Washoe County Health District

WASHOE COUNTY HEALTH DISTRICT
1001 East Ninth Street / P.O. Box 11130
Reno, Nevada 89520
Telephone 775.328-2400 • Fax 775.328.2279
www.washoecountv.us/health

MEETING NOTICE AND AGENDA

Washoe County District Board of Health

Date and Time of Meeting: Thursday, September 26, 2013, 1:00 p.m.

Place of Meeting: Washoe County Health District
1001 East Ninth Street, Building B
South Auditorium
Reno, Nevada 89520

District Board of Health Meeting Agenda

All items numbered or lettered below are hereby designated **for possible action** as if the words "for possible action" were written next to each item (NRS 241.020). An item listed with asterisk (*) next to it is an item for which no action will be taken.

Time	Agenda Item No.	Agenda Item	Presenter
1:00 PM	*1.	Call to Order, Pledge of Allegiance Led by Invitation	Mr. Smith
	*2.	Roll Call	Mr. Flores
Public Comment	*3.	Public Comment (limited to three (3) minutes per person)	Mr. Smith
	4.	Approval/Deletions to Agenda for the September 26, 2013 Meeting	Mr. Smith
	5.	Approval/Additions/Deletions to the **Minutes** of the **August 22, 2013 Regular Meeting**	Mr. Smith
	*6.	Recognitions A. Introduction of New Employee(s) – 1. Joshua Restori – F/T AQ Spec II – AQM – 9/09/13 2. Introduction of Jessica Ponce and Andrew Stutman, Public Health Associate Program (PHAP) Staff from CDC B. Promotions – 1. Daniel Timmons – AQ Spec II – AQM C. Years of Service – 1. Virginia Williamson – CCHS – 20 years D. Retirements – None.	Mr. Smith and Mr. Dick
	7.	Proclamations – Approval of a Proclamation Declaring September as National Preparedness Month	Mr. Smith and Mr. Dick

Time	Agenda Item No.	Agenda Item	Presenter
	8.	**Consent Agenda: Matters which the District Board of Health may consider in one motion. Any exceptions to the Consent Agenda must be stated prior to approval.** A. **Air Quality Management Cases:** 1. Recommendation to Uphold Unappealed Citations to the Air Pollution Control Hearing Board: **a. Builtall Construction – Case 1124, NOV 5277** 911 Linda Way, Sparks, NV 89431 **b. Bailor Construction – Case 1125, NOV 5278** PO Box 21231, Carson City, NV 89721 **c. Bison Construction – Case 1126, NOV 5279** PO Box 3198, Carson City, NV 89702 **d. Boys & Girls Club – Case 1128, NOV 5274** 2680 East 9th Street, Reno, NV 89512 **e. Montane Building Group – Case 1131, NOV 5383** 5310 Keitzke Lane, Suite 206, Reno, NV 89511 2. Recommendation of Cases Appealed to the Air Pollution Control Hearing Board. **None.** 3. Recommendation for Variance: **None**. B. **Sewage, Wastewater & Sanitation Cases**: Recommendation to Approve Variance Case(s) Presented to the Sewage, Wastewater & Sanitation Hearing Board. **None.** C. **Budget Amendments / Interlocal Agreements:** 1. Approve termination of the Interlocal Agreement between the Washoe County Health District and the University of Nevada School of Medicine Integrated Clinical Services, Inc., and University of Nevada School of Medicine Multispecialty Group Practice North, Inc. dba MEDSchool Associates North (MSAN), to provide a faculty physician to serve as a consultant on pediatric Tuberculosis cases effective October 31, 2013. 2. Authorize Travel and Travel Reimbursements for two Centers for Disease Control and Prevention (CDC) Assignees (Jessica Ponce and Andrew Stutman), for the period of July 29, 2013 through August 1, 2015 in a total amount not to exceed $2,500. 3. Approval of Subgrant Amendment #2 from the Nevada State Health Division for the Women, Infants and Children (WIC) Clinic Program for the period of October 1, 2012 through September 30, 2014 in the total amount of $2,143,996 in support of Salaries and Benefits, Travel and Training, and Operating Expenditures; and if approved authorize the Chairman to execute.	Ms. Albee Ms. Buxton

Time	Agenda Item No.	Agenda Item	Presenter
		4. Approve Subgrant Amendment #2 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health for the period January 1, 2013 through December 31, 2013 in the amount of $99,227, bringing the total CY 2013 funding for the Immunization Program Grant (IOs 10028 & 10029), to $297,673; and if approved authorize the Chairman to execute. 5. Approve Notice of Subgrant Award for the period August 1, 2013 through July 31, 2014 in the total amount of $136,833 in support of the Centers for Disease Control and Prevention (CDC) Epidemiology and Laboratory Capacity (ELC) Affordable Care Act Federal Program, IO 10984; and if approved authorize the Chairman to execute. 6. Approval of Subgrant Amendment #2 from the Division of Public and Behavioral Health in the total amount of $623,386.50 (with $62,338.65 or 10% match) for the budget period July 1, 2012 through December 31, 2013 in support of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program; approve amendments totaling an increase of $37,058 in both revenue and expense to the FY14 ASPR Hospital Preparedness Federal Grant Program, IO 10708; Authorize travel and travel reimbursements for non-County employees (individuals to be determined) in the approximate amount of $3,000 specific to the Northern Nevada Disaster Victim Recovery Team Project, supported by the grant award; and if approved authorize the Chairman to execute. 7. Approval of Subgrant Amendment #2 from the Division of Public and Behavioral Health in the total amount of $1,045,473 (with $104,547.30 or 10% match) for the budget period July 1, 2013 through December 31, 2013 in support of the Centers for Disease Control and Prevention (CDC) Public Health Preparedness Program; approve amendments totaling an increase of $128,275 in both revenue and expense to the FY14 CDC Public Health Preparedness Federal Grant Program, IO 10713; and if approved authorize the Chairman to execute. 8. Proposed Approval of Agreement between the Washoe County Health District and Public Health Foundation in the amount of $63,900 to conduct part of a Fundamental Review of the Health District; and if approved, authorize the Chairman to execute the agreement.	Ms. Stickney
	9.	**Air Pollution Control Hearing Board Cases appealed to the District Board of Health.** None.	Ms. Albee

Time	Agenda Item No.	Agenda Item	Presenter
	10.	**Regional Emergency Medical Services Authority:** A. Review and Acceptance of the Operations and Financial Reports for August, 2013; and *B. Update of REMSA's Community Activities Since August, 2013	Mr. Gubbels
	11.	Presentation, Discussion, and Possible Direction to Staff regarding Emergency Medical Services ("EMS"), Including Recommendations Contained in the TriData Report and Various Other EMS Studies	Dr. Todd
	12.	Request and possible approval of extension of time to complete REMSA Franchise Agreement Negotiations	Mr. Dick
	13.	Review and Acceptance of the Monthly Public Health Fund Revenue and Expenditure Report for August, 2013	Ms. Stickney
	14.	Update on Citation and Enforcement regarding Prevention of Bear Activity within Populated Areas	Mr. English
	*15.	Presentation on National Association of Local Boards of Health (NALBOH) 21st Annual Conference held August 14-16, 2013 in Salt Lake City, Utah	Dr. Furman
	*16.	Informational Update regarding Nevada Revised Statute Requirements for District Board of Health Appointment of a District Health Officer, and the Washoe County Job Specification for the District Health Officer Position	Chair Smith and Ms. Admirand
	*17.	**Staff Reports and Program Updates** A. **Director, Epidemiology and Public Health Preparedness** Communicable Disease; Public Health Preparedness; Emergency Medical Services; and Vital Statistics	Dr. Todd
		B. **Director, Community and Clinical Health Services** Clinical Programs and Non-Communicable Disease Updates	Mr. Kutz
		C. **Director, Environmental Health Services** Food Program; Land Development; Solid Waste / Special Events; and Vector-Borne Disease Program	Mr. Sack
		D. **Acting Director, Air Quality Management** Air Quality; Planning and Monitoring Activity; Permitting Activity; Compliance & Inspection Activity; and Permitting & Enforcement Activity	Ms. Albee
		E. **Administrative Health Services Officer** Technology and WIC Updates	Ms. Stickney
		F. **Interim District Health Officer** REMSA / EMS, Fundamental Review, Staffing, Permit Software Project, Cross Divisional Initiatives, Other Events and Activities, and Health District Media Contacts and Outreach	Mr. Dick

Time	Agenda Item No.	Agenda Item	Presenter
Board Comment	*18.	Limited to Announcements or Issues for Future Agendas	Mr. Smith
	19.	Emergency Items	Mr. Dick
Public Comment	*20.	Public Comment (limited to three (3) minutes per person). No action may be taken.	Mr. Smith
	21.	Adjournment	Mr. Smith

Business Impact Statement: A Business Impact Statement is available at the Washoe County Health District for those items denoted with a "**$**."

Items on the agenda may be taken out of order, combined with other items, withdrawn from the agenda, moved to the agenda of another later meeting; moved to or from the Consent section, or they may be voted on in a block. Items with a specific time designation will not be heard prior to the stated time, but may be heard later. Items listed in the Consent section of the agenda are voted on as a block and will not be read or considered separately unless withdrawn from the Consent.

The District Board of Health Meetings are accessible to the disabled. Disabled members of the public who require special accommodations or assistance at the meeting are requested to notify Administrative Health Services in writing at the Washoe County Health District, PO Box 1130, Reno, NV 89520-0027, or by calling 775.328.2416, 24 hours prior to the meeting.

Time Limits: Public comments are welcomed during the Public Comment periods for all matters whether listed on the agenda or not. All comments are limited to three (3) minutes per person. Additionally, public comment of three (3) minutes per person may be heard during individual action items on the agenda. Persons are invited to submit comments in writing on the agenda items and/or attend and make comment on that item at the Board meeting. Persons may not allocate unused time to other speakers.

Response to Public Comments: The Board of Health can deliberate or take action only if a matter has been listed on an agenda properly posted prior to the meeting. During the public comment period, speakers may address matters listed or not listed on the published agenda. The *Open Meeting Law* does not expressly prohibit responses to public comments by the Board of Health. However, responses from the Board members to unlisted public comment topics could become deliberation on a matter without notice to the public. On the advice of legal counsel and to ensure the public has notice of all matters the Board of Health will consider, Board members may choose not to respond to public comments, except to correct factual inaccuracies, ask for Health District Staff action or to ask that a matter be listed on a future agenda. The Board of Health may do this either during the public comment item or during the following item: "Board Comments – Limited to Announcement or Issues for future Agendas."

Pursuant to NRS 241.020, Notice of this meeting was posted at the following locations:

Washoe County Health District, 1001 E. 9th St., Reno, NV
Reno City Hall, 1 E. 1st St., Reno, NV
Sparks City Hall, 431 Prater Way, Sparks, NV
Washoe County Administration Building, 1001 E. 9th St, Reno, NV
Washoe County Health District Website www.washoecounty.us/health

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Supporting materials are available to the public at the Washoe County Health District located at 1001 E. 9th Street, in Reno, Nevada. Mr. Bill Flores, Administrative Secretary to the District Board of Health is the person designated by the Washoe County District Board of Health to respond to requests for supporting materials. Mr. Flores is located at the Washoe County Health District and may be reached by telephone at (775) 328-2427 or by email at wflores@washoecounty.us. Supporting materials are also available at the Washoe County Health District Website www.washoecounty.us/health pursuant to the requirements of NRS 241.020.

Washoe County Health District

Washoe County District Board of Health
Regular Meeting Minutes
August 22, 2013

PRESENT: Chair Matt Smith, Vice Chair Kitty Jung, Dr. George Furman, Dr. George Hess, Dr. Denis Humphreys, Council Member Ratti, and Council Member Sharon Zadra

ABSENT: None.

STAFF:

Leslie Admirand, Deputy District Attorney
Kevin Dick, Interim District Health Officer
Eileen Stickney, Administrative Health Services Officer, AHS
Charlene Albee, Acting Division Director, AQM
Daniel Inouye, Monitoring and Planning Branch Chief, AQM
Steve Kutz, Division Director, CCHS
Robert Sack, Division Director, EHS
Randall Todd, DrPH, Division Director, EPHP
Phil Ulibarri, Public Information Officer, AHS
Steve Fisher, Department Computer Application Specialist, AHS
Bill Flores, Recording Secretary
Laurie Griffey, Administrative Assistant I, AHS
Patsy Buxton, Fiscal Compliance Officer, AHS
Kelli Seals, Health Educator, CCHS
David Boland, Senior Environmental Health Specialist, EHS
James English, Environmental Health Specialist Supervisor, EHS

TIME / ITEM	SUBJECT / AGENDA	DISCUSSION	ACTION
1:02 pm 1, 2	**Meeting Called to Order, Pledge of Allegiance and Roll Call**	**Chair Smith** called the meeting to order. Roll call was taken and a quorum noted. The Pledge of Allegiance was led by Council Member Zadra.	
3.	**Public Comment**	None.	
4.	**Approval / Deletions – Agenda – August 22, 2013**	**Chair Smith** called for any deletions to the Agenda of the August 22, 2013 DBOH Meeting.	**Council Member Ratti** moved, seconded by **Dr. Hess**, that the August 22, 2013, Agenda be approved as presented. **MOTION CARRIED**

TIME / ITEM	SUBJECT / AGENDA	DISCUSSION	ACTION
5.	**Approval / Additions / Deletions to the Minutes of the June 27, 2013 Regular Meeting and July 25, 2013 Regular Meeting**	**Chair Smith** called for any additions or corrections to the Minutes of the June 27, 2013 Regular Meeting and July 25, 2013 Regular Meeting.	**Council Member Ratti** moved, seconded by **Vice Chair Jung**, that the Minutes of the June 27, 2013 Regular Meeting and July 25, 2013 Regular Meeting be approved as presented. **MOTION CARRIED** **Council Member Zadra** noted abstention from approval of the July 25, 2013 Minutes.
6.	**Recognitions**	Mr. Dick and **Chair Smith** made the following recognitions: A. Introduction of new employee(s) – None. B. Years of Service – None. C. Retirements – 1. Stacey Akurosawa – EPHP – 16 years D. Recognitions – 1. Certificate of Senatorial Recognition and plaque presented to the Washoe County Health District in recognition of sponsoring the Keep Truckee Meadows Beautiful "Beautiful Business Program" accepted by Bob Sack and Jim English of EHS.	
7.	**Proclamations**	Healthy Living Week – September 15 – 21, 2013 – Proclamation accepted by Kelli Seals, Health Educator, CCHS. Ms. Seals presented handouts for upcoming events (filed).	**Vice Chair Jung** moved, seconded by **Council Member Zadra**, to approve the proclamation as presented. **MOTION CARRIED**
8.	**Consent Agenda**	**A. Air Quality Management Cases:** 1. Recommendation to Uphold Unappealed Citations to the Air Pollution Control Hearing Board: None.	

