NNPH Quarterly Report

FY24

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 1.1.1.1 Reach at least 3,000 residents and visitors about the impact of secondhand cannabis smoke exposure through communications efforts. (# of residents reached)	Staff developed four (4) social media posts, which had 411 impressions and 183 engagements. Social media posts focused on addressing the impact of cannabis secondhand smoke exposure, and provided information about toxins present in secondhand cannabis smoke and related health risks. In addition to the health messaging, the posts included information on resources available for quitting. Staff also distributed 150 updated Need to Know cannabis educational cards.	300	2,029	2,250	2,590	1.1.1.1.1 Provide education about the dangers of secondhand cannabis smoke exposure through distributing Need to Know cards and developing posts to be shared on social media platforms.
(PI) 1.1.1.2 Maintain breastfeeding rates at 80% among WIC clients who report ever breastfeeding.	The breastfeeding rates of NNPH WIC clients in the year timeframe through Q3 is 80% for ever breastfed. Staff continue to provide information, encouragement, education and referrals to pregnant and post-partum moms about breastfeeding. In Q3 there were 44 items issued to WIC participants to support breastfeeding, including electric and hand pumps and accessories.	80.00%	80.00%	80.00%	80.00%	1.1.1.2.1 Support staff receiving breastfeeding training. 1.1.1.2.2 Offer clients breastfeeding support and services.
(PI) 1.1.1.3 Increase multi-family housing properties that have smoke free policies by at least 2.	Staff recruited two new properties which opened with NS/NV policies in place: The Edison (232 units, impacting 232-928 individuals). Seasons at Stonebrook (216 units, impacting 216-864 individuals). Additionally, the Dick Scott (RHA property) discussed in Q2 is set to open in Summer 2024 with NS policy. Signage already ordered & received and will be delivered in Q4	0	1	1	3	1.1.1.3.1 Recruit and provide technical assistance to owners and managers of multi-unit housing properties.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 1.1.1.4 Reach at least 4 groups or stakeholders with information on how smoke-free workplace policies impact overall community health. (# of partners that receive smoke-free workplace policy information)	Reached two additional stakeholder groups, NAACP and Make the Road Nevada, with information about the Smoke-Free Workplaces Initiative and opportunities to collaborate.	2	3	3	5	1.1.1.4.1 Provide education and technical assistance to new community partners about smoke-free workplaces.
(PI) 1.1.2.1 Reach seniors with fall prevention messaging at least once per quarter. (# of messaging/ education attempts including events, tabling, and media)	Staff connected with the local home safety modifications agency, Rebuilding Together Northern Nevada, to help stand up their falls-prevention activities in Washoe County. Additionally, staff wrote two letters of support to RTNNV for home safety modification expansion grant applications.	1	2	3	3	1.1.2.1.1 Provide education, outreach, and support to seniors and senior groups in Washoe County.
(VI) 1.2.1.1a # of WIC participants (quarterly average enrollment, annual average enrollment in Q4)		3,463	3,410		3,342	
(PI) 1.2.1.1 Maintain at least 95% of enrolled WIC participants as compared to last FY enrollment.	Q3 WIC enrollment in FY24 is comparable to Q3 WIC enrollment last year. This quarter there was an average of 3342 clients enrolled each month. In Q3 of FY 23 there was an average of 3334 enrolled each month. This is a 0.25% increase from last fiscal year, or 100.25% of last fiscal year.	102.60%	102.10%	95.00%	100.25%	1.2.1.1.1 Implement retention efforts and new participant recruitment and enrollment activities. 1.2.1.1.2 Provide outreach to underserved communities.
(VI) 1.2.1.2a # of clients served in the immunization program		1,007	2,396		3,271	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 1.2.1.3a # of VFC compliance visits		0	8		17	
(PI) 1.2.1.3 Assure 50% of Vaccine for Children (VFC) providers receive a compliance visit yearly.	For Q3 of FY24, program staff conducted (9) Vaccines for Children (VFC) compliance visits with area providers, on target to meet the annual goals set forth by the Nevada State Immunization Program. The program is responsible for conducting visits with 50% of VFC providers each year, bringing the up-to-date total to (17), or 40%. The number of total providers fluctuates during the review period to account for provider enrollments or de-enrollments. In July, Washoe County had (43) VFC providers to review; at this time, there are (48) providers for staff to manage.	0%	18.00%	0%	40.00%	1.2.1.3.1 Perform compliance visits.
(VI) 1.2.1.4a # of clients served in the Family Planning and Sexual Health program		1,003	1,951		2,948	
(PI) 1.2.1.5 Implement 100 community/ provider Sexual Health education and outreach activities.	During the reporting period, educational presentations were provided on the topics of syphilis and sexual health (3 presentations), as well as participation in community outreach by CHWs (8), and 28 offsite testing events in the jail, weekly community testing, at Our Center, and at TMCC.	21	58	75	97	1.2.1.5.1 Provide educational presentations as requested by the community. 1.2.1.5.2 Conduct Academic Detailing to providers addressing sexual health topics. 1.2.1.5.3 Participate in community outreach events. 1.2.1.5.4 Provide offsite testing in partnership with community organizations and businesses.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 1.2.2.1a # of reported HIV cases investigated		11	27		39	
(PI) 1.2.2.1 Initiate investigation of 90% of reported HIV cases within 5 business days of report.	Twelve (12) HIV and advanced HIV cases were reported during Q3, and all case investigations were initiated within 5 days of report.	100.00%	100.00%	90.00%	100.00%	
(VI) 1.2.2.2a # of primary, secondary syphilis cases investigated		35	60		85	
(PI) 1.2.2.2 % of primary, secondary syphilis cases initiated within 5 days.	During the reporting period, 25 primary & secondary cases of syphilis were reported to NNPH, with 25 case investigations (100%) being initiated within 5 days of report.	68.60%	80.00%	90.00%	100.00%	
(VI) 1.2.2.3a # of maternal syphilis cases investigated		4	8		13	
(PI) 1.2.2.3 % of maternal syphilis cases initiated within 5 days	During Q3, all five (5) maternal syphilis case investigations were initiated within 5 days.	100.00%	100.00%	90.00%	100.00%	
(VI) 1.2.2.4a # of other syphilis cases investigated (early latent, late latent/unknown duration, biological false positives, old disease)		181	219		505	
(PI) 1.2.2.4 % of other syphilis cases initiated within 5 days	During Q3, of the syphilis cases deemed to be early latent, late latent/unknown duration, biological false positive, and old disease, 275 (96%) case investigations were initiated within 5 days of report.	76.80%	74.00%	90.00%	96.00%	
(VI) 1.2.2.5a # of congenital syphilis cases investigated		6	7		10	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 1.2.2.5 % of congenital syphilis cases initiated within 5 days	During Q3, three (3) congenital syphilis cases were reported to NNPH. Of these, 100% of case investigations were initiated within 5 days of report.	100.00%	100.00%	90.00%	100.00%	
(VI) 1.2.2.6a # of reported gonorrhea cases investigated		126	311		458	
(PI) 1.2.2.6 Initiate 90% of prioritized gonorrhea case investigations within 5 business days of report.	During the reporting period, 147 cases of gonorrhea were reported, with 141 (96%) cases being initiated within 5 days of report.	60.00%	74.68%	90.00%	77.51%	
(VI) 1.2.2.7a # of reporterd chlamydia cases investigated		608	1,156		1,718	
(PI) 1.2.2.7 Review 90% of chlamydia cases within 5 days of report.	During the reporting period, 562 cases of chlamydia were reported, with 552 case investigations being initiated within 5 days.	100.00%	89.62%	90.00%	95.87%	
(VI) 1.2.2.8a # of individuals suspected to have active tuberculosis disease and investigated		5	12		18	
(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).	Eight out of nine suspect TB cases were confirmed with a Nucleic Acid Amplification Test (NAAT) within 24 hours of sputum collection. These cases were then started on standard TB treatment within the same day NAAT confirmation was received. The one case that did not have a NAAT performed was hospitalized at the time and the NAAT was not ordered.	100.00%	80.00%	100.00%	88.00%	1.2.2.8.3 Collect, review, and process lab and provider reports for suspected or confirmed active TB disease. 1.2.2.8.4 Utilize Directly Observed Therapy (DOT) and virtual DOT to assist with case treatment adherence.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						1.2.2.8.5 Establish partnerships with community providers to effectively communicate case management and treatment status.
						1.2.2.8.6 Utilize contact tracing for all sputum smear positive disease cases.
						1.2.2.8.1 Increase staff who are trained to take select high frequency diseases, in order to reduce burden on any one person or set of staff.
						1.2.2.8.2 Ensure workflows are designed so staff know when a lab is reported so they can begin the investigation as soon as feasible.
(PI) 1.2.2.9 For clients with active tuberculosis, increase the percentage that have sputum culture conversion within 60 days of treatment initiation.	There was one case during Q3-24 that was confirmed to have culture converted to no mycobacterium tuberculosis in their sputum within 2 months of treatment. This was the only case that had a pending culture during this time period. To date 100% of our active cases have converted within 60 days.	100.00%	100.00%	83.00%	100.00%	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 1.2.2.10 Initiate the index/source case interview and contact investigation for 100% of sputum smear positive tuberculosis cases within 14 days.	For the sputum smear positive cases for Q3-24 100% of the cases had contact elicited within 14 days. During this time one source investigation was initiated and the index case was investigated and confirmed to have TB disease within 24 hours of the confirmation of the source case. This was a huge win for our program; to have discovered the index case so quickly.	100.00%	100.00%	100.00%	100.00%	
(VI) 1.2.2.11a # of foodborne, vector borne, vaccine preventable, disease of unusual occurrence, etc. cases investigated	Q1 - 434 reported, 366 investigated Q2 - 390 reported, 341 investigated Q3 - 434 reported, 366 investigated (I know, exact same as Q1, very suspicious - I triple checked).	430	673		1,073	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 1.2.2.11 Investigate 100% of foodborne, vector borne, vaccine preventable, disease of unusual occurrence, etc. disease cases within their designated time frame.	Q1 total = 239/279 = 85.6% Same day follow up = 46/57 reported = 80% Within 1 day follow up = 145/164 reported = 88% Within 1 week follow up = 25/25 reported = 100% Outbreaks = 23/33 declared = 69% Q2 total = 239/279 = 80.7% Same day follow up = 49/62 reported = 79% Within 1 day follow up = 99/122 reported = 81% Within 1 week follow up = 26/26 reported = 100% Outbreaks = 31/44 declared = 70% Q3 total = 226/258 = 87.5% Same day follow up = 30/39 reported = 81% Within 1 day follow up = 121/136 reported = 90% Within 1 week follow up = 39/39 reported = 100% Outbreaks = 36/44 declared = 70% Total to date = 670/791 = 84.7% Factors preventing 100% investigations on time: We do not have 24/7coverage, cannot pick up calls or labs that come in Friday when we don't get in until Monday.	85.60%	80.70%	100.00%	84.70%	
(VI) 1.2.3.1a # of community-based vaccine provision events		12	26		40	1.2.3.1a.1 Provide education at 1 outreach event per quarter.
(VI) 1.3.1.1a # of clients that see the Enrollment Assister annually		37	73		104	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 1.3.1.1 Maintain or increase the number of clients that see the Enrollment Assister annually.	The program saw 5 less clients this quarter compared to the previous quarter, but is still seeing more clients than what we aimed for.	37	73	48	104	1.3.1.1.1 Collaborate with State Enrollment Assister onsite to provide assistance, by educating staff, thus increasing education to clients and providing proper paperwork and education to clients prior to appointments. 1.3.1.1.2 Provide reminder calls for scheduled appointments with the Enrollment Assister.
(VI) 1.3.2.1a # of clients and community members provided assistance with navigation of community resources		119	263		524	
(PI) 1.3.2.1 Increase the number of clients and community members provided assistance with navigation of community resources. (# provided assistance)	The number of clients provided services by the CHWs continues to increase more than expected. Part of this increase is from the addition of 2 new CHWs to the team. From April 2023-August 2023 there were only 2 CHWs providing client services. One CHW was hired August 2023 and a fourth CHW was hired in September. This has resulted in more referrals and more clients served from CCHS programs that were working without a CHW for a large amount of time in 2023.	119	263	270	503	1.3.2.1.1 Monitor number of referrals from each CCHS program. 1.3.2.1.2 Evaluate need for standardized referral process. 1.3.2.1.3 Meet with intermittent hourly staff from each program to educate on services provided by CHWs.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 1.3.2.2 Increase community reach through new partnerships and outreach activities. (# of outreach activities)	The CHWs continue to actively seek outreach events with the purpose of developing new partnerships and informing the community of the services provided at NNPH. The CHWs have expanded outreach efforts with the Food Bank of Northern Nevada and have developed a partnership with Anthem Medicaid to continue access to the Cribs For Kids program. Additionally, the CHWs evaluate outreach events occurring in the community on a weekly basis to ensure outreach efforts are targeted to vulnerable and under served communities.	15	22	67	37	1.3.2.2.1 Identify 2 new community partners for recurring outreach. 1.3.2.2.2 Identify 2 new community outreach events to table.
(PI) 1.3.3.1 Increase access to programs and services through completing 3 system improvements.	Two new system improvements made in Q3. 1. Zebra printers for client lab labels put in Family Planning Sexual Health exam rooms to improve efficiencies and decrease errors. 2. Walk-in appointments dispersed throughout all provider schedules instead of designating one nurse for walk-ins. These interventions have decreased down time due to no shows.	0	3	2	5	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.
(PI) 2.1.1.1 Meet or exceed a 75% data capture rate for ozone.	FY24 Q3 Data Completeness Reports will not be available until June 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the October 1 to December 31, 2023, reporting period. This report summarizes the number of hourly ozone observations as well as data completeness percentages for all ozone monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	98.60%	98.40%	75.00%	97.90%	2.1.1.1.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (ozone)

