burning device prior to the close of escrow.</b>

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 2.1.3.1 % wood-burning permits managed within internal best practice standard (NOE 4 business days, COC 10 business days)</b>	100.00%	89.00%	The AQMD has an internal best practice standard timeframe of processing wood-burning device registrations. Notices of Exemptions are expected to be processed within (4) business days of receipt and Certificates of Compliance within (10) business days of receipt. In Q1 of FY25 (1,844) NOE's and COC's were processed; (1,633) of these were processed within the internal best practice standard timeframes (64 of 64 COC's and 1569 of 1780 NOE's). This equates to a success rate of 89%. The delay in completing the processing of NOE's can be attributed to fluctuations in staffing, training new staff on SOP's for processing NOE's and the checks associated with NOE's.	
 <b>(VI) 2.1.3.1b # of wood-burning device registrations</b>		1,865		 <b>2.1.3.1b.1 Process and issue Notice of Exemption Registrations submitted to the Air Quality Management Division.</b>
				 <b>2.1.3.1b.2 Process and issue Certificate of Compliance Registrations submitted to the Air Quality Management Division.</b>
				 <b>2.1.3.1b.3 Process and issue Dealers Affidavit of Sale Registrations submitted to the Air Quality Management Division.</b>
 <b>(VI) 2.1.3.2a # of dust control permit inspections completed</b>		136		 <b>2.1.3.2a.1 Complete dust control inspections to determine compliance with dust control permit requirements.</b>
 <b>(VI) 2.1.3.2b # of dust control permits</b>		43		 <b>2.1.3.2b.1 Process and issue Dust Control Permit applications submitted to the Air Quality Management Division.</b>
 <b>(PI) 2.1.3.2 % of dust permits managed within 10 business days.</b>	100.00%	86.00%	The AQMD has an internal best practice standard timeframe of processing dust control permitting. Dust Control Permits are expected to be processed within (10) business days of receipt. In Q1 of FY25 (43) Dust Control Permits were processed; (37) of these were processed within the internal best practice standard timeframes. This equates to a success rate of 86%.The delay in completing the processing can be attributed to fluctuations in staffing and training new staff on SOP's. The average number of days to process a Dust Control Permit is approximately 2.4 days.	
 <b>(VI) 2.1.3.2c Total acreage disturbed by dust permits</b>		367		












Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
● (VI) 2.1.3.3a # of asbestos renovation and demolition inspections completed		18		● 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		40		● 2.1.3.3b.1 Process asbestos NESHAP notifications for demolition and renovation activities.
● (VI) 2.1.3.3c Total square feet of asbestos materials		45,760		
● (VI) 2.1.3.3d Total linear feet of asbestos materials		172		
● (PI) 2.1.3.3 % of asbestos permits managed within internal best practice standard.	100.00%	100.00%	The AQMD has an internal best practice standard timeframe of processing asbestos NESHAP Notifications. NESHAP Notifications are expected to be processed within (10) business days of receipt. In Q1 of FY25 (40) NESHAP Notifications were processed; (40) of these were processed within the internal best practice standard timeframes. This equates to a success rate of 100%. The average number of days to process an asbestos NESHAP Notification is approximately 1.2 days.	
● (VI) 2.1.3.3e Total cubic feet of asbestos materials		0		
● (VI) 2.1.3.4a # of complaint inspection/investigations		80		
● (VI) 2.1.3.5a # of warnings and notices of violations issued		11		
● (VI) 2.1.3.6a # of stationary source inspections assigned		147		
● (PI) 2.1.3.6 Complete 100% of stationary source inspections assigned.	100.00%	100.00%	Of (147) Stationary Source inspections assigned in Q1 of FY25, (147) were completed, for a completion rate of 100%.	● 2.1.3.6.1 Complete inspections of stationary sources to determine compliance with permit and regulatory requirements.
● (VI) 2.1.3.7a # of stationary source authority to construct/permit to operate permits issued		8		

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <p>(PI) 2.1.3.7 100% of stationary source authority to construct/permit to operate permits are issued within 180 days.</p>	100.00%	88.00%	Of the (8) Stationary Source Authority to Construct permits issued in Q1 of FY25, (7) Stationary Source Authority to Construct permits were issued within 180 days. This represents a success rate of 88%. One Stationary Source Authority to Construct was issued outside of the 180-day period. The processing of the application was paused multiple times to request additional information and clarification from the applicant. In addition, this permit required the conversion of multiple minor source operating permits into one synthetic minor operating permit, which required a concurrent 30-day EPA review and public review. These factors caused the issuance of the Authority to Construct to exceed the 180-day period.	 2.1.3.7.1 Issue authorities to construct to new sources of regulated air pollutants in Washoe County.  2.1.3.7.2 Renew permits to operate to sources of regulated air pollutants in Washoe County
 <p>(VI) 2.1.4.1a # of inspections completed at permitted waste management facilities per year.</p>		43		
 <p>(VI) 2.1.4.1b # of waste management facility permits</p>		312		
 <p>(VI) 2.1.4.1c # of waste-related complaints</p>		70		
 <p>(PI) 2.1.4.1 Complete 100% of inspections at permitted waste management facilities per year.</p>	25.00%	13.70%	During the 1st quarter of FY25, 13.7% of permitted waste management facilities were inspected. This does not meet the target of approximately 25% per quarter. However, inspections fluctuate by quarter based on expiration dates and that inspections are due once per calendar year. At the end of the first quarter of FY25, 225 out of the 312 permitted facilities had received an inspection, or 72%. This is tracking slightly behind where the program would like to be. All facilities will receive an inspection for CY24.	 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.
 <p>(PI) 2.1.4.2 Partner with a minimum of 3 outside agencies to assist in waste reduction/clean up initiatives.</p>	0	0	Over the 1st quarter of FY25, the team did not partner with any outside agencies for waste reduction/clean up initiatives. Over the 2nd quarter, the goal is to put together a tire fund proposal program that will enable the group to meet its goal of 3 partnerships for the year.	 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.
 <p>(VI) 2.1.5.1a # of first review plans reviewed for compliance with AQ regulations and processed (AQM)</p>		114		