TIME / ITEM	SUBJECT / AGENDA	DISCUSSION	ACTION
		2. Recommendation of Cases Appealed to the Air Pollution Control Hearing Board. None. 3. Recommendation for Variance: None. **B. <u>Sewage, Wastewater & Sanitation Cases</u>**: Recommendation to Approve Variance Case(s) Presented to the Sewage, Wastewater & Sanitation Hearing Board. Variance Case No. 1-13S Mr. Richard Cook 4890 Turning Leaf Way Reno, NV 89519 **C. <u>Budget Amendments / Interlocal Agreements</u>:** a. Approval of Notice of Grant Award dated June 21, 2013 from the Department of Health and Human Services Public Health Service for the period June 30, 2013 to June 29, 2014 in the amount of $799,838 in support of the Family Planning Program; Approval of amendments totaling an increase of $14,838 in both revenue and expense to the FY 14 Title X Family Planning Federal Grant Program (IO 10025).	**Dr. Humphreys** moved, seconded by **Council Member Zadra**, that the Consent Agenda be approved as presented in a single motion. **<u>MOTION CARRIED</u>**
9.	**Air Pollution Control Hearing Board Cases Appealed to the District Board of Health.**	There were no cases for consideration this month.	
10.	**<u>Regional Emergency Medical Services Authority</u>:** A. Review and Acceptance of the Operations and Financial Reports for July, 2013; and	Mr. Jim Gubbels, President of REMSA, reported that in July, 2013, Priority 1 Compliance was at 92%, and Priority 2 Compliance was at 96%. Looking at Priority 1 Compliance by zone, the 8-minute zone was at 92%, the 15-minute zone was at 97%, and the 20-minute zone was at 98%. Looking at the average bill for the month for Care Flight, the average bill was $7,798, bringing the year-to-date total to $7,798. On the ground side, the average bill for the month was $1,066, bringing the year-to-date ground average to $1,066. Mr. Gubbels provided an update from a request from the Board of Health on July 25, 2013 regarding annexations. In 2004, there were many annexations taking place in the community which remained quite frequent until 2008. The Health District and REMSA got together to determine how they were going to deal with the influx of annexations. They called other ambulance companies across the nation, but there was not a lot of experience with annexations. This region was one of the few places dealing with this issue. Next, they went to both the planning committees in Sparks and Reno to understand how they deal with annexations and received explanations of their process	**Council Member Ratti** moved, seconded by **Council Member Zadra**, to accept the REMSA Operations and Financial Report for July 2013 as presented. **<u>MOTION CARRIED</u>**

TIME / ITEM	SUBJECT / AGENDA	DISCUSSION	ACTION
		with building and development of infrastructure. They then decided to develop a plan and create a process. First, the Health District would notify REMSA every time there was an annexation, and REMSA would have sixty days to look at the planned annexation and respond. Mr. Gubbels provided a handout (filed) illustrating annexations from 2004 to present with parcel number and ordinance number. These annexations are either included in an 8-minute zone or included within a study area. Out of 159 annexations on the list, 85 have been placed into the 8-minute zone, and 74 have been placed into the study area. From there, they developed a process to monitor and follow (filed). The annexations placed into the study area are studied to examine performance if placed into the 8-minute zone. As the cities look at public safety needs and placing of resources as the community grows, REMSA does the same. Double Diamond is a good example where they are just now looking at whether they should position a fire station in that area; Verdi and Spanish Springs are other examples. There is a fire station out in Wingfield Springs but not on Pyramid Highway. As the population grows, REMSA has to determine how they move forward and serve those people. Each month, REMSA sends a report to the Health District displaying who fell into the study zone. Every six months, they sit down and look at it cumulatively to see if they are going to change any of those zones. For example, during the month of July, 2013, there were 17 transports into the test area zones. Those test area zones are 15-minute zones, one is a 20-minute zone, and they studied them to an 8-minute zone. Out of those 17 calls, out of a total of 3,513 transports, representing .005%, they were late on 9 of the calls to the 8-minute standard, and 8 of the calls were on-time for a 47% compliance. There were two calls in a 15-minute zone in Arrowcreek Parkway. Both of those calls were on-time. Even though they are in a 15-minute assigned zone, they were on-time to a studied 8-minute response. There were two calls in a 15-minute zone in Double Diamond. They were late to an 8-minute standard, but they were on-time to a 15-minute standard. One call was .2 seconds late for an 8-minute standard, and the other one was 56 second late for an 8-minute standard. Therefore, Mr. Gubbels explained that they are not talking about a huge amount of time behind the 8-minute zone even though it is a defined 15-minute zone. In Northeast Sparks, there were five calls in that area for the month of which one call was late, coming in at 80%. That late call was four minutes past the 8-minute standard. That call was in a currently defined 20-minute zone, and they were there within 12 minutes and 43 seconds. These areas are not just automatically placed into the 8-minute zone due to compliance. For every one call late, he needs to be on-time ten times to make a 90% compliance. He pointed out that REMSA is not taking this lightly; this is something that is ongoing and is being studied.	
	BOARD COMMENT	**Dr. Hess** requested clarification on the color-coded map filed. Mr. Gubbels explained that all of the pink are 8-minute response zones, all of the orange are 15-minute response zones, and all of the yellow are 20-minute response zones. The study areas are in blue with some in Somersett, Verdi, Cold Springs, Sparks, Double Diamond, and a little bit of Arrowcreek Parkway. No different when looking at public safety services or city services, as these areas enlarge and develop with transportation and population base present, REMSA changes their resources to meet those needs. In the mean time, they are studying, no different than the cities would study, when there will be the economical opportunity to go ahead and change those	

TIME / ITEM	SUBJECT / AGENDA	DISCUSSION	ACTION
		response zones. **Chair Smith** asked if Mr. Gubbels had the fire response times for all of those areas. Mr. Gubbels responded that Dr. Todd had taken the period of April and matched data to determine if somebody arrived within the 8-minute standard. That one month study showed that 94% of the time, one of the agencies arrived within an 8-minute period of time. The importance of that study is to determine if there are gaps within the system. That was very limited, as we only had one month of shared data, and Dr. Todd wants to expand that further. One of the questions Mr. Gubbels raised in the EMS Working Group was if there are gaps in the community. If there are gaps, then either fire first response or REMSA needs to determine how those gaps are filled. He explained that the report was helpful in providing a picture that, between the response agencies combined, they are meeting response goals 94% of the time or greater. Even the unincorporated areas with Truckee Meadows Fire still show that one of them is still getting there within that period of time. **Dr. Humphreys** asked how the term "best effort" applies in this system. Mr. Gubbels responded that "best effort" does not apply here, because the annexations were defined as unincorporated areas and are now incorporated. **Dr. Hess** clarified that the white area on the map would be the "best effort" area. Mr. Gubbels responded in the affirmative but clarified that this area runs all the way to the Oregon border and down to Carson City as well as East and West. **Vice Chair Jung** asked if the Board could have a copy of the list to which Mr. Gubbels was referring. Mr. Gubbels responded that the list may be reviewed at the Health District, but, because it has addresses, it cannot be released per HIPAA. **Council Member Ratti** asked if a list could be created listing the 159 annexation areas and which ones were placed in the 8-minute zone and which were placed in the study area. Mr. Gubbels responded in the affirmative and provided a copy of that information to place in the record. Mr. Gubbels announced that REMSA received their reaccreditation from the International Academies of Emergency Dispatch of which the document was provided within the REMSA report. Internationally, REMSA is one of 4% that have this accreditation; they have maintained this accreditation since 2001. He is very proud of the REMSA staff to be able to continue to reach those measurements and meet these reaccreditations.	
	B. Update of REMSA's Community Activities Since July, 2013		

TIME / ITEM	SUBJECT / AGENDA	DISCUSSION	ACTION
11.	Presentation, Discussion, and Possible Direction to Staff regarding Emergency Medical Services ("EMS"), Including Recommendations Contained in the TriData Report and Various Other EMS Studies **BOARD COMMENT**	Randall Todd, DrPH, reported that the Board has been provided a fairly brief report of the last EMS Working Group due to the meeting's short length. He pointed out that he thinks it is a major accomplishment that the group got the resupply agreement signed. It had been the topic of discussion at several of these working groups. What REMSA has put together and what the fire first response agencies have agreed to try, at least on a 90-day trial basis, is a substantial improvement in terms of accountability for how these supplies get used by one agency and then resupplied by another agency. Dr. Todd noted that at the time of this meeting they had not received any of the 911 data that they were hoping to be able to merge in with the earlier study presented to the Board previously. They have received some data but not all; he believes there are some technical challenges in pulling the data the way they need it. Dr. Todd has offered his staff to assist if desired. They will continue to pull that data and refine the picture that was presented in the PowerPoint previously, providing better data going forward. **Chair Smith** noted that he received a call from the Reno Mayor who explained that REMSA is not reimbursing supplies to the Fire Department. He asked if that was the case. Dr. Todd responded in the negative. Mr. Gubbels responded that the supply exchange agreement is very old between the agencies, created in 1996. It is an exchange for supply goods at the scene. At that time, the fire service was supposed to complete a form indicating what supplies had been used, handing it to REMSA, which never occurred. The part of exchanging supplies did occur, but no documentation ever occurred. He pointed out that he needs to be accountable to his Board for the amount of supplies being used, and he is also asking the fire departments to be accountable. In the past, the fire department was basically taking the supplies that they felt they needed, and there was no accountability or measurement. Mr. Gubbels explained that he could not report how much money he spent last year in resupplying fire first response. Furthermore, some medications were being exchanged, and that cannot be done by law. He asked the fire chiefs back in June to work with him to change this process. At that point, medications were taken off the list, and there is another group of prescribed items, IV supplies, that by law cannot be exchanged. He admitted that even he did not know that. IV supplies are a prescription along with airway supplies. The first agreement allowed sending over a list of supplies used once per week which would then be replaced. With the items that cannot be exchanged, they will be tracked and reimbursed monetarily. Then, they agreed to reimburse monetarily on all items. REMSA agreed to reimburse on their cost. They did not like that idea, because REMSA buys supplies in bulk, resulting in different pricing. Now, the newly signed agreement involves fire agencies tracking what they use on a case. They actually login to REMSA's supply system, enter the run number, the date, and what they used. Every month, REMSA will monitor those entries, audit some of them, and then provide cash reimbursement for soft good supplies, IV supplies, and airway supplies used. This is a 90-day trial period. It puts accountability on both the fire side and the REMSA side so that they know exactly what is being spent.	

TIME / ITEM	SUBJECT / AGENDA	DISCUSSION	ACTION
		Council Member Ratti asked if REMSA staff ever take supplies from Fire. Mr. Gubbels responded in the negative. He continued that the one thing that will be exchanged at the scene is immobilization devices. Those are the backboards that REMSA purchased for the entire community. The Fire Department carries backboards, and REMSA carries backboards, including C collars. These are exchanged provided that they do not get depleted. They carry three in the ambulance, but once they get to the hospital, the backboard goes with the patient, creating the need to resupply the ambulance. **Council Member Zadra** asked if there was concurrence with the City that the IVs and drugs cannot be legally transferred. Mr. Gubbels responded that medication was an issue that obtained agreement that they will be responsible for their own. The IV and airway supplies will have remuneration through dollars. **Ms. Zadra** asked if this issue was just with the City of Reno or others as well. Mr. Gubbels responded that they began having conversations in June. The chiefs were more amenable, but when they got it down to their supply level, it came back up the chain of command with the chiefs voicing more concern. He had thought they were done in June, but now they are. It was signed with an effective date of August 15, 2013. No one has called him. Therefore, as far as he knows, the system is working. **Ms. Zadra** clarified if after this 90-day trial period this process will just continue if everything is working. Mr. Gubbels responded in the affirmative. **Ms. Zadra** asked if it will require a policy action from the Board. Mr. Gubbels responded in the negative and added that none of this is in the Franchise. Mr. Dick pointed out that Dr. Todd has included the resupply agreement in the Board packet and is signed by all of the fire chiefs. He thinks that this is a positive accomplishment of the EMS Working Group. **Chair Smith** asked **Council Member Zadra** if she could make sure that the Reno Mayor gets this information. **Ms. Zadra** agreed. **Dr. Hess** explained that it made no sense to him why the Sheriff wants to have medical dispatch.	

TIME / ITEM	SUBJECT / AGENDA	DISCUSSION	ACTION
		He asked for clarification on the Sheriff's position. Dr. Todd offered to very briefly summarize the Sheriff's position as he has heard it several times. He explained that the Sheriff maintains that when a call comes in to 911, that is purportedly a medical call, what might not be immediate apparent is that it could be a law enforcement issue. As an example, as provided by the Sheriff at the last meeting, a call came in to 911 as an apparent cardiac arrest. That is clearly a medical issue requiring an ambulance to be sent as quickly as possible. Therefore, dispatch will disconnect the call once REMSA is on the line and maintaining contact with the caller while the ambulance is en route. This is necessary so that pre-arrival instructions can be given, CPR can be started, where minutes and second can be critical with this type of event. However, as things continued to unfold, it became known that this incident was perhaps not a cardiac arrest but instead a self-inflicted gunshot wound. Apparently, the assertion was that nobody had asked about the location of the gun. When you have a gunshot wound, whether or not self-inflicted, and you do not know the whereabouts of the gun, then you have personnel potentially being in harm's way. It has been difficult to understand what percentage of the time does this happen. There were several examples like this provided. You can follow the logic that the Sheriff would be using, but Mr. Gubbels brought up the question if any of these incidents have been forwarded for review. The Sheriff's solution to this issue is that his office takes over dispatch. Dr. Todd explained that his solution at the meeting was that he believes they would all agree that better and timely exchange of information between the agencies would be useful in addressing the type of scenario that the Sheriff was describing. Dr. Todd argued, and the Sheriff agreed with him, that Mr. Gubbels' proposal was also a valid one. Looking at these specifics and finding some ways to do process improvement on how information is gathered as an event is unfolding, would also be useful. He thinks that they perhaps made some progress there. He also pointed out that the Sheriff does do emergency medical dispatch for the North Lake Tahoe Fire Protection District, falling outside the Franchise Area and acting as its own transport agency. **Council Member Zadra** requested clarification that the working group is going to attempt to perform some evaluation behind improving the current system versus changing dispatch. Dr. Todd responded that he believes that there is an agreement that they need better and timelier information. The TriData report suggested that this could happen through collocation of dispatch, meaning that REMSA's dispatch could simply be moved to the location of 911 dispatch. However, the TriData report also very clearly said that this could be done virtually. There are good examples of this occurring successfully in a virtual way. This means that the computer-aided dispatch (CAD) system that the PSAP is using to dispatch law enforcement and fire with a transfer to REMSA dispatch for EMD, could be linked with REMSA so that information inputted would immediately appear in both dispatch systems. Dr. Todd personally believes, and he noted that this is an area where they do not have consensus, that this would solve all of the problems that the Sheriff has identified as reasons why he should take over the dispatch operation. He also thinks that it would address many of the concerns that REMSA has expressed, from a medical standpoint, as to why they should retain EMD. In a very real sense, doing emergency medical dispatch and providing	