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 2.1.1.2 Meet or exceed a 75% data capture rate for PM2.5.	FY24 Q3 Data Completeness Reports will not be available until June 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the October 1 to December 31, 2023, reporting period. This report summarizes the number of hourly PM2.5 observations as well as data completeness percentages for all PM2.5 monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	98.40%	98.80%	75.00%	99.60%	2.1.1.2.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (PM2.5)
(PI) 2.1.1.3 Meet or exceed a 75% data capture rate for PM10.	FY24 Q3 Data Completeness Reports will not be available until June 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the October 1 to December 31, 2023, reporting period. This report summarizes the number of hourly PM10 observations as well as data completeness percentages for all PM10 monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	98.40%	98.50%	75.00%	98.20%	2.1.1.3.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (PM10)
(PI) 2.1.1.4 Meet or exceed a 75% data capture rate for carbon monoxide.	FY24 Q3 Data Completeness Reports will not be available until June 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the October 1 to December 31, 2023, reporting period. This report summarizes the number of hourly CO observations as well as data completeness percentages for all CO monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	98.50%	97.00%	75.00%	96.00%	2.1.1.4.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (carbon monoxide)

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 2.1.1.5 Meet or exceed a 75% data capture rate for nitrogen dioxide.	FY24 Q3 Data Completeness Reports will not be available until June 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the October 1 to December 31, 2023, reporting period. This report summarizes the number of hourly NO2 observations as well as data completeness percentages for all NO2 monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	97.00%	98.00%	75.00%	98.00%	2.1.1.5.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (nitrogen dioxide)
(PI) 2.1.1.6 Meet or exceed a 75% data capture rate for sulfur dioxide.	FY24 Q3 Data Completeness Reports will not be available until June 2024. In order to have data to report, we ran EPA's AMP 430 Data Completeness Report for the October 1 to December 30, 2023, reporting period. This report summarizes the number of hourly SO2 observations as well as data completeness percentages for all SO2 monitors in the ambient air monitoring network. The actual data capture rate is an average of all network monitors.	96.00%	96.00%	75.00%	95.50%	2.1.1.6.1 Follow EPA QA/QC data capture requirements and report data capture rate on a quarterly basis. (sulfur dioxide)
(VI) 2.1.2.1a # of air quality plans and reports worked on during this period.		8	15		21	2.1.2.1a.1 Develop Ozone Mitigation Plan and submit to EPA for approval. 2.1.2.1a.2 Complete Dixie/ Antelope Exceptional Event demonstration and submit to EPA for concurrence. 2.1.2.1a.3 Complete Dixie/ Caldor Exceptional Event demonstraion and submit to EPA for concurrence.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						2.1.2.1a.4 Complete Dixie/ Tamarack Exceptional Event demonstration and submit to EPA for concurrence.
						2.1.2.1a.5 Complete Mosquito Exceptional Event demonstraion and submit to EPA for approval.
						2.1.2.1a.6 Develop Second 10-Year PM10 Maintenance Plan and submit to EPA for approval.
						2.1.2.1a.7 Update 2024 Ambient Air Monitoring Network Plan and submit to EPA for approval.
						2.1.2.1a.8 Update 2014-2023 Air Quality Trends Report and present to DBOH for acceptance.
(PI) 2.1.2.1 Educate and empower leaders, decision makers and regulated entities through a minimum of 3 AQ outreach opportunities. (# of outreach events)	Outreach opportunities completed by AQMD staff during the January 1 to March 31, 2024, reporting period include: 1. RX410 Smoke Management Techniques Presentation and Panel Discussion at Truckee Meadows Community College Redfield Campus – Brendan Schnieder, January 24, 2024.	8	12	0	13	2.1.2.1.1 Identify and contact community groups and partners.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 2.1.2.2a # of community planning efforts where AQMD commented.		2	4		14	
(VI) 2.1.2.2b # of community planning efforts where AQMD participated as a technical advisor.		5	13		26	
(PI) 2.1.2.3 Complete updates of 11 parts of regulation chapters.	Updates to regulation Parts completed by AQMD staff during the January 1 to March 31, 2024, reporting period include: 1. No updates to regulation Parts were completed by AQMD staff during the reporting period. Updates worked on by AQMD staff during the reporting period, but not completed include: 1. 040.110 – Asbestos Control Standards	0	4	0	0	2.1.2.3.1 Update Chapter 020 – Parts 020.000 – 020.200 (3 parts) 2.1.2.3.2 Update Chapter 030 – Parts 030.000 – 030.500 (6 parts) 2.1.2.3.3 Update Chapter 040 – Asbestos Control Standards and Asbestos Acknowledgements (2 parts)
(VI) 2.1.3.1a # of wood-burning devices inspections completed		88	164		231	2.1.3.1a.1 Inspect properties which have removed a wood-burning device prior to the close of escrow.
(PI) 2.1.3.1 % wood-burning permits managed within internal best practice standard (NOE 2 business days, COC 10 business days)	Currently, the AQMD is developing a report to determine performance with this indicator.			100.00%		

