NNPH Quarterly Outcomes Report

FY26

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 1.1.1.1 Reach at least 2,000 residents with information about youth cannabis prevention and the impacts of secondhand cannabis smoke through communication efforts. (# of residents reached)	500	1,787	Staff disseminated 500 Need to Know (NTK) cards at five dispensaries (100 cards per location), along with an additional 50 cards to each of two head shops. In total, 600 Need to Know cards were distributed. Further, the five dispensaries were provided posters from the Nevada Division of Public and Behavioral Health on the impact of cannabis use during pregnancy for display in staff-only areas. A total of eight posters were distributed. Additionally, targeted messaging about cannabis secondhand smoke exposure was shared via social media platforms. Four published “Cannabis: Smoke is Smoke” posts received a total of 1,187 impressions.
(PI) 1.1.1.2 Maintain breastfeeding rates at 80% among WIC clients who report ever breastfeeding.	80.00%	82.00%	The breastfeeding rate for NNPH WIC clients reporting ever breastfeeding for the year ending September 30, 2025, was 82%. Last year, the ever BF rate ending September 30, 2024, was 80%. Staff professional development might contribute to this measure being on track. In July, NNPH WIC staff participated in a four-part training on motivational interviewing (MI) for breastfeeding (BF). MI has been linked with positive outcomes in patient-centered care, using empathetic listening, open-ended questions, and reflective listening. The results of MI in BF include empowering mothers, resolving BF ambivalence, increasing motivation and improving success with BF goals. In August, staff participated in the state Breastfeeding Coordinator's call where key BF information was shared, including BF resources offered through managed care organizations and acknowledging WIC team successes in BF.
(PI) 1.1.1.3 Increase multi-family housing properties that have smoke-free policies by at least 2.	0	1	Staff provided technical assistance to Sage by Vintage management, including reviewing policy language and sharing available resources. They have just opened the first of eight buildings, all of which will have a no-smoking/no-vaping policy in place. Once all 180 units are open, the policy will protect between 180 and 1,080 individuals.
(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)	1	2	In collaboration with the Nevada Cancer Coalition (NCC), staff conducted outreach at the Northern Nevada Pride celebration on September 6th in Reno’s Midtown District, engaging with over 150 attendees to share information about smoke-free workplaces and nicotine cessation resources. Staff also partnered with Northern Nevada Pride organizers to implement a smoke-free event policy for the second consecutive year, helping to protect approximately 15,000 attendees from secondhand smoke exposure. Finally, staff met with representatives from the Northern Nevada Chapter of the Alzheimer’s Association to discuss smoke-free workplace policies and promote the adoption of a smoke-free/vape-free policy for their upcoming Walk to End Alzheimer’s event on October 18th at Sparks Marina. Event organizers agreed to implement the policy and are now working with staff and NCC on event signage and distributing information to attendees about the importance of smoke-free environments where people live, work, and play.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 1.1.1.5 Reach at least 12 groups—including youth, parents, and service providers—with prevention messaging on e-cigarettes and other emerging tobacco products targeted at youth and young adults.	3	6	On September 10, staff delivered prevention messaging on e-cigarettes and emerging tobacco products to 13 healthcare professionals at the NNPH Family Planning Clinic. The following day, on September 11, staff engaged 26 medical providers at the Nevada Chapter of the National Hispanic Medical Association event, sharing Ask-Advise-Refer messaging and distributing cessation resources. Additionally, staff conducted outreach to three community organizations—Join Together Northern Nevada, Black Wall Street, and Safe Talk Teens—by providing educational materials focused on vaping prevention. To further support education efforts, staff published 17 Attracting Addiction Nevada social media posts aimed at informing parents about the role of flavored tobacco products in youth addiction. The posts were shared across five platforms, generating a total of 2,844 impressions.
(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	3	During National Falls Prevention Awareness Week (September 22–26, 2025), staff promoted the September 25 Balance Screening Event through social media and partner outreach. Additionally, senior falls prevention education was conducted at Washoe County Senior Services on September 9 and 16, reaching more than 40 seniors. Finally, the Stepping On (fall prevention workshop series) flyer was distributed through all senior service agencies and the Washoe County Meals on Wheels program, extending outreach to more than 350 seniors.
(VI) 1.2.1.1a # of WIC participants (quarterly average enrollment, annual average enrollment in Q4)		3,556	
(PI) 1.2.1.1 Maintain at least 95% of enrolled WIC participants as compared to last FY enrollment.	95.00%	105.25%	The quarterly average enrollment for Q1 was 3,556 participants. This is 5.25% higher than last FY. This increase was likely because the program is fully staffed with all staff fully trained in their positions. In addition, the program has intermittent hourly staff that help maintain participation rates by covering schedules when a full-time staff person is on leave.
(VI) 1.2.1.2a # of clients served in the immunization program (NNPH clinic and offsite events)		1,311	
(VI) 1.2.1.3a # of VFC compliance visits		0	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 1.2.1.3 Assure 50% of Vaccine for Children (VFC) providers receive a compliance visit yearly.	0%	0%	During the first quarter of each fiscal year, NNPH Immunization Staff and respective VFC provider availability is largely prioritized for seasonal disease prevention initiatives over compliance audits. For example, direct service clinic demand increases in July and August for Back-To- School vaccinations and events, and likewise in September- October for the influenza or other respiratory vaccination campaigns. It has been the preferred historical rhythm of both site visit reviewers and front-line vaccine provider coordinators (Medical Assistants, Nurses, Providers) to conduct compliance meetings during seasons of "less" appointment demand, which is largely Q2-Q4. In this respect, scheduling for six compliance visits (12% of 50%) were put in motion or confirmed for the Q2. Provider offices must participate in a compliance visit once every two years, and no providers were due/ overdue in Q1.
(VI) 1.2.1.4a # of clients served in the Family Planning and Sexual Health program		782	
(PI) 1.2.1.5 Implement 100 community/provider Sexual Health education and outreach activities.	25	26	During Q1, 26 educational and testing sessions were provided. Educational sessions included information on STD/HIV disease process, testing, treatment, and prevention interventions. Testing was provided weekly at the Washoe County Detention Center (jail) and Our Center, the LGBTQIA+ community center.
(VI) 1.2.2.1a # of reported HIV cases investigated		12	
(VI) 1.2.2.1b # of reported HIV cases		12	
(PI) 1.2.2.1 Initiate investigation of 90% of reported HIV cases within 5 days of report.	90.00%	100.00%	During the reporting period, 12 of 12 of the newly HIV case investigations were initiated within 5 days of report. These include new stage 3 (advanced HIV disease known as AIDS) cases that may be a completely new diagnosis or a known diagnosis that had progressed to advanced HIV disease. More cases that occurred during Q1 may be retroactively reported in Q2 due to the HIV-related disease reporting database becoming unavailable during the Nevada state cyberattack event that took place this quarter.
(PI) 1.2.2.2 90% of newly diagnosed HIV cases and identified out-of-care cases will be linked to HIV care	90.00%	83.33%	Of the six newly diagnosed and out-of-care cases reported during Q1 needing linkage to HIV care, five (83.33%) were linked to HIV care services. The case not linked to care was due to the client's preference. The client was provided referral information.
(VI) 1.2.2.3a # of primary, secondary syphilis cases investigated		16	
(PI) 1.2.2.3 % of primary, secondary syphilis cases initiated within 5 days.	90.00%	81.25%	During Q1, 13 of 16 (81%) primary and secondary syphilis case investigations were initiated within 5 days of report. These are the most infectious stages of syphilis. The drop in case initiation was due to staff adjusting to an expanded caseload with the program transitioning to Population Health division, as well as the loss of a disease investigator as a result of that transition. Improvements are expected as staff adjust their processes to the increased workload.
(VI) 1.2.2.4a # of maternal syphilis cases investigated		3	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 1.2.2.4 % of maternal syphilis cases initiated within 5 days	90.00%	100.00%	During Q1, three of three (100%) of pregnant syphilis case investigations were initiated within 5 days of report.
(VI) 1.2.2.5a # of other syphilis cases investigated (early latent, late latent/ unknown duration, biological false positives, old disease)		261	
(PI) 1.2.2.5 % of other syphilis cases initiated within 5 days	90.00%	80.84%	During the reporting period, 261 other syphilis cases were reported to NNPH. "Other" cases include early latent, late latent/ unknown duration stages, biological false positive, and results/reports of previous infection. All cases require a significant amount of investigative work to determine staging, old disease, and whether a result is a biological false positive. During Q1, 211 of 261 (81%) other syphilis case investigations were initiated within 5 days of report. The drop in case initiation was due to staff adjusting to an expanded caseload with the program transitioning to Population Health Division, as well as the loss of a disease investigator as a result of that transition. Improvements are expected as staff adjust their processes to the increased workload.