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		emergency medical services is the practice of medicine outside of the hospital, and the dispatch is a critical piece of that. He explained that the Sheriff makes some valid points, and REMSA makes some equally valid points. Where it comes apart is in how they resolve those points. He personally believes that technology can resolve that; he does not think the Sheriff is quite so sure of that. **Ms. Zadra** asked for confirmation that the EMS Working Group is committed to continue to evaluate. Dr. Todd responded in the affirmative. He is going to take the Sheriff's agreement, and he is hoping the Mr. Gubbels is going to take the Sheriff's agreement, and look at both as a yes. They should also take a look at the run numbers that he was citing so that REMSA can evaluate on a case-by-case basis. He hears the Sheriff saying that we need to look at this from a systems standpoint, not a case-by-case standpoint, but he thinks that REMSA is also correct that looking at specific cases can be useful for affecting process improvements. **Ms. Zadra** asked what is best practice for communities of similar size. Dr. Todd explained that there are so many differences from community to community. He thinks that we have a very fine emergency medical dispatch system with REMSA that is state of the art. The fact that it is staffed with people who are certified as EMTs or paramedics and who have significant field experience makes them very well able. EMD does require the ability to provide specific instructions and make modifications based on information obtained from the caller. There are many communities who use their PSAP for dispatching fire, law enforcement, and ambulance. He explained that if they did not have the state of the art dispatch that they have for EMD, that might be a good way to go. However, he explained that they have this system, it is working very effectively and has worked very effectively for a number of years. He noted that he has a hard time seeing why they should be changing this system except through technology to make it better and more transparent across the disciplines. **Ms. Zadra** asked if Dr. Todd is aware if any of the EMS recommendations will be on the next September 16th concurrent meeting agenda between the cities, County, school district, and potentially the Health Board. Mr. Dick responded that he has been told that it will not be on the concurrent meeting agenda for September 16th, and the Board of Health will not be part of the concurrent meeting. The 120-day period that commenced at the June 10th concurrent meeting is going to be coming to a close on or about October 2nd. He has continued to meet with the City and County Managers, or their representatives, to discuss the approach forward with the modernization of the Franchise Agreement, and they do not see how they can get to closure on this in that timeframe. They do not have any concurrent meeting that will be occurring before that timeframe; therefore, they have discussed working together to bring pretty much an identical item to each of the governing bodies to request an extension so that they can continue to work on the Franchise negotiations. In regard	

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		to the Franchise negotiations, they are working together with the City and County Managers and have developed an outline format structure for a franchise agreement where they have looked at a lot of different agreements in place in different counties in California and the types of components that are included in those agreements. They are trying to incorporate the types of components they think are important to have a more comprehensive and detailed franchise agreement than is currently in place. They are also assessing the overall EMS structure and coming up with some conceptual structures of how EMS oversight might work over all of the EMS agencies, not just oversight of the REMSA Franchise Agreement. He communicated this information to the REMSA Board at their most recent meeting. The Managers had intended to visit with the REMSA Board on August 16th, but they pushed that back to September 20th, due to Shaun Carey's injury. He also mentioned that he received the Board of County Commissioners' August 27, 2013 meeting agenda, and Item 14 is a status report on the EMS Working Group, including progress on previous direction, etc. It says that the Sheriff and Truckee Meadows Fire Protection District will be reporting on that item at the request of Chairman Humke. Mr. Dick expressed that he found that to be odd since they are working with the County Manager on this project. **Chair Smith** commented that when he was in front of the County Commission, when Commissioner Breternitz was there, Commissioner Breternitz asked him if after taking a look at a report, if he found anything in there that could better the system, if he would be willing to partake in that. Chair Smith explained that he told him that he would absolutely be willing. He explained that this EMD issue, the only way to better it, or get close to it, is to be accredited and have every single person up there at dispatch be a paramedic or EMT. He expressed frustration, because he feels that this effort is not bettering things; it is a downgrade. It is all about bettering the system. Dr. Todd mentioned that he believes the EMD that is at REMSA is accredited. **Chair Smith** clarified that the Sheriff should have every single person up there at least a paramedic to take that call and also be accredited even to be equal to what is in place right now. He added that it is not making the system better by giving it to the Sheriff for the one or two phone calls where there might be a gunshot, etc. **Council Member Ratti** commented that she thinks they all need to be cautious about drawing any lines in the sand this early in the process, because the working group is still working on it. She thinks that there still could be a great collaborative solution that could come from the ongoing conversations. She also mentioned that she agrees that medical dispatch is the practice of medicine and that they need to be very careful in toying with that. She pointed out that it is the first step in the data collection process. She added that when they are only talking about dispatch, they also need to make sure that they are talking about it as part of accountability in the data collection process that has failed them in the past in terms of being able to blend the information from fire departments, law enforcement, and REMSA. She does not want to be in a place where she has to pay $60,000 to an outside consultant to tell her what is going on in her own community. She does not want to be in a place again where staff is spending many hours with an intern to look at one	

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		month's worth of data. She added that they need to get to a place where they can have regular, transparent data that starts with a shared dispatch or shared dispatch protocol and good communication between the two. It has to be examined globally in terms of a starting point for the data collection for everybody, including unique identifiers for each rollout and vehicle locators. The final decision has to be holistic to make sure that data can be collected, showing red flags. Having annexations that happen at the pace they did between 2004 and 2008, she does not want to wait until 2013 to know if there is a problem in the system. It is only through the regular collection of that data that they will know whether they have gaps in the system on a regular basis. Dr. Todd responded that the good news is that he is hearing consensus around the EMS Working Group table on everything Ms. Ratti just said; there is agreement that they need the data, they need the AVL (automatic vehicle location), and they need it timely. Unfortunately, they are about a year to a year and a half away from a full blown technological solution to that. They would probably be that far away even if they dismantled REMSA dispatch and collocated. There is no fast answer; the time that he and his staff are spending crunching some data and trying to match things up is a band-aid. Every time they get some answers, additional questions are raised, which is not a bad thing. However, they do not want to continue this band-aid effort. They will get it down to where it is a little bit less labor-intensive so that they can get a little bit more data, but it is not the final solution. The really good news is that no one is disagreeing on what is needed; there is a little bit of disagreement as to how they go about accomplishing that. **Ms. Ratti** commented that she is merely saying that those things also inform what our dispatch should look like. **Chair Smith** asked since it is a year and a half before they are ready to go, what has to happen. Dr. Todd responded that in order to put in place a CAD-to-CAD linkage, the PSAPs need to upgrade their CAD software. There is the collocated 911 center; Washoe County Sheriff collocated with Reno ECom Dispatch Center. In Sparks, there is the Sparks 911 Dispatch. **Mr. Smith** asked who needs to upgrade in order to make it work. Dr. Todd responded that those two need to upgrade. The Sheriff and Reno are currently using a CAD system that is called "Tiburon." It is at the end of its life. It makes no sense to try to upgrade and spend money putting in a CAD-to-CAD linkage with REMSA when that software has to go away. Fortunately, the Sheriff has obtained grant funding to upgrade the Tiburon system so that it will be worth putting in a CAD-to-CAD linkage. REMSA would need to obtain the software necessary to link their TriTech CAD system so that it will talk in real-time to the upgraded Tiburon system. Sparks is using the West Covina system which is a fairly antiquated CAD system. There appears to be consensus that it also needs to be upgraded. The Sheriff hopes that the City of Sparks will decide to upgrade to the same version of Tiburon software that he is using. That would certainly provide some interoperability and make it easier to shift calls if one PSAP goes down.	

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		They are probably nine months to a year away from the installation of the upgrade to Tiburon for Reno and Washoe County. He does not know where Sparks is with theirs. **Mr. Smith** asked for clarification that the Sheriff wants to take EMD and place it in an antiquated system and do the dispatch. Dr. Todd clarified that the Sheriff wants to take it and put it into a new Tiburon system. **Mr. Smith** commented that if he has a new Tiburon then they can do CAD-to-CAD. Dr. Todd responded in agreement. **Mr. Smith** added that they cannot do CAD-to-CAD now, because they are not upgraded enough to do it. Therefore, what he wants to do, since they do not have the software to do the CAD, he is going to take it and do the EMD. Dr. Todd explained that that would presuppose there is a timeline on this effort, and he has not heard anybody talk timelines. He has heard them talk conceptually if EMD should be collocated with the Sheriff's Office. The other thing that has not been raised is where this leaves Sparks. **Mr. Smith** commented that this comes back to the same question of whether or not this system will be better, which he cannot yet see. Until they get upgraded, he explained, it is not going to be better. **Council Member Zadra** commented that there may be an opportunity for discussion with the Sheriff federal framework. Dr. Todd added that Stacey Akurosawa's retirement took his EMS staff down to zero. Therefore, they have expedited with the Human Resources Department, who has posted the vacancy, and he has been able to bring in an intermittent-hourly employee who is learning as she goes along. He also has to get her EMD-certified in order to take on some of the auditing processes that they do to validate some of these numbers that Mr. Gubbels provides to the Board every month. **Dr. Humphreys** asked how often the EMS Working Group is meeting, and who are the members of this working group. Dr. Todd responded that they have been meeting more or less a couple times a month. They had some scheduling issues; the meeting he just reported took place on August 9th, and the next meeting will be held on September 6th. Normally, they get together for a couple hours every couple weeks. This came out of an earlier concurrent meeting of the boards. The two City Managers, the County Manager, and the District Health Officer were assigned to the working group. In practice, there has been some expansion of that. For example, he attends that group regularly, the cities	

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		and the County have brought in their respective Fire Chiefs, and the City of Sparks Assistant City Manager, Steve Driscoll, has been routinely there and has taken over chairmanship during Mr. Carey's recovery. The Reno City Manager brings along the City of Reno Finance Director, Robert Chisel. It is a good group, and he believes they have the right people to debate and discuss and hopefully get to some consensus and improvements. **Dr. Humphreys** asked if REMSA is represented in this working group. Dr. Todd responded that REMSA was not initially but is now represented as well. Mr. Gubbels is regularly in attendance at that meeting.	**NO MOTION**
12.	**PUBLIC HEARING:** Proposed Approval and Adoption of Amendments to the Washoe County District Board of Health Regulations Governing Air Quality Management, Section 040.051, Woodstove / Fireplace Insert Emissions, and Section 040.052, Outdoor Wood-Fired Boilers	Charlene Albee, Acting Division Director of Air Quality Management, noted that before the Board today are some proposed amendments to the District Board of Health Regulations Governing Air Quality Management, specifically Section 040.51, which regulates the woodstove / fireplace insert emissions, and Section 040.52, regarding outdoor wood-fired boilers. The proposed amendments for the woodstove Section 051 is primarily to bring commercial facilities that have solid fuel burning devices into compliance with the regulations in the same way that residential properties have been done for a number of years. This has been happening more and more recently with the old historic homes in Downtown Reno and Sparks that are being converted to business property. The zoning has changed prior to them becoming a business; once the zoning changes to commercial, they no longer have any authority to make sure that the solid fuel burning devices in those houses are up to the cleanest standards. They end up with basically a doughnut in the neighborhood where all of the residential homes around it have clean burning devices and there is one old smoker in the middle which causes neighborhood complaints regarding why theirs has to be clean when that one does not. What really pushed this into the forefront is they actually had a new warehouse that was being built out in Sparks, in the industrial area, where there was a desire to have a caretaker's residence built in the back of the warehouse with a wood stove inside the residence. Since it was on a commercial property, they could not make them put in a clean burning stove, potentially creating some real smoke impacts for the businesses in the area. Luckily, the fire department stepped in and did not allow that to happen, alleviating the problem. However, this incident really brought the issue to their attention that they needed to have the commercial properties brought in. They are not asking them to do anything that the private residences are not already doing. The other change that is put into this 051 amendment is in Subsection 051.C.3.c., as a result of the Caughlin Fire and the Washoe fires, they had made a policy decision to allow the people who had lost their homes to rebuild with whatever they had preexisting. They decided that it would be best to build that into the regulations so that they have something as a foundation to stand upon. Therefore, that is why the statement of being rebuilt following a natural disaster was included. The rest of the changes in that section are really just cleanup language. Section 040.052, Outdoor Wood-Fired Boilers, is proposing to be renamed as Hydronic Heaters. This is actually the result of a citizen that came in who is looking to build an off-the-grid house out in the Northeast end of Palomino Valley, approximately seven to ten miles off the main highway. He wanted to put in one of these hydronic heaters, and they had specifically prohibited the installation of those heaters, based on experiences	

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		they had heard from other air agencies. The first generations of these hydronic heaters were basically a little metal shed where you opened the door and stacked a whole bunch of wood that was set on fire and left to smolder to the point where they did have highways up in the Northeast that were having to close due to high levels of smoke with several of these located close together. They had put the prohibition in place to stay away from those. There are not a lot of timber resources; therefore, they did not think it would be a problem. Since those first generation units came out, there has been a lot of work by EPA, in conjunction with the manufacturers, to come up with some cleaner burning units. They are now qualifying the units similarly to how they certify the wood stoves. In recognition of the work that they have done and this request that they received, they decided to go ahead and acknowledge the hydronic heaters and go ahead and approve the installation under certain conditions, primarily being on a minimum 40-acre parcel, attempting to prevent overlapping impacts. In addition, it would also have to be located outside of a non-attainment basin so that they do not have any problems meeting their ambient air quality standards. They held a public workshop. One member of the public showed up from the Reno-Sparks Association of Realtors. He is neutral on this subject, realizing that in Section 051, bringing the commercial buildings up to the same standards as the residential was probably the right thing to do. **Chair Smith** opened the public hearing and asked for any public comment. There was no public comment.	**Vice Chair Jung** moved, seconded by **Dr. Hess**, to adopt amendments to Sections 040.51 and 040.52 of the Washoe County District Board of Health Regulations Governing Air Quality Management as presented. **MOTION CARRIED**
13.	Presentation of Environmental Health Services Division Programs, Mandates, Fees – Activities and Mandates for the Waste Management Program	Bob Sack, Division Director of Environmental Health Services (EHS), noted that this is the third and final presentation from Environmental Health Services in an overview of the Division's different programs, today taking a look at the Institutions Program, Land Development, and Vector Program. He mentioned that he included within the agenda packet all of the enabling statutes that they deal with, not the regulations, but the actual NRS statutes that are associated with each of these programs. He mentioned specifically that Well Construction, Tattoo Invasive Body Decorations, and Vector-Borne Disease and Mosquito Abatement programs are not mandated specifically, but the Health District is the only agency carrying out these programs. He showed the structure of Environmental Health Services as also provided within the staff report. The Land Development and Drinking Water Program processes are oriented around protecting groundwater supplies and ensuring that the groundwater is acceptable for drinking and other recreational uses. They oversee all of the public water systems, such as Truckee Meadows Water Authority (TMWA) and the County, totaling 94 regulated water systems. They inspect one-third of those systems per year. Although this is mandated, there is some state Safe Drinking Water Act money received from the feds that helps offset the costs. They also respond to water- and sewage-related complaints. They often work with the cities on sewage backups and water line breaks, ensuring that they are properly repaired and still safe for the public. They do consider those leaks to be imminently dangerous issues, especially on the sewage side. They perform plan review and construction inspections for domestic wells, septic tanks and water systems. Even though they are not mandated directly, domestic wells are almost impossible to separate on a residential basis from the residential septic systems. For example, within Historic Verdi, there are drinking water wells and septic systems that	

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	BOARD COMMENT	are 10-15 feet apart. In essence, they are directly drinking their sewage in some of that older part of town. Therefore, making sure that these systems are designed properly and generally taking the needs of each into account on a piece of property is really needed and works real well. They provide continuous support and guidance to all public water systems in Washoe County. There are a lot of regulatory requirements at the federal and state level that they report to the Health District, such as when they get a bad Bac-T sample, requiring a lot of interaction to ensure that the law is being implemented, which is extremely complex. They also regulate the drinking water hauler and sewage pumper trucks. They have found that there are very few actual drinking water haulers out there; there is not much of a need for just drinking water, except on an emergency basis. There are some issues with being able to haul drinking water on a bulk basis if they had a large emergency with a lot of water outage. That is something that they have been discussing with TMWA and the County. **Council Member Zadra** left at 2:18pm. **Dr. Furman** left at 2:19pm and returned at 2:22pm. **Dr. Hess** asked if there is a record of who is out there and easily accessible in the event of an emergency. Mr. Sack responded that as an example, there is a planning effort that is just now being undertaken to plan for a large outage and how they are going to get water to specific areas. That could be a problem. There are mechanisms to get bottled water in, but actually supplying bulk water into a system could be problematic. They are finding with the sewage pumper trucks, totaling about 50 or 60, that there are quite a few that are unpermitted. They are in the middle of an effort to identify the unpermitted trucks and bring them into compliance. There has been a problem with waste products being discharged into storm drains. Part of their permitting process is knowing where they are dumping waste and ensuring that it is an acceptable location. Mr. Sack showed an example of a septic system and aquifer system as provided within the staff report but also displayed animation illustrating the injection of sewage from an improperly installed septic system, contaminating groundwater and surface water with fecal matter, and the flow of groundwater protected from contamination as sewage flows from the septic tank out to the leach field, dispersed not at a point source but over a wider area. Mr. Sack showed an example of an overturned sewage truck as provided within the staff report. When this type of incident occurs, there is an immediate sewage contamination issue that must be resolved, causing active response from staff. Some of the efficiencies implemented over the last few years include streamlining of plan submittal requirements. They had received quite a few complaints from the public who did not understand why they had to have all of the things that were required with plans. They determined that they were requiring too many things. Since that time, they have changed those submittal requirements, and he has not received any such complaints over the past year and a half. These improvements take away the need for the public to come back multiple times as they attempt to satisfy all of those requirements. It can still happen, but the lessening of requirements has been quite successful.	