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <p>(PI) 2.1.5.1 Ensure 90% of first review plans for compliance with AQ regulations meet jurisdictional timeframes. (AQM)</p>	90.00%	92.00%	<p>Of the (114) plans assigned for AQM review in Q1 of FY25, (106) met jurisdictional timeframes for a rate of 92%.</p> <p>It should be noted, (2) 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.</p>	
 <p>(VI) 2.1.5.2a # of residential septic and well plans reviewed and processed</p>		210		
 <p>(PI) 2.1.5.2 Ensure 90% of residential septic and well plan reviews meet a 2-week turnaround</p>	90.00%	98.00%	<p>Of the 210 plans that the program took in the 1st quarter of FY25, 206, or 98%, met the desired outcome of meeting the jurisdictional time frame for review.</p>	 <p>2.1.5.2.1 Build record types for Land Development Program in Accela by the end of FY25</p>  <p>2.1.5.2.2 Update Land Development regulations and set a schedule for updating by the end of FY25</p>  <p>2.1.5.2.3 Update SOPs and develop standardized comments by the end of FY25</p>  <p>2.1.5.2.4 Develop an audit system and conduct a minimum of 3 audits per staff member.</p>  <p>2.1.5.2.5 Update Land Development electronic stamps and plan review process.</p>
 <p>(PI) 2.1.5.3 Conduct a minimum of 3 outreach events to inform interested stakeholders on residential septic and wells. (# of outreach events)</p>	0	1	<p>The team conducted one realtor outreach presentation over the first quarter of FY25. The presentation was attended by 10 realtors.</p>	 <p>2.1.5.3.1 Conduct social media campaigns in collaboration with partners.</p>  <p>2.1.5.3.2 Track number of event attendees.</p>
 <p>(VI) 2.1.5.4a # of UST inspections</p>		56		
 <p>(VI) 2.1.5.4b # of UST permits</p>		214		















Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 2.1.5.4 Complete 100% of inspections at UST permitted facilities per year.</b>	25.00%	26.00%	<p>During the 1st quarter of FY25, 26% of permitted waste management facilities were inspected. This meets the target of approximately 25% per quarter. Inspections may fluctuate by quarter based on expiration dates - inspections are due once per calendar year. At the end of the first quarter of FY25, 170 out of the 214 permitted facilities had received an inspection, or 79%. This is tracking slightly ahead where the program needs to be. All facilities will receive an inspection for CY24.</p>	<p> <b>2.1.5.4.1 Establish training program or standards for new staff in Solid Waste Management and Underground Storage Tank (UST) programs</b></p> <p> <b>2.1.5.4.2 Develop an audit system and conduct a minimum of 3 audits per staff member.</b></p> <p> <b>2.1.5.4.3 Assess success of permit holder educational tools</b></p>
 <b>(PI) 2.2.1.1 Set a baseline for the occurrence of foodborne illness risk factors in inspected facilities.</b>	25	0	<p>This is off target until the completion of the VIP Accela project (December 2024). Once the project is completed, a ticket will be submitted to Washoe County TS to develop a checklist report to track food establishment inspection data.</p>	<p> <b>2.2.1.1.1 Develop a system to track occurrence of foodborne illness risk factors in inspected facilities.</b></p> <p> <b>2.2.1.1.2 Complete the final report and determine intervention strategies based on results from the 2023-2024 Risk Factor Assessment</b></p> <p> <b>2.2.1.1.3 Create a system to track food-related complaints for surveillance purposes.</b></p>
 <b>(VI) 2.2.1.2a # of foodborne illness assessments.</b>		2		
 <b>(VI) 2.2.1.2b # of inspections for food establishments.</b>		633		
 <b>(VI) 2.2.1.2c # of temporary food event inspections.</b>		627		
 <b>(VI) 2.2.1.2d # of permitted food establishments</b>		3,959		
 <b>(VI) 2.2.1.2e # of complaints responded to.</b>		59		














Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
<p>● (VI) 2.2.1.2f Total # of permitted facilities (non-food permits) at the end of the current quarter (permits include the following: Childcare, Schools, Hotel/Motel, RV/MHP, IBD, Jails, Aquatic Facilities, and RV Dump Stations.)</p>		1,217		
<p>● (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)</p>	1	1	Additional component of Standard 9 completed - data analysis for risk factor study. Standard 9 anticipated to be fully met by December 31, 2025.	<ul style="list-style-type: none"> <li>● 2.2.1.2.1 Standard 2- Complete initial training for all employees.</li> <li>● 2.2.1.2.2 Standard 2- Maintain CEUs.</li> <li>● 2.2.1.2.3 Standard 2- Complete initial standardization for all employees.</li> <li>● 2.2.1.2.4 Standard 3- Develop and implement annual permit for temporary food vendors.</li> <li>● 2.2.1.2.5 Standard 3- Develop assessment documents for change of ownership and new facilities.</li> <li>● 2.2.1.2.6 Standard 4- Develop schedule for process to review inspection reports and conduct field evaluations of assigned staff.</li> <li>● 2.2.1.2.7 Standard 4- Transition opening inspection report review.</li> <li>● 2.2.1.2.8 Standard 5- Revise Outbreak Response Plan with CD.</li> <li>● 2.2.1.2.9 Standard 6- Implement active managerial control (AMC) program.</li> <li>● 2.2.1.2.10 Standard 6- Develop a new compliance and enforcement branch.</li> </ul>















Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
				<p> 2.2.1.2.11 Standard 7- Increase outreach and education opportunities through social media, public workshops, videos, handouts, and newsletter.</p> <p> 2.2.1.2.12 Standard 7- Identify barriers to language accessibility.</p> <p> 2.2.1.2.13 Standard 8- Develop a plan to ensure adequate inspection staff to complete inspections and increase conformance with program standards.</p> <p> 2.2.1.2.14 Standard 9- Meet Standard 9 and demonstrate status of foodborne illness risk factors over the last 5 years.</p> <p> 2.2.1.2.15 Standard 9- Develop intervention strategies to address the foodborne illness risk factors identified as needing priority attention.</p>
<p> (PI) 2.2.1.3 Percentage of required inspections of food establishments completed.</p>	25.00%	13.00%	This outcome is off target due to lack of staffing resources, and staff turnover. One vacant EHS Trainee position is scheduled to be filled by Q2. The program has submitted calculations to demonstrate the need for additional staffing resources.	
<p> (VI) 2.2.1.4a % of passing inspections for routine food inspections</p>		84.00%		<p> 2.2.1.4a.1 Evaluate the effectiveness of the AMC program and operator recidivism</p>
<p> (VI) 2.2.1.4b % of passing inspections for routine commercial facility inspections (including childcares, schools, pools, hotels/motels, RV parks, mobile home parks, and dump stations)</p>		84.00%		<p> 2.2.1.4b.1 Update Pool &amp; Spa regulations to reflect current design and construction</p> <p> 2.1.1.4b.2 Establish Childcare regulations and other documentation necessary for program success (inspection form, field guide, guidance documents, etc.)</p>
















Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
● (VI) 2.2.1.5a # of total inspections of non-food based permitted facilities including other elements (re-inspections, etc.).		230		● 2.2.1.5a.1 Establish training program or standards for new staff in Permitted Facilities
● (VI) 2.2.1.6a # of other permitted facility complaints		0		
● (VI) 2.2.1.7a # of sanitary surveys of public water systems		14		
● (VI) 2.2.1.7b # of public water system permits		76		
● (VI) 2.2.1.7c % of public water systems in compliance with lead and copper rule revisions		33		
● (VI) 2.2.1.7d % of sanitary surveys for year with a significant deficiency		8		
● (PI) 2.2.1.7 Complete 100% of required sanitary surveys of public water systems to help ensure proper public health protection.	25.00%	42.00%	Over the first quarter of FY25, the team conducted 14 sanitary surveys - 8 public water systems and 6 water haulers. Of the 33 required surveys this year, this is approximately 42%, which exceeds the goal of 25% a quarter.  For CY25, the team has 10 systems, or 33% percent to complete all required surveys. All surveys will be completed as required.	● 2.2.1.7.1 Establish training program or standards for new staff in Land Development and Safe Drinking Water  ● 2.2.1.7.2 Achieve 100% compliance with lead and copper rule revisions for Washoe County Public Water Systems
● (VI) 2.2.2.2a # of New Jersey daily trap counts that contain more than 10 mosquitos from May to October		0		
● (VI) 2.2.2.3a # of mosquito pools submitted for testing.		711		
● (VI) 2.2.2.4a # of mosquito pools positive for arbovirus (West Nile/St. Louis Encephalitis/Western Equine virus).		3		
● (VI) 2.2.3.1a # of commercial plans reviewed for health standards (Including food establishments)		435		















Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 2.2.3.1 Ensure 90% of first review for commercial plans meet a 2-week turnaround</b>	90.00%	53.10%	53% of plans submitted and reviewed during the first quarter were outside of the 14-day regional goal. This was due to a number of issues this past year. During the busiest time of the year, plan review staff were also in the field completing pool and spa inspections for the community over the summer. This took time away from their ability to complete all commercial plans in a timely manner. As the pool and spa season progressed, the team was able to get caught up and are back on track with more reasonable time frames.	 <b>2.2.3.1.1 Test an updated workflow into Accela for each jurisdiction to create a uniform plan review mechanism.</b>  <b>2.2.3.1.2 Establish training program or standards for new staff in Commercial Plan Review</b>
 <b>(VI) 3.1.1.1a # total social media posts in English and Spanish</b>		340		
 <b>(VI) 3.1.1.1b # of culturally relevant or health equity social media posts</b>		86		 <b>3.1.1.1b.1 Work with community members or organizations to create culturally relevant content.</b>
 <b>(VI) 3.1.1.1c # of social media followers</b>		12,707		
 <b>(VI) 3.1.1.1d # of web hits</b>		143,527		
 <b>(PI) 3.1.1.2 Increase audience growth across all platforms by 10%. (followers)</b>	2.50%	4.90%	NNPH went from 12,113 total followers on X, Facebook (English and Spanish pages), Instagram, and LinkedIn to 12,707 total followers, for an increase of 4.9%. This growth may be attributed to a combination of creating unique/appropriate content for each platform and reaching a larger audience through Meta advertising.	
 <b>(PI) 3.1.1.3 Increase Spanish language Facebook followers by 5%</b>	1,164	1,262	In Q1, NNPH went from 1,171 followers on the Spanish language Facebook page to 1,262, an increase of 7.8%. This growth may be attributed to several partnerships with prominent community influencers that have a larger following, such as Latinos De Nevada, Juan 101.7 and Renoticias.	
 <b>(PI) 3.1.1.4 Increase impressions across all social media posts by 10%. (comments, shares, link, clicks and more)</b>	2.50%	0%	NNPH had several campaigns running in Q4 2024 that led to a tremendous increase in social media impressions (1.7 million, a record). In Q1 2025, the health district did not have an increase due to that comparison with an unusually inflated number. NNPH hopes to bring back the average next quarter.	 <b>3.1.1.4.1 Create and post videos and graphic design content to drive engagement.</b>
 <b>(PI) 3.1.2.1 Collaborate with at least 2 grant-funded programs to execute marketing tactics that reach populations experiencing health disparities</b>	0	1	<p>The two programs are below. NNPH is still in progress with the first program, and the other can be considered complete since the ads are already running.</p> <ol style="list-style-type: none"> <li>1. Food Safety - The program had grant dollars available to use toward marketing, so they were used them on a campaign promoting the Excellence in Food Safety Awards. Staff is creating vinyl window placards in English, Spanish, and Chinese to reach diverse populations. The project is ongoing.</li> <li>2. Senior falls - Staff collaborated with the CDIP program to help promote senior falls prevention information on social media.</li> </ol>	 <b>3.1.2.1.1 Maintain and increase Spanish language earned media</b>






Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
				<p> 3.1.2.1.2 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)</p> <p> 3.1.2.1.3 Identify opportunities to utilize grant funds to promote health equity and reduce health disparities</p>
 (VI) 3.1.2.3a # of public records request fulfilled (ODHO)		0		
 (VI) 3.1.2.3b # of public records request fulfilled (AQM)		16		
 (VI) 3.1.2.3c # of public records request fulfilled (CCHS)		0		
 (VI) 3.1.2.3d # of public records request fulfilled (EPHP)		7		
 (VI) 3.1.2.3e # of public records request fulfilled (EHS)		917		
 (VI) 3.1.2.4a # of press releases, media alerts, media availability.		30		
 (VI) 3.1.2.5a # of community presentations (ODHO)		4		
 (VI) 3.1.2.5b # of community presentations (CCHS)		6		
 (VI) 3.1.2.5c # of community presentations (EPHP)		3		
 (VI) 3.1.2.5d # of community presentations (EHS)		9		
 (VI) 3.2.1.1a # of vital records requests and services		13,376		

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 3.2.1.1 Process 90% of vital records requests and services within 96 hours.</b>	90.00%	100.00%	<p>All requests received are processed at the time staff gets the request.</p> <p>Deaths records are registered as soon as received to not hold the Funeral homes from printing the Burial Permit.</p> <p>Births are registered as received to have ready for printing.</p>	 <b>3.2.1.1.1 Assist the state by testing and implementing the NETSMART system and providing feedback.</b>  <b>3.2.1.1.2 Improve communications with other Nevada vital statistics jurisdictions through monthly meetings.</b>  <b>3.2.1.1.3 Identify gaps to improve procedures and processing time with funeral homes.</b>  <b>3.2.1.1.4 Identify gaps to improve procedures and processing time with physicians and medical examiner's office</b>  <b>3.2.1.1.5 Update the vital statistics manual to incorporate NETSMART system updates and processing</b>
 <b>(VI) 3.2.2.1a # of reports (Communicable Disease Annual; CPO Quarterly; COVID-Bi-Weekly; ILI Weekly) provided to the community</b>		5		
 <b>(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.</b>	100.00%	100.00%	<p>The Epidemiology team published five (5) reports during July-September 2024. These included the last monthly COVID report (transitioning to the combined Respiratory report in Q2), the 2023 COVID Annual Report, ILI (Influenza-like Illness) End of Season Summary, 2024 Q2 CPO Report, and the 2023 Communicable Disease Annual Report.</p> <p>All reports with internal deadlines during Q1 of 2025 were published during Q1.</p>	 <b>3.2.2.1.1 Maintain a tracking mechanism to know which reports were released on which dates.</b>  <b>3.2.2.1.2 Explore merging COVID-19 data in ILI reports.</b>
 <b>(VI) 3.2.3.1a # of statistical analysis requests met.</b>		8		
 <b>(PI) 3.2.3.1 Deliver on 95% of requests for statistical analysis. (# of requests)</b>	95.00%	100.00%	<p>In FY25 Q1, 100% of statistical requests were met. These included 8 internal cross divisional requests completed by statisticians.</p>	 <b>3.2.3.1.1 Capture measurable outcomes for all programs.</b>  <b>3.2.3.1.2 Maintain statistical capacity to serve EPHP and NNPH</b>









Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <p>(VI) 3.3.1.1a # of interim committee meetings, public workshops, and coalition meetings attended/monitored.</p>		42		 <p>3.3.1.1a.1 Generate a list of potential 2027 legislative priorities.</p>
 <p>(PI) 3.3.1.1 Pursue and achieve 2 local government health in all policies initiatives.</p>	0	0	<p>Several meetings relevant to this goal took place in September.</p> <p>9/25/24- A meeting with the Washoe County Sustainability team and several members of NNPH was held to discuss local policy initiatives that the county may consider pursuing in the future. A draft sustainability plan has been released and will eventually go to the Board of County Commissioners for a vote. Goals to reduce VMT (vehicle miles traveled) is discussed in the draft plan, although not in detail. NNPH expressed support in future collaborations. Discussions around other ways to reduce VMT/emissions was also discussed: employee carpool, RTC rideshare expansions etc. The barriers are political will and lack of funding for projects related to emissions and sustainability.</p> <p>9/11/24- A meeting with the City of Reno and several members of NNPH was held to discuss the COR's sustainability plan and where priorities could be aligned. The City has a sustainability plan, but very little has been done around VMT/Rideshare/ reduction of emissions. The City said that funding opportunities for rideshare programs are largely held at the RTC, however there isn't much to develop robust programs.</p> <p>Internal meetings with NNPH staff were also held to discuss potential ways to benefit the community and reduce emissions. Community organizers are exploring a rideshare program for casino workers; however, lack of funding, lack of community interest, and lack of casinos' will to aid workers seems to lead to a dead end on that project idea. Accordingly, increased fatalities for pedestrians and cyclists as an alternative possibility to address was discussed, along with improving rideshare programs to the Tahoe Regional Industrial Center (TRIC), where hundreds of Reno/Sparks residents commute to and from every day.</p>	 <p>3.3.1.1.1 Generate a list and identify local government priority initiatives to pursue.</p>
 <p>(PI) 4.1.1.1 Residents have access to multiple elements of a best practice crisis response system.</p>	0	0	<p>The Core team continues to make progress towards building Washoe County's Crisis Response System. Currently, the group is focused on the stabilization center and plans to open at the end of the year.</p>	 <p>4.1.1.1.1 Work with community partners and the state to implement additional elements of the behavioral health crisis system.</p>
















Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <p>(PI) 4.1.2.1 Implement at least one lethal means reduction strategy in coordination with the Washoe Suicide Prevention Alliance.</p>	0	1	Staff successfully coordinated, received consent, and launched the first four (4) gun shops on the Temporary Safe Storage Map for Washoe County. Partnering with gun shops to temporarily store firearms is an effective lethal means reduction strategy that allows the firearm to be separated from the individual. Participating gun shops were provided with essential information, suicide prevention gun locks, and other materials. Staff also had the opportunity to present the program and performed outreach at the Alcohol Tobacco and Firearms seminar for about 50 local gun shops. All attendees received materials and sign-up options, as well as suicide prevention items.	 <p>4.1.2.1.1 Facilitate the operation of the Washoe Suicide Prevention Alliance, and collaborate with local and state stakeholders.</p>
 <p>(PI) 4.1.3.1 90% of applicable WIC participant interactions will receive substance abuse screening, education and referrals.</p>	90.00%	84.00%	<p>Chart audits showed that 84% of WIC client appointments included SA screening, education and referrals. Of the five staff completing client appointments, 4 reached above a 90% compliance rate for SA screening, education, and referrals, and one had a 40% compliance rate, which lowered the team's overall compliance. Coaching and education will be provided to the team member who is less consistent with providing SA screening, education and referrals to improve compliance.</p>	 <p>4.1.3.1.1 Provide staff with training refreshers on substance abuse screening, education and referrals.</p>
				 <p>4.1.3.1.2 Complete chart audits for compliance with substance abuse screening, education and referrals.</p>
 <p>(PI) 4.2.1.1 Increase the number of corner stores engaged in offering healthy food with the addition of 3 new stores.</p>	0	0	<p>After assessing the challenges and barriers faced with engaging and recruiting stores in fiscal year 2024, staff dedicated the first quarter of 2025 to brainstorm and revamp the program offering, including restructuring store guidelines, requirements, and expectations. In order for the program to be sustainable, staff recognized the importance of not only recruiting stores but having a committed role from store owners and staff who are already onboarded with the program. Recruitment documents were updated to reflect a more streamlined process with the onboarding of stores. In addition, staff are working on updating the website to provide more information about the program and make it more enticing for both customers and stores that are interested in participating. A detailed toolkit was created to help store owners stay engaged, but mostly to use as a guide. This toolkit will be distributed in the upcoming weeks.</p> <p>During this quarter staff worked diligently to recruit one store who showed great interest in the program. Multiple visits and numerous communications were exchanged. The store owner saw the benefit but was not ready to commit and declined joining at this time. Staff will continue to keep this store on the radar and will follow-up in the next few months. The program lost a store, 7-Eleven on Sutro, due to new ownership and management. Staff met with new owner of 7-Eleven and explained how the store was a part of the program. Owner would need to get approval from management and will follow up. Staff will continue to work on keeping this store, as it was part of the original pilot. To date, three stores are onboarded with the program. Staff will continue to work diligently and will continue mapping and recruiting stores and assessing best practices to support program efforts.</p>	 <p>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.</p>


Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 (PI) 4.2.1.2 Expand the number of sites that are implementing the 5210 Healthy Washoe program from 5 to 7 elementary schools.	5	6	Echo Loader will begin implementing the 5210 HW program in SY 24-25. The team is working with staff to complete the school environmental scan to determine opportunities for nutrition and physical activity improvements.	 4.2.1.2.1 Provide technical assistance to partner sites.
 (VI) 4.3.1.1a # of FHF attendees (total individual members)		1,093		
 (PI) 4.3.1.1 At least 80% of FHF participants will receive the services needed.	80.00%	87.00%	The Family Health Festival committee held one FHF event during this quarter at Hug High School in early August 2024. Of the 236 households served, 87% of them stated in their end-of-event survey that they had received all of the services they needed. Most of the remaining 13% stated that they had not received the back-to-school immunizations they had come for, given how the NNPH immunizations team had to close that line down during the last hour of the event since they were already at capacity for what the vaccinators could handle. The FHF committee is working with the immunizations team to devise improved logistics plans so that even more clients might be served at future FHF vaccination clinics.	 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 communities.  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.	0	0	The coalition is a focus of the ODHO team in this fiscal year. The team is determining what the coalition's role and responsibilities are.	 4.3.1.2.1 Facilitate coalition convenings and identify strategies and actions to be implemented.
 (PI) 4.3.1.3 Implement at least three initiatives designed to improve access to care.	0	0	Several initiatives continue to be implemented to improve access to health care as part of the CHIP. Community partners will determine CHIP year 3 strategies in December-January. The details can be found in the document online.	 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) 4.5.1.1 Implement/execute 4 strategies in the EMS Strategic Plan FY24-29.	1	0	Q1: The EMS Joint Advisory Committee (JAC) have been diligently working on the revision of the Franchise Agreement. As a result, the JAC has not made as much progress as anticipated but has revised timelines to meet strategies outlined in the EMS Strategic Plan.	 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.