(VI) 1.2.2.6a # of congenital syphilis cases investigated		6	
(PI) 1.2.2.6 % of congenital syphilis cases initiated within 5 days	90.00%	100.00%	During Q1, six of six (100%) of congenital syphilis case investigations were initiated within 5 days of report. Cases are mostly initiated the day of report if it is a business day due to the need for appropriate testing and treatment to begin upon delivery.
(PI) 1.2.2.7 At least 90% of all syphilis cases will be closed within 60 days of being reported.	80.00%	63.74%	This performance measure was added in FY26 to assess the timeliness of closing cases. Following timelines established with the State of Nevada STD program, syphilis cases are to be closed within 60 days of report, with the exception of maternal (pregnant) and congenital syphilis cases. The timeframe accounts for the complexity of investigating syphilis cases and the treatment timeframes. Therefore, cases reported in July were to be closed by September. Deadlines for closing August and September cases occurs outside of Q1 reporting. During the reporting period, 58 of the 91 (64%) syphilis cases reported in July were closed within 60 days of report, except maternal (pregnant) and congenital cases. Staff are incorporating this new measure into their workflow, as well as adjusting to the increase of their caseload due to the transition of the program into the Population Health division and loss of a Public Health Nurse that was assigned to a disease investigation role. Improvements are expected to be made as staff adjust to their new workload.
(VI) 1.2.2.8a # of reported gonorrhea cases investigated		156	
(PI) 1.2.2.8 Initiate 90% of prioritized gonorrhea case investigations within 5 days of report.	90.00%	56.41%	During Q1, 88 of 156 (56%) of reported gonorrhea case investigations were initiated within 5 days of report. The drop in case initiation was due to staff adjusting to an expanded caseload with the program transitioning to Population Health division and the loss of a disease investigator as a result of that transition. Improvements are expected as staff adjust their processes to the increased workload.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 1.2.2.9 At least 90% of gonorrhea cases will be closed within 30 days of report.	80.00%	53.13%	During Q1, this performance measure was added to measure the timeliness of closing cases. Following timelines established with the state STD program, gonorrhea cases are to be closed within 30 days of report. The timeframe accounts for investigation and treatment. Therefore, cases reported in July and August were to be closed by September and are thus included in this reporting. During the reporting period, 34 of the 64 July and August (53%) gonorrhea cases were closed within 30 days of report. Timelines for closing September cases occur outside of Q1 reporting. Staff are incorporating this new measure into their workflow, as well as adjusting to the increase of their caseload due to the transition of the program into the Population Health division and loss of a Public Health Nurse that was assigned to a disease investigation role. Improvements are expected to be made as staff adjust to their new workload.
(VI) 1.2.2.10a # of chlamydia cases investigated		504	
(PI) 1.2.2.10 Investigate 90% of chlamydia cases within 5 days of report	90.00%	83.93%	During Q1, 423 of 504 (84%) of reported chlamydia case investigations were initiated within 5 days of report. The drop in case initiation was due to staff adjusting to an expanded caseload with the program transitioning to Population Health Division and the loss of a disease investigator as a result of that transition. Improvements are expected as staff adjust their processes to the increased workload.
(PI) 1.2.2.11 At least 90% of chlamydia cases will be closed within 30 days of report.	80.00%	87.00%	During Q1, this performance measure was added to measure the timeliness of closing case investigations. Following timelines established with the state STD program, chlamydia cases are to be closed within 30 days of report. The timeframe accounts for investigation and treatment. Therefore, cases reported in July and August were to be closed by September and are thus included in this reporting. During the reporting period, 252 of the 289 of July and August (87%) chlamydia cases were closed within 30 days of report. September case-closing measures are not included because the closing timeframe falls outside of the Q1 reporting time period. Staff are incorporating this new measure into their workflow, as well as adjusting to the increase of their caseload due to the transition of the program into the Population Health division and loss of a Public Health Nurse that was assigned to a disease investigation role. Improvements are expected to be made as staff adjust to their new workload.
(VI) 1.2.2.12a # of point-of-care tests completed (chlamydia, gonorrhea, HIV, syphilis)		822	
(VI) 1.2.2.12b # of walk-in clients to sexual health clinic		354	
(VI) 1.2.2.13a # of individuals suspected to have active tuberculosis disease and investigated		5	
(VI) 1.2.2.13b # of burden cases being treated for active TB		0	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 1.2.2.13c # of latent TB cases in the community		254	
(PI) 1.2.2.13 % of all individuals suspected to have active TB status confirmed within 1 business day via Nucleic Acid Amplification Test (NAAT)	100.00%	100.00%	One case was diagnosed with TB during the reporting period that was NAAT positive for the TB bacteria. This allowed treatment to begin more rapidly than if the clinic had to wait for cultures to grow for confirmation.
(PI) 1.2.2.14 For clients with active tuberculosis, increase the percentage that have sputum culture conversion within 60 days of treatment initiation.	83.00%	100.00%	One case culture converted prior to the sixty-day period. This was a case that had been diagnosed during FY25Q4.
(PI) 1.2.2.15 Initiate the index/source case interview and contact investigation for 100% of sputum smear positive tuberculosis cases within 14 days.	100.00%	100.00%	Six contacts were investigated for the case that was diagnosed during this period within 14 days. Contacts were tested using 2 blood tests for TB. These tests were conducted 8 weeks apart to ensure thorough clearance from the bacteria.
(VI) 1.2.2.16a # of reports requiring epidemiology follow up of foodborne, vector borne, vaccine preventable, disease of unusual occurrence (all reportable conditions requiring epidemiology investigation)		437	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 1.2.2.16 Investigate 90% of foodborne, vector borne, vaccine preventable, disease of unusual occurrence (all reportable conditions requiring Epi time) cases within their designated time frame.	90.00%	93.14%	During 07/01/2025 through 09/30/2025, there were 407 cases investigated within their designated timeframe out of 437 total number of investigated/documented cases. Some of the challenges faced include the lack of form builder and EMSA3 in EpiTrax, including daily errors (duplicates, false positives from eCRs, etc.) that need correction from the Nevada Office of State Epidemiology. The Epidemiology Program is unable to enter Case Report Forms (CRF) electronically, which leads to redundant and lengthy data entry. The program has consistently been limited in coverage, which leads to triaging of most-urgent cases based on risk to the public.
(VI) 1.2.3.1a # of community-based vaccine provision events		5	
(PI) 1.2.3.1 Improve vaccination rates among racial and ethnic minority groups (total # individuals identifying as Hispanic, Black/ African American, Asian, American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, multi-racial, or "unknown/declined to answer" race)	900	810	This is a new measure for FY26 that has not been previously reported on in the NNPH strategic plan. As such, baselines are currently being established. For the purposes of this metric, people of Hispanic ethnicity and/or non-White racial groups are counted. To not potentially over-report numbers for this measure, any client who declines to answer race/ethnicity questions is not counted toward this total.
(VI) 1.3.1.1a # of clients that see the Enrollment Assister annually		32	
(PI) 1.3.1.1 Maintain or increase the number of clients that see the Enrollment Assister annually.	16	32	The Medicaid assister was onsite 12.5 days during Q1 FY26. During this quarter, The State of Nevada Division of Welfare and Supportive Services office computers were down one day, during which the Medicaid assister did not work in person at NNPH. The assister was also out for half of a day at another time. Despite these obstacles, a total of 32 clients were seen during the quarter. This is up by approximately 10 clients from the last two quarters.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 1.3.2.1a - # of community outreach activities targeting health disparities conducted by community health educators (not reported under another item)		3	
(VI) 1.3.2.1b - # of PSE efforts engaged in by community health educator team		2	
(PI) 1.3.2.1 Increase the number of clients and community members provided assistance with navigation of community resources. (# provided assistance)	100	252	The Community Health Worker program provided resource navigation to 252 clients this quarter, exceeding the number of clients provided services in the previous quarter. The top five reasons for referral to resources were health insurance navigation, primary care provider resources, food insecurity, resources for clothing or household items, and oral health services. The elevated CHW caseload and nature of referrals indicate growing economic concerns in the community.
(PI) 1.3.2.2 Increase community reach through new partnerships and outreach activities (# of outreach activities)	10	13	During this quarter, the Community Health Workers (CHWs) conducted 13 outreach events. Thanks to a new partnership with Communities In Schools (CIS), they participated in three CIS-hosted events. CHWs also maintained their ongoing monthly collaborations with the Food Bank of Northern Nevada's Mobile Harvest program and the Eddy House. Additionally, they took part in a Baby Shower event held onsite at Northern Nevada Public Health (NNPH). The increase in outreach activities this quarter is largely attributed to back-to-school events. Staff remain proactive in identifying outreach opportunities and building community partnerships to connect vulnerable populations with CCHS services.