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		They have implemented a health information system where they are scanning new septic and well data into GIS. They have historical data back into the early sixties on microfilm. Over the last six or seven years, all new information has been scanned into GIS rather than being placed on microfilm. Records are a lot more readily available, but they still have probably over 30,000 records on microfilm that require resources to transfer into the new system. They experienced a reduction in workload on septic system inspections. They used to perform about 1,000 per year, dropped to about 100 at the low. Wells went from over 300 inspections to 40 or 50. They reduced staff resources in this area; as some retirements occurred and they lost almost 30% of staff, a number of them came from this area. Workload is now going back up on both the commercial and residential development side. They negotiated with both TMWA and the State whereby small water projects do not have to be submitted to them for review and approval; small pipe replacements, etc. were just being handled the same way that TMWA or the County was already doing. They just agreed upon the process, the other entities do them that way, and the Health District receives a list of small-scale water projects. Their relationship with the County and TMWA is very good. Their Vector Program has a goal of no human disease outbreaks in Washoe County. They do early surveillance in order to target disease outbreaks. They are also implementing design standards in public and private infrastructure to minimize habitat for disease-bearing rodents and insects. One, if the habitat is not there then they do not have to go back every year, multiple times, and treat the area with larvicide, perform plague dusting, or trap rodents to try and remove them. They have a very high level of collaboration with stakeholders in the cities, Washoe County's Community Development and Public Works Departments, homeowner's associations, and the Nevada Department of Agriculture Animal Disease Lab. They especially have a very tight relationship with the Animal Disease Lab. Animal bite investigations and residential insect infestation advisory inspections include rabies cases. They are going to develop a formal agreement with Washoe County Regional Animal Services to memorialize what is working real well. They perform the dog and cat bite investigations while EHS does all of the wild animal, high-risk investigations where they would typically see rabies from bats, foxes, etc. If Regional Animal Services has a problem, EHS will come in on the routine dog and cat bites to exercise their rabies authority. On the residential insect infestation advisory, it used to be pretty much related to roaches, such as in an apartment building, but now, by far, it is bed bugs. They are not a huge, immediate health hazard, but they are an "ick" factor. Even within the hotel statutes, they are required to respond to those bed bug infestations. On an advisory basis, their vector staff provides advice to the public as well. They perform the proactive, reactive habitat treatment to prevent disease, such as spraying for mosquitoes and dusting boroughs in the spring for fleas to try and reduce plague problems. Their mosquito abatement program is by far the biggest aspect of the program. They perform larviciding on a proactive basis, applications by helicopter, which is the best control they have for mosquitoes. On a reactive basis, the fogging they do is specific to areas where the adults are there and they know there is going to be a problem or the problem already exists in that area. They know that they have West Nile Virus out there; there have been press releases regarding the positive mosquito pools. Currently, the reports are coming from the East Valley side. When their robust surveillance indicates that they have a problem in an area, before they get a human case, they try and go out	

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		and perform fogging. Whatever insects it hits will die on that particular day. However, that does not assist with mosquitoes that hatch after the period of time when the fogging is out there, typically done under ideal conditions early in the morning. This is an area where they have reduced quite a bit of monetary resources over the last few years. The larviciding is dramatically lower; the products they use are very specific to mosquitoes and very expensive to not affect other insects. Furthermore, it requires a helicopter to apply in the larger areas. They have to do more by hand. Some of the areas they can no longer fly; therefore, they are hitting areas that are very close to residential housing, such as Mira Loma, Spanish Springs, and Washoe Valley. They are not hitting all of the acreage that needs to be treated, but they are hitting the highest risk areas in order to try and prevent interaction. In 2007, they performed 11 aerial treatments, treating 6,000 acres, and they performed 25 fog applications, treating 1,600 acres. They take mosquito pools or sample, trapping a group of mosquitoes at a particular location, blending them together and testing for West Nile Virus. **Vice Chair Jung** asked in regard to mosquito abatement if they introduce the mosquito-eating fish. Mr. Sack responded in the affirmative and confirmed that the fish is the gambusia. **Ms. Jung** asked if introducing the fish is the cheapest form of abatement. Mr. Sack responded that in small sources, such as ponds, it is quite effective, but in larger sources, the fish will often not survive. The gambusia are inexpensive, because they grow them. Rancho San Rafael is one of the spots used to grow them, and they procreate quite rapidly. They provide them to the public free of charge. In 2012, they were down to 5 total aerial treatments with an increase in fogging applications. In 2007, West Nile Virus was hitting pretty hard with a lot of positive samples, including positive human cases. The more larviciding they do, the less fogging they have to do, in general, and vice versa. They utilize a small plastic cup to obtain samples to determine presence of mosquito larvae as shown in a picture, as provided within the staff report. He also showed an example of a storm drain inlet, as provided within the staff report, which could produce thousands of mosquitoes within one day under the right conditions. They are discovering that the use of treated sewage for irrigation is very safe from the standpoint of bacteria and virus, but it still has a chemical soup that mosquitoes find extremely nutritious. They are seeing an increase in larvae in some of these storm drain basins around those areas where treated sewage is being used. He is not saying that treated sewage should not be used, but it is an interesting byproduct that they are seeing. There are over 25,000 of these catch basins within the urban environment here. They have GPS-mapped a large number of those basins. They are treating 7,000 to 8,000 catch basins annually, including in the Incline area that has quite a few catch basins with mosquito problems. In regard to design standards in development, they are trying to reduce wetlands that will have to be treated. They use low-flow channels, a picture of which is provided within the staff report, which compresses stagnant water into a smaller area that will continue to runoff. In regard to plague suppression, dog and cat owners do not really see fleas here, but they do exist in rodent boroughs on the rodents. When there is plague active in an area and a lot of	

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		rodents die, those fleas then come out of the boroughs due to hunger. That is when they can transmit plague to animals, such as a dog in a field, possibly bringing plague back to the home. They have had historically at least one death from the plague in this area. They do identify plague almost every year somewhere in the area. It is cyclical, and the area is overdue for a pretty large event involving plague. In regard to efficiencies, acres treated with larvicide has decreased, they have made changes to survey and treatment procedures for plague reduction, just doing enough to determine that indeed they need to apply dusting, implemented engineering controls to reduce vector habitat, and increased use of handheld GIS devices in order for the helicopter pilot to have the exact area that he needs to treat, reducing overspray and ultimately less pesticide necessary to apply per area. The Institutions area category is a combination of many smaller programs. In general, they are required to have these programs to protect and prevent disease and injury or adverse health effects and contamination in these environments. They inspect child care facilities and respond to complaints. Most of these complaints deal with some sort of EPI outbreak, requiring the need for them to go in and help interdict. The Hand, Foot, and Mouth Disease outbreak last year existed within child care. Giardia and Norovirus have a lot of transmission within these facilities as well. Invasive Body Decorations (IBDs), tattoo and piercing facilities, total about 60 active facilities, previously totaling about 40. The Health District is the only agency authorized to implement health and safety regulations. The first set of these types of regulations were brought to the Board about 15-20 years ago. No other agency does these which EHS feels is important in order to protect the patrons that are getting these tattoos and body piercings done. A lot of tattoo parlors have artists who do not have a lot of technical expertise or medical training. Therefore, there is a lot that goes into permitting one of these parlors to ensure that they are operating correctly. They performed 896 inspections. Unique to them, part of being the “Special Events Capital of the World” is that the area is now getting tattoo conventions. There can be upwards of 40 or 50 booths, and they have to perform multiple inspections to ensure that they are sterilizing their equipment, etc. There are 5 or 6 of these conventions on an annual basis. **Vice Chair Jung** asked if there is a licensing or state standard. Mr. Sack responded in the negative. The only regulations that are there are the Health District’s regulations. **Ms. Jung** asked if the Board of Health has considered taking a Bill Draft Request (BDR) to the legislature. Mr. Sack responded that they have not. Almost every health agency in the country is in a similar situation. The state has taken its own regulations, Southern Nevada Health District has taken its own regulations, all of which are fairly similar, modeled after Washoe County Health District. He does not think that the demand has been there, because it is actually effectively regulated. What	

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		they are getting into, and they are starting to see it in Southern Nevada, is things like implants and digitizing where people are intentionally removing fingers or joints or implanting a shark fin in their back. They want to do these things in these piercing places, and that is crossing the line into medical practice. They are starting to run into those types of pressures where they are trying to do some pretty invasive modifications. The Medical Board is looking at that as well. **Ms. Jung** commented that she still thinks that there should be some sort of training and/or certification that makes the person legitimate in terms of knowing how to properly sanitize and dispose the needles. As a policy board, she feels that they need to potentially bring back a bill request. Mr. Sack responded that they do not have the ability to offer bill drafts, but they can bring something back to the Board. **Ms. Jung** responded that the Board of County Commissioners only gets two BDRs, but they can always find somebody to carry it. She continued by asking about the age limit for acquiring piercings and tattoos. Mr. Sack responded with the general answer of age 18. **Ms. Jung** asked if their parents can waive that age limit. Mr. Sack responded that parents can sign for it. They have ran into a problem, but not in the last few years, where a 16-year old would come in with his parent who looked about 17 or 18 and sign as the parent. Part of what they do on these inspections is making sure that they have checked for parental authorization. **Ms. Jung** inquired about the minimum age. Mr. Sack recalls a State law where it may be a minimum age of 15 or 16. **Ms. Jung** asked if the Health District would be the reporting agency if a known 14-year old has tattoos. Mr. Sack responded that it is not illegal for somebody underage to have tattoos; it is illegal for somebody to tattoo them. The complaint would be regarding where they got tattooed. It would be against the facility, and they would be the reporting agency in that case. Mr. Sack continued with Hotel / Motel Room / Mobile Home / RV Facility Inspections, explaining that they all require routine inspections, responding to complaints, and plan reviews. They have a pretty high reinspection rate on their RV parks and a portion of their motels, which are the “weeklies”, and they are really the only agency on the “weeklies” that keep them in compliance. He explained that some of these motels are in deplorable condition; therefore, they have a high reinspection rate and problems	

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		associated with them. They are also seeing a tremendous turnover with these weekly motels, sometimes three or four times per year. Therefore, it is a continuous process of going in, evaluating, trying to get them up to code. Some of it is due to the clientele abusing their physical facilities. It is something that has to be chased, staying after those owners. They have about 800 annual and seasonal pools and spas that they regulate. An improperly operated pool is extremely high risk from both a chemical basis and safety aspect. Therefore, they take them pretty seriously. They have cut down the number of inspections. In the past, they did one inspection per month on both annual and seasonal pools. Now, they are doing about two to three per each on an annual basis and putting more on the pool operators and their certifications to keep them in compliance. In the Certified Pool Operator Program that has been in place for about one year, they already have 260 operators. They are also required to perform school and jail facility inspections. By statute, they must inspect schools one time per semester, including regulating the kitchens associated with them. There are only a couple jail facilities. They perform one annual inspection of those and respond to quite a few complaints, usually from inmates. Additionally, on a complaint basis, typically from other agencies, such as Social Services, they inspect housing to assist in determining if it is an environment safe for kids or any person to live. They will ask EHS to make an evaluation on whether or not the conditions are considered a health hazard. They can see these issues both in weekly hotels or residential apartments or houses. They are probably responding to one or two of these types of complaints every month. Mr. Sack explained that some of them are incredibly deplorable, usually with multiple agencies involved. If kids are involved, it is a lot easier to get everybody out. Often times on the adult side, and they are not considered elderly but possibly mentally ill or have a hoarding complex, it is very difficult to get resources to help these people. In regard to Institutions, they have created the CPO (Certified Pool Operator) program, allowing approved businesses to open seasonal facilities, eliminating a round of inspections on a detailed basis. They have reduced pool and spa inspections by 75%. They have streamlined change of ownership inspections of all institution facilities. They are focusing on disease prevention in major resort properties. For example, instead of inspecting every room at the Nugget, they will inspect about 10% of the rooms and really concentrate on the floors, how are they cleaning the rooms, how are they cleaning up a vomiting event, how are they cleaning the trash cans and ice buckets. Mr. Sack calls it more of a norovirus prevention inspection, because if what they are doing will prevent norovirus, then it is going to take care of virtually every other disease transmission problem within those facilities. In regard to school and child care facility inspections, they are focusing on disease prevention and child safety. Mr. Sack explained that their biggest value to the community is performing risk assessments to determine risk from both a general health hazard standpoint and in a regulatory environment. Mr. Sack displayed a picture of a special event crowd and explained that their goal is to ensure that those crowds continue to come to the area. **Dr. Humphreys** commented that he was out at Red Hawk Golf Course about four weeks ago, fairly early in the morning, and stopped for about 10 minutes to watch the application of larvicide. He explained that seeing the helicopter maneuver to apply the larvicide is quite interesting to watch.	