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 2.1.3.1b # of wood-burning device registrations		2,129	3,744		5,281	2.1.3.1b.1 Process and issue Notice of Exemption Registrations submitted to the Air Quality Management Division. 2.1.3.1b.2 Process and issue Certificate of Compliance Registrations submitted to the Air Quality Management Division. 2.1.3.1b.3 Process and issue Dealers Affidavit of Sale Registrations submitted to the Air Quality Management Division.
(VI) 2.1.3.2a # of dust control permit inspections completed		117	251		396	2.1.3.2a.1 Complete dust control inspections to determine compliance with dust control permit requirements.
(VI) 2.1.3.2b # of dust control permits		45	100		146	2.1.3.2b.1 Process and issue Dust Control Permit applications submitted to the Air Quality Management Division.
(PI) 2.1.3.2 % of dust permits managed within 10 business days.	Currently, the AQMD is developing a report to determine performance with this indicator.			100.00%		

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 2.1.3.2c Total acreage disturbed by dust permits		443	1,246		2,022	
(VI) 2.1.3.3a # of asbestos renovation and demolition inspections completed		37	33		68	2.1.3.3a.1 Complete inspections of asbestos notifications for demolitions and renovations to determine compliance with asbestos NESHAP standards.
(VI) 2.1.3.3b # of asbestos renovation and demolition notifications		37	77		119	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		78,300	185,464		302,091	
(VI) 2.1.3.3d Total linear feet of asbestos materials		5,948	6,371		6,410	
(PI) 2.1.3.3 % of asbestos permits managed within internal best practice standard.	Currently, the AQMD is developing a report to determine performance with this indicator.			100.00%		
(VI) 2.1.3.3e Total cubic feet of asbestos materials		0	0		0	
(VI) 2.1.3.4a # of complaint inspection/ investigations		47	84		111	
(VI) 2.1.3.5a # of warnings and notices of violations issued		13	19		42	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 2.1.3.6a # of stationary source inspections assigned		153	263		385	
(PI) 2.1.3.6 Complete 100% of stationary source inspections assigned.	Of (122) Stationary Source inspections assigned in Quarter 3 of FY24, (122) were completed, for a completion rate of 100%.	100.00%	100.00%	100.00%	100.00%	2.1.3.6.1 Complete inspections of stationary sources to determine compliance with permit and regulatory requirements.
(VI) 2.1.3.7a # of stationary source authority to construct/ permit to operate permits issued		15	31		44	
(PI) 2.1.3.7 100% of stationary source authority to construct/ permit to operate permits are issued within 180 days.	Of the (16) Stationary Source Authority to Construct permits issued in Quarter 3 of FY24, (16) Stationary Source Authority to Construct permits were issued within 180 days.	93.00%	88.00%	100.00%	100.00%	2.1.3.7.1 Issue authorities to construct to new sources of regulated air pollutants in Washoe County. 2.1.3.7.2 Reissue permits to operate on an annual basis to sources of regulated air pollutants in Washoe County.
(VI) 2.1.4.1a # of inspections completed at permitted waste management facilities per year.		52	111		200	
(VI) 2.1.4.1b # of waste management facility permits		307	299		302	
(VI) 2.1.4.1c # of waste related complaints		59	95		125	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 2.1.4.1 Complete 100% of inspections at permitted waste management facilities per year.	During the third quarter of FY24, 29% of permitted waste management facilities were inspected. This meets the target of approximately 25% per quarter. It is expected that CY 24 will not have any issues completing 100% of inspections	14.00%	34.00%	75.00%	63.00%	2.1.4.1.1 Develop an audit system and conduct a minimum of 3 audits per staff member. 2.1.4.1.2 Update SOPs and develop standardized processes for solid waste complaints.
(PI) 2.1.4.2 Partner with a minimum of 3 outside agencies to assist in waste reduction/ clean up initiatives.	In the first quarter, EHS partnered up with CDIP to look at reducing waste from disposable vapes. Over the third quarter of FY24, EHS partnered with greenUP! by assisting with funding for their annual awards dinner. greenUP! is a local organization that works in the community to cut down on waste, reduce valuable resource consumption and fight climate change. The team also began working with the County Manager's office for an upcoming clean up in the fourth quarter.	1	1	2	2	2.1.4.2.1 Collaborate with KTMB on community engagement regarding reduced waste initiatives. 2.1.4.2.2 Utilize tire funds to create grant program to assist local groups with clean up and sustainability efforts in the community.
(VI) 2.1.5.1a # of first review plans reviewed for compliance with AQ regulations and processed (AQM)		293	460		596	
(PI) 2.1.5.1 Ensure 90% of first review plans for compliance with AQ regulations meet jurisdictional timeframes. (AQM)	Of the (136) plans assigned for AQM review in Quarter 3 of FY24, (136) met jurisdictional timeframes for a rate of 100%.	90.00%	96.00%	90.00%	94.90%	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 2.1.5.2a # of residential septic and well plans reviewed and processed		200	362		600	
(PI) 2.1.5.2 Ensure 90% of residential septic and well plan reviews meet jurisdictional timeframe. (EHS)	Of the 238 plans that the program took in in the third quarter of FY24, 220, or 92%, met the desired outcome of meeting the jurisdictional time frame for review. Cumulatively for the first three quarters, the team is at 549 on time out of 600, or 92%.	92.00%	91.00%	90.00%	92.00%	2.1.5.2.1 Build record types for Land Development Program in Accela by the end of FY24. 2.1.5.2.2 Update Land Development regulations and set a schedule for updating by the end of FY24. 2.1.5.2.3 Update SOPs and develop standardized comments by the end of FY24. 2.1.5.2.4 Develop an audit system and conduct a minimum of 3 audits per staff member. 2.1.5.2.5 Establish training requirements for programs and provide staff the opportunity to attend. 2.1.5.2.6 Update Land Development electronic stamps and plan review process.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 2.1.5.3 Conduct a minimum of 4 outreach events to inform interested stakeholders on residential septics and wells. (# of outreach events)	One outreach event was held with RealtyOneGroup this quarter, and two others have been hosted in previous quarters. There were approximately 35 attendees at the Q3 event. A new tracking sheet has been developed for more accurate counts.	1	2	3	3	2.1.5.3.1 Conduct social media campaigns in collaboration with partners. 2.1.5.3.2 Track number of event attendees.
(VI) 2.1.5.4a # of UST inspections		61	101		152	
(VI) 2.1.5.4b # of UST permits		211	212		212	
(PI) 2.1.5.4 Complete 100% of inspections at UST permitted facilities per year.	Over the first three quarters of FY24, the team has inspected 72% of the 212 UST permits. This meets the target of completing approximately 25% each quarter and is likely slightly behind 75% due to the winter weather. In CY23, all permits were inspected.	28.00%	47.00%	75.00%	72.00%	2.1.5.4.1 Establish training requirements for programs and provide staff the opportunity to attend. 2.1.5.4.2 Develop an audit system and conduct a minimum of 3 audits per staff member. 2.1.5.4.3 Create checklist/tools to assist permit holders with compliance.
(PI) 2.2.1.1 Set a baseline for the occurrence of foodborne illness risk factors in inspected facilities.	Waiting for Accela VIP project completion to get food establishment foodborne illness risk factor data, and waiting on completion of 2023 Risk Factor Study.	0%	0%	0%	0%	2.2.1.1.3 Create system to track food related complaints for surveillance purposes. 2.2.1.1.1 Develop a system to track occurence of foodborne illness risk factors in inspected facilities.

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

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 2.2.1.2 Complete at least 4 components of standards to make progress toward conformance with FDA retail food program standards. (# of components completed)	Currently meet 4 of 9 standards and working towards meeting additional criteria for each standard not currently met with a goal of meeting a total of 4 additional criteria by Q4. 1. Regulatory Foundation - Fully met 2. Trained Regulatory Staff - 88.9% met 3. Inspection Program Based on Hazard Analysis and Critical Control Point (HACCP) Principles - Fully met 4. Uniform Inspection Program - 93.8% met 5. Foodborne Illness and Food Defense Preparedness and Response - Fully met 6. Compliance and Enforcement - 75% met 7. Industry and Community Relations - Fully met 8. Program Support and Resources - 61.5% met 9. Program Assessment - 85.7%	1	1	3	2	2.2.1.2.1 Standard 2- Complete initial training for all employees. 2.2.1.2.2 Standard 2- Maintain CEUs. 2.2.1.2.3 Standard 2- Complete initial standardization for all employees. 2.2.1.2.4 Standard 3- Develop and implement annual permit for temporary food vendors. 2.2.1.2.5 Standard 3- Develop assessment documents for change of ownership and new facilities. 2.2.1.2.6 Standard 4- Develop schedule for process to review inspection reports and conduct field evaluations of assigned staff. 2.2.1.2.7 Standard 4- Transition opening inspection report review. 2.2.1.2.8 Standard 5- Revise Outbreak Response Plan with CD.