(PI) 1.3.3.1 Increase access to programs and services through completing 3 system improvements.	0	3	CCHS completed three system improvements to increase access to programs and services: 1. CCHS received State Opioid Response funding from the Nevada State Immunization Program to expand the number and type of vaccines available to uninsured and underinsured adults. This funding was also used to support mpox vaccination efforts for uninsured/underinsured adults in the Family Planning Sexual Health Clinic. 2. At the end of the fiscal year, the team responsible for conducting investigations for sexually transmitted infections transitioned to the Population Health division (PHD). During the transition, it was identified that maintaining communication between CCHS clinic staff and the now-PHD disease investigators was critical. To continue to facilitate access for those in need of testing and treatment, a Microsoft Teams chat was created to share information and ensure clients were able to access services in a timely manner. 3. The Community Health Workers, in collaboration with Silver Summitt Health Plan, hosted a community baby shower in July at NNPH. A variety of community organizations collaborated to offer resources and connect pregnant individuals with essential services during a single coordinated event.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 2.1.1.1 Meet or exceed a 75% data capture rate for ozone.	75.00%	98.70%	FY26 Q1 Data Completeness Reports will not be available until December 2025. In order to have data to report, AQMD staff ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 2025, 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. 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.
(PI) 2.1.1.2 Meet or exceed a 75% data capture rate for PM2.5.	75.00%	96.80%	FY26 Q1 Data Completeness Reports will not be available until December 2025. In order to have data to report, AQMD staff ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 2025, 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. 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.
(PI) 2.1.1.3 Meet or exceed a 75% data capture rate for PM10.	75.00%	96.00%	FY26 Q1 Data Completeness Reports will not be available until December 2025. In order to have data to report, AQMD staff ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 2025, 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. 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.
(PI) 2.1.1.4 Meet or exceed a 75% data capture rate for carbon monoxide.	75.00%	97.00%	FY26 Q1 Data Completeness Reports will not be available until December 2025. In order to have data to report, AQMD staff ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 2025, 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. 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.
(PI) 2.1.1.5 Meet or exceed a 75% data capture rate for nitrogen dioxide.	75.00%	98.00%	FY26 Q1 Data Completeness Reports will not be available until December 2025. In order to have data to report, AQMD staff ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 2025, 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. 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.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 2.1.1.6 Meet or exceed a 75% data capture rate for sulfur dioxide.	75.00%	95.00%	FY26 Q1 Data Completeness Reports will not be available until December 2025. In order to have data to report, AQMD staff ran EPA's AMP 430 Data Completeness Report for the April 1 to June 30, 2025, 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. 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.
(VI) 2.1.2.1a # of air quality plans and reports worked on during this period.		10	
(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)	0	9	Outreach opportunities completed by AQMD staff during the July 1 to September 30, 2025, reporting period include the below. Outreach efforts are intended to inform stakeholders and the general public about area air quality updates and best health practices. 1. Sierra Club Interview regarding data centers – Ben McMullen, July 8, 2025. 2. KOLO Interview regarding the DRI Heat and Smoke Project – Brendan Schnieder, July 14, 2025. 3. KOLO Interview regarding hazy skies – Ben McMullen, September 4, 2025. 4. KRNV Interview regarding hazy skies – Ben McMullen, September 4, 2025. 5. KRNV Interview regarding current AQ conditions and EPA budget cuts – Craig Petersen, September 8, 2025. 6. Huntsberger ES Meeting regarding AQ and sustainability curriculum – Ben McMullen, September 16, 2025. 7. 2015-2024 Washoe County, Nevada Air Quality Trends Report Presentation to Interagency Consultation Group – Ben McMullen, September 23, 2025. 8. AQM Strategic Plan Results Presentation to DBOH – Craig Petersen, September 25, 2025. 9. Asbestos NESHAP Renovation and Demolition Notification Requirements Workshop – Megan Rennie, September 25, 2025.
(VI) 2.1.2.2a # of community planning efforts where AQMD commented.		1	
(VI) 2.1.2.2b # of community planning efforts where AQMD participated as a technical advisor.		7	
(PI) 2.1.2.3 Complete all necessary reviews and any associated updates to air quality regulations.	0	0	AQMD has goals to review and update regulations based on priorities identified in quarterly rule development team meetings. During the July 1 – September 30, 2025 reporting period, AQMD worked on the following regulation reviews and revisions: 1. Part 040.030 – Dust Control 2. Part 040.033 – Food Establishments 3. Part 040.040 – Fires Set for Training Purposes
(VI) 2.1.2.3a Number of regulations reviewed		3	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 2.1.3.1a # of wood-burning devices inspections completed		29	
(PI) 2.1.3.1 % Notices of Exemption (NOE) managed within internal best practice standards (4 business days)	100.00%	100.00%	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. In Q1 of FY26, (2,138) of (2,138) NOE's were processed within the internal best practice standard timeframes. This equates to a success rate of 100%.
(VI) 2.1.3.1b # of wood-burning device registrations		2,236	
(PI) 2.1.3.2 % Certificates of Compliance (CoC) managed within internal best practice standards (10 business days)	100.00%	100.00%	The AQMD has an internal best practice standard timeframe of processing wood-burning device registrations. Certificates of Compliance (COC) are expected to be processed within (10) business days of receipt. In Q1 of FY26, (73) of (73) COC's were processed within the internal best practice standard timeframes. This equates to a success rate of 100%.
(PI) 2.1.3.3 % Dealers Affidavit of Sales (DAS) managed within internal best practice standards (10 business days)	100.00%	100.00%	The AQMD has an internal best practice standard timeframe of processing wood-burning device registrations. Dealers' Affidavit of Sale (DAS) are expected to be processed within (10) business days of receipt. In Q1 of FY26, (25) of (25) DAS's were processed within the internal best practice standard timeframes. This equates to a success rate of 100%.
(VI) 2.1.3.4a # of dust control permit inspections completed		129	
(VI) 2.1.3.4b # of dust control permits issued		47	
(VI) 2.1.3.4c Total acreage disturbed by dust permits		706	
(PI) 2.1.3.4 % of dust permits issued within internal best practice standards (10 business days)	100.00%	100.00%	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 FY26, (47) Dust Control Permits were processed; (47) of these were processed within the internal best practice standard timeframes. This equates to a success rate of 100%.
(VI) 2.1.3.5a # of asbestos renovation and demolition inspections completed		32	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 2.1.3.5b # of asbestos renovation and demolition notifications		28	
(VI) 2.1.3.5c Total square feet of asbestos materials		48,715	
(VI) 2.1.3.5d Total linear feet of asbestos materials		410	
(VI) 2.1.3.5e Total cubic feet of asbestos materials		0	
(PI) 2.1.3.5 % of asbestos NESHAP notifications processed within the 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 FY26, (28) NESHAP Notifications were processed; (28) of these were processed within the internal best practice standard timeframes. This equates to a success rate of 100%.
(PI) 2.1.3.6 % of acknowledgement asbestos assessment processed within internal best practice standard	100.00%	0%	The AQMD is working on a report to accurately reflect the data associated with this Performance Indicator. The information should be available by Q2 of FY26.
(VI) 2.1.3.7a # of complaint inspection/ investigations		51	
(VI) 2.1.3.7b # of warnings and notices of violations issued		9	
(PI) 2.1.3.7 % of required complaint inspections/ investigations responded to in accodrance with internal best practice standard (2 business days)	100.00%	100.00%	Of the (51) complaints filed with the AQMD in Q1 of FY26, (51) were responded to with an initial investigation within the internal best practice of 2 business days. This represents a success rate of 100%. On average, the AQMD Compliance Branch took 0.9 days to respond to an air quality complaint.
(VI) 2.1.3.8a # of stationary source inspections completed		125	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 2.1.3.8 Complete 100% of stationary source inspections assigned.	100.00%	100.00%	Of (125) Stationary Source inspections assigned in Q1 of FY26, (125) were completed, for a completion rate of 100%.
(VI) 2.1.3.9a # of stationary source permits to construct/permits to operate issued		12	
(PI) 2.1.3.9 100% of stationary source permits to construct issued within 180 days.	100.00%	75.00%	Of the (12) Stationary Source Permits to Construct (PTC) issued in Q1 of FY26, (9) Stationary Source PTCs were issued within 180 days. This represents a success rate of 75%. On average, the permits that exceeded the requirement were 80 days beyond the 180-day time limit. Some of the permits which exceeded 180 days, there were significant requests for clarification and correction of applications submitted. The Authority to Construct Permits consisted of new stationary sources and modifications to existing stationary sources.