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		Mr. Sack commented that the guy they currently use and have used for the past 20+ years, Joel, is a former Vietnam helicopter pilot, can fly those mosquito applications very precisely and very low. Mr. Sack added that he is an incredibly good pilot. They still get some complaints that he is too close to the houses, etc., and they try to keep the helicopter as far away as possible. The areas they are working right now involve them working the interface close to residential neighborhoods. **Vice Chair Jung** asked if there is a reason why they use a helicopter and not a crop duster. Mr. Sack responded that it is basically due to the preciseness. A lot of those products do not handle well out of a plane. It is too fast, spreading around a lot more, whereas the helicopter application is incredibly precise. **Dr. Humphreys** added that one thing he witnessed was the helicopter maneuvered as if the pilot had backed up and was able to hover and then go right down to hit a specific target area and then right back up. That would be tough for a plane.	**NO MOTION**
14.	Review and Acceptance of the Monthly Public Health Fund Revenue and Expenditure Report for July, 2013	Eileen Stickney, Administrative Health Services Officer, presented the Monthly Public Health Fund Revenue and Expenditure Report for July 2013, beginning of Fiscal Year 14, stating that Staff recommends the Board accept the report. Ms. Stickney pointed out the top of the second page, stating that Holiday Work is at 73% this month and 7% last month. She explained that she did confirm with Mr. Sack that he had four EHS staff that were working special events on Fourth of July. She will highlight items like this at a variance so that when they prepare the budget for Fiscal Year 15, they will make appropriate adjustments.	**Dr. Hess** moved, seconded by **Vice Chair Jung**, to accept the Health Fund Revenue and Expenditure Report for July, 2013. **MOTION CARRIED**
15.	Presentation, Discussion, and Possible Direction to Staff regarding a Fundamental Review	Mr. Dick commented that since the last meeting, he has been in contact with two individuals that had been referred by NACCHO, Dr. Les Beitsch and Mr. Matt Stefanak, who both have significant experience with public health, both at the local and state levels. Mr. Stefanak is a leading expert in financial management for health districts, and Dr. Beitsch is an expert in the focus area of performance management and quality improvement. Ms. Stickney made several calls to the President of Management Partners, but she did not receive any response back regarding if they had, or knew companies who had, experience performing reviews of health districts. Links were included within the staff report to papers authored by these two individuals. Mr. Stefanak authored one on financial turnaround at the health district that he managed in a county in Ohio. The other one was sent to them by Dr. Beitsch. The paper outlines how the accreditation framework was used in a county in Illinois that experienced a 50% staff reduction as a way of aligning their resources and their programs with those limited resources to attempt to address the needs of the community. Both of the papers indicate that there is really a lack of studies of health districts with these kinds of projects. Mr. Dick noted that late yesterday afternoon, he received draft scopes of work from Mr. Stefanak and Dr. Beitsch. Dr. Beitsch does consulting work in conjunction with the Public Health Foundation, and he suggested that the Health District work with them so that they could provide some staff support for a fundamental review here. When they first contacted these	

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		two individuals, it was somewhat a shot in the dark to see whether they might be willing to work with each other and bring their expertise to the table in their different areas. Coincidentally, they had been on a panel together the previous month at a conference. While they had not worked together previously, they knew of each other, and they were happy to do a collaborative project. The scopes of work received are designed to work in conjunction with each other. The process would be that they would come out and meet with management, the Board, and stakeholders within the community to obtain information input on the front-end. Staff would then work to conduct a self-assessment; there is a tool that has been created using the accreditation framework. That would be work that would be done internally. They would also be doing some work on the financial aspects of the Health District as well to provide that information to them. They would then come out again and basically meet to ground truth the information provided to them through the self-assessment. They would then work on synthesizing that information and developing a report which they would provide as a draft and then come out and present a final report to the Board. The timeline that they have outlined is assuming that there is a contract in place to commence work October 1st. The end date for the final report that they identified is March 7th. One of Mr. Dick's task, if proceeding with the fundamental review, would be to work with them on moving up the final report presentation to the February meeting. The Board budget meeting is anticipated to take place in early March; this could be helpful to address the financial situation at that time. **Vice Chair Jung** asked if the Board will see the scope of work and the contract. Mr. Dick responded that in order to proceed, showing the draft scopes of work provided to the Board today (filed), he would request approval to proceed with finalizing the scopes of work and getting the contract in place, because he does not want to delay another month to bring it back to the Board, continuing to shoot for that October 1st timeframe. He did discuss with them the comments received from the Board. Also, in response to some of Ms. Zadra's concerns, Dr. Beitsch also has a J.D. He feels very comfortable in doing the NRS review. Mr. Dick feels that it is really an exceptional team, and he is excited about being able to have these leaders in their areas working with the Health District. **Ms. Jung** noted to keep in mind to look at what areas would be cheaper to outsource rather than insource, because that is an efficiency that many commissions and boards and elected department heads are examining as well. Mr. Dick responded that he will mention that, and he believes Mr. Stefanak would have some of the background to be able to assess that. **Dr. Hess** asked if this includes the other individual even though that name is not on the scope of work. Mr. Dick responded that one of the things he will request with the proposal received from the Public Health Foundation is that it specifically designate Dr. Beitch's time. It turns out that Mr. Stefanak is	**Vice Chair Jung** moved, seconded by **Council Member Ratti**, to proceed. **MOTION CARRIED**

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		actually a board member of the Public Health Foundation; therefore, he preferred to have a separate contractual relationship so that he does not get into conflict of interest issues with that organization. **Council Member Ratti** commented that the proposal discussed today is significantly improved upon last month's proposal, and she is really excited about the direction they are headed.	
16.	Discussion and Possible Direction to Staff regarding process for appointing a permanent District Health Officer **BOARD COMMENT**	**Chair Smith** pointed at that when the Board appointed Mr. Dick as the Interim District Health Officer, part of that motion was that they were not going to talk about it for at least six months. **Dr. Hess** commented that he thought it was for just six months. **Mr. Smith** responded that it was for at least six months at which time the Board would review Mr. Dick's performance and decide if that want to solicit applicants. **Dr. Hess** commented that that was not his understanding. **Vice Chair Jung** commented that that could be easily rectified by looking at the Minutes. **Mr. Smith** commented that he does not mind explaining the process to allow the Board to proceed. **Dr. Hess** commented that he does not know why they need to wait until the end of six months; it seems to him that the process needs to get started. **Mr. Smith** commented that his feelings are that they currently have an Interim District Health Officer who is doing a fantastic job. He wanted to give him six months to really get his feet on the ground. At that point, the Board can talk about it. His feelings are, and he explained that he has been on the Board for a long time, that they need an administrator for this position, not a doctor. They have had numerous doctors over the years, and they need somebody to run an organization rather than a doctor. That is his personal feelings, and he does not know what the other board members feel. **Dr. Hess** commented that he would like to counter that. He feels that the previous doctor who was their administrator, from his perspective on the outside looking in, he thinks that there were some issues. However, he personally feels that in living in Washoe County for 20 years, and with interactions with those folks, due to his work at the University, the last director was the best they have ever had in those 20+ years. He also thinks that they need to start laying the groundwork, if Mr. Dick is going to be the selection, in figuring out how they go contrary to state law. He explained that NRS Chapter 439 says that the District Health Officer needs to have a graduate education in public health or what is called a class specification for District Health Officer which he stumbled upon during a web search. He explained that he does not have a problem with people finding alternative ways to meet those qualifications, but he thinks that the Board needs to sit down and	

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		decide what it is that they are looking for in their administrator. Deputy District Attorney Leslie Admirand requested the NRS section cited by Dr. Hess. **Dr. Hess** responded that it was NRS 439.400, Paragraph 2. Ms. Admirand commented that she wanted to ensure that the section applied to this population. **Dr. Hess** continued that one of the problems with this situation is that he feels that a free flowing discussion cannot truly take place. He personally thinks that they should have a subcommittee that can sit down and decide what they are looking for and bring it back to the Board for approval or disapproval and get on with the process. He explained that he did not go through this process in the past when they picked Dr. Iser or Dr. Anderson. As the new kid on the block, he does not think that they are properly approaching this process at the current time. **Council Member Ratti** commented that she thinks that they have not even started the process; she feels that there are many different ways to do it. She has had the benefit of being part of the process on the District Board of Health but also doing it for the City of Sparks for different positions that have been open. There are different philosophies, such as developing folks from the inside and providing them opportunity to promote, or conducting a national search. She thinks that those are some of the questions that need to be answered first. She thinks that they have put Mr. Dick in a very awkward position, as the Interim Director, of having to defend or tell them whether or not he meets the minimum qualifications. She needs somebody to verify for her the answer to that question. Ms. Admirand responded that she is able to do that. **Dr. Hess** explained that he has been in situations where he has been on the search committee for a dean and for a variety of people, and he has never been in a situation where he has been forced into voting, not voting, or abstaining on a particular position without at least having a curriculum vitae and a resume in front of him. **Ms. Ratti** commented that she does not think there is any proposal in front of her today to vote on any position. **Dr. Hess** responded in the negative, but added that for the interim appointment, there was, and he is still angered by that situation. **Ms. Ratti** responded that that is fair. **Dr. Furman** commented that they had a previous director, Barbara Hunt, who did not meet these qualifications. She did not have a Master of Public Health, and she was not a physician. This was	

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		allowed, because it was felt that there are other things that can happen; it is not an absolute. He was unsure if there had been any changes to the requirements since then. Ms. Admirand responded that there have not been any changes in the statute; therefore, she can outline what the NRS says and their parameters in choosing a health officer. **Mr. Smith** commented that they should start with that. Based on her conclusion on that, this discussion can continue. He does not want to put Mr. Dick in any kind of position whatsoever at this point. He feels that Mr. Dick is doing a very good job and advised Mr. Dick to continue doing what he is doing. They are going to look at a couple of statutes and have a discussion next month. Then, they will have to find out what they did with Barbara Hunt. Ms. Admirand commented that there is the Personnel and Administration Committee as a Board of Health committee. That is something that the Board could utilize. **Mr. Smith** commented that they will get that information and then get the committee going. **Ms. Ratti** asked if assignments were made to that committee. Ms. Admirand believes that there are assignments but does not have the updated list; she would have to check for the updated list. **Ms. Ratti** commented that that would be good to know. **Dr. Furman** commented that they also looked at other candidates, and they were also not physicians. **Dr. Hess** commented that it does not have to be a physician; it needs to be somebody with a graduate degree in public health or the equivalent. **Dr. Furman** explained that some of the people they interviewed did not have either a graduate degree in public health or a M.D.	**NO MOTION**
*17.	**Staff Reports and Program Updates** A. Director, Epidemiology and Public Health Preparedness	Dr. Randall Todd, Director, Epidemiology and Public Health Preparedness, presented his monthly Division Director's Report, a copy of which was placed on file for the record. Dr. Todd added that under the first item of the report, Communicable Disease – Pertussis, they have had a couple of clusters of pertussis cases. He just today received a report from the State that Washoe County is not alone in Nevada of having pertussis (whooping cough). The statewide year-to-date total is 107 cases of whooping cough, compared to 112 cases for all of last year within the State. They are only a little over halfway through the year, because communicable diseases are counted on the calendar year, not the fiscal year. Of those 107 cases, Clark County accounts for 84. Washoe County has had 13 cases. Of those 13, 12 have been reported since May, and 10 of those have	

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		been reported within the last week. They are seeing this spiral upwards; he was feeling pretty good last year when neighboring states had pertussis outbreaks and Nevada did not. It may be Nevada's turn. There are concerns that a number of these cases have been fully immunized. **Vice Chair Jung** commented that she has had the worst allergies of her life. She explained that she went to the urgent clinic yesterday, unable to go to her own primary care physician due to a current wait of one and a half months, but when she examined her, the physician's assistant explained that she was draining like crazy without necessarily feeling sick. The nurse had told her that in her 20 years of practicing in the West, this season has been the worst allergy season of all ages, genders, and socioeconomic status, and her theory was that this year's weird weather has reactivated certain things that would be dead by now. She has seen tons of ear infections, tons of throat infections, and bronchitis. Ms. Jung wondered if there was any correlation between the two. Dr. Todd commented that there is not likely a correlation, because the majority, at least 9 of 13 cases confirmed from the laboratory, that they actually have pertussis. **Council Member Ratti** left at 3:17pm. **Dr. Hess** asked about the current DTaP vaccine and if these kids would have received that immunization. Dr. Todd responded that the wholesale pertussis vaccine, although it did not cause too many side effects in young people, when you became an adult and got your tetanus booster, you got a TD and not a DTP, because pertussis was not good for you. To make the pertussis vaccine safer, they went to an acellular formulation of the vaccine that is safer, but they are now just getting to the point where they have an age cohort of kids where all they have had is the acellular pertussis. There is a theory out there that maybe it is not as effective unless you have had at least a dose of whole-cell. **Dr. Hess** asked if any of these cases required hospitalization. Dr. Todd responded that he is not aware of any hospitalizations. **Dr. Hess** commented that there was some discussion that when they do get it with this vaccine, they do not get as sick; it is modified. Dr. Todd responded that that is correct. He also explained that this is a cough that is extremely severe to the point where you can literally turn blue due to inability to take in enough oxygen.	
	B. <u>Director, Community and</u>	Mr. Steve Kutz, Director, Community and Clinical Health Services, presented his monthly Division Director's Report, a copy of which was placed on file for the record. He highlighted that under the Immunization Program, he wanted to remind the Board of Health that they had performed almost	

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	Clinical Health Services	50 school-located vaccination clinics over the past year. This really assisted with the launch of the new school year. In speaking with Dana Baltunas, Director of Student Health Services, there were around 200 students in need of immunizations at the start of school, a far lower number than they had experienced in the previous year. Therefore, their efforts are paying off. Under the Tuberculosis Prevention and Control Program, over the last week or so, they have put in two applications for additional funding related to their ongoing cases of tuberculosis here. A program through the vendor who provides them with QuantiFERON testing, called the TBoss Reimbursement Program, and they are looking forward to about $10,000 in reimbursement costs for the tubes and the testing through the Nevada State Public Health Laboratory. He expressed appreciation to Ms. Stickney and her staff for helping them to make that happen. They also just put in an application for $10,000 for intermittent / hourly staff to help support the TB Program with the additional staffing needs in order to meet the demands in the community, helping to prevent and control TB. **Dr. Hess** asked about how many active cases of TB are being investigated. Mr. Kutz responded that they have two cases. One is in an aggregate dormitory-type setting, and one is at a hospitality-type setting. They actually had two cases that were positive which initiates testing in concentric rings. The risk assessments take a lot of time, with the blood draws and testing, and he acknowledged and expressed appreciation for Dr. Todd's staff as well as the Nevada State Health Division Tuberculosis Prevention and Control Program. In regard to the Chronic Disease Prevention Program, Mr. Kutz acknowledged Kelli Seals for highlighting some things that will be done for the Fifth Annual Obesity Forum. Flyers were provided at the meeting (filed) for the Obesity Forum. Mr. Kutz explained that he attended last year for the first time, and it one of the best day-long conferences, locally produced, well-polished and impressive, and he was very proud of staff's efforts.	
	C. Director, Environmental Health Services	Mr. Robert Sack, Director, Environmental Health Services, presented his monthly Division Director's Report, a copy of which was placed on file for the record. He highlighted the additional three positive mosquito pools the received for West Nile Virus this week, bringing them up to six. **Dr. Humphreys** asked about the locations of those findings. Mr. Sack responded that the latest findings were in the Rosewood Lakes area. Everything is on the east side of the valley, Damonte Ranch, up to the south of the river.	
	D. Acting Director, Air Quality Management	Ms. Charlene Albee, Acting Division Director, Air Quality Management, presented the monthly Division Director's Report, a copy of which was placed on file for the record. She provided an update on their smoke impacts from the American Fire. The fire started on August 10th, with Truckee Meadows impact starting on Sunday, August 11th. They have been seeing a dramatic change in the Air Quality Index, due to PM2.5 impacts. The highest to date for the 24-hour rolling	