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

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						2.2.1.2.15 Standard 9- Develop intervention strategies to address the foodborne illness risk factors identified as needing priority attention.
(PI) 2.2.1.3 Percentage of required inspections of food establishments completed.	Percent of routine inspections conducted is off target due to lack of trained staff to complete inspections. Staff that are trained to complete inspections are spending more time training new staff.	11.00%	24.00%	75.00%	40.00%	
(PI) 2.2.1.4 Number of permitted facility (non-food based) programs with the foundation necessary to complete risk-based inspections from 0 to 1. (programs developed)	** Note: This has always been reported as the number of inspections completed in total for the time period. We do not have any risk-based inspections for permitted facilities, so the numbers that are reported here are the total inspections that have been completed.* At this time no permitted facility programs have the foundation to complete risk-based inspections. Due to staffing limitations to complete inspections, not having time to invest in program development, and the ongoing build-out of records within Accela, this has not been a focus and cannot be completed at this time.	226	346	1,464	890	2.2.1.4.1 Pool & Spa program finalized in Acella and in use (complete draft review of pool regulations, finalize working drafts of pool regulations, provide outreach, draft field guide, host public workshops, boards for approval, finalize working drafts of pool regulations).
						2.2.1.4.2 PACC program finalized in Acella and in use (finalize inspection form, upload form into Accela, finalize field guide, develop guidance documents).

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 2.2.1.5a # of total inspections of non-food based permitted facilities including other elements (reinspections etc).		226	408		726	
(VI) 2.2.1.5b # of non food-based facility permits		1,193	1,179		1,208	
(VI) 2.2.1.6a # of other permitted facility complaints		19	27		40	
(VI) 2.2.1.7a # of sanitary surveys of public water systems		9	23		25	
(VI) 2.2.1.7b # of public water system permits		75	76		75	
(PI) 2.2.1.7 Complete 100% of required sanitary surveys of public water systems to help ensure proper public health protection.	Over the first three quarters of FY24, the team has inspected 76% of the total permits. This meets the target of 25% per quarter. The team expects to meet the goal of 100% by the end of FY24. For CY23, the team reporting completed 100% of all required surveys.	25.00%	30.00%	75.00%	76.00%	2.2.1.7.1 Establish training requirements for programs and provide staff the opportunity to attend. 2.2.1.7.2 Update chemical compliance templates and SOPs. 2.2.1.7.3 Implement continuous verification process for possible water systems.

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

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 2.2.3.1 Ensure 90% of first review for commericial plans meet jurisdictional deadlines.	Currently, plans are close to the 90% goal for first reviews in all 3 jurisdictions. Process improvements are underway to improve plan review efficiencies by changing the process from 3 different processes with different capabilities to one unified process. However, the workflow build for commercial plan review is currently on hold pending the completion of the record build with VIP. All resources have shifted to completing this project since funding is slated to end on July 30, 2024. Therefore this project has been placed on hold until such time there are additional resources available or the VIP project is completed.	77.39%	81.17%	90.00%	81.34%	2.2.3.1.1 Test an updated workflow into Accela for each jurisdiction to create a uniform plan review mechanism.
(VI) 3.1.1.1a # total social media posts		384	898		1,445	
(VI) 3.1.1.1b # of culturally relevant or health equity social media posts		106	191		368	3.1.1.1b.1 Work with community members or organizations to create culturally relevant content.
(VI) 3.1.1.1c # of social media followers		11,094	11,518		11,868	
(VI) 3.1.1.1d # of web hits		76,102	182,812		322,590	
(PI) 3.1.1.2 Increase audience growth on all platforms by 10%. (followers)	Our total number of followers on X, Facebook, Instagram and LinkedIn is 11,868, which is a 3% increase from Q2. We moved from in progress to on target this quarter.	2.00%	4.90%	7.50%	7.90%	3.1.1.2.1 Launch LinkedIn profile.
(PI) 3.1.1.3 Increase engagement on all social media posts by 10%. (comments, shares, link, clinks and more)	Our total engagements on our X, Facebook, Instagram and LinkedIn accounts was 16,648 during Q3, which is an increase of 73.7% compared to Q2. The largest jump in engagement is from our LinkedIn page.	20.00%	41.10%	7.50%	114.80%	3.1.1.3.1 Create and post videos and graphic design content to drive engagement.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 3.1.2.1 Garner 1 million impressions through rebranding effort. (# of rebranding effort impressions)	January - 3,169,870 impressions February - 10,887,718 impressions March - 3,218,918 impressions	1,500,000	8,930,000	3,000,000	26,206,506	3.1.2.1.1 Launch new website. 3.1.2.1.2 Execute outreach plan. 3.1.2.1.3 Implement outdoor signage. 3.1.2.1.4 Advertise buy. 3.1.2.1.5 Update style guide. 3.1.2.1.6 Maintain brand standards internally.
(PI) 3.1.2.2 Reach at least 10,000 people per quarter through paid media featuring equity content promoted by WCHD. (# of people reached through paid media featuring equity content)	Juan 101.7: 374 spots on Juan 101.7 (reach not available). Bi-weekly segment concluded on March 14, 2024. Facebook: 32,937 reached	60,500	320,284	30,000	353,221	3.1.2.2.1 Maintain and increase Spanish language presence on live media and on Spanish-language radio. (HE Plan Goal 4, Initiative 2) 3.1.2.2.2 Implement public information campaigns designed to promote health equity and reduce health disparities. Include 5210 Healthy Washoe and other campaigns targeting co-morbidities of COVID. (HE Plan Goal 4, Initiative 1)
(VI) 3.1.2.3a # of public records request fulfilled (ODHO)		0	0		0	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 3.1.2.3b # of public records request fulfilled (AQM)		14	23		38	
(VI) 3.1.2.3c # of public records request fulfilled (CCHS)		0	0		1	
(VI) 3.1.2.3d # of public records request fulfilled (EPHP)		13	40		60	
(VI) 3.1.2.3e # of public records request fulfilled (EHS)		1,656	2,951		4,023	
(VI) 3.1.2.4a # of press releases, media alerts, media availability.		23	70		91	
(VI) 3.1.2.5a # of community presentations (ODHO)			10		19	
(VI) 3.1.2.5b # of community presentations (AQM)		8	12		13	
(VI) 3.1.2.5c # of community presentations (CCHS)		9	31		39	
(VI) 3.1.2.5d # of community presentations (EPHP)		11	18		24	
(VI) 3.1.2.5e # of community presentations (EHS)		7	11		15	
(VI) 3.2.1.1a # of vital records requests and services		13,538	25,454		39,221	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 3.2.1.1 Process 90% of vital records requests and services within 96 hours.	**Death Requests** **July 2023**: Number of Request 2037, Completed within 96 hours 2037 **August 2023**: 2356, 2356 **September 2023**: 1937, 1937 **October 2023**: 1895, 1895 **November 2023**: 2169, 2139 **December 2023**: 1962, 1962 **January 2024**: 2364, 2364 **February 2024**: 2153, 2153 **March 2024**: 2018, 2018 **Birth Requests** **July 2023**: Number of Request 1397, Completed within 96 hours 1397 **August 2023**: 1790, 1790 **September 2023**: 1068, 1068	100.00%	100.00%	90.00%	100.00%	3.2.1.1.1 Assist the state by testing and implementing the NETSMART system and providing feedback. 3.2.1.1.2 Improve communications with other Nevada vital statistics jurisdictions through monthly meetings. 3.2.1.1.3 Identify gaps to improve procedures and processing time with funeral homes. 3.2.1.1.4 Identify gaps to improve procedures and processing time with physicians and medical examiner's office

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
	October 2023 1055 1055 **November 2023** 958 958 **December 2023** 901 901 **January 2024** 1389 1389 **February 2024** 1389 1389 **March 2024** 1274 1274					
(VI) 3.2.2.1a # of reports (Communicable Disease Annual; CPO Quarterly; COVID-Bi-Weekly; ILI Weekly) provided to the community		4	19		38	
(PI) 3.2.2.1 Publish 100% of reports (Communicable Disease Annual; CPO Quarterly; Covid-Bi-Weekly; ILI Weekly) provided to the community based on designated time frame.	Q1 4/6 = 66.6% out on time Q2 15/15 = 100% out on time Q3 16/17 = 94.1% out on time Total = 92% out on time	66.00%	90.50%	100.00%	92.10%	3.2.2.1.1 Build a tracking mechanism to know which reports were released on which dates. 3.2.2.1.2 Increase staff who are trained to take select high frequency diseases, in order to reduce burden on any one person or set of staff.
(VI) 3.2.3.1a # of statistical analysis requests met.		13	19		23	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 3.2.3.1 Deliver on 95% of requests for statistical analysis. (# of requests)	In Q1, We had 8 internal health district divisional related requests for data analysis or pulls, 1 public records request data pull, and 4 requests for statistical analysis requests from community partners. All these requests were met in Q1. In Q2, we had 3 public records or media statistical analysis requests, 3 data analysis for community partners. All these requests were met in Q2. In Q3, we had 1 data analysis request for community partner and 3 public records or media requests and all were met in Q3	100.00%	100.00%	95.00%	100.00%	3.2.3.1.1 Capture measurable outcomes for all programs. 3.2.3.1.2 Maintain statistical capacity to serve EPHP and the WCHD.
(VI) 3.3.1.1a # of interim committee meetings, public workshops, and coalition meetings attended/ monitored.		17	43		65	3.3.1.1a.1 Generate a list of potential 2025 legislative priorities.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 3.3.1.1 Pursue and achieve 2 local government health in all policies initiatives.	While specific policy initiatives have not been identified, that doesn't mean NNPH hasn't been involved in many different policies at the local and federal level. This particular quarter has been focused on closely monitoring federal funding for our STI and WIC programs. Both programs have been faced with and continue to face economic uncertainty. Our teams have been in contact with our federal delegation regarding our concerns. We have also submitted a letter of concern and plan to make comment about potential regulations around vaccine requirements for families fostering children in Nevada. Air Quality has also weighed in on a federal bill, H. R. 7193. We submitted letters of support for our two US Senators as well as Congressman Amodei. The bill streamlines the process related to excluding air monitoring data affected by wildfire events, helping air agencies prioritize programs that improve air quality, rather than spend time excluding air monitoring data. Additionally, Air Quality weighs in at a local level on building permits, promoting better land use practices, tree canopies, multi-modal programs, and anything that can potentially make the air quality better in Washoe County. NNPH monitors local and state meetings and actively participates in the Street Food Vendor Task Force, which is a state and local priority. Additionally, if more resources become available there are potential opportunities to lean into work to support local policies that align with the CHIP focus areas.	0	0	0	0	**3.3.1.1.1 Generate a list and identify local government priority initiatives to pursue.**