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
				<ul style="list-style-type: none"> <li>4.5.1.1.3 Increase EMS practitioner driver safety.</li> <li>4.5.1.1.4 Create and implement a CQI process for pre-hospital treatment/patient outcome.</li> </ul>
 (PI) 4.6.1.1 Increase community access to CHA data via online dashboard from 0 to 500. (# of web visits)	125	43	Between July and September 2024, there were 43 sessions/visits to the Truckee Meadows Tomorrow site dashboard made of Community Health Assessment indicators ( <a href="https://www.nevadatomorrow.org/tiles/index/display?alias=nnph_cha_2022_2025">https://www.nevadatomorrow.org/tiles/index/display?alias=nnph_cha_2022_2025</a> ). The 43 sessions were made up of 25 distinct users, 11 of which were new users and the average session duration was 1 minute and 35 seconds.	<ul style="list-style-type: none"> <li>4.6.1.1.1 Maintain a dashboard with CHA indicators as data.</li> </ul>
 (VI) 4.6.2.1a # of collaborative initiatives in the CHIP		31		
 (PI) 4.6.2.1 Complete at least 60% of activities planned in the CHIP.	0%	0%	Annually, in 2023 71% of CHIP strategies were implemented as planned. Community partners will begin reporting their progress at the end of the year to determine how much progress the community made in 2024. The results will be available in February.	<ul style="list-style-type: none"> <li>4.6.2.1.1 Invest in community partners to improve community health improvement outcomes.</li> </ul>
 (PI) 4.6.2.2 Maintain the number of organizations leading CHIP initiatives	0	35	The same number of CHIP partners are leading initiatives as this is the third year of implementation. There is a possibility of new partners joining the CHIP following the CHIP subcommittee meetings at the end of the year.	
 (PI) 4.6.2.3 Implement at least 2 CHIP initiatives focused on policy changes that alleviate causes of health inequities.	0	0	The team is having discussions about tracking policies that align with the CHIP and with NNPH priorities.	<ul style="list-style-type: none"> <li>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.</li> <li>4.6.2.3.2 Gather input from stakeholders about policies under review and collaborate with stakeholders to share findings of the review.</li> </ul>


















Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <p>(PI) 4.6.2.4 Address at least three gaps to improve disparate health outcomes by involving partners that represent underserved communities.</p>	0	4	<p>For 5210 Healthy Cafeterias, Glenn Duncan Elementary cafeteria staff choose two initiatives to implement in their cafeteria. One initiative was to add fun name cards on fruit and vegetable options to increase consumption among students. The other initiative was to include a 5210 Poster providing guidance to kids on how to develop healthy habits through 5210 messaging. A social media video was also created to highlight the collaborative efforts between WCSD Nutrition Services, Glenn Duncan and 5210.</p> <p>For financial literacy, the first bilingual class was held at the Women and Children Center of the Sierra. A total of 10 clients attended to learn more about basic budgeting skills. Participants filled out a worksheet to help them create a budget and learned how to name or tag every dollar to something (e.g. rent, childcare, insurance, etc.) The class also sparked conversations about how money is viewed in their culture and the barriers they experience.</p> <p>Aca Entre Nos continues to increase mental health awareness among Spanish families that are limited English proficient and who have children enrolled in a Title I school. The next mental health session includes a four-part series in collaboration with Clayton Middle School, who's identified 7-10 families to participate. A bilingual provider will facilitate the first session which will focus on relationship building among families.</p> <p>Anything but the Gym has 6 participants enrolled in the program. Participant's have completed a total of 79 physical fitness activities, 27 health coaching sessions, and 6 exercise adherence plans. Program participants have also received a total of 38 educational emails and 105 healthy recipes.</p>	 <p>4.6.2.4.1 Expand the number of partners representing underserved parts of our community collaborating in PSE and/or health equity initiatives.</p>
 <p>(PI) 4.6.2.5 Maintain the number of individuals who provide input to the CHIP. (# of people at Steering Committee, subcommittee meetings, and planning meetings)</p>	0	0	The first set of CHIP meetings in FY25 are scheduled in December.	 <p>4.6.2.5.1 Engage community members in the decision-making process to update initiatives for year 3.</p>
 <p>(PI) 4.6.2.6 Recruit at least 10 community representatives to establish 1 cross-sector health coalition. (# of committee members)</p>	0	0	The team is discussing the roles and responsibilities of the coalition. The team is also researching how other LHD are using coalitions.	 <p>4.6.2.6.1 Develop a process to respond to community members and organizations on commitments.</p>
 <p>(VI) 4.6.2.7a # of relationships maintained with priority contacts.</p>		18		
 <p>(VI) 4.6.2.8 # of new relationships built with key organizations, programs, and leaders.</p>		5		











Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <p>(PI) 4.6.3.1 Identify at least 3 initiatives or projects for divisions to work with the health equity team and/or community-based partners to impact health disparities.</p>	0	2	<p>The Health Equity Team helped the Northern Nevada Maternal and Childcare Coalition recruit WACCS as a host site for the Momma Care Kits, now bringing the total number of community host sites to 8. These kits provide postpartum recovery supplies and resources needed for a healthier recovery for low-income mothers. WACCS will receive 25 kits to begin with.</p> <p>Lastly, for the Heat and Smoke project, a total of 20 households were recruited for the study that reside in low-income and underserved zip code areas. The research team also completed data collection at each of these households over the summer. The data is currently being analyzed and the research team should have some preliminary results to share in Q2.</p>	<p> 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.</p> <p> 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)</p>
 <p>(PI) 4.7.1.1 Execute a regional emergency response exercise with regional healthcare partners and finalize After Action Report within 90 days following.</p>	25.00%	25.00%	<p>Q1: CDC T.E.S.T exercise conducted on 9/10—AAR in Q2. The T.E.S.T. is a training and exercise simulation tool designed to foster collaborative emergency preparedness activities. The T.E.S.T game played focused on Point of Dispensing/ Distribution with partners from State, Quad Counties Public Health, Central Nevada Public Health, Tribal partners, regional hospitals among other community partners. The exercise was conducted on 9/10, but the team will not complete the AAR until sometime in the second quarter.</p>	<p> 4.7.1.1.1 Develop a MOU for partner utilization of the mobile medical/command post vehicle.</p> <p> 4.7.1.1.2 Participate in 90% of requested school EOP meetings.</p> <p> 4.7.1.1.3 Produce an after action/improvement plan within 90 days following the exercise.</p> <p> 4.7.1.1.4 Conduct HSEEP planning meetings.</p>
 <p>4.7.1.2 Implement 1-2 strategies from the jurisdictional risk assessment</p>	0	0	<p>Q1: No activity this quarter.</p>	<p> 4.7.1.2.1 Complete a Project Health Ready review</p> <p> 4.7.1.2.2 Collaborate with the State of Nevada to coordinate behavioral health efforts</p>
 <p>(PI) 4.7.2.1 Complete 75% of planned activities identified by the IHCC.</p>	10.00%	11.00%	<p>Q1: The HPP has 115 activities, with 2 activities currently at 100% completion (2%). Many other activities are in progress and remain on schedule according to the timeline outlined in the scope of work. Coalition members are also actively working on their objectives based on their specific provider types. Of the 35 total objectives, 4 have been completed (11%). Several activities are ongoing and, while they will be considered complete by the end of the federal grant, they are expected to continue for years to come.</p>	<p> 4.7.2.1.1 Update IHCC guidelines annually.</p> <p> 4.7.2.1.2 Complete Resource and Gap Analysis annually.</p> <p> 4.7.2.1.3 EMS/Fire Planned Activities: MCI plan updates, Interagency training with law enforcement, MAEA, and MCI training and exercises</p>












Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
				<p> 4.7.2.1.4 Hospital Planned Activities: MAEA and MCI training and exercising, Business Continuity Recovery/Down-Time Planning, and CHEMPACK Training</p> <p> 4.7.2.1.5 Skilled Nursing/Memory Care/Assisted Living Planned Activities: Evacuation Planning/ Training, Staff and Resources Sharing Plan, Cybersecurity Plan, and Exercise Plan</p> <p> 4.7.2.1.6 Clinic/Ambulatory Surgery Center Planned Activities: Recruitment, Emergency Operations Planning, Surge Capacity Planning, Staff and Resource Sharing Planning</p> <p> 4.7.2.1.7 Home Health/Hospice Planned Activities: Data Collection Exercises, Incorporate lessons learned from real-world example, Exercise Plan</p> <p> 4.7.2.1.8 Public Health Planned Activities: MAEA updates and Cybersecurity exercises</p>
<p> (PI) 4.8.1.1 Initiate at least one new project collaboration with UNR per year. (# project collaborations)</p>	0	0	<p>The mentorship project under the AHD UNR/NNPH collaboration is in the discussion phase. This will support gaps in internship opportunities.</p> <p>Additionally, to support immunization efforts in the community, discussion with UNR and the connection to the state is also underway.</p> <p>Finally, discussions between NNPH and UNR are also underway regarding how to better streamline the process for internships.</p>	<p> 4.8.1.1.1 Maintain regular communications through a joint advisory committee for new research and developments.</p> <p> 4.8.1.1.2 Participate on UNR's graduate committee.</p> <p> 4.8.1.1.3 Identify joint research opportunities and joint grant funding resources.</p> <p> 4.8.1.1.4 Identify training opportunities for NNPH staff through UNR.</p>

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
				<ul style="list-style-type: none"> <li>4.8.1.1.5 Maintain the continuity of and improve joint course on real-world public health applications.</li> <li>4.8.1.1.6 Implement mentorship program between NNPH staff and UNR students.</li> </ul>
<ul style="list-style-type: none"> <li>(PI) 4.8.1.2 Ensure standardized, recurring internship opportunities. (# of recurring internship opportunities) (maintain minimum of 3 per year)</li> </ul>	0	1	One internship opportunity being set in place this year starting in the Fall semester is the community antibiogram work. This is currently taken on by someone who is also a graduate assistant from UNR working on an MPH internship. Going forward, this internship opportunity for the community antibiogram will continue yearly.	<ul style="list-style-type: none"> <li>4.8.1.2.1 Improve the quality of internship opportunities for UNR students in all disciplines.</li> </ul>
<ul style="list-style-type: none"> <li>(VI) 5.1.1.1a # of retirements.</li> </ul>		2		
<ul style="list-style-type: none"> <li>(VI) 5.1.1.1b # of non-retirements, promotion or transfer departures</li> </ul>		8		<ul style="list-style-type: none"> <li>5.1.1.1b.1 Conduct exit interviews with all departing staff via online survey.</li> </ul>
<ul style="list-style-type: none"> <li>(VI) 5.1.1.1c # of promotions/transfers.</li> </ul>		1		
<ul style="list-style-type: none"> <li>(PI) 5.1.1.1 Maintain 5% or less employee vacancy rate (vacancy rate= average monthly vacancy rate including all employees).</li> </ul>	5.00%	9.83%	Currently NNPH is at a 9.83% vacancy rate. This vacancy rate is due in part to retirements, promotions, and new positions that were approved but are not currently funded. NNPH has several recruitments in progress at this time to help fill the funded positions.	<ul style="list-style-type: none"> <li>5.1.1.1.1 Provide monthly vacancy report to include insights/trends on hard-to-fill positions.</li> <li>5.1.1.1.2 Recruit and promote career opportunities via social media outlets and other direct channels that reach individuals within the community.</li> </ul>
<ul style="list-style-type: none"> <li>(PI) 5.1.1.2 Increase mandatory training completion rate from 96% to 98%.</li> </ul>	98.00%	97.50%	The training completion rate for this quarter is 97.5%, which shows staff are working hard to complete required trainings within the required time frame. The completion rate is impacted by the Title VI training that is currently unavailable to staff. This training is being revised and updated by County HR Training, so staff are unable to complete this training by their due date. At times there are also conflicting priorities for staff when trying to balance training and on the job requirements.	<ul style="list-style-type: none"> <li>5.1.1.2.1 Remind staff of mandatory trainings via email.</li> <li>5.1.1.2.2 Track mandatory training completion rate to present to DDs and Supervisors.</li> </ul>

















Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 5.1.1.3 Increase probationary/annual evaluation completion rate from 80% to 85%.</b>	85.00%	69.39%	Supervisors who are required to complete staff performance evaluations are sometimes stretched thin in terms of workloads and existing priorities. Staff evaluations can sometimes fall through the cracks because of this. NNPH is mindful of this and trying to get back on track. Staff turnover and new supervisors also played a role in why performance evaluation percentage is below our goal. Reminders are sent to supervisors on a regular basis outlining employee evaluation due dates so supervisors can prioritize the evaluations they need to complete and schedule time to work on these during their already busy workload.	 <b>5.1.1.3.1 Generate monthly communication to DDs and supervisors to keep them informed of schedule.</b>  <b>5.1.1.3.2 Provide training related to running effective and meaningful evaluations.</b>
 <b>(PI) 5.1.1.4 Increase percentage of employees who recommend NNPH as a good place to work from 76% to 78%.</b>	0%	0%	Washoe County is conducting the Employee Engagement Survey in September-October. The survey closes October 14th, so results will not be known until future quarters.	 <b>5.1.1.4.1 Continue to provide thoughtful, consistent, optional flex, hybrid, and remote work as appropriate based on position.</b>  <b>5.1.1.4.2 Support and implement an employee recognition program.</b>  <b>5.1.1.4.3 Create opportunities for staff to work across divisions on projects and task forces.</b>  <b>5.1.1.4.4 Provide onboarding program to integrate staff into the NNPH team.</b>  <b>5.1.1.4.5 Promote relationship-building activities, including key takeaways.</b>  <b>5.1.1.4.6 Equip supervisors with the tools necessary to complete Employee Performance Evaluations on time.</b>
 <b>(PI) 5.1.1.5 Increase internal newsletter distribution to bi-weekly for FY25</b>	6	6	NNPH has achieved a cadence of bi-weekly every Thursday for the NNPH Buzz, the internal newsletter, and has been getting good feedback and engagement about the content.	
 <b>(PI) 5.1.1.6 Implement at least 25% of the FY25-FY27 Workforce Development Plan and strategies</b>	10.00%	0%	The WFD assessment is being conducted with NNPH staff.	 <b>5.1.1.6.1 Develop WFD Plan and Implementation Strategies</b>
 <b>(VI) 5.1.2.1a # of staff participating in district-wide professional development opportunities.</b>		0		 <b>5.1.2.1a.1 Provide at least 2 leadership development opportunities to staff.</b>