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		average is 128, occurring on Saturday, August 17th. That is Unhealthy for Sensitive Groups. On August 18th, when thunderstorms rolled into the valley, a video of the increasing smoke was captured by the National Weather Service camera (filed). That is something they usually cannot see on average. The video is only about five minutes of elapsed time. They went from a single digit of 6 PM2.5 to 130. The American Fire is expected to be contained by Sunday, September 1st. Unfortunately, the Yosemite Rim Fire impacts have hit the Truckee Meadows Basin during this meeting. They have conducted four interviews in the past hour, and AP has actually picked up the story as well. There is not expected containment on the Rim Fire. **Dr. Humphreys** asked about changes in air quality other than the obvious change in visibility. Ms. Albee explained that there are health impacts associated with this air quality, such as an increase in allergies, burning eyes, drainage, and sore throats. Anybody who is sensitive to bronchitis can suffer with this type of air quality. The ozone numbers and all of the other pollutants have not really been impacted by the fires. Mr. Dick expressed appreciation to Ms. Albee and Mr. Inouye for the fantastic job they have been doing as they continue to do their own jobs and his job in Air Quality. Mr. Inouye has been on the run with the media, doing multiple interviews every day.	
	E. Administrative Health Services Officer	The Administrative Health Services Officer's Reports for this month were addressed in other agenda items. Ms. Stickney added that she would start including a WIC update to provide some data. **Dr. Hess** commented that he was very impressed with her ability to get a contract renegotiation with the owner of the property. He feels that they need to thank that person, making a substantial contribution to the Health District. Mr. Stickney responded that they could provide a certificate. She knows that property values have reduced, and there are a lot of places available.	
	F. Interim District Health Officer and Health District Updates	Mr. Kevin Dick, Interim District Health Officer, presented the monthly District Health Officer Report, a copy of which was placed on file for the record. Mr. Dick highlighted steps taken with the Health District's Quality Improvement (QI) initiative. The Accreditation Readiness Team (ART) has been meeting for over the course of the last year or more to discuss QI and training and a QI plan. They are moving forward. Veronica Frenkel, Organizational Development Coordinator with the County Manager's Office, assisted them in designing and implementing a survey of staff on QI which was just completed. Tomorrow, they will be having a special session with her and the Division Directors to discuss their approach to QI. They will then hold a series of meetings with the Division Directors and Supervisors to launch the	

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		initiative. QI is the jargon in public health, but it is also process improvement and continuous improvement and continuous quality improvement. In order to have a successful approach to QI, you need leadership behind that, and that is what they are working to do through the upcoming sessions. This will be foundational to be able to respond to recommendations received through the fundamental review.	
*18.	Board Comment – Limited to Announcements or Issues for Future Agendas	None.	
19.	Emergency Items	None.	
*20.	Public Comment (limited to three (3) minutes per person). No action may be taken.	None.	
21.	**Adjournment**	There being no further business to come before the Board, the meeting was adjourned.	**Vice Chair Jung** moved, seconded by **Dr. Humphreys**, that the meeting be adjourned. **MOTION CARRIED** The meeting was adjourned at 3:28 p.m.

KEVIN DICK,
INTERIM DISTRICT HEALTH OFFICER

WILLIAM FLORES,
RECORDING SECRETARY

PROCLAMATION
National Preparedness Month

WHEREAS, "National Preparedness Month" creates an important opportunity for every resident of Washoe County to learn more about ways to prepare for all types of emergencies, including public health threats, potential terrorist attacks, and natural disasters; and

WHEREAS, it is often neighbors and friends who respond first on the scene after an emergency. This year's National Preparedness Month theme is *"You Can Be the Hero"*, asking all citizens to ready themselves to assist in case of emergency; and

WHEREAS, experience tells us that investing in the preparedness of ourselves, our families, businesses and communities can improve the response to and recovery from a disaster or other emergency, thereby reducing the physical, emotional and financial impact of that disaster or emergency in our communities and in our nation; and

WHEREAS, the Washoe County Health District, throughout the various divisions, and other state, local, private and volunteer agencies are working together to increase public awareness in preparing for public health emergencies and to educate individuals on how to take responsibility for preparedness; and

WHEREAS, emergency preparedness is the responsibility of every citizen of Washoe County, and everyone is urged to make preparedness a priority, working together to ensure that individuals, families and communities are prepared for any type of emergency; and

WHEREAS, all citizens are encouraged to participate in citizen preparedness activities and to visit the website www.ReadyWashoe.com to learn more about emergency preparedness, which includes these simple steps:

- Make a Plan – know who to call, where to meet
- Assemble a Kit – know what to pack and have enough supplies for at least 3 days
- Stay Informed – know about types of emergencies and related response actions

PROCLAIMED, by the Washoe County District Board of Health that September 2013 is National Preparedness Month, and encourages all citizens and businesses to develop their own emergency preparedness plan, and work together toward creating a more prepared community.

ADOPTED, this 26th day of September, 2013.

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A.M. Smith III, Chairman
Washoe County District Board of Health

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

DATE: September 26, 2013

TO: District Board of Health

FROM: Daniel Inouye, Acting Director, Air Quality Management

SUBJECT: Built All Construction – Case No. 1124
Unappealed Citation No. 5277
Agenda Item: **8. A. 1. a.**

Recommendation

Air Quality Management Division Staff recommends that Citation No. 5277 be upheld and a fine of $1,360, with attendance of an asbestos awareness course, be levied against Built All Construction for failure to have an asbestos survey performed by a qualified person and submitted to Air Quality for the issuance of an Acknowledgement of Asbestos Assessment prior to the demolition/renovation of a commercial facility. Conducting demolition/renovation activities without obtaining an asbestos survey and an Acknowledgement of Asbestos Assessment is a major violation of the District Board of Health Regulations Governing Air Quality Management, specifically Section 030.105(B)(10) National Emission Standards for Hazardous Air Pollutants (NESHAP), Subpart M - Asbestos, which is implemented through Section 030.107(A), Hazardous Air Pollutants, Asbestos Sampling and Notification. This is a negotiated settlement.

Recommended Fine: $4,400.00 Negotiated Fine: $1,360.00

Background

On July 11, 2013, Washoe County Air Quality Management Division received a citizen complaint from Mr. Jim Brown, Construction Specialist, for the commercial property located at 911 Linda Way in Sparks. The complaint was regarding the removal of possible asbestos containing materials associated with demolition/renovation activities occurring at the facility. A review of the Air Quality Management records determined an Asbestos Acknowledgement Form had not been completed for any renovation activities at that location.

Air Quality Specialist II Wallace Prichard was dispatched to the above address and found that several walls had been removed from the interior of the building. During his investigation, AQ Specialist Prichard was able to determine the work had been initiated by Built All Construction. The suspect asbestos containing materials were illegally removed and hauled away for disposal in Built All Construction trucks that were located on site. AQ Specialist Prichard then made contact with Mr. Fred Olson, City of Sparks Building and Enforcement Division, to determine if a building permit had been issued for the renovation activities in question. Mr. Olson was able to confirm a building permit had not been issued for the 911 Linda Way address and, in fact, a Stop Work had been issued by the City of Sparks for the construction activities at that address.

AQ Specialist Prichard contacted Mr. Tomas Madrigal, representative for Built All Construction, and directed him to stop work immediately and contract with a licensed Asbestos Consultant to perform a survey of all of the materials to be disturbed as part of the renovation activities. Mr. Madrigal contracted with Mr. Larry Thir, Environmental Inspection and Control Services, and a survey was performed on June 27, 2013. The laboratory results from the survey found no asbestos detected. On July 24, 2013, Mr. Madrigal submitted a copy of the asbestos survey to Air Quality Management and obtained an Acknowledgement of Asbestos Assessment.

Based on the results of the file review and investigation, AQ Specialist Prichard issued Notice of Violation Citation No. 5277 for a major violation of Section 030.107 (A), Asbestos Sampling and Notification.

Settlement

On July 24, 2013, Senior AQ Specialist Dennis Cerfoglio conducted a negotiated settlement meeting attended by AQ Specialist Prichard and Mr. Madrigal. After careful consideration of all the facts in the case, AQ Specialist Cerfoglio recommended that Citation No. 5316 be upheld with a fine of $1,360 and attendance of an asbestos awareness course. A Memorandum of Understanding was signed by all parties.

Alternatives

1. The District Board of Health may determine that no violation of the Regulations has taken place and dismiss Citation No. 5277.

2. The Board may determine to uphold Citation No. 5277 but levy any fine in the range of $0 to $10,000 per day.

In the event the Board determines to change the proposed penalty, the matter should be continued so that Mr. Madrigal and Built All Construction may be properly noticed.

Daniel Inouye

Daniel Inouye, Acting Division Director
Air Quality Management

DI/DC: ma

#1124

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION
1001 EAST NINTH ST. • SUITE B171 • RENO NV 89512
(775) 784-7200

NOTICE OF VIOLATION

NOV 5277 DATE ISSUED: 7/11/13

ISSUED TO: BuiltALL Construction PHONE #: 702-280-1445

MAILING ADDRESS: 2890 Vassar St. (17B) CITY/ST: Reno, NV ZIP: 89502

NAME/OPERATOR: Peter Meyerson PHONE #: 786-1112

PERMIT NO. N/A COMPLAINT NO. CMP13-0095

YOU ARE HEREBY OFFICIALLY NOTIFIED THAT ON _____ (DATE) AT _____ (TIME), YOU ARE IN VIOLATION OF THE FOLLOWING SECTION(S) OF THE WASHOE COUNTY DISTRICT BOARD OF HEALTH REGULATIONS GOVERNING AIR QUALITY MANAGEMENT:

☐ **MINOR VIOLATION OF SECTION:**	☒ **MAJOR VIOLATION OF SECTION:**
☐ 040.030 __DUST CONTROL	☐ 030.000 OPERATING W/O PERMIT
☐ 040.055 __ ODOR/NUISANCE	☐ 030.2175 VIOLATION OF PERMIT CONDITION
☐ 040.200 __ DIESEL IDLING	☒ 030.105 ASBESTOS/NESHAP
☐ OTHER _____	☒ OTHER 030.107

VIOLATION DESCRIPTION: Failure to conduct an asbestos survey, or obtain a completed "Asbestos Assessment Acknowledgement Form".

LOCATION OF VIOLATION: 911 Linda Way, Sparks, NV. 89431

POINT OF OBSERVATION: Inside the structure

Weather: N/A Wind Direction From: ~~N~~ E S W

Emissions Observed: N/A
(If Visual Emissions Performed - See attached Plume Evaluation Record)

☐ **WARNING ONLY:** Effective _____ a.m./p.m. _____ (date) you are hereby ordered to abate the above violation within _____ hours/days. I hereby acknowledge receipt of this warning on the date indicated.

Signature _____

☒ **CITATION:** You are hereby notified that effective on 7/11/13 (date) you are in violation of the section(s) cited above. You are hereby ordered to abate the above violation within Immediately hours/days. You may contact the Air Quality Management Division to request a negotiated settlement meeting by calling (775) 784-7200. You are further advised that within 10 working days of the date of this Notice of Violation, you may submit a written petition for appeal to the Washoe County Health District, Air Quality Management Division, P.O. Box 11130, Reno, Nevada 89520-0027. Failure to submit a petition within the specified time will result in the submission of this Notice of Violation to the District Board of Health with a recommendation for the assessment of an administrative fine.

SIGNING THIS FORM IS NOT AN ADMISSION OF GUILT

Signature: _____ Date: 7-24-2013

Issued by: Wallace Pritchard Title: Air Quality Specialist

☐ **PETITION FOR APPEAL FORM PROVIDED**

H-AIR-09 (Rev. 04/12)

DISTRICT HEALTH DEPARTMENT
AIR QUALITY MANAGEMENT DIVISION

MEMORANDUM OF UNDERSTANDING

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Date: 7/24/2013

Company Name: Built All Construction

Address: 2890 Vassar Street, Reno, NV.

Notice of Violation No.: 5277 Case No.: 1124

The staff of the Air Quality Management Division of the Washoe County District Health Department issued the above referenced citation for the violation of Regulation: 030.105 & 030.107 Asbestos Neshap.

A settlement of this matter has been negotiated between the undersigned parties resulting in a penalty amount of $ 1,360.00. This settlement will be submitted to the District Board of Health for review at the regularly scheduled meeting on 9/26/2013.

Signature of Company Representative	Signature of District Representative
TOMAS MADRIGAL	DENNIS A. CERFOGLIO
Print Name	Print Name
SALES & MARKETING.	Sr. Air Quality Spec.
Title	Title
	Witness
Witness	
Witness	Witness

AIR QUALITY MANAGEMENT - ADMINISTRATIVE PENALTY TABLE & RECOMMENDED FINE CALCULATION WORKSHEET

Administrative Penalty Table

Air Quality Management Division
Washoe County Health District

I. Minor Violations - Section 020.040(C)

Regulation		1st Violation	2nd Violation
040.005	Visible Emissions	$ 1,000	$ 2,500
040.030	Dust Control (fugitive)	250	750
040.035	Open Fires	500	1,000
040.040	Fire Training	500	1,000
040.050	Incinerator	1,000	2,000
040.051	Woodstoves	500	1,000
040.055	Odors	1,000	2,000
040.080	Gasoline Transfer (maintenance)	1,000	2,000
040.200	Diesel Idling	500	1,000
050.001	Emergency Episode	1,000	2,000

II. Major Violations - Section 020.040

		Source Category	
Regulation	Violation	Minimum	Maximum
030.000	Construction/Operating without Permit (per major process system or unit/day)	$ 5,000	$ 10,000
030.1402	Failure to Comply with Stop Work Order	10,000/day	10,000/day
030.2175	Operation Contrary to Permit Conditions (per day or event)	5,000	10,000
030.235	Failure to Conduct Source Test or Report (per Reporting Period for Each Unit)	2,500	5,000
	All other Major Violations (per day or event)	$10,000	$ 10,000
030.000	Construction Without a Dust Control Permit		
	Project Size – Less than 10 acres	$ 500 + $50 per acre	
	Project Size – 10 acres or more	$1,000 + $50 per acre	

III. Major Violations - Section 030.107 Asbestos

A. Asbestos Sampling & Notification	$ 2,000 - $10,000
B. Asbestos Control Work Practices (per day or event)	$ 5,000 - $10,000
C. Asbestos Containment & Abatement (per day or event)	$ 5,000 - $10,000

Washoe County Air Quality Management
Permitting & Enforcement Branch
Recommended Fine Calculation Worksheet

Company Name Built All Construction
Contact Name Tom Madrigal

Case #1124 NOV #5277 Complaint CMP13-0095

Violation of Section 030.107 (A) Asbestos Sampling and Notification

I. Base Penalty as specified in the Penalty Table = $ **4,000**
Contractor is new to the area so a lower base penalty was chosen

II. Severity of Violation

A. Public Health Impact

1. Degree of Violation
(The degree of which the person/company has deviated from the regulatory requirements)
Minor – 0.5 Moderate – 0.75 Major – 1.0 **Adjustment Factor** **1.0**

2. Toxicity of Release
Criteria Pollutant – 1x
Hazardous Air Pollutant – 2x **Adjustment Factor** **N/A**

3. Environmental/Public Health Risk **(Proximity to sensitive environment or group)**
Negligible – 1x Moderate – 1.5x Significant – 2x **Adjustment Factor** **1.0**

Total Adjustment Factors (1 x 2 x 3) = **1.0**

B. Adjusted Base Penalty
Base Penalty 4,000 x Adjustment Factor 1.0 = **$ 4,000**

C. Multiple Days or Units in Violation

Adjusted Penalty 4,000 x Number of Days or Units 1.0 = **$ 4,000**

D. Economic Benefit
Avoided Costs $ 400 = **$ 400**
Cost of Asbestos Survey

Penalty Subtotal – Recommended Fine
Adjusted Base Penalty $ 4,000 + Economic Benefit $ 400 = **$ 4,400**

III. Penalty Adjustment Consideration

A. Degree of Cooperation (0 – 25%) - 25 %

B. Mitigating Factors (0 – 25%) - 25 %

1. Negotiated Settlement
2. Ability to Pay
3. Other (explain)

C. Compliance History

No Previous Violations (0 – 10%) - 10 %

Similar Violation in Past 12 months (25 - 50%) + ____ %

Similar Violation within past 3 year (10 - 25%) + ____ %

Previous Unrelated Violation (5 – 25%) + ____ %

Total Penalty Adjustment Factors – sum of A, B, & C **-60 %**

IV. Recommended/Negotiated Fine

Penalty Adjustment:

$ 4,400	x	-60 %	=	$ 2,640
Penalty Subtotal (From Section II)		Total Adjustment Factors (From Section III)		Total Adjustment Value

Additional Credit for Environmental Investment/Training – $400
Cost for Asbestos Awareness Course for Built All Construction

Adjusted Penalty:

$ 4,400	-	$ 3,040	=	**$ 1,360**
Penalty Subtotal (From Section II)		Total Adjustment Value (From Section III + Credit)		**Negotiated Fine**

Dennis Corfoglio
Air Quality Specialist

7-24-2013
Date

COMPLAINT INVESTIGATION REPORT

Washoe County Air Quality Management Division

Complaint Number: **CMP13-0095**

Complaint Status: NOV Source of Complaint: CITIZEN

Complaint Type: ASBESTOS Date Received: 07/08/2013 Time: 4:40 P.M.