(PI) 2.1.3.10 100% of stationary source permits to operate renewals issued within 180 days.	100.00%	0%	The Air Quality Management Division (AQMD) is the delegated air agency of Region 9 EPA for issuing permits to stationary sources of air contaminants in Washoe County. On January 1, 2025, revised Chapter 030 Source Permitting and Operation regulations were implemented, which changed the renewal period from an annual permit reissuance to a true 5-year renewal period. As part of this change, the AQMD Permitting Branch assigned new expiration dates to each active Stationary Source Permit to Operate to renew all Permits to Operate in the next 5 years. The AQMD Permitting Branch is anticipating completing approximately 80-100 true renewals annually because of this change. Based on the change to Chapter 030, the renewal of an existing Permit to Operate will require a complete application from a source between 270 and 180 days of expiration of an existing Permit to Operate. During this reporting period, the AQMD did not issue any renewed Permits to Operate to provide a success rate percentage.
(PI) 2.1.3.11 100% of stationary source permits PTC to PTO conversions issued within 180 days.	100.00%	0%	The Air Quality Management Division (AQMD) is the delegated air agency of Region 9 EPA for issuing permits to stationary sources of air contaminants in Washoe County. On January 1, 2025, revised Chapter 030 Source Permitting and Operation regulations were implemented, which changed the process of converting a Permit to Construct (PTC) to a Permit to Operate (PTO). After a PTC has been issued and a facility and its emissions units are constructed, the permittee is required to convert the PTC to a PTO through the submittal of an application. The AQMD started issuing PTCs in calendar year 2025 and has not had a request to convert the PTC to a PTO during this calendar year or reporting period. As stationary sources who have been issued a PTC complete construction and commissioning of their emissions units, applications to convert PTCs to PTO's will begin to be submitted to the AQMD.
(VI) 2.1.4.1a # of inspections completed at permitted waste management facilities per year.		77	
(VI) 2.1.4.1b # of waste management facility permits		327	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 2.1.4.1c # of waste-related complaints		71	
(PI) 2.1.4.1 Complete 100% of inspections at permitted waste management facilities per year.	25.00%	24.00%	For the first quarter of FY26, 77 routine inspections were completed, equating to 24% of all issued permits. This meets the general goal of 25% a quarter. However, inspections fluctuate by quarter based on expiration dates, and inspections are due once per calendar year versus fiscal year. For CY25, 90 inspections remain to be completed, or approximately 28%. All permitted waste management facilities will receive an inspection in CY25.
(PI) 2.1.4.2 Partner with a minimum of 3 outside agencies to assist in waste reduction/clean up initiatives.	0	1	Over the first quarter of FY26, the team began working with the Washoe County Managers office to help them through a variance process to allow a small-scale composting operation within city limits. The original intent of this goal - to put together a tire fund proposal program - is still in draft form and is expected to be finalized in FY26, once a new Senior Environmental Health Specialist is hired for this program. The implementation of that program will enable the group to meet its goal of 3 partnerships each year moving forward.
(VI) 2.1.5.1a # of first review plans reviewed for compliance with AQ regulations and processed (AQM)		183	(183) Plans were reviewed to determine compliance with AQMD regulations in Q1 of FY26.
(PI) 2.1.5.1 Ensure 90% of first review plans for compliance with AQ regulations meet jurisdictional timeframes. (AQM)	90.00%	99.45%	Of the (183) plans assigned for AQM review in Q1 of FY26, (182) met jurisdictional timeframes for a rate of 99%.
(VI) 2.1.5.2a # of residential septic and well plans reviewed and processed		187	
(PI) 2.1.5.2 Ensure 90% of residential septic and well plan reviews meet a 2-week turnaround	90.00%	99.00%	Of the 187 plans that the program took over the first quarters of FY26, 185 or 99%, met or exceeded the desired outcome of meeting the jurisdictional time frame for review.
(PI) 2.1.5.3 Conduct a minimum of 3 outreach events to inform interested stakeholders on residential septics and wells. (# of outreach events)	0	2	Two outreach events occurred in the 1st quarter of FY26. In July, staff attended the Warm Springs Citizen Advisory Board. The CAB was interested in the subdivision that recently received a variance for minimum acreage requirements and how that was expected to impact ground water. The team presented on the rationale behind the variance and how impacts from septic were not increased with the proposal. In September, the team also held a presentation for realtors, hosted at NNPH. Rather than going out to specific realtor offices, the program is transitioning to hosting them quarterly at NNPH. This will reduce staff time needed and hopefully reach a larger audience. Outreach events like these deepen NNPH's ties with the community and promote education on various public health topics.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 2.1.5.4a # of UST inspections		54	
(VI) 2.1.5.4b # of UST permits		210	
(PI) 2.1.5.4 Complete 100% of inspections at UST permitted facilities per year.	25.00%	26.00%	For the first quarter of FY26, 54 UST inspections were completed. This equates to 26% of total permits, which exceeds the quarter's target. Inspections are due once per calendar year, and each quarter can fluctuate. For CY 2025, 51 UST inspections, or 24% of total permits, remain to be inspected, indicating the team is on track to complete all inspections for the calendar year.
(PI) 2.2.1.1 Reduce the occurrence of foodborne illness risk factors (violations)	0.40	0.43	Last year, the program established a performance baseline for the average number of violations per inspection associated with the top three risk factors linked to foodborne illness. The baseline rate of occurrence is 0.42 violations per inspection, and the goal for FY26 is to see a reduction of approximately 0.02 violations per inspection each quarter. During this quarter, the rate of occurrence increased to 0.43 violations per inspection, with the following top three violation risk factors identified: • Cold holding • Date marking • Demonstration of knowledge Contributing factors may include: • A transition period as newly trained staff began conducting independent inspections for the first time • Increased accuracy in documentation following recent staff training and renewed focus on high-risk behaviors • Evolving risk factor trends, including a rise in “demonstration of knowledge” violations, which may indicate gaps in managerial control or staff awareness • Early phase of intervention efforts, with education and outreach initiatives still ramping up **Next Steps:** • Continue targeted operator education on cold holding, date marking, and demonstrations of knowledge • Reinforce inspector consistency through QA and supervisory field evaluations • Monitor risk factor trends quarterly and adjust strategies accordingly
(VI) 2.2.1.2a # of foodborne illness assessments.		1	
(VI) 2.2.1.2b # of inspections for food establishments (report as quarterly figure)		1,174	
(VI) 2.2.1.2c # of temporary food event inspections (report as quarterly figure)		597	
(VI) 2.2.1.2d # of permitted food establishments		4,031	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 2.2.1.2e # of complaints responded to (report as quarterly figure)		115	
(VI) 2.2.1.2f # of temporary food vendor permits (report as quarterly figure)		467	
(VI) 2.2.1.2g # of promoter permits issued		25	
(VI) 2.2.1.2h # of unpermitted vendor complaints received		0	The program has met with Washoe County Technology Services (TS) to identify enhancements to the existing EHS complaint module, including modifications that will allow more efficient categorization and reporting of unpermitted vendor complaints. In addition, the program is in discussions with a mobile app developer regarding the development of a tool to track both permitted and unpermitted mobile and sidewalk vendors. The proposed app will also include a public-facing complaint portal, which will improve accessibility and data collection related to unpermitted food vendor activities.
(VI) 2.2.1.2i # of unpermitted vendors required to cease operations		0	The program has met with Washoe County Technology Services (TS) to identify enhancements to the existing EHS complaint module, including modifications that will allow more efficient categorization and reporting of unpermitted vendor complaints. In addition, the program is in discussions with a mobile app developer regarding the development of a tool to track both permitted and unpermitted mobile and sidewalk vendors. The proposed app will also include a public-facing complaint portal, which will improve accessibility and data collection related to unpermitted food vendor activities.
(VI) 2.2.1.2j 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.)		1,223	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(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)	1	0	Although no additional components have been fully met this quarter, the program has made measurable progress toward conformance through the initial standardization of newly hired staff and re-standardization of existing staff in alignment with Standard 2 (Training Program). Additionally, the program implemented the field evaluation component of Standard 4 (Quality Assurance Program), which strengthens oversight and consistency in field inspections. This work establishes the groundwork for meeting specific elements of Standards 2 and 4 later in the fiscal year. As noted previously, these standards involve multi-quarter projects that require several stages of documentation, training, and verification before completion can be reported. **Status Summary:** • No new components fully completed this quarter. • Progress made toward Standards 2 and 4 through staff standardization and field evaluation implementation. • Standards 1, 3, 5, 7, and 9 remain complete. • Standards 2, 4, 6, and 8 continue to have outstanding elements. • FY26 goals remain focused on meeting Standard 2 elements 4a and 4b.
(PI) 2.2.1.3 Percentage of required annual inspections of food establishments completed.	25.00%	18.00%	Although the five newest EHS Trainees are now fully trained and conducting independent inspections, the program continues to operate below the staffing level needed to meet the required number of annual inspections. During this quarter, several staff were also reassigned to support the temporary food and special event program, which experienced a significant seasonal increase in workload. This diversion of resources further impacted routine inspection completion rates. As a result, 18% of the required annual inspections were completed this quarter, below the 25% quarterly target. To meet ongoing inspection demand and maintain compliance with annual inspection requirements, the program will likely need to add additional positions and focus on retaining current staff.