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.1.1.1 Residents have access to multiple elements of a best practice crisis response system.	The Washoe County community coalition continues to make progress toward standing up the Crisis Response System of Care in collaboration with the State of Nevada with good progress this quarter. An RFP for enhancement and operation of the 988 Hub was released and closed in early April. The selected vendor should be announced in Q1 of next year. A groundbreaking for the Renown Community Crisis Center will happen in Q4 - the second element of the crisis response system to come on line. Additionally, existing law enforcement MOST Teams, state's Children's Mobile Crisis Team and CCBHC mobile teams respond to individuals experiencing a behavioral health crisis, fulfilling a portion of the third element - mobile crisis response teams. More work to be done on buliding out this element of the system.	1	1	2	1	4.1.1.1.1 Work with community partners and the state to implement additional elements of the behavioral health crisis system.
(PI) 4.1.2.1 Pilot the Zero Suicide Program in 2 CCHS clinic programs.	Reconvened the ZS implementation team and began implementing the remaining program steps in two pilot programs. This will be fully implemented in Q4.	0	0	1	1	4.1.2.1.1 Facilitate at least 2 suicide prevention training opportunities and assist with the creation and implementation of program-specific suicide prevention internal procedures. 4.1.2.1.2 Identify at least one community partner to accept warm hand-offs for Community and Clinical Health Services clients determined at-risk of suicide.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.1.2.2 Implement at least one lethal means reduction strategy in coordination with the Washoe County Lethal Means Coalition.	Staff led development of local Washoe Suicide Prevention Alliance (WSPA) Gun Shops survey and completion coordination. This Action step goal was to make first contact with local Federal Firearm Licensed (FFL) dealers and determine any existing suicide prevention activities, connection with suicide, interest in WSPA suicide prevention resources, and status/interest in temporary storage.	1	1	1	1	4.1.2.2.1 Facilitate the formation and operation of a Lethal Means Coalition in Washoe County, and collaborate with local and state stakeholders.
(PI) 4.1.3.1 90% of applicable WIC participant interactions will receive substance abuse screening, education and referrals.	A sampling of chart audits shows that 87% of applicable WIC participant interactions included screening, education and referral for substance abuse.	100.00%	92.00%	90.00%	87.00%	4.1.3.1.1 Provide staff with training refreshers on substance abuse screening, education and referrals. 4.1.3.1.2 Complete chart audits for compliance with substance abuse screening, education and referrals.
(VI) 4.1.3.2a # of organizations participating in the substance abuse task force		26	14		25	
(PI) 4.1.3.2 Reach at least 4 additional local organizations to participate in quarterly Washoe County Substance Abuse Task Force partner meetings focusing on reducing drug-related overdoses in Washoe County.	Staff reached two (2) new organizations that participated in the Washoe County SATF: New Dawn Treatment Centers and Bristlecone Reno.	0	2	3	4	4.1.3.2.1 Coordinate and schedule at least 6 presentations during SATF meetings of exemplary strategies and emerging best practices in the field of SUD and drug-related overdose prevention.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						4.1.3.2.2 Coordinate sharing of local drug-related overdose statistics, trends and prevention activities and initiative updates in at least 6 instances among SATF participants.
(PI) 4.2.1.1 Increase the number of corner stores engaged in offering healthy food with the addition of 3 new stores.	The recruitment for stores continues. Staff made visits to 12 stores in quarter 3 with at least two follow-up attempts. On March 13th, one store committed to joining the program, JG Town Liquor and Smoke. It is the first store located in the Sparks area. Staff are now working with the store owner to make healthy inventory changes with a full conversion process to be implemented by mid-April. Staff will continue outreach efforts for more store onboarding.	0	0	2	1	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.
(PI) 4.2.1.2 Expand the number of sites that are implementing the 5210 Healthy Washoe program from 5 to 10 elementary schools.	Two new sites were adopted to begin implementing the program 1. Glenn Duncan ES and 2. Alice Taylor ES. The ODHO team and the CDIP team continue to work together to identify strategies to bridge nutrition and physical activities components together to create more opportunities for students to engage in healthier behaviors while at school. The five pilot schools continue to receive TA and are focused on adopting more implementation strategies as outlined in their action plans.	0	0	7	2	4.2.1.2.1 Provide technical assistance to partner sites.
(VI) 4.3.1.1a # of FHF attendees	The next FHF is on May 22, 2024 at the Neil Rd. Recreation Center. There is no data to report until that date.	397	550		550	
(PI) 4.3.1.1 At least 80% of FHF participants will recieve the services needed.	The next FHF is on May 22 at the Neil Rd. Recreation Center. The Committee is working to bring direct services to families in the area and are working to secure funding sponsorships.	96.00%	95.00%	80.00%	95.00%	4.3.1.1.1 Screen 100% of FHF attendees during intake for primary care homes and insurance.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						4.3.1.1.2 Conduct outreach for partners and community-based organization's to participate in FHF's and promote events to underserved communtties.
						4.3.1.1.3 Secure partnerships with healthcare providers and Managed Care Organizations.
(PI) 4.3.1.2 Create 1 new coalition to increase the number of individuals in Washoe County covered by health insurance.	It was determined by staff and partners to redirect efforts to focus on other CHIP activities that are improving access to health care for the community. As such, this effort will retire.	0	0	0	0	4.3.1.2.1 Facilitate coalition convenings and identify strategies and actions to be implemented.
						4.3.1.2.2 Complete 2023 health insurance enrollment campaign.
(PI) 4.3.1.3 Implement at least three initiatives designed to improve access to care.	Staff are working to identify other activities that require collaboration to include in the CHIP. Many of the CHIP activities expired in 2023 due to efforts being redirected or lack of resources to provide programming such as Greet, Eat and Meet, an effort to increase the community's knowledge of insurance benefits. While not a CHIP initiative, NNPH is working with statewide partners to complete an assessment to determine access to health care in Washoe County and will complete an improvement plan based on the data gathered. We can anticipate onboarding more activities focused on improving access to health care once the improvement plan is completed in May/June.	3	3	0	1	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.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.4.1.1 Serve an average of 500 seniors monthly through all Golden Groceries pantries in Washoe County.	About 650 clients are accessing Golden Grocery pantries each month. FBNN shared that the number of clients being served is likely due to SNAP benefits being pulled back from receiving additional help during the pandemic. Staff are looking for other partners and locations to place additional pantries because the need has increased in the community.	0	1,328	500	3,273	4.4.1.1.1 Promote access to existing Golden Grocery Client Choice pantries in Washoe County.
(PI) 4.5.1.1 Implement/ execute 4 strategies in the EMS Strategic Plan FY24-29.	Only one of the three strategies for this fiscal year have been completed (in Q1, it was determined a continuous quality improvement process for pre-hospital treatment/patient outcome already existed and was compliant with the law. Goal 7 of the EMS Strategic Plan is considered completed.). The other strategies are all still in progress.	1	1	3	1	4.5.1.1.1 Reduce EMS practitioner exposures to infectious illnesses. 4.5.1.1.2 Decrease EMS practitioner physical and psychological injuries due to active shooter and civil unrest. 4.5.1.1.3 Increase EMS practitioner driver safety. 4.5.1.1.4 Create and implement a CQI process for pre-hospital treatment/ patient outcome.
(PI) 4.6.1.1 Increase community access to CHA data via online dashboard from 0 to 500. (# of web visits)	Q1 - 0 Q2 - 0 Q3 - 353 visits, 185 new users Online dashboard just launched near the end of Q3.	0	0	0	353	4.6.1.1.1 Work with TMT to develop a dashboard. 4.6.1.1.2 Maintain a dashboard with CHA indicators as data.
(VI) 4.6.2.1a # of collaborative initiatives in the CHIP		19	19		23	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.6.2.1 Complete at least 60% of activities planned in the CHIP.	71% of CHIP Activities were achieved as planned in year 1 of implementation. Included in the 2023 CHIP Annual Report are the details about year 1 activities and updates going into year 2 of implementation.	59.00%	60.00%	0%	71.00%	4.6.2.1.1 Invest in community partners to improve community health improvement outcomes.
(PI) 4.6.2.2 Maintain the number of organizations leading CHIP initiatives	In year 2, three new initiatives were added to the CHIP. 1.Focus Area Mental Health: Washoe County Sequential Intercept Model. The initiative has two lead agencies implementing activities, Washoe County Manager's Office and the Second Judicial Court 2. Focus Area Mental Health: Rez Girls Wellness Retreat and Boys Wellness Retreat 3.Focus Area Social Determinants of Health: Hello Real Estate	27	27	30	31	
(PI) 4.6.2.3 Implement at least 2 CHIP initiatives focused on policy changes that alleviate causes of health inequities.	Staff solicited input from community partners during the CHIP Subcommittee meetings to identify opportunities to work together on policy changes. Housing is an area that subcommittee members expressed a desire to work on or to include in the CHIP. NNPH's Government Affairs Liaison and Management Analyst met with housing specialists with the City of Reno, Reno Housing Authority and Washoe County to discuss opportunities to collaborate. More discussions are needed in the future as jurisdictions need some time to identify next steps with their current projects. Additionally, staff are looking into other policy efforts that align with the CHIP focus areas.	0	3	1	3	4.6.2.3.1 Review policies or laws that have a disproportionate effect on one or more subpopulations in Washoe County; impact CHIP focus areas or the Health District's legislative priority areas. 4.6.2.3.2 Gather input from stakeholders about policies under review and collaborate with stakeholders to share findings of the review.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.6.2.4 Increase the number of partners representing underserved parts of our community participating in CHIP initiatives from 2 to 8.	Through the Financial Literacy Initiative, the Health Equity Team (HET) has been able to create relationships with partners that are subject matter experts in financial literacy such as Guild Mortgage, Marvin Insurance, Amity Insurance, and Arbor Financial Group. The presenters for these classes are Hispanic/Latino and are able to offer the sessions in English and Spanish to better reach underserved populations that have limited English proficiency. Additionally, the Anything But the Gym initiative kicked off this quarter with the Black Community Collective collaborating with Black and minority women to improve physical activity, mitigate chronic disease, and encourage nutritious habits.	3	5	6	10	4.6.2.4.1 Build partnerships through community based meetings, discussions with community leaders and events. (HE Plan Goal 3, Initiative 1)
(PI) 4.6.2.5 Maintain the number of individuals who provide input to the CHIP. (# of people at Steering Commitee, subcommittee meetings, and plannings meetings)	Partners updated their action plans to reflect implementation activities for year 2. The next set of CHIP Subcommittees are scheduled for the fall to determine CHIP support and to prepare partners for year 3 of implementation.	0	198	175	229	4.6.2.5.1 Engage community members in the decision making process to update initiatives for year 2. 4.6.2.5.2 Complete CHIP Annual Report.
(PI) 4.6.2.6 Recruit at least 10 community representatives to establish 1 cross-sector health coalition. (# of committee members)	The CHIP Steering Committee continues to be the cross-sector health coalition needed to discuss the evolving needs of the community and opportunities to collaborate with partners to improve the health of the community. Other efforts will likely be explored to add to the Steering Committee as the needs of the community evolve.	0	16	5	16	4.6.2.6.1 Develop a process to respond to community members and organizations on commitments.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.6.2.7 Maintain a network of relationships with key organizations and leaders, and address at least 3 gaps in relationships to address disparate health outcomes.	The Health Equity team (HET) became a member of the NAACP this quarter. Also, the HET continues to maintain relationships with the Latino Stakeholders Council (specifically, their education pillar), the Asian Community Development Council (ACDC, to connect them to vaccine resources for an immunization event at the Thai temple), and with Tribal Minds to connect them to managed care organizations for additional financial support for their Indigenous Youth Wellness retreats. These are examples of relationships that continue to be tended to and strengthened.	2	4	2	8	4.6.2.7.1 Identify, pilot and implement a system to track health equity relationships with key community partners and leaders. 4.6.2.7.2 Establish participatory leadership opportunities for community members to influence public health through the CHIP Steering Committee, CHIP initiative subcommittees, Health District Advisory Boards, and/or Health District Hearing Boards or other opportunities.
(PI) 4.6.3.1 Identify at least 3 initiatives or projects for divisions to work with community-based partners to impact health disparities.	This quarter, members of the Health Equity Team (HET) collaborated with WIC regarding new mama care kits. This program is a partnership with NNPH and the Northern Nevada Maternal and Child Health Coalition (MCH). Necessary after-birth supplies are often unattainable for low-income families and these kits fill this need. The HET supported WIC in connecting them to community contacts that could distribute the kits at their community locations, as well as connect the WIC team to potential donors in the community to support the purchase of additional after-birth supplies.	1	1	2	2	4.6.3.1.1 Apply community organizing principles and health equity best practices among Health District programs to address health disparities. (HE Plan Goal 3, Initiative 2)