Inspector: WPRICHARD Inspector Area: 4

Complaint Description: NOV CITATION 5277 CASE 1124 - NO ASBESTOS ASSESSMENT & NO PERMITS

Address: 911 LINDA WAY SPKS

Location:

Parcel Number: 03435222

Related Permit Number:

Complainant:
JIM BROWN

911 LINDA WAY
SPARKS NV 89431
775-786-6070

Responsible Party:
BUILTALL CONSTRUCTION
PETER MEYERSON
2890 VASSAR STREET SUITE #17B
RENO,NV 89502
702-280-1445

Investigation:
Removal of material without asbestos assessment and no permits.

The Air Quality Management Division (AQMD) of the Washoe County District Health Department is issuing Notice of Violation #5277 on July 11, 2013, to the company known as BuiltAll Construction for removal and demolition of materials before an EPA NESHAP Notification OF DEMOLITION and RENOVATION had been obtained by the general contractor.

On July 11,2013 Washoe County Air Quality Management Division received a complaint from Jim Brown Construction Specialist for the property at 911 Linda Way, Sparks, NV. 89431. This was regarding possible asbestos containing material being removed from 911 Linda Way. Complaint #CMP13-0095 was generated and assigned to investigator Air Quality Specialist Prichard.

Specialist Prichard was dispatched to the above address and found that several walls had been removed from the interior of the building. The work had been initiated with removal of walls, electrical, and sheetrock by BuiltAll Constructions workmen and the materials were loaded into their truck and removed from the premise.

Specialist Prichard contacted Fred Olson at the City of Sparks building enforcement to confirm if a building permit had been issued to BuiltAll Construction. It was confirmed that no building permit had been issued by the City of Sparks and Fred Olson had issued a Stop Work Order at the building.

At that time Mr. Olson did not know who the contractor was and Specialist Prichard found that BuiltAll Construction was the responsible party after speaking with Mr. Brown who manages the building. There was never an Asbestos Assessment Acknowledgement Form issued.

Based on the results of the Air Quality Management Division's investigation a Notice of Violation of Section 030.105 and 030.107 Asbestos/NESHAP, a Major Violation of National Emission Standards for Hazardous Air Pollutants, Citation #5277 was issued on July 11, 2013.

Enforcement Activities

Warning Citation..:	Citation Number: 5277
NOV.....:	NOV Number....: 0
	Case Number.....: 1124
Settlement.....: 07/24/2013	Amount.....: $0.00
Appealed.....:	
Upheld.....:	Amount.....: $0.00

Status Information

Initialized By.....: TBURTON	Completed Date...:
Date Assigned.....: 07/08/2013	Completed By.....:

AIR QUALITY MANAGEMENT
ACKNOWLEDGEMENT OF ASBESTOS ASSESSMENT
FOR BRINKS LOCATED AT
911 LINDA WAY, SUITE 100, SPARKS NV

DATED: JULY 24, 2013

ACKNOWLEDGMENT OF ASBESTOS ASSESSMENT
Washoe County Air Quality Management Division

Permit Number: ASB13-0617

$62.00 CHECK 1 0724'13 M050805 THO

Property Owner: CAROL JO CROSBY ET AL **Phone:** 741-2766

Property Being Evaluated: BRINKS - SUITE #100

Address: 911 LINDA WAY SPKS

TYPE OF PROJECT	TYPE OF PROPERTY	PROPERTY BEING ASSESSED
RENO	NON-RES	PARTIAL*

FILING FEE: $62.00 √√

*Note: If this project is a partial renovation and additional work is to be conducted later, additional asbestos assessment(s) will be required unless this assessment covers all pertinent representative asbestos suspected materials throughout the building.

General Contractor:
BUILTALL CONSTRUCTION
TOMAS MADRIGAL
2890 VASSAR #17B
RENO, NV 89502

Consultant or Assessment Company:
EICS

2900 VASSAR #503
RENO, NV 89502

Abatement Contractor:

Assessment Results: ACM ABSENT

Abatement Completed:

** Note: If asbestos present, abatement must be conducted in accordance with NESHAP and OSHA regulations before renovation or demolition work may proceed.

10-DAY NOTIFICATION MANDATORY FOR DEMOLITION

Owner / Representative's Name

Comments:
Tenant improvement for current occupant Brinks, consisting of removal of demising wall. No ACM detected during sampling. Use best management practices for dust control, and dispose of all waste properly.

Health District Representive

7/24/13
Date

Signature on this asbestos assessment document does NOT constitute full Health District approval for this project. Any additional Health permits such as are required for bar or restaurant operations, underground storage tanks, hazardous material disposal or air pollution sources must be obtained separately.

Signature by the Washoe County Health District does not warrant, nor should this report be taken to warrant, that asbestos was or was not present on stated property. Exposure to even small amounts of airborne asbestos fibers may cause cancer. For this reason the Health District recommends that all asbestos handling and abatement work be performed by certified asbestos contractors.

EICS - BULK SAMPLE ASBESTOS REPORT
DATED JUNE 28, 2013

AND

ASBESTOS TEM LABORATORIES INC REPORT
DATED JUNE 28, 2013

BOTH FOR BRINKS INC LOCATED AT
911 LINDA WAY, SPARKS NV

EICS Environmental Inspection & Control Services

June 28, 2013

CLIENT
BuiltAll Construction Co.
2890 Vassar St #BB-17
Reno, NV 89502
Mr. Tom Madrigal

LOCATION
911 Linda Way #100
Sparks, NV

PURPOSE OF INSPECTION
Planned tenant improvement

REFERENCES
Exhibit A
Asbestos TEM Laboratories report 122715

Background

EICS was engaged by the client to inspect the above noted location for the presence of asbestos containing materials (acm). The site consists of a one story tilt wall warehouse. The age of the building was approximately 22 years. The client indicated plans to disturb several interior non-load bearing walls in the course of a tenant improvement project. The inspection was performed on June 27, 2013 by Lawrence G. Thir, owner and senior hygienist of EICS. Access was provided by the client.

Inspection

I first discussed the project with the client. I carefully inspected the affected areas for suspect acm. I wetted and using a clean sharp instrument, extracted 4 bulk samples of suspect acm from the targeted areas. Each sample was placed in an individual sealed and labeled container and logged on a chain of custody. The samples were packaged and taken to Asbestos TEM Laboratories in Sparks, NV for 24 hr. analysis by polarized light microscopy (PLM) using EPA method 600/R-93/116.

Laboratory results

Sample no.	Location	Material	Asbestos content
1	Restrm. S. wall	Wall surface texture	None detected
2	Restrm. W.wall	Wall surface texture	None detected
3	Warehouse W. wall	Wall surface texture	None detected
4	Warehouse S. wall	Wall surface texture	None detected

Discussion and recommendations

USEPA and NV DEISH consider any building material with asbestos content greater than 1% as asbestos containing material (ACM). The above note materials were found with no asbestos content. They may be disturbed with no precautionary measures for asbestos exposure.

Limitation

This report is applicable only to the area of the building, herein discussed. Destructive/invasive investigation was not performed.

Thank you for the opportunity to be of service. If you have any questions, please call me at (775)786-2800.

Respectfully submitted,

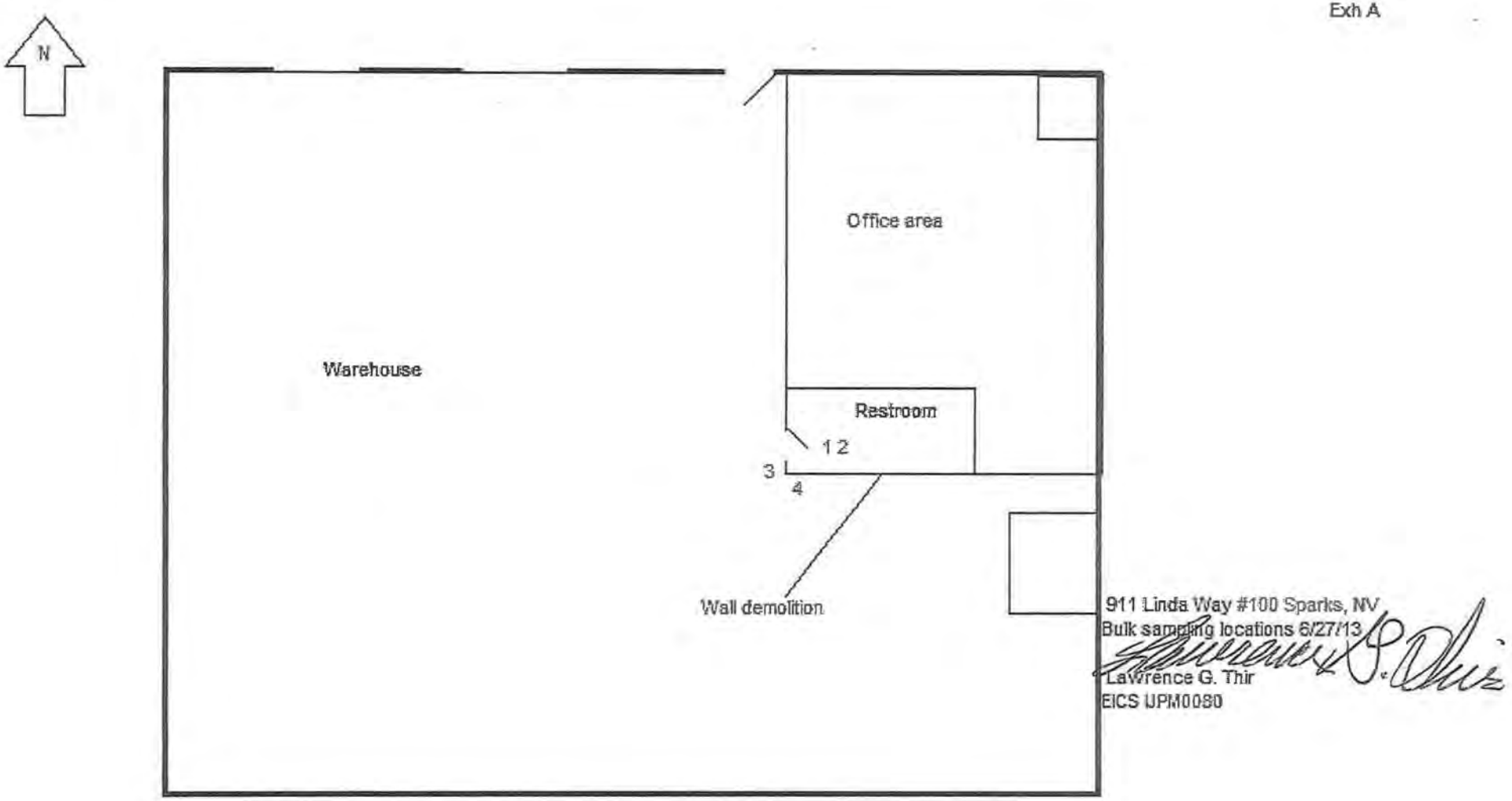
Lawrence G. Thir
EICS-Senior Hygienist
IJPM0080

2900 Vassar Street #503
Reno, NV 89502

eicsnevada.com
thir_eics@hotmail.com

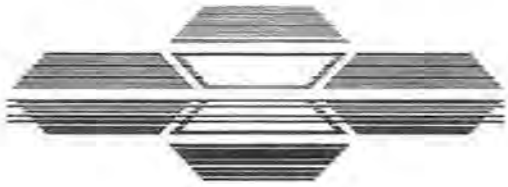
PH. (775) 786-2800
FAX. (775) 786-9599

Exh A



911 Linda Way #100 Sparks, NV
Bulk sampling locations 6/27/13

Lawrence G. Thir
EICS UPM0080



ASBESTOS TEM LABORATORIES, INC.

EPA Method 600/R-93/116
Polarized Light Microscopy
Analytical Report

Report No. 122715

1350 Freeport Blvd., Unit 104
Sparks, NV 89431
(775) 359-3377
FAX (775) 359-2798

With Main Office Located At:
630 Bancroft Way, Berkeley, CA 94710
Ph. (510) 704-8930 Fax (510) 704-8929

ASBESTOS TEM LABORATORIES, INC

Accredited by
NVLAP®
NVLAP Lab Code 200104-0

Jun-28-13

Mr. Larry Thir
E.I.C.S.
2900 Vassar Street, #503
Reno, NV 89502

RE: LABORATORY JOB # 875-###
Polarized light microscopy analytical results for 4 bulk sample(s).
Job Site: 911 Linda Way #100, Sparks
Job No.: BAC62713-2
Report No.: 122715

Enclosed please find the bulk material analytical results for one or more samples submitted for asbestos analysis. The analyses were performed in accordance with EPA Method 600/R-93/116 or 600/M4-82-020 for the determination of asbestos in bulk building materials by polarized light microscopy (PLM). Please note that while PLM analysis is commonly performed on non-friable and fine grained materials such as floor tiles and dust, the EPA method recognizes that PLM is subject to limitations. In these situations, accurate results may only be obtainable through the use of more sophisticated and accurate techniques such as transmission electron microscopy (TEM) or X-ray diffraction (XRD).

Prior to analysis, samples are logged-in and all data pertinent to the sample recorded. The samples are checked for damage or disruption of any chain-of-custody seals. A unique laboratory ID number is assigned to each sample. A hard copy log-in sheet containing all pertinent information concerning the sample is generated. This and all other relevant paper work are kept with the sample throughout the analytical procedures to assure proper analysis.

Each sample is opened in a class 100 HEPA negative air hood. A representative sampling of the material is selected and placed onto a glass microscope slide containing a drop of refractive index oil. The glass slide is placed under a polarizing light microscope where standard mineralogical techniques are used to analyze and quantify the various materials present, including asbestos. The data is then compiled into standard report format and subjected to a thorough quality assurance check before the information is released to the client.

For possible future reference, samples are normally kept on file for one year.

Sincerely Yours,

Laboratory Analyst
ASBESTOS TEM LABORATORIES, INC.