(VI) 2.2.1.4a % of passing inspections for routine food inspections (reported as quarterly figure)		85.00%	
(VI) 2.2.1.4b % of passing inspections for routine commercial facility inspections (reported as quarterly figure, not YTD) (includes childcares, schools, pools, invasive body decoration establishments, hotels/motels, RV parks, mobile home parks, and dump stations)		80.83%	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 2.2.1.4c Number of commercial facility inspections required this quarter		503	
(VI) 2.2.1.4d Number of commercial facility inspections completed this quarter		360	
(VI) 2.2.1.4e % of required annual inspections of non-food based permitted facilities completed		59.20%	
(VI) 2.2.1.5a # of total inspections of non-food based permitted facilities including other elements (re-inspections, etc.) (includes childcares, schools, pools, invasive body decoration establishments, hotels/motels, RV parks, mobile home parks, and dump stations) (reported as quarterly figure)		434	
(VI) 2.2.1.6a # of non-food permitted facility complaints		76	
(VI) 2.2.1.7a # of sanitary surveys of public water systems		11	
(VI) 2.2.1.7b # of public water system permits		77	
(VI) 2.2.1.7c % of sanitary surveys for year with a significant deficiency		2	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 2.2.1.7 Complete 100% of required sanitary surveys of public water systems to help ensure proper public health protection.	25.00%	33.00%	Through the first quarter of FY26, the team conducted 11 sanitary surveys - 7 public water systems and 4 water haulers. Of the 32 required surveys, this is 33%, exceeding the target of 25% per quarter. Surveys are due on a calendar year basis. For CY25, 20 of 26 surveys, or 77%, have been completed, exceeding the target of 75%. All required sanitary surveys for the year are expected to be completed on schedule.
(VI) 2.2.2.2a # of New Jersey daily trap counts that contain more than 10 mosquitos from May to October		24	
(VI) 2.2.2.3a # of mosquito pools submitted for testing.		565	
(VI) 2.2.2.3b # of vector-borne disease outreach efforts		0	
(VI) 2.2.2.4a # of mosquito pools positive for arbovirus (West Nile/St. Louis Encephalitis/ Western Equine virus).		0	
(VI) 2.2.3.1a # of commercial plans reviewed for health standards (Including food establishments)		463	
(PI) 2.2.3.1 Ensure 90% of first review for commercial plans meet a 2-week turnaround (reported as a quarterly figure)	90.00%	90.00%	90% of all commercial plans met the regional goal of review within 2-weeks. Of the 463 plans reviewed this quarter, 47 commercial plans did not meet this goal, often due to competing work priorities among staff conducting commercial plan review.
(VI) 2.2.3.2a # EHS development reviews conducted (Land Use/ Subdivision projects)		84	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 2.2.3.3a # of health reviews (e.g. Food, Pools, Schools, etc.) conducted for all commercial projects		626	
(PI) 2.3.3.3 Average days in review for all commercial projects (INITIAL SUBMITTALS) (reported as quarterly figure)	14.00	5.60	The total average number of days for review of all initial submittal projects is 5.6 days. This team has received approximately 25% less plan submittals for the past year than in previous years, so it has been easier to keep up with timely plan reviews and keep these numbers in check.
(PI) 2.3.3.4 Average days in review for all commercial projects (REVISIONS) (reported as quarterly figure)	7.00	5.80	The total average number of days for review for all revisions is 5.8 days. This team has received approximately 25% less plan submittals for the past year than in previous years, so it has been easier to keep up with timely plan reviews and keep these numbers in check.
(VI) 3.1.1.1a # total social media posts in English and Spanish		282	
(VI) 3.1.1.1b # of culturally relevant social media posts		82	
(VI) 3.1.1.1c # of social media followers		13,766	
(VI) 3.1.1.1d # of web hits		110,251	
(VI) 3.1.1.1e # of impressions across all social media posts (comments, shares, link, clicks, etc.)		91,216	
(PI) 3.1.1.2 Increase audience growth across all platforms by 10%. (followers)	2.50%	1.60%	Audience (followers) increased by 1.6%, which is below the quarterly expectation of 2.5%. NNPH is seeing some downward trends in Facebook and Instagram engagement, which is also being seen nationwide in the broader social media landscape as a result of more people shifting to private messaging platforms. Staff are working to create more videos to drive engagement and increase followers.
(PI) 3.1.1.3 Increase Spanish language Facebook followers by 5%	1,358	1,341	The number of followers remained flat from last quarter/FY, with both new followers and "unfollows" balancing each other out to account for this. This trajectory is in line with national trends, with a combination of fewer people using social media and Meta deactivating inactive accounts, thus losing followers. NNPH will continue focusing on how to make ever-more entertaining and informative content to promote increased engagement.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 3.1.2.1 Collaborate with at least 2 programs to execute marketing tactics that reach populations experiencing health disparities	0	2	NNPH worked with two programs, Inner Tribal Council of Nevada (ITCN) and Kindred Health. • For ITCN, staff helped create meaningful and engaging social media content to help increase clients. Their social media platforms have been struggling, so NNPH assisted in creating video reels and other content to drive engagement up. • For Kindred Health, NNPH staff created two reels as part of a partnership to help community members increase physical health with free workouts to people in the Hispanic community who might be more open to non-traditional workouts.
(VI) 3.1.2.3a # of public records request fulfilled (ODHO)		0	
(VI) 3.1.2.3b # of public records request fulfilled (AQM)		26	
(VI) 3.1.2.3c # of public records request fulfilled (CCHS)		1	
(VI) 3.1.2.3d # of public records request fulfilled (PHD)		12	
(VI) 3.1.2.3e # of public records request fulfilled (EHS)		571	
(VI) 3.1.2.4a # of press releases, media alerts, media availability.		14	
(VI) 3.1.2.5a # of community presentations (ODHO)		2	
(VI) 3.1.2.5b # of community presentations (CCHS)		2	
(VI) 3.1.2.5c # of community presentations (PHD)		10	
(VI) 3.1.2.5d # of community presentations (EHS)		9	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 3.2.1.1a # of vital records requests and services		13,728	
(PI) 3.2.1.1 Process 90% of vital records requests and services within 96 hours.	90.00%	100.00%	Vitals processes Death and Birth records as soon as they come into the queue to register. This makes the records available for printing once clients place an order. This allows Vitals to consistently complete 100% of all requests within 96 hours.
(VI) 3.2.2.1a # of reports (Communicable Disease Annual; CPO Quarterly; Respiratory Weekly; Epi News) provided to the community		14	
(PI) 3.2.2.1 Publish 100% weekly updates to the respiratory dashboard during the respiratory season	100.00%	100.00%	The respiratory dashboard was continued during the off-season to release COVID-19 updates to the public. Additional follow-up as needed was performed on RSV and influenza data to clean up (quality assurance) and freeze data in preparation for a new cycle. Staff also published the new Power BI dashboard summarizing the previous respiratory season (2024-2025) summary of findings, which is available here: https://app.powerbigov.us/view?r=eyJrIjoiZDFjNTVmMzItYmJjYy00ZTUyLWJmMWYtYTFiMTNlMDk5M2JkIiwidCI6ImEyYTIxYjYwLTU2MjUtNDNmZS1hNTVhLTUyZjVlMTExZDcxYyJ9&pageName=9c4432405ec441185c91.
(VI) 3.2.3.1a # of statistical analysis requests met.		9	
(PI) 3.2.3.1 Deliver on 95% of requests for statistical analysis. (# of requests)	95.00%	100.00%	PHD receives internal statistical analysis requests from fellow NNPH divisions as well as external requests from EMS community partners requesting statistical support. Staff keep a log to ensure all requests are completed. This quarter, most internal requests came from CCHS, and most external requests were from EMS agencies. Staff are well organized and do an excellent job tracking and keeping up with these statistical analysis requests. To date, all requests have been completed and delivered.
(VI) 3.3.1.1a # of interim committee meetings, public workshops, and coalition meetings attended/monitored.		20	
(PI) 3.3.1.1 Pursue and achieve 2 local government health in all policies initiatives.	0	0	NNPH continues to look for opportunities to collaborate with community partners to ensure the public health needs of the community are being addressed. Given current political uncertainties at the federal level, it is imperative that NNPH collaborate with outside partners to promote and protect public health goals. The public health field is dealing with many changes and uncertainties happening at the federal level, and it makes policy work all the more difficult due to the daily changes in directives. NNPH continues to advocate for sustained funding and laws/directives that protect and promote public health.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 3.3.1.2 Explore sustainable funding for public health by attending State working group at least quarterly.	1	1	Several meetings have taken place with other health districts and the State since the end of the 2025 legislative session. Nothing formal has taken place to discuss the 2027 sustainable funding ask. To date, much of the time between June 2025 and the end of Q1 FY26 has been spent summarizing wins and losses from the 2025 legislative session.