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.7.1.1 Execute a Chemical Surge Exercise with regional healthcare partners and finalize After Action Report within 90 days following.	Planning meetings held on January 4, January 30, February 7, March 12, March 18. Planning continues. The Exercise is scheduled for April 9 and 10. An After-Action Report will be completed after the exercise.	25.00%	50.00%	75.00%	75.00%	4.7.1.1.1 Develop a MOU for partner utilization of the mobile medical/ command post vehicle. 4.7.1.1.2 Participate in 90% of requested school EOP meetings. 4.7.1.1.3 Produce an after action/ improvement plan within 90 days following the exercise. 4.7.1.1.4 Conduct HSEEP planning meetings.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.7.2.1 Complete 75% of planned activities identified by the IHCC.	EMS/Fire YTD: A workgroup was held with EMS and Fire agencies in September to discuss updates to the MCI Plan and a timeline of these updates is currently being drafted. A meeting will be scheduled following the MCI drill in November to discuss the integration of REMSA as the Medical Branch Leader. Northern Nevada Public Health will connect with Reno Fire Department as they are already working on interagency training with law enforcement. Lessons learned from the MCI Functional and MCI Full-Scale Exercise will be incorporated into the MCI Plan and brought to IHCC for review and approval. Hospital YTD: MCI Plan and MAEA training continues to be promoted through the IHCC weekly emails and monthly IHCC meetings. In July, the EMS Oversight Program and HPP held MCI trainings for Northern Nevada Sierra Medical Center and Incline Village Community Hospital. Incline Village Community Hospital also received training on the MAEA. MCI and MAEA training continues to be provided to community partners. The filming of the MAEA Video is expected to be completed in Q4 and will be shared with partners. Skilled Nursing YTD: In September, a workgroup was held with these agencies to discuss their top priorities. Northern Nevada Public Health in collaboration with partners will create a video explaining the evacuation process in healthcare facilities. To address the staff and resource sharing plan, Northern Nevada Public Health will send out a survey to all IHCC partners in quarter 2. Filming of the evacuation video is ongoing and is expected to be finalized in Q4. Clinic YTD: In September, a workgroup was held with these partners to discuss their top priorities. Northern Nevada Public Health will send out trainings, resources, and examples for Continuity of Operations (COOP) plans in	10.00%	40.00%	50.00%	75.00%	4.7.2.1.1 Update IHCC guidelines annually. 4.7.2.1.2 Complete Resource and Gap Analysis annually. 4.7.2.1.3 EMS/ FIRE Planned Activities: MCI Plan Updates and Interagency training with law enforcement. 4.7.2.1.4 Hospital Planned Activities: Training and Exercising the MAEA and MCI plans. 4.7.2.1.5 Skilled Nursing/Memory Care/Assisted Living PLanned Activities: Evacuation planning/training and staff and resource sharing plan. 4.7.2.1.6 Clinic/ Ambulatory Surgery Center Planned Activities: COOP, Recovery/ Business Continuity Planning; Staff and Resource Sharing Plan; Emergency Operations Planning; Staff and Resource Sharing Planning.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
	quarter 2. To address the staff and resource sharing plan, NNPH will send out a survey to all IHCC partners in quarter 2. NNPH will share information on active assailant training and provide updates about emergency credentialing to address emergency operations planning. In regard to surge capacity planning, partners and NNPH will explore ways to transition ambulatory centers to the mechanism of an Emergency Department (ED) in the event of a Mass Casualty Incident (MCI) or other large event. During the MCI Functional Exercise in Q3, partners discussed the integration of ambulatory surgery centers during an MCI. Hospital Preparedness Program (HPP) Capability Survey results were shared with these partners and top priorities for FY25 were identified. Home Health YTD: A workgroup was held in September with these partners to discuss their top priorities. Renown Home Health and Hospice and NNPH shared information about Joint Commission consultants to the group. NNPH conducted two Home Health, Hospice, and Dialysis Data Collection exercises to identify if these partners can successfully pull patient information and securely send information to the Medical Service Unit in the event of an emergency that would require evacuation. These exercises will continue to be held every other month. In Q3, partners expressed reducing the frequency of data collection exercises to biannually. HPP Capability Survey results were shared with these partners and top priorities for FY25 were identified.					4.7.2.1.7 Home Health/Hospice Planned Activities: Informaiton Sharing/ Communications Plan and Exercise Plan. 4.7.2.1.8 Public Health Planned Activities: MCI/ MAEA Plan updates and Shelter Support Plan.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 4.8.1.1 Initiate at least one new project collaboration with UNR per year. (# project collaborations)	An asynchronous training opportunity offered at UNR School of Public Health will be offered as a resource of training those without public health-specific degree or training. The course feedback and continued review is ongoing.	0	0	0	0	4.8.1.1.1 Maintain regular communications through a joint advisory committee for new research and developments. 4.8.1.1.2 Participate on UNR's graduate committee. 4.8.1.1.3 Increase research resources through identifying shared resources. 4.8.1.1.4 Identify joint research opportunities and joint grant funding resources. 4.8.1.1.5 Identify training opportunities for WCHD staff through UNR. 4.8.1.1.6 Maintain the continunity of and improve joint course on real world public health applications.
(PI) 4.8.1.2 Ensure standardized, recurring intership opportunities. (# of recurring internship opportunities) (maintain minimum of 3 per year)	Recurring internship opportunities are continuously being discussed with programs, and staff is always working to implement them. Currently, two internship projects that can be recurring are being discussed and are looking for MPH students, one being in government affairs and another in EMS data cleaning and reporting.	0	0	0	0	4.8.1.2.1 Improve the quality of internship opportunities for UNR students in all disciplines.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 5.1.1.1a # of retirements.		1	1		0	
(VI) 5.1.1.1b # of non-retirements, promotion or transfer departures		10	17		11	5.1.1.1b.1 Conduct exit interviews with all departing staff via online survey.
(VI) 5.1.1.1c # of promotions/ transfers.		5	7		1	
(PI) 5.1.1.1 Maintain 5% or less employee vacancy rate (vacancy rate= average monthly vacancy rate including all employees).	Several of the positions included in this vacancy report are COVID positions and the AHS Office Assistant position that will be delimited during this budget cycle. The positions in Health are complex, and it is hard to find qualified staff that are willing to stay (for example, even though we have raised our Nursing wages, they can still make better money working in a hospital). Many candidates nowadays do not take a position with the plan of staying long term. Many like to test out a position, and if it is not exactly what they want, they move on.	11.00%	13.64%	5.00%	7.94%	5.1.1.1.1 Provide monthly vacancy report to include insights/trends on hard to fill positions. 5.1.1.1.2 Recruit and promote career opportunities via social media outl ets and other direct channels that reach individuals withi n the community.
(PI) 5.1.1.2 Increase mandatory training completion rate from 96% to 98%.	Staff ultimately are accomplishing all required training; however, sometimes it doesn't get done within the target time frame.	0%	91.38%	98.00%	96.41%	5.1.1.2.1 Remind staff of mandatory trainings via email. 5.1.1.2.2 Track mandatory training completion rate to present to DDs and Supervisors.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 5.1.1.3 Increase probationary/ annual evaluation completion rate from 80% to 85%.	Supervisors required to perform staff performance evaluations are sometimes stretched thin in terms of workloads and existing priorities. Unfortunately, yearly staff evaluations can sometimes fall through the cracks because of this. We are mindful of this and trying to get back on track, but staff turnover and new supervisors and even DDs (who are not as familiar with the employee evaluation process) have also played a role in why we can fall behind.	79.00%	75.55%	85.00%	68.20%	5.1.1.3.1 Generate monthly communication to DDs and supervisors to keep them informed of schedule. 5.1.1.3.2 Provide training related to running effective and meaningful evaluations.
(PI) 5.1.1.4 Increase percentage of employees who recommend WCHD as a good place to work from 76% to 78%.	The survey will be conducted by WC HR in the Spring of 2024	0%	0%	0%		5.1.1.4.1 Continue to provide thoughtful, consistent, optional flex, hybrid, and remote work as appropriate based on position. 5.1.1.4.2 Identify and provide ongoing opportunities for staff to provide input. 5.1.1.4.3 Support and implement an employee recognition program. 5.1.1.4.4 Create opportunities for staff to work across divisions on projects and task forces. 5.1.1.4.5 Provide onboarding program to integrate staff into WCHD team.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						5.1.1.4.6 Provide a quarterly orientation about the full organization to new employees.
						5.1.1.4.7 Promote key takeaways activity.
(PI) 5.1.1.5 Increase transparent internal communications from 0 to 4.	We've been consistent in sending our NNPH internal newsletter, named "The Buzz", every two weeks in Q3. • On Jan. 25, the main update was promotion of a series of trainings about advancing understanding of diversity, equity and inclusion. • On Feb. 22, the main update was about promotion of the City of Reno/NNPH public community forum for sidewalk vending regulations, which was available in English and Spanish. • On March 7, we had an update about a training "How do social barriers affect health?", which is part of a free interactive cultural competency training course developed by NNPH, DEI consultant Tiffany Young and the Larson Institute.	0	2	3	9	5.1.1.5.1 Launch internal newsletter. (promote Tell Kevin, workforce development, budget)
(VI) 5.1.2.1a # of staff participating in district-wide professional development opportunities.		114	239		280	5.1.2.1a.1 Provide at least 2 leadership development opportunities to staff.
						5.1.2.1a.2 Identify at least one professional development opportunity as part of each employee goal setting.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						5.1.2.1a.3 Collaborate with DDs and ODHO to identify training challenges.
(PI) 5.1.2.1 At least 50% of of employees will report feeling proficient on targeted core competencies.	Core Competencies were assessed in the training evaluation led by Brian Bullock with International City/County Management. He is the training consultant delivering the leadership training series to supervisors. The results from the assessment will be provided in April. Supervisors were provided with a list of reflection questions to discuss with their Division Director in an effort to continue the conversation and learnings from the training.	0%	78.00%	50.00%	78.00%	5.1.2.1.1 Provide targeted core competency training on areas identified through staff and supervisor input.
						5.1.2.1.2 Identify 1-2 core competencies for trainings to include on pre-post assessments.
						5.1.2.1.3 Evaluate improvement on targeted core competencies as assessed by employees and supervisors.
						5.1.2.1.4 Train DDs and supervisors on the budget process.
						5.1.2.1.5 Provide FAQs for staff on budget process and grants.
						5.1.2.1.6 Build out additional onboarding activities for supervisors over their first year.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 5.1.3.1 Increase the number of mental health resources provided to staff in the workplace from 2 to 3.	Three webinars focused on wellness were promoted and added to the WFD portal. **April 16** - Workforce Wellness Recharge: Self-Awareness **May 14** - Workforce Wellness Recharge: Personal Stress Management **June 11** - Workforce Wellness Recharge: Managing Systemic Stress	0	0	2	3	5.1.3.1.1 Provide optional opportunities to learn about wellness techniques and strategies.
(PI) 5.2.1.1 Meet 100% of requirements to maintain accreditation.	The PHAB committee continues to make progress towards completing measures for NNPH's reaccreditation application. The next major milestone to complete is to have 80% of all documents ready for submission by the end of May.	100.00%	100.00%	100.00%	100.00%	5.2.1.1.1 Submit annual reports with all required documentation. 5.2.1.1.2 Convene reaccreditation committee. 5.2.1.1.3 Gather at least 50% of documents required for reaccreditation by the end of year.
(PI) 5.2.1.2 Increase the number of QI projects implemented across the HD from 0 to 3.	The PHAB team distributed the NACCHO QI survey to staff to diagnose the current state of a culture of quality in the organization. The culture is being assessed against the six phases promoted within NACCHO's Roadmap to a Culture of QI. Preliminary data suggests NNPH falls between phase 3 or phase 4 where QI is occurring informally, but data is not used consistently for decision making. Furthermore, the data highlights the need to regularly seek opportunities to infuse QI through divisional activities. Additional efforts have been made to relaunch the QI council by recruiting a representative from each division. Strategies to enhance the culture of QI are being discussed with leadership and will be shared with staff once the next steps have been determined.	0	0	2	0	5.2.1.2.1 Establish and convene QI team . 5.2.1.2.2 Develop a QI plan. 5.2.1.2.3 Train staff about QI concepts and internal process. 5.2.1.2.4 Communicate with leadership, governing body, and stakeholders about QI activities.
(VI) 5.3.1.1a # of filled positions		224	227		220	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 5.3.1.1b # of FTE		197	202		202	
(VI) 5.3.1.1c # of filled FT/PT employees		172	176		177	
(VI) 5.3.1.1d # of internship opportunities at WCHD		9	9		9	
(PI) 5.3.1.1 Increase investment in personnel where workforce capacity is a barrier to productivity. (% increase in FTE)	One of the most significant ways we increase workforce capacity is through trainings and opportunities paid for by grants, but there currently are no new grants available to take advantage of. Funding is the biggest challenge related to advancing this measure.	0%	0%	0%	0%	5.3.1.1.1 Update FPHS assessment for FY24 and work statewide to build the case for support for ongoing public health funding.
(PI) 5.3.2.1 Make progess on the health equity plan by completing 8 initiatives.	This quarter, four health equity initiatives either continued or were completed from the health equity plan. The progress made includes maintaining and increasing Spanish language presence on live and social media, continuing to implement public health campaigns that promote health equity and reduce health disparities including 5210, provide easily accessible community health data utilizing the Truckee Meadows Tomorrow dashboard, and collaborating with Washoe County HR on a workforce development pilot project, to include reviewing job descriptions for systemic barriers.	0	7	0	11	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 5.3.3.1 Review at least 10 job descriptions to evaluate for systemic barriers to hiring a diverse workforce.	NNPH's PHAB and Health Equity team have been meeting with Washoe County Human Resources to discuss a pilot project of reviewing a handful of job descriptions as a strategy to recruit and maintain a diverse workforce. To date, three meetings have been held to continue to discuss the pilot project and look into potential consultants who have experience in reviewing job descriptions with a health equity lens.	0	0	0	0	5.3.3.1.1 Review targeted job descriptions to evaluate for systemic barriers such as language, educational requirements, or other access issues, starting with those positions that have the highest potential to impact health equity (HE Plan Goal 7, Initiative 2)
						5.3.3.1.2 Annually review how the demographics of the health district workforce compare to the demographics of the community we serve. (HE Plan Goal 7, Initiative 3)
						5.3.3.1.3 Create inclusive job descriptions that attract candidates.
(VI) 5.3.3.2a # of existing staff who complete asynchronous cultural competency training.		0	0		2	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 5.3.3.2 100% of new staff will take asynchronous cultural competeny training as part of the onboarding process.	NNPH's first cohort of new staff have taken the training. The course was built to be 6 hours of training; however, new staff have reported that the training is taking them longer to complete. Therefore, this has provided challenges with 100% of staff completing the training on time as part of the onboarding program. Three new staff are currently enrolled, and 14 total new staff have completed the training.	0%	0%	100.00%	58.00%	5.3.3.2.1 In partnership with the Larson Institute build, pilot and launch an asynchronous, online training designed specifically to build health equity competencies from the Council on Linkages and Public Health Practices. Require all new staff to complete within the first 180 days and offer to all existing staff regularly.
(VI) 5.3.3.3a # of staff participating in district offered DEI/cultural competency professional development opportunities.		90	116		160	5.3.3.3a.1 Offer district-wide diversity, equity, inlcusion, cultural competency and/ or health equity training to health district staff.
(VI) 5.3.3.4a # of staff participating in informal opportuntiies to explore DEI, cultural competency and equity topics		0	0		0	5.3.3.4a.1 Continue and expand optional opportunities for staff to participaite in dialogue and reflection on diversity and equity topics. (HE Plan Goal 1, Initiative 3)