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
				<ul style="list-style-type: none"> <li>5.1.2.1a.2 Identify at least one professional development opportunity as part of each employee goal setting.</li> <li>5.1.2.1a.3 Collaborate with DDs and ODHO to identify training challenges.</li> </ul>
<ul style="list-style-type: none"> <li>(PI) 5.1.2.1 At least 50% of employees will report feeling proficient on targeted core competencies.</li> </ul>	0%	0%	Training hasn't kicked off yet for FY25 yet. The first all staff training will be in December.	<ul style="list-style-type: none"> <li>5.1.2.1.1 Provide targeted core competency training on areas identified through staff and supervisor input.</li> <li>5.1.2.1.2 Evaluate improvement on targeted core competencies as assessed by employees and supervisors.</li> <li>5.1.2.1.3 Train DDs and supervisors on the budget process.</li> <li>5.1.2.1.4 Provide FAQs for staff on budget process and grants.</li> <li>5.1.2.1.5 Build out additional onboarding activities for supervisors over their first year.</li> </ul>
<ul style="list-style-type: none"> <li>(PI) 5.1.3.1 Increase the number of mental health resources provided to staff in the workplace from 2 to 3.</li> </ul>	2	2	Staff continue to have access to the Calm app and the EAP program through WC HR. The NNPH team will continue to promote other resources as they become available.	<ul style="list-style-type: none"> <li>5.1.3.1.1 Provide optional opportunities to learn about wellness techniques and strategies.</li> </ul>
<ul style="list-style-type: none"> <li>(PI) 5.2.1.1 Meet 100% of requirements to maintain accreditation.</li> </ul>	0%	0%	NNPH's Reaccreditation Application was submitted on September 30th.	<ul style="list-style-type: none"> <li>5.2.1.1.1 Submit annual reports with all required documentation.</li> <li>5.2.1.1.2 Convene reaccreditation committee.</li> <li>5.2.1.1.3 Gather at least 50% of documents required for reaccreditation by the end of year.</li> </ul>









Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 5.2.1.2 Increase the number of QI projects implemented across the HD from 0 to 2.</b>	0	0	<p>The 2024-2026 NNPH Quality Improvement plan was approved by the District Board of Health during the September 2024 board meeting. This QI Plan outlines the rationale and process for how NNPH staff members undertake QI projects. Now that DBOH has signed off on these procedures, NNPH staff has started educating staff about QI opportunities and methods.</p> <p>With the QI plan now approved, the health district's first official QI project for FY25 is underway. The project aims to revamp several procedures in the current employee onboarding process to make sure incoming employees have a smooth, uniform, and informative onboarding experience. The project is a collaboration between the Administrative Health Services division and the Office of the District Health Officer. It includes the following key components:</p> <ul style="list-style-type: none"> <li>• More clearly defining HR and supervisor roles from the time the search for a new employee starts to that employee's first day of work.</li> <li>• Updating each slideshow of the New Employee Onboarding class series to present up-to-date material on performance management, quality improvement, and cultural competency.</li> <li>• Creating a video with division director interviews and footage of each division's activities for use during a revamped "Intro to Health" class.</li> </ul> <p>Staff working on this project expect to complete it by January 2025.</p>	 <b>5.2.1.2.1 Collaborate with QI Council to advance NNPH QI initiatives</b>  <b>5.2.1.2.2 Train staff about QI concepts and internal process.</b>  <b>5.2.1.2.3 Communicate with leadership, governing body, and stakeholders about QI activities.</b>  <b>5.2.1.2.4 Identify two QI projects using data from performance management system</b>
 <b>(VI) 5.3.1.1a # of filled positions (FT and PT employees)</b>		171		
 <b>(VI) 5.3.1.1b # of FTE</b>		188		
 <b>(VI) 5.3.1.1d # of internship opportunities at NNPH</b>		5		
 <b>(PI) 5.3.1.1 Increase investment in personnel where workforce capacity is a barrier to productivity. (% increase in FTE)</b>	228	198	<p>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. Total FTE has decreased from 200.58 in 4th Qtr FY24 to 197.56 in 1st Qtr FY25. NNPH continues to look for more efficient ways to complete the workload and recruit new employees to fill vacancies.</p>	 <b>5.3.1.1.1 Implement strategies to address findings of FPHS assessment and work statewide to build the case for support for ongoing public health funding.</b>

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 5.3.2.1 Make progress on the health equity plan by completing 10 initiatives.</b>	2	3	There are three initiatives that are complete, with two initiatives underway. The completed initiatives include 1) annually reviewing Washoe County demographics and comparing to NNPH's workforce demographics, 2) annually reviewing the health equity assessment and plan for needed updates, and 3) adopting Washoe County's Language Access Plan. The initiatives that are currently underway include reviewing job descriptions to evaluate for systemic barriers and continuing to produce culturally relevant content with an accessibility lens.	
 <b>(PI) 5.3.3.1 Review at least 4 job descriptions to evaluate for systemic barriers to hiring a diverse workforce.</b>	1	1	One job description, the Environmental Health Specialist Trainee position, has been reviewed.	 <b>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)</b>
				 <b>5.3.3.1.2 Annually review how the demographics of the health district workforce compare to the demographics of the community NNPH serves. (HE Plan Goal 7, Initiative 3)</b>
				 <b>5.3.3.1.3 Create inclusive job descriptions that attract candidates.</b>
 <b>(VI) 5.3.3.2a # of existing staff who complete asynchronous cultural competency training.</b>		0		
 <b>(PI) 5.3.3.2 100% of new staff will take asynchronous cultural competency training as part of the onboarding process.</b>	100.00%	89.00%	89% of new staff completed the cultural competency training that is part of the onboarding process. There is one new staff member who did not yet complete the training. NNPH will monitor the completion rate at least once per quarter and follow up with outstanding staff members.	
 <b>(VI) 5.3.3.3a # of staff participating in district offered DEI/cultural competency professional development opportunities.</b>		0		 <b>5.3.3.3a.1 Expand district-wide opportunities for staff to participate in diversity, equity, inclusion, cultural competency, and/or health equity training.</b>
 <b>(VI) 5.3.3.4a # of language accessibility initiatives implemented from the language access plan.</b>		2		 <b>5.3.3.4a.1 Adopt and implement an organization-wide language access plan.</b>



Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 5.4.1.1 Develop and implement a plan to meet the office space needs of the Health District employees. (% of completion)</b>	10.00%	10.00%	As of September 30, 2024, Washoe County had not finalized the new design for Building C. This is the location for NNPH expansion. The design is expected in the next quarter.	 <b>5.4.1.1.1 Redesign floor plans to maximize the use of current space and implement changes.</b>  <b>5.4.1.1.2 Develop and implement plan for hybrid/remote work to address unmet space needs.</b>
 <b>(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)</b>	2	2	The Clinic design has been finalized and the permits have been submitted to the appropriate jurisdictions. Groundbreaking is on track for the end of the calendar year, and the project is within budget.	
 <b>(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)</b>	0%	16.00%	The AQMD continues to make improvements to self service platforms. In programs such as Dust and Asbestos, the AQMD has transitioned to nearly 100% online submittals. The Stationary Source and Wood-Burning Device programs continue to be a barrier to transitioning to 100% online submittals. With the Stationary Source program, Accela will continue to be a barrier due to the inability to be designated EPA CROMEER compliant.	 <b>5.5.1.1.1 Work with Technology Services and consultant to streamline Accela Customer Access submittal process.</b>
 <b>(PI) 5.5.1.2 Increase payments made via Accela to 50% of total EHS transactions (EHS)</b>	50.00%	51.20%	The bulk of all EHS transactions (67%) are for the Food Program. with 67% of Food Program transactions taking placing online. The next largest segment of transactions for this quarter is Pools and Septics (5% each). Currently, on track with the goal, but there is seasonality in EHS permitting that may impact the overall number in future quarters.	 <b>5.5.1.2.1 Transition vendors and promoters to (online only) Accela Citizen Access submittal process for Temporary Food Events by March 1, 2025 (90% submittal rate)</b>  <b>5.5.1.2.2 Obtain 80% ACA account creation for annual permit holders by July 1, 2025</b>
 <b>(PI) 5.5.2.1 % of new/renewed sources integrated into the software.</b>	100.00%	0%	The AQMD is on track to have the IMAPCT software live as of January 1, 2025.	 <b>5.5.2.1.1 Draft SOP for use of software by 12/31/2024.</b>
 <b>(VI) 5.5.3.1a # of all Health IT help desk tickets</b>		352		
 <b>(VI) 5.5.3.1b # of health desk tickets going through County TS</b>		54		
 <b>(PI) 5.5.3.1 Support new county ticketing system as appropriate</b>		0	The County Technology Services is still implementing this system. This activity will be completed when the new system is in place. Update from Technology Services as of 9/27/24 indicates that the project is 45% complete with an expected completion date of 11/29/24.	 <b>5.5.3.1.1 Track 100% of IT time by cost allocation.</b>  <b>5.5.3.1.2 Identify TS capacity dedicated to each division and identify workload capacity.</b>

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
				<ul style="list-style-type: none"> <li><span style="color: green;">●</span> 5.5.3.1.3 Track 100% of projects by category.</li> <li><span style="color: orange;">●</span> 5.5.3.1.4 Work with TS to revamp ticket categories based on type and then track going forward.</li> <li><span style="color: orange;">●</span> 5.5.3.1.5 Categorize help desk tickets to identify problem areas/projects where staff need support.</li> <li><span style="color: orange;">●</span> 5.5.3.1.6 Create training for staff based on challenging areas identified.</li> </ul>
<span style="color: black;">●</span> (VI) 6.1.1.1a Amount of expenditures.		\$ 8,135,473.00		
<span style="color: black;">●</span> (VI) 6.1.1.1b Amount of income.		\$ 8,995,704.00		<span style="color: orange;">●</span> 6.1.1.1b.1 Advocate for dedicated public health funding at the federal, state, and local level.
<span style="color: green;">●</span> (PI) 6.1.2.1 Maintain 100% compliance with purchasing and contract procedures.	100.00%	100.00%	Northern Nevada Public Health is currently 100% compliant with purchasing and contract procedures.	
<span style="color: green;">●</span> (PI) 6.1.2.2 Maintain 100% of grant compliance.	100.00%	100.00%	Northern Nevada Public Health is currently 100% compliant with grants.	
<span style="color: black;">●</span> (VI) 6.1.2.3a Amount of revenue generated by grants and relief funding		\$ 1,616,813.00		
<span style="color: black;">●</span> (VI) 6.1.2.3b # of grants received		53		
<span style="color: orange;">●</span> (PI) 6.1.3.1 % of costs recovered for clinic services through client and third-party payer payments.			CCHS revenue will be reported at the end of FY	
<span style="color: green;">●</span> (PI) 6.1.3.2 Maintain or increase access to services and revenue through billable services. (# of contracted insurance companies) (10 to 12)	10	12	The number of contracted insurance companies increased last year from 10 to 12. CCHS has been able to maintain the 12 contracts, which enables more clients to receive services.	<ul style="list-style-type: none"> <li><span style="color: green;">●</span> 6.1.3.2.1 Review error and rejection report daily to minimize inaccurate claim submission.</li> <li><span style="color: green;">●</span> 6.1.3.2.2 Submit clean claims to insurance companies the first time to eliminate costly appeals and ensure maximum reimbursement for services.</li> </ul>

Outcomes	Q1-25 Target	Q1-25 Actual	Analysis	Initiatives
 <b>(PI) 6.1.3.3 Maintain 100% cost recovery for AQM permitting and compliance programs.</b>	100.00%	100.00%	The AQMD is currently on track to recover 100% of all direct expenses for FY25.	 <b>6.1.3.3.1 Work with DDHO and AHS staff to assess current fee structure and develop new methodology.</b>  <b>6.1.3.3.2 Present new fee methodology to regulated community, stakeholders and DBOH.</b>
 <b>(PI) 6.1.3.4 Increase the percent of costs recovered through EHS fees.</b>	0%	0%	This metric is reported on an annual basis.	 <b>6.1.3.4.1 Meet with admin staff at least quarterly to monitor fee trends and improve admin functions</b>
 <b>(PI) 6.1.3.5 Maintain 100% cost recovery for vital records services.</b>	100.00%	100.00%	Vital Statistics is able to recover costs through fees collected from birth and death certificates sales.	
 <b>(PI) 6.1.4.1 Make progress toward maintaining an ending fund balance of 10-17%.</b>	0%	46.00%	Northern Nevada Public Health reduced the health fund balance by approximately \$2.8million in fiscal year 2024.	 <b>6.1.4.1.1 Provide monthly financial review to the Board.</b>