(PI) 4.1.1.1 Residents have access to multiple elements of a best practice crisis response system.	1	1	• Washoe County completed one year of operations of the Children's Mobile Crisis Response Team (CMCRT). The program was transferred from the State to the County in July 2024. In its first year of operations, the CMCRT received 985 calls through the hotline, resulting in 257 responses with 72 stabilizations recommended. Of those responses, only 13 resulted in hospitalization while 244 were diverted from the emergency room. • Carelon Behavioral Health kicked off their role as the statewide Management Services Organization for the Crisis Services Hub, finalizing a 4-year contract with the State.
(PI) 4.1.2.1 Implement at least one lethal means reduction strategy in coordination with the Washoe Suicide Prevention Alliance.	0	1	With support from Renown grant funding, NNPH launched a local suicide prevention media campaign in partnership with Spectrum-Reach. The campaign featured Washoe Suicide Prevention Alliance (WSPA) secure storage video ads, custom banners, and digital outreach driving traffic to the WSPA website and Temporary Secure Storage network. In September alone, the campaign generated more than 15,000 online video impressions, 31,000 streaming TV impressions, and nearly 142,000 online display impressions, resulting in 92 visits to the WSPA website. The videos also aired on television over 1,000 times.
(PI) 4.2.1.1 Increase the number of corner stores engaged in offering healthy food with the addition of 1 new store.	0	0	The Healthy Corner Store Program maintained five participating stores this quarter, with no new stores onboarded. Progress was made in strengthening existing partnerships, particularly by expanding access to fresh produce. Three stores - Vassar Market, Go Mart, and 7-Eleven on Sutro - now offer fresh fruits and vegetables, with Go Mart and 7-Eleven introducing produce for the first time. Seasonal crops, supplied by Reno Food Systems, included tomatoes, garlic, squash, cucumbers, peppers, and tomatillos, furthering access to locally grown food. These efforts demonstrate ongoing momentum in sustaining healthy food availability within engaged stores and highlight the growing commitment of store owners to support community health.
(PI) 4.2.1.2 Expand the number of sites that are implementing the 5210 Healthy Washoe program from 5 to 7 elementary schools.	7	7	Donner Springs is completing their school assessment to determine 5210 implementation strategies for school year 2025-2026. With the addition of this school, the total number of schools participating in 5210 is up to seven.
(PI) 4.2.1.3 Increase the number of partners implementing 5210 Healthy Washoe into other sectors of the community by adding three new sites	0	1	One new school is working with the team to implement 5210. The school is completing the environmental assessment to determine healthier eating and active living practices for implementation.
(VI) 4.3.1.1a # of FHF attendees (total individual members)		1,493	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 4.3.1.1 At least 80% of FHF participants will receive the services needed.	80.00%	81.25%	The Family Health Festival committee held one event during this quarter at Hug High School in July 2025. This was the largest in-person event the committee has ever hosted in the approximately 10 years that FHF has been operating. Of the 400 households served, 81.25% stated in their end-of-event survey that they had received all the services they needed and had zero negative feedback. Of the remaining ~18%, most people's dissatisfaction stemmed exclusively from how the free school supplies had run out before they got into the venue. The FHF committee will continue soliciting donations and researching supply sources for raffle prizes and giveaways at these events to try and fulfill the requests of the ever-growing number of attendees.
(PI) 4.3.1.2 Implement at least three initiatives designed to improve access to care.	0	2	1. NNPH continues to lead the Family Health Festival Committee to provide the community with a hub of health services quarterly. 2. Aca Entre Nos is a targeted mental health initiative that is collectively implemented by NNPH, Quest, and Renown to provide listening and discussion sessions with Spanish-speaking families about mental wellness to support their loved ones. 3. Renown and NNPH are exploring strategies to provide expecting mothers with resources to care.
(PI) 4.5.1.1 Create a continuous quality improvement (CQI) process for pre-hospital treatment/ patient outcomes.	0	0	The process to create a continuous quality improvement (CQI) process for pre-hospital treatment/patient outcomes has not started. The EMS Oversight Program is currently awaiting approval from leadership and the community to proceed with restructuring the Emergency Medical Services Advisory Board (EMSAB), which will involve updates to the Interlocal Agreement (ILA) and revisions to the program's bylaws.
(PI) 4.6.1.1 Produce and analyze the 2026-2028 CHA.	0	0	The 2026-2028 Community Health Assessment is in progress. There have been four meetings with the Steering Committee as follows: • Kick-off meeting and introductions/processes • Two meetings related to secondary data indicators and primary data indicator review • Summary of final selection of primary data indicators with updates on qualitative data collection and upcoming surveys. The key informant interviews are underway, and the focus groups are completed. The community survey and agency survey have been reviewed several times for content to match gaps identified by the Steering Committee about missing indicators (not covered by secondary data sources), and it is set for release and promotion on October 10.
(VI) 4.6.2.1a # of collaborative initiatives in the CHIP		33	
(PI) 4.6.2.1 Complete at least 60% of activities planned in the CHIP.	0%	0%	The CHIP Annual Report will be available Spring 2026
(PI) 4.6.2.2 Maintain the number of organizations leading CHIP initiatives	32	37	Partners continue to stay engaged in CHIP efforts. There are no significant changes to implementation efforts, and it's important to note that partners are beginning to collect data about projects.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 4.6.2.3 Implement at least 2 CHIP initiatives focused on policy changes that alleviate causes of health inequities.	0	0	Efforts are underway that are potential opportunities for policy implementation. These include working with 5210 schools to update their site policies, thereby uplifting healthier eating, practices, and environments. More will be known once the school's environmental assessment has concluded. In addition, many activities are in progress to continue building the Crisis Response System. Small "p" activities like developing protocols and practices that assure a warm hand-off between agencies could be explored further.
(PI) 4.6.2.4 Address at least 3 key gaps to improve health outcomes by engaging partners that represent underserved communities to drive targeted improvements.	0	3	This quarter, WIC ITCN launched the Fresh Connect program for WIC clients to receive fresh produce at local farmers markets. This program was also promoted through social media, which included how to use vouchers and included culturally appropriate recipes that used items from the farmer's market. To address financial wellness, a class was held in collaboration with Hello Real Estate at the Women and Children's Center of the Sierra (WACCS) with 4 attendees present. The topic of focus was life insurance, a theme that was requested by WACCS clients in the past. Lastly, for the Aca Entre Nos English/Spanish mental health initiative, the project team has been coordinating two upcoming sessions for Q2.
(PI) 4.6.2.5 Maintain the number of individuals who provide input to the CHIP. (# of people at Steering Committee, subcommittee meetings, and plannings meetings)	350	363	This item will remain the same until the community is solicited to participate in the Community Forum to determine the next set of CHIP focus areas. The event will be in the Winter of 2026.
(PI) 4.6.2.6 Recruit at least 10 community representatives to establish 1 cross-sector health coalition. (# of committee members)	0	27	The 26-29 CHA Committee was formed to begin working on the Washoe County CHA/CHIP. Members include representation from Renown Health, the University of Nevada Reno, NNPH Maternal and Child Health and Air Quality, Guinn Center, UNR School of Medicine and Office of Statewide Initiatives, Washoe County Commission, Community Health Alliance, WCSO, WC Office of the County Manager, UNR Latino Research Center, UNR School of Public Health, Bethel AME Church, Anthem, Silver Summit, Molina, Community Foundation of Western Nevada, and United Way.
(PI) 4.6.3.1 Identify at least three initiatives or projects across divisions that collaborate with the Health Impact Team and/or community-based partners to address health disparities.	0	1	The Supplemental Environmental Project (SEP) program has been launched as a strategic initiative to align enforcement with community health outcomes. The program enables funds from assessed violations of Air Quality Management regulations to support community-benefiting projects, rather than being limited to fine payments. Violators may submit project proposals that aim to improve public health, reduce air pollution, enhance regulatory compliance, conserve energy, and increase public awareness of air quality issues. This initiative demonstrates a proactive approach to integrating environmental enforcement with health equity goals.
(PI) 4.6.3.2 90% of priority contacts in Salesforce will have updated communication records by the end of each quarter.	90.00%	0%	This quarter, the Health Impact Team focused on strengthening their understanding of Salesforce reporting capabilities to support future data tracking. Due to competing high-priority projects, the review and updating of priority contact communication records has not yet started. This work is planned for upcoming quarters.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 4.7.1.1 Complete 50% of the after-action items identified as NNPH's responsibility.	0%	10.00%	During FY26, Northern Nevada Public Health (NNPH) will focus on completing after-action items identified from the Continuity of Operations Plan (COOP) Exercise conducted in May 2025. NNPH leadership convened once this quarter to review progress on identified improvement items and to determine next steps to strengthen the agency's COOP. Several action items are in progress, with continued efforts planned in upcoming quarters to ensure completion of 50% of assigned improvements by the end of the fiscal year.