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 5.4.1.1 Develop and implement a plan to meet the office space needs of the Health District employees. (% of completion)	The 9th Street space plan has been delayed. An update on the project was provided at the Washoe County Department Heads meeting on February 14, 2024. The plan has not yet been presented to the Board of County Commissioners and it is anticipated that this presentation will occur in April. The ability to develop a plan is contingent upon knowing how much space will be provided to Health District staff.	10.00%	10.00%	75.00%	10.00%	5.4.1.1.1 Redesign floor plans to maximize the use of current space and implement changes. 5.4.1.1.2 Develop and implement plan for hybrid/ remote work to address unmet space needs.
(PI) 5.4.2.1 Ensure completion of new TB and expanded office space building. (Complete 3 steps - location identified, building design complete, contractor identified)	The County closed escrow on February 26, 2024 for the West Hills property. The TB Clinic will be located on this property (Step 1). A bid process was conducted for the selection of a contractor with final presentations held on March 5th and a vendor was selected through this process (Step 3). In addition, multiple building designs have been created, discussed, and edited. A final design is anticipated in April.	1	1	1	2	5.4.2.1.1 Confirm final location based on Washoe County Commissioners and County Manager decisions. 5.4.2.1.2 Support CSD in the approval of contractors and building design.
(PI) 5.5.1.1 Increase the percentage of AQMD customers paying through the Accela Customer Access platform to 25%. (estimated average for all programs)	The rolling average of AQMD customers paying through the Accela Customer Access platform is 18%. The inability of customers of the Wood-Burning Device program has and will continue to be a barrier to achieving the stated goal.	15.00%	17.00%	0%	18.00%	5.5.1.1.1 Work with Technology Services and consultant to streamline Accela Customer Access submittal process.
(PI) 5.5.1.2 Increase payments made via Accela. (EHS)	Accela VIP project is still under way. Temporary Food Event permits are projected to go live in early Q4 which is the first record type to go live for NNPH.	12.45%	19.00%	50.00%	20.38%	5.5.1.2.1 Ensure kiosk is set up and available to customers by August 1, 2023. 5.5.1.2.2 Create written instructions by August 1, 2023.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						5.5.1.2.3 Create videos by September 1, 2023.
						5.5.1.2.4 Distribute public service announcements.
						5.5.1.2.5 Add announcement to website.
						5.5.1.2.6 Educate customers to help them understand how to submit payment via Accela by November 1, 2023.
						5.5.1.2.7 Revise and communicate instructions with customers by October 1, 2023.
						5.5.1.2.8 Communicate November 1, 2023 Accela launch date to customers via distribution lists, press releases, etc.
						5.5.1.2.9 Monitor and document lessons learned.
(PI) 5.5.2.1 % of new/renewed sources integrated into the software.	The air quality specific software continues to be developed to better reflect AQMD business processes and systems. In addition, AQMD is in the process of a quality improvement project related to the development and issuance of stationary source permits. It is expected that permits will begin to be integrated into the software beginning January 2025.	0%	0%	100.00%	0%	5.5.2.1.1 Draft SOP for use of software by January 2024.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 5.5.3.1a # of all Health IT help desk tickets			683		1,034	
(VI) 5.5.3.1b # of health desk tickets going through County TS			198		277	
(PI) 5.5.3.1 Montior average time (in minutes) to close help desk ticket.	County TS is implementing a new ticketing system that will be implemented through summer 2024. This activity will be completed when the new system is in place.	0	0	0	0	5.5.3.1.1 Establish help desk ticketing system workflow for employees. 5.5.3.1.2 Train employees on the help desk ticketing system workflow. 5.5.3.1.3 Track 100% of IT time by cost allocation. 5.5.3.1.4 Identify TS capacity dedicated to each division and identify workload capacity. 5.5.3.1.5 Track 100% of projects by category. 5.5.3.1.6 Work with TS to revamp ticket categories based on type and then track going foward. 5.5.3.1.7 Categorize help desk tickets to identify problem areas/projects where staff need support.