(PI) 4.7.1.2 Obtain Project Public Health Ready recognition	10.00%	5.00%	The Public Health Preparedness Program continues to work toward achieving Project Public Health Ready (PPHR) recognition. While initial progress was delayed, the program has completed a detailed review of current documentation and conducted a gap analysis to identify areas requiring alignment with PPHR criteria. Efforts are now focused on systematically updating and enhancing preparedness plans, policies, and procedures to meet national standards. This work is being integrated into ongoing program activities and will continue throughout the fiscal year. The program remains committed to achieving PPHR recognition as a key milestone in strengthening regional public health emergency preparedness and demonstrating compliance with national benchmarks.
(PI) 4.7.2.1 Complete 75% of planned activities identified by the IHCC.	0%	15.00%	Across planning, training, and coordination efforts, Inter-Hospital Coordinating Council (IHCC) activities are on track to reach 75% completion by the end of the fiscal year. Structured review schedules, planned exercises, cross-sector collaboration, and system enhancements reflect sustained forward momentum and measurable progress in strengthening coalition preparedness and response capabilities.
(PI) 4.8.1.1 Initiate at least one new project collaboration with UNR per year. (# project collaborations)	0	1	In the fall semester of 2025, the new student-shadowing program was stood up between UNR School of Public Health and NNPH to support student learning opportunities in a real-work practice setting. EHS and AQM divisions have both provided opportunities and available slots for shadowing in terms of monitoring, permitting, and the active managerial control program. UNR is coordinating student sign-ups currently.
(PI) 4.8.1.2 Ensure standardized, recurring internship opportunities. (# of recurring internship opportunities) (maintain minimum of 3 per year)	0	3	Current recurring internships include: 1. Epidemiology - a current graduate assistant from UNR is onboarded to support various projects. 2. Statistics and EMS- this recurring internship is again taking place in the Informatics and Statistics program. A UNR graduate assistant is currently onboarded to support work in trauma data and analysis. 3. Statistics and CDIP - This is a new recurring opportunity being stood up this year to support work on the CDIP dashboard. Currently, a graduate assistant from UNR is onboarded to build the chronic disease dashboard and perform data analytics work.
(VI) 5.1.1.1a # of retirements.		2	
(VI) 5.1.1.1b # of non-retirements, promotion or transfer departures		13	
(VI) 5.1.1.1c # of promotions/ transfers.		3	
(VI) 5.1.1.1d # of vacancies in AHS (average vacancies FYTD)		0.00	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(VI) 5.1.1.1e # of vacancies in AQM (average vacancies FYTD)		1.00	
(VI) 5.1.1.1f # of vacancies in CCHS (average vacancies FYTD)		7.80	
(VI) 5.1.1.1g # of vacancies in EHS (average vacancies FYTD)		4.98	
(VI) 5.1.1.1h # of vacancies in ODHO (average vacancies FYTD)		2.50	
(VI) 5.1.1.1i # of vacancies in PHD (average vacancies FYTD)		7.00	
(VI) 5.1.1.1j % of retention (minus retirement and non-County promotions of FTEs and PTs)		89.00%	
(PI) 5.1.1.1 Maintain 5% or less employee vacancy rate (vacancy rate= average monthly vacancy rate including all employees).	5.00%	12.17%	Total Vacant FTEs for July 2025 (beginning of Q1 FY26) were 19.88 FTE, August was 21.08 FTE, and beginning of September 2025 (end of Q1 FY26) is at 23.38 FTE. This netted a monthly average of 21.45 Vacant FTE's. The 1st Quarter vacant position percentage came in at ~12.17%. Due to reduced grant funding and the current state of both the County and NNPH budget, NNPH had to let 5 intermittent hourly RNs go and is unable to refill most of the positions which have become vacant. This measure is likely to remain off track unless the budgetary situation changes.
(PI) 5.1.1.2 Increase mandatory training completion rate from 96% to 98%.	98.00%	98.79%	The mandatory training completion rate increased from 98.32% during the 4th quarter of FY25 to 98.79% in the 1st Qtr of FY26. NNPH staff exceeded the goal of 98% completion rate for training. NNPH HR will continue to encourage staff to complete their mandatory trainings in a timely manner. The completion rate does not include the mandatory Title VI training, which was supposed to be completed in FY25. Thus, it has been removed from NNPH tracking. County HR Training does not have an estimated date for the training to come online at this time. NNPH has also removed the Diversity training from this list, as County HR has removed that course from the mandatory training list.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 5.1.1.3 Increase probationary/annual evaluation completion rate from 80% to 85%.	85.00%	79.18%	At the end of FY26 1st quarter, the completion rate for performance evaluations sits at 79.18%. One division exceeded the 90% completion rate (91.18%), one division came in at 88.64%, one came in at 87.50%, two divisions are in the 70% range (77.78% and 75%), and one division is at a 55% completion rate. All divisions had multiple evaluations come due in August due to Korn Ferry reclassing multiple position on 8/14/2023. The lowest rated division has some evaluations more than 2 years past due. The NNPH HR rep continues to provide monthly or bi-monthly employee evaluation reports to all supervisors. All divisions are encouraged to get their evaluations up to date and to increase the overall probationary and annual evaluation completion rate. Supervisors are reminded what performance evaluations are due and encouraged to complete their staff's evaluations on time. Workload and other competing obligations can cause delays.
(PI) 5.1.1.4 Increase percentage of employees who recommend NNPH as a good place to work from 76% to 78%.	0%	0%	This initiative takes place on a calendar year basis, and the survey is conducted annually in the Spring. In Spring 2025, 80% of employees recommended the organization as a good place to work.
(PI) 5.1.1.5 Increase internal newsletter distribution to bi-weekly for FY26	6	3	Due to budget constraints and the resultant inability to rehire for the Media and Communications Support Specialist position that has been vacant since January, NNPH could not do bi-weekly newsletters and is instead publishing them monthly.
(PI) 5.1.1.6 Implement at least 25% of the FY25-FY27 Workforce Development Plan and strategies	0%	25.00%	Onboarding continues to be provided to new staff as they are hired. The second professional development training for staff is being planned for all staff Oct 15th and 16th. The Supervisor toolkit continues to be updated as more information is requested, such as clarity on hiring interns. Mindfulness trainings and other such related opportunities are also promoted via the Health District intranet or email when they become available. Finally, coaching and mentoring discussions are happening with leadership to deepen the team's understanding and use of best practices to support staff.
(VI) 5.1.2.1a # of staff participating in district-wide professional development opportunities.		0	
(PI) 5.1.2.1 At least 50% of employees will report feeling proficient on targeted core competencies.	0%	0%	The next pre-post evaluation will be conducted for the all-staff training taking place in October.
(PI) 5.1.2.2 % of staff reporting confidence in using data for decision making	0%	0%	Discussions about strategies to track and measure this goal are underway.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 5.1.3.1 Increase the number of mental health resources provided to staff in the workplace from 2 to 3.	0	0	Suggested resources from FY25 continue to be promoted. New information will be shared with staff as it becomes available.
(PI) 5.2.1.1 Meet 100% of requirements to maintain accreditation.	0%	100.00%	NNPH was accredited in August 2025. Staff from various levels of the organization participated in the site visit, providing valuable insights into NNPH's practices and procedures related to the Foundational Public Health Services. Following the site visit, the final report and application materials were submitted and included on the agenda for PHAB's August Board meeting for review and determination of accreditation status. The PHAB site visit team highlighted several notable strengths and opportunities for further growth of the organization, including: Strengths: • Supportive Work Environment: NNPH prioritizes employee satisfaction, professional growth, and continuous learning. Thoughtful policies, staff engagement, and opportunities to build expertise demonstrate commitment to a positive workplace culture. • Commitment to Equity: NNPH ensures Spanish-speaking residents and disproportionately impacted communities can access critical information and services. The establishment of the Health Impact Team strengthens partnerships and fosters inclusive collaboration. • Data-Driven Culture: NNPH intentionally gathers and uses data to guide decisions, track progress, and drive quality improvement. Staff demonstrated strong knowledge of how data informs program design and evaluation. Opportunities for Growth: Community Engagement: NNPH can strengthen its ability to address community needs by moving beyond feedback collection toward more direct collaboration and co-creation with partners and residents. • Consistent Objectives: Adopt a standardized format (e.g., SMART or SMARTIE) across all plans and programs to improve cohesion, strengthen monitoring and tracking, and ensure initiatives remain accessible and responsive to community needs. • Use of the Community Health Assessment (CHA): NNPH can further increase the use of CHA data across all divisions to better measure health outcomes and to strengthen its position as a trusted public health leader. Leveraging national and regional indicators will help demonstrate impact and inform strategies that improve community health.
(VI) 5.2.1.2a Number of employee-submitted ideas for improvement		1	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 5.2.1.2 Implement at least three QI projects in the current fiscal year	0	2	There are two ongoing QI projects to report progress on for Q1 FY26: • Work continues on the employee onboarding program revamp, with the "Introduction to Health" video still in the editing and post-production phase. The ongoing staff shortages in the Comms section of ODHO means that only one staff member has been available to work on this project amidst other competing priorities. All footage and interviews have been recorded, but final editing and production remains to be done. • Work also continues on the QI project AQMD launched in Q3 FY25. The AQMD team has been developing an automated process with the goal of getting 100% annual permit maintenance fees paid within 45 days of invoicing. This new process will decrease the amount of staff time and resources AQM currently spends working on the invoice process. Throughout the course of last year, AQM collected on average approximately 87% of stationary source permit maintenance fees within the 45-day target range. The division aims for a 100% rate stemming from the improved data collection, data management, and general automation this QI effort will bring. Based on 8 months of data for 2025, AQM has collected 95.03% of annual permit maintenance fees within the 45-day target range. This is having a positive effect on both AQM revenues and stationary source permit holders, given how more permit holders are paying their fees on time. In 2024, an average of 11-12 permitted sources received a late fee per month compared to an average of 3-4 permitted sources that have received a late fee per month in 2025. The AQMD is looking to complete this project January 2026.
(PI) 5.2.1.3 % of strategic decisions supported by data (key initiatives or decisions that include referenced data sources)	50.00%	50.00%	Data informing key decisions is being supported by leadership. A better tracking mechanism is being considered to consistently monitor this effort.
(VI) 5.3.1.1a # of filled positions (FT and PT employees)		165	
(VI) 5.3.1.1b # of FTE		187	
(VI) 5.3.1.1c # of internship opportunities at NNPH		7	
(PI) 5.3.1.1 Increase investment in personnel where workforce capacity is a barrier to productivity. (% increase in FTE)	228	197	Budget constraints at all levels (local, state, and federal) have impacted NNPH with reductions in funding from multiple subawards. Budget concerns at the County level have resulted in many currently unfilled positions being temporarily frozen. Leadership continues to work with both the State and County on budget issues and long-term budget planning. NNPH continues to look for efficient ways to complete the workload with limited staff. Total authorized FTEs have decreased from 198.18 in July to 196.89 in September. Many of the vacant, authorized positions are frozen until additional funding can be secured. NNPH has not lost positions or budget authority permanently - these positions are being held vacant due to the ongoing budget constraints.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 5.3.2.1 Demonstrate progress on the BARHII assessment results through the completion of at least 80% of deliverables aligned with identified priorities.	20.00%	0%	In Q1, the primary focus was the completion of the BARHII assessment, which has been successfully finalized. The collected data is currently undergoing analysis and will be compiled into a final report. Following the completion of data analysis, an action plan will be developed and integrated into the report. Once the action plan is in place, NNPH will begin implementing steps to advance progress on the deliverables aligned with the identified priorities.
(PI) 5.3.3.1 Review at least two job descriptions to evaluate for systemic barriers to hiring a diverse workforce.	0	0	Due to an ongoing hiring freeze, NNPH is not actively recruiting for most positions. As a result, there have been no opportunities this quarter to review or revise targeted job descriptions.
(PI) 5.3.3.2 Host two watch parties to engage existing staff in ongoing cultural competency training.	0	0	An all-staff training session is planned for Q2, with additional cultural competency efforts in Q3 through facilitated watch parties designed to promote continued staff engagement and learning.
(PI) 5.3.3.3 100% of new staff will take asynchronous cultural competency training as part of the onboarding process (staff who completed CC course FYTD/staff who was due to complete course FYTD)	100.00%	29.00%	The Q1 percentage reflects carryover from FY25. By the end of Q4 FY25, seven staff members were still expected to have completed cultural competency training as part of their onboarding process. To date, only two of the seven have completed the training. Given the ongoing nature of this goal, it does not expire but continues to roll over each quarter until all designated staff have completed the requirement.
(VI) 5.3.3.3a # of staff participating in district-wide SDOH and data training opportunities.		0	A training will be held in Q2.
(VI) 5.3.3.4a # of language accessibility initiatives implemented from the language access plan.		1	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 5.3.3.4 At least one internal policy or procedure that reduces health disparities is revised/created and implemented	0	0	NNPH plans to implement a community advisory group in Q3. The community advisory groups will provide a structured and inclusive way to engage residents, especially those from historically underserved populations, in public health decision-making. By centering community voices in the planning, implementation, and evaluation of programs and policies, the advisory group will help ensure that services are culturally relevant, accessible, and responsive to local needs. This approach will contribute to the reduction of health disparities.
(PI) 5.3.3.5 Complete one BARHII assessment to identify key areas for improvement in addressing health disparities, guiding the development of targeted interventions.	0	1	The BARHII Organizational Self-Assessment has been completed, drawing on a comprehensive range of inputs, including a staff survey, partner survey, staff focus groups, management interviews, and an HR worksheet. The collected data are currently being analyzed, with a final report expected in the coming quarters. Preliminary results highlight five key focus areas: advancing workforce diversity and representation; promoting inclusive recruitment and selection practices; strengthening organizational commitment to addressing health disparities; enhancing workforce development and capacity building; and improving data-driven planning and resource allocation.
(PI) 5.4.2.1 Ensure completion of new TB and expanded office space building by April 1, 2026	0	1	Construction of the TB clinic is on time and on budget. Interior walls have been constructed. Staff should be in the new building before April 1, 2026.
(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)	0%	18.00%	For Q1 of FY26, 18% of all transactions were competed through the Accela online platform. This is consistent with historical data. Continued barriers to further Accela online usage is the Wood-Burning Device program, processing by Title Companies, and continued development of the Accela systems themselves.
(PI) 5.5.1.2 Increase payments made via Accela to 75% of total EHS transactions (EHS)	50.00%	57.94%	The bulk of all EHS transactions (72%) are for the Food Program, with 55% of Food Program transactions taking placing online. The only program that has under 50% of transactions in ACA is Permitted Facilities, specifically RV Parks, Pools, and Hotels/ Motels. There is seasonality in EHS permitting that may impact the overall number in future quarters/fiscal years.
(PI) 5.5.2.1 % of new/renewed sources integrated into the software.	0%	0%	To date, no facilities have been uploaded into the IMPACT software. Work on an SOP to guide staff on the process is nearly complete, and integration is estimated to begin on 11/1/2026.
(VI) 5.5.3.1a # of all Health IT help desk tickets		293	
(VI) 5.5.3.1b # of health desk tickets going through County TS		0	

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 5.5.3.1 Support new county ticketing system as appropriate	0	1	The new Washoe County system is live. NNPH is supporting the system as needed. As it is a new system, NNPH is giving feedback on nuances of how the new system (HALO) works and potential improvements for it. County TS made an improvement so NNPH can see tickets that it sends on to TS. Before this system improvement, tickets were closed off to NNPH unless staff specifically followed the ticket.
(VI) 6.1.1.1a Amount of expenditures.		$ 8,054,868.00	
(VI) 6.1.1.1b Amount of revenue		$ 6,743,814.00	
(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.
(VI) 6.1.2.2a Amount of revenue generated by grants		$ 1,163,590.00	
(VI) 6.1.2.2b # of grants received		53	
(PI) 6.1.2.2 Maintain 100% of grant compliance.	100.00%	100.00%	Northern Nevada Public Health is currently 100% compliant with grant-related matters.
(VI) 6.1.3.1a Annual reimbursement revenue (less expenditures) at year end		$ 0.00	
(VI) 6.1.3.1b Number of claims submitted		2,533	
(VI) 6.1.3.1c # of self-pay, third party, Medicaid at year end (total clients overall and revenue)		0	
(PI) 6.1.3.3 Maintain 100% cost recovery for AQM permitting and compliance programs.	0%	104.00%	The AQM is currently at 104% cost recovery. It is expected this will continue through the remainder of the fiscal year.
(PI) 6.1.3.4 Increase the percent of costs recovered through EHS fees.	0%	0%	This metric is reported on an annual basis.
(PI) 6.1.3.5 Maintain 100% cost recovery for vital records services.	100.00%	100.00%	Vitals is able to recover 100% costs through fees collected from birth and death certificate sales.

Outcomes	Q1-26 Target	Q1-26 Actual	Analysis
(PI) 6.1.4.1 Make progress toward maintaining an ending fund balance of 10-17%.	0%	36.00%	Northern Nevada Public Health reduced the health fund balance by approximately $2.8 million in Fiscal Year 2024 and approximately $1.9 Million for Fiscal Year 2025.