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
						5.5.3.1.8 Create training for staff based on challenging areas identified.
(VI) 6.1.1.1a Amount of expenditures.		$ 0.00	$ 16,278,184.00		$ 26,012,232.00	
(VI) 6.1.1.1b Amount of income.		$ 0.00	$ 13,495,237.00		$ 22,231,930.00	6.1.1.1b.1 Advocate for dedicated public health funding at the federal, state and local level.
(PI) 6.1.2.1 Maintain 100% compliance with purchasing and contract procedures.	As a government agency, we must stay 100% compliant with this measure, so it is a top priority we always attend to.	100.00%	100.00%	100.00%	100.00%	6.1.2.1.1 Deliver and record 1 staff training on the purchasing and contract process. 6.1.2.1.2 Provide FAQs for staff.
(PI) 6.1.2.2 Maintain 100% of grant compliance.	As a government agency, we must stay 100% compliant with this measure, so it is a top priority we always attend to.	100.00%	100.00%	100.00%	100.00%	6.1.2.2.1 Meet with program managers to understand areas of opportunity to learn about grant process 6.1.2.2.2 Standardize training process to ensure staff is clear on grant process and compliance expectations. 6.1.2.2.3 Provide 1 training on grant compliance to staff.
(VI) 6.1.2.3a Amount of revenue generated by grants and relief funding		$ 0.00			$ 8,056,904.00	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(VI) 6.1.2.3b # of grants received		0			53	
(PI) 6.1.3.1 Set a baseline for % of costs recovered for clinic services through client and third-party payer payments.	As of 1/1/2024 CCHS fees increased by 10%. CCHS is on track for planned cost recovery for FY24. Plan was $508,376.95 and to date $513,344.04 has been recovered through client and third party payers.				100.98%	
(PI) 6.1.3.2 Maintain or increase access to services and revenue through billable services. (# of contracted insurance companies) (10 to 12)	We are still contracted with 11 insurance companies at this time. For months, we have been negotiating with Silver Summit to try and secure a contract with them. At this time, we are at a stand still over insurance requirements. The contract has been sent to Risk and Legal and we awaiting a response from Silver Summit about the insurance requirements and for Legal to give their go ahead.	10	11	10	11	6.1.3.2.1 Review error and rejection report daily to minimize inaccurate claim submission. 6.1.3.2.2 Submit clean claims to insurance companies the first time to eliminate costly appeals and ensure maximum reimbursement for services.
(PI) 6.1.3.3 Maintain 100% cost recovery for AQM permitting and compliance programs.	AQMD has been diligently tracking the budget to be prepared to assess cost recovery at the close of the fiscal year.	0%	0%	0%	0%	6.1.3.3.1 Work with DDHO and AHS staff to assess current fee structure and develop new methodology. 6.1.3.3.2 Present new fee methodology to regulated community, stakeholders and DBOH.
(PI) 6.1.3.4 Increase the percent of costs recovered through EHS fees.	This metric is reported on an annual basis.	0%	0%	0%	0%	6.1.3.4.1 Meet with admin staff at least quarterly to monitor fee trends.
(PI) 6.1.3.5 Maintain 100% cost recovery for vital records services.	The % cost recovery will be calculated at the end of the fiscal year.	0%	0%	0%	0%	

Outcome	Analysis	Q1 Actual	Q2 Actual	Q3-24 Target	Q3-24 Actual	Initiative
(PI) 6.1.4.1 Make progress toward maintaining an ending fund balance of 10-17%.	We won't know an exact number until the books close at the end of the fiscal year. However, we have been tracking our expenses consistently throughout the year and appear to be on track. Based on current projections, we'll be within the 10-17% range within the next 24 months.			0%		6.1.4.1.1 Provide monthly financial review to the Board.

Legend

- **On Target** if the Outcome/Initiative met or exceeded the expected target.
- **In Progress** if the Outcome/Initiative has partially met its intended target or is an ongoing effort.
- **Off Target** if the Outcome/Initiative did not meet its intended target.
- **Not Started** if the Outcome/Initiative has not yet been started.
- **Volume Indicator** measures the number of activities completed or services provided.