Accredited by

NVLAP

NVLAP Lab Code 200104-0

POLARIZED LIGHT MICROSCOPY ANALYTICAL REPORT

EPA Method 600/R-93/116 or 600/M4-82-020

Contact: Mr. Larry Thir

Address: E.I.C.S.
2900 Vassar Street, #503
Reno, NV 89502

Samples Indicated: 4
Reg. Samples Analyzed: 4
Split Layers Analyzed: 0

Job Site / No. 911 Linda Way #100, Sparks
BAC62713-2

Report No. 122715
Date Submitted: Jun-27-13
Date Reported: Jun-28-13

SAMPLE ID	ASBESTOS %	ASBESTOS TYPE	OTHER DATA (1) Non-Asbestos Fibers (2) Matrix Materials (3) Date/Time Collected (4) Date Analyzed	DESCRIPTION FIELD / LAB
1.		None Detected	1) 1-5% Cellulose 2) 95-99% Calc, Paint, Other m.p.	Wall Surface Texture, Restroom South Wall
Lab ID # 875-02191-001			3) 4) Jun-28-13	Texture-Blue/White
2.		None Detected	1) 1-5% Cellulose 2) 95-99% Calc, Paint, Other m.p.	Wall Surface Texture, Restroom West Wall
Lab ID # 875-02191-002			3) 4) Jun-28-13	Texture-Blue/White
3.		None Detected	1) 5-10% Cellulose 2) 90-95% Paint, Calc, Other m.p.	Wall Surface Texture, Warehouse West Wall
Lab ID # 875-02191-003			3) 4) Jun-28-13	Texture-Brown/White
4.		None Detected	1) 1-5% Cellulose 2) 95-99% Paint, Calc, Other m.p.	Wall Surface Texture, Warehouse South Wall
Lab ID # 875-02191-004			3) 4) Jun-28-13	Texture-White
			1) 2)	
Lab ID #			3) 4)	
			1) 2)	
Lab ID #			3) 4)	
			1) 2)	
Lab ID #			3) 4)	
			1) 2)	
Lab ID #			3) 4)	
			1) 2)	
Lab ID #			3) 4)	
			1) 2)	
Lab ID #			3) 4)	

Limit of Quantitation of Method is Estimated to be 1% Asbestos Using a Visual Area Estimation Technique

Laboratory Analyst Greg Hanes

ASBESTOS TEM LABORATORIES, INC. **1350 Freeport Blvd., Unit 104, Sparks, NV 89431** **(775) 359-3377**
With Main Office in Berkeley, CA (510) 704-8930

ASBESTOS TEM LABORATORIES, INC

1350 Freeport Blvd., Unit #104 * Sparks, NV 89431 * Ph: (775) 359-3377 * Fax: (775) 359-2798
Home office at: 630 Bancroft Way * Berkeley, CA 94710 * Ph: (510) 704-8930 * Fax: (510) 704-8429

*** BULK SAMPLE SUBMISSION FORM / CHAIN-OF-CUSTODY ***

Company: E.I.C.S. ___ 2 hr ___ 4 hr ___ 8 hr (24 hr) ___ 2 Day ___ 3 Day

Address: 2900 VASSAR ST 503 Job Site: 911 LINDA WAY #100 SPARKS

City-State-Zip: RENO Job No: BAC6271-2 P.O.#: ___

Contact Person: LARRY TURK Phone: ___ Fax: ___

Email: ___

Sample Number	Sample Description	Sample Location
1	WALL SURFACE TEX	REST ROOM S. WALL
	" " "	REST ROOM W. WALL
	" " "	WAREHOUSE W. WALL
	" " "	WAREHOUSE S. WALL

Special instructions: e-mail

Relinquished by	Date / Time	Received by	Date / Time
Name/Company EICS	6-27-13	Name/Company - Sue Ehrlich, / ATEM	6/27/13
Signature (Larry Turk)	3:30PM	Signature Sue Ehrlich	3:30 PM
Name/Company		Name/Company	
Signature		Signature	

 Send original to lab - keep yellow copy Page ___ of ___

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

DATE: September 26, 2013

TO: District Board of Health

FROM: Daniel Inouye, Acting Director, Air Quality Management

SUBJECT: Bailor Construction – Case No. 1125
Unappealed Citation No. 5278
Agenda Item: **8. A. 1. b.**

Recommendation

Air Quality Management Division Staff recommends that Citation No. 5278 be upheld and a fine of $2,000 be levied against Bailor Construction for failure to have an asbestos survey performed by a qualified person and submitted to Air Quality for the issuance of an Acknowledgement of Asbestos Assessment prior to the demolition/renovation of a commercial facility. Conducting demolition/renovation activities without obtaining an asbestos survey and an Acknowledgement of Asbestos Assessment is a major violation of the District Board of Health Regulations Governing Air Quality Management, specifically Section 030.105(B)(10) National Emission Standards for Hazardous Air Pollutants (NESHAP), Subpart M - Asbestos, which is implemented through Section 030.107(A), Hazardous Air Pollutants, Asbestos Sampling and Notification. This is a negotiated settlement.

Recommended Fine: $5,400.00 Negotiated Fine: $2,000.00

Background

On July 11, 2013, Washoe County Air Quality Management Division received an anonymous citizen complaint regarding a commercial building located at 609 Sierra Rose Drive, Unit #3, in Reno. The complainant was concerned about the disturbance of possible asbestos containing materials associated with demolition/renovation activities at that address. A review of the Air Quality Management records determined an Asbestos Acknowledgement Form had not been completed for any renovation activities at that location.

Air Quality Specialist II Wallace Prichard was dispatched to the above address and found that several walls had been removed from the interior of Unit #3. During his investigation, AQ Specialist Prichard was able to determine the work had been initiated by Bailor Construction, acting as a subcontractor for Bison Construction. The suspect materials were illegally removed and hauled away for disposal utilizing pickup trucks on the jobsite. AQ Specialist Prichard made contact with Mr. Greg Bailor, owner of Bailor Construction, to inquire about the asbestos survey and Acknowledgement of Asbestos Assessment required for the removal of any suspect asbestos containing materials. Mr. Bailor informed AQ Specialist Prichard that he thought all of the permits had been obtained by the general contractor, Mr. John Martin, Bison Construction. AQ Specialist Prichard instructed Mr. Bailor to stop work immediately until a determination could be made regarding the status of the required permits.

AQ Specialist Prichard was able to confirm an asbestos survey had not been completed and submitted to Air Quality in order to obtain the required Acknowledgment of Asbestos Assessment. AQ Specialist Prichard also contacted Mr. Bill Warner, City of Reno Building Department, and confirmed a building permit had not been issued to Bison Construction for activities in Unit #3.

Mr. Martin, Bison Construction, contracted with Lisa Monroe & Associates and an asbestos survey was performed on July 11, 2013. The laboratory results from the survey found no asbestos detected. On July 15, 2013, Mr. Martin submitted a copy of the asbestos survey to Air Quality Management and obtained an Acknowledgement of Asbestos Assessment.

Based on the results of the file review and investigation, AQ Specialist Prichard issued Notice of Violation Citation No. 5278 to Bailor Construction for a major violation of Section 030.107 (A), Asbestos Sampling and Notification. On July 24, 2013 the citation was delivered by certified mail to Mr. Bailor in Carson City.

Settlement

On August 15, 2013, Senior AQ Specialist Dennis Cerfoglio conducted a negotiated settlement meeting attended by AQ Specialist Prichard and Mr. Greg Bailor. After careful consideration of all the facts in the case, AQ Specialist Cerfoglio recommended that Citation No. 5278 be upheld with a fine of $2,000. A Memorandum of Understanding was signed by all parties.

Alternatives

1. The District Board of Health may determine that no violation of the Regulations has taken place and dismiss Citation No. 5278.

2. The Board may determine to uphold Citation No. 5278 but levy any fine in the range of $0 to $10,000 per day.

In the event the Board determines to change the proposed penalty, the matter should be continued so that Mr. Bailor and Bailor Construction may be properly noticed.

Daniel Inouye

Daniel Inouye, Acting Division Director
Air Quality Management

DI/DC: ma

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION
1001 EAST NINTH ST. • SUITE B171 • RENO NV 89512
(775) 784-7200

NOTICE OF VIOLATION

NOV 5278 DATE ISSUED: 07/11/2013

ISSUED TO: Bailor PHONE #: 849-0534

MAILING ADDRESS: P.O. Box 21231 CITY/ST: Carson City, NV ZIP: 89721

NAME/OPERATOR: Grey A. Bailor PHONE #:

PERMIT NO. COMPLAINT NO. CMP 13-0099

YOU ARE HEREBY OFFICIALLY NOTIFIED THAT ON 7/11/2013 (DATE) AT 9:30 AM (TIME), YOU ARE IN VIOLATION OF THE FOLLOWING SECTION(S) OF THE WASHOE COUNTY DISTRICT BOARD OF HEALTH REGULATIONS GOVERNING AIR QUALITY MANAGEMENT:

☐ **MINOR VIOLATION OF SECTION:**	☐ **MAJOR VIOLATION OF SECTION:**
☐ 040.030 __DUST CONTROL	☐ 030.000 OPERATING W/O PERMIT
☐ 040.055 __ ODOR/NUISANCE	☐ 030.2175 VIOLATION OF PERMIT CONDITION
☐ 040.200 __ DIESEL IDLING	☒ 030.105 ASBESTOS/NESHAP
☐ OTHER	☒ OTHER 030.107

VIOLATION DESCRIPTION: Failure to conduct an asbestos survey, or obtain a completed "Asbestos Assessment Acknowledgement Form"

LOCATION OF VIOLATION: 609 Sierra Rose Dr. Reno, NV.

POINT OF OBSERVATION: Inside Unit #3

Weather: N/A Wind Direction From: ~~N E S W~~

Emissions Observed: N/A
(If Visual Emissions Performed - See attached Plume Evaluation Record)

☐ **WARNING ONLY:** Effective _____ a.m./p.m. _____ (date) you are hereby ordered to abate the above violation within _____ hours/days. I hereby acknowledge receipt of this warning on the date indicated.

Signature N/A

☒ **CITATION:** You are hereby notified that effective on 7/11/13 (date) you are in violation of the section(s) cited above. You are hereby ordered to abate the above violation within 10:00 hours/days. You may contact the Air Quality Management Division to request a negotiated settlement meeting by calling (775) 784-7200. You are further advised that within 10 working days of the date of this Notice of Violation, you may submit a written petition for appeal to the Washoe County Health District, Air Quality Management Division, P.O. Box 11130, Reno, Nevada 89520-0027. Failure to submit a petition within the specified time will result in the submission of this Notice of Violation to the District Board of Health with a recommendation for the assessment of an administrative fine.

SIGNING THIS FORM IS NOT AN ADMISSION OF GUILT

Signature: _____ Date: _____

Issued by: Wallace Pruchard Title: Air Quality Specialist

☐ **PETITION FOR APPEAL FORM PROVIDED**

H-AIR-09 (Rev. 04/12)

DISTRICT HEALTH DEPARTMENT
AIR QUALITY MANAGEMENT DIVISION

MEMORANDUM OF UNDERSTANDING

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Date: 8/15/2013

Company Name: Greg A. Bailor

Address: P.O. Box 21231 Carson City, NV 89721

Notice of Violation No.: 5278 Case No.: 1125

The staff of the Air Quality Management Division of the Washoe County District Health Department issued the above referenced citation for the violation of Regulation: Section 030.105 and 030.107 Asbestos/NESHAP

A settlement of this matter has been negotiated between the undersigned parties resulting in a penalty amount of $ $2,000^{00}$. This settlement will be submitted to the District Board of Health for review at the regularly scheduled meeting on September 26, 2013. 2 payments of $1,000^{00}$ Each

Signature of Company Representative

Signature of District Representative

GREG A BAILOR
Print Name

DENNIS A. CERFOGLIO
Print Name

OWNER
Title

Sr. Air Quality Spec.
Title

Witness

Wallace Tucker
Witness

Witness

Witness

AIR QUALITY MANAGEMENT - ADMINISTRATIVE PENALTY TABLE & RECOMMENDED FINE CALCULATION WORKSHEET

Administrative Penalty Table

Air Quality Management Division
Washoe County Health District

I. Minor Violations - Section 020.040(C)

Regulation		1st Violation	2nd Violation
040.005	Visible Emissions	$ 1,000	$ 2,500
040.030	Dust Control (fugitive)	250	750
040.035	Open Fires	500	1,000
040.040	Fire Training	500	1,000
040.050	Incinerator	1,000	2,000
040.051	Woodstoves	500	1,000
040.055	Odors	1,000	2,000
040.080	Gasoline Transfer (maintenance)	1,000	2,000
040.200	Diesel Idling	500	1,000
050.001	Emergency Episode	1,000	2,000

II. Major Violations - Section 020.040

		Source Category	
Regulation	Violation	Minimum	Maximum
030.000	Construction/Operating without Permit (per major process system or unit/day)	$ 5,000	$ 10,000
030.1402	Failure to Comply with Stop Work Order	10,000/day	10,000/day
030.2175	Operation Contrary to Permit Conditions (per day or event)	5,000	10,000
030.235	Failure to Conduct Source Test or Report (per Reporting Period for Each Unit)	2,500	5,000
	All other Major Violations (per day or event)	$10,000	$ 10,000
030.000	Construction Without a Dust Control Permit		
	Project Size – Less than 10 acres	$ 500 + $50 per acre	
	Project Size – 10 acres or more	$1,000 + $50 per acre	

III. Major Violations - Section 030.107 Asbestos

A. Asbestos Sampling & Notification	$ 2,000 - $10,000
B. Asbestos Control Work Practices (per day or event)	$ 5,000 - $10,000
C. Asbestos Containment & Abatement (per day or event)	$ 5,000 - $10,000

Washoe County Air Quality Management
Permitting & Enforcement Branch
Recommended Fine Calculation Worksheet

Company Name Bailor Construction
Contact Name Greg Bailor

Case #1125 NOV #5278 Complaint CMP13-0099

Violation of Section 030.107 (A) Asbestos Sampling and Notification

I. Base Penalty as specified in the Penalty Table = $ 5,000

II. Severity of Violation

A. Public Health Impact

1. Degree of Violation
(The degree of which the person/company has deviated from the regulatory requirements)
Minor – 0.5 Moderate – 0.75 Major – 1.0 **Adjustment Factor** **1.0**

2. Toxicity of Release
Criteria Pollutant – 1x
Hazardous Air Pollutant – 2x **Adjustment Factor** **N/A**

3. Environmental/Public Health Risk **(Proximity to sensitive environment or group)**
Negligible – 1x Moderate – 1.5x Significant – 2x **Adjustment Factor** **1.0**

Total Adjustment Factors (1 x 2 x 3) = **1.0**

B. Adjusted Base Penalty
Base Penalty 5,000 x Adjustment Factor 1.0 = **$ 5,000**

C. Multiple Days or Units in Violation

Adjusted Penalty 5,000 x Number of Days or Units 1.0 = **$ 5,000**

D. Economic Benefit
Avoided Costs $ 400 = **$ 400**
Cost of Asbestos Survey

Penalty Subtotal – Recommended Fine
Adjusted Base Penalty $ 5,000 + Economic Benefit $ 400 = **$ 5,400**

III. Penalty Adjustment Consideration

A. Degree of Cooperation (0 – 25%) - 25 %

B. Mitigating Factors (0 – 25%) - 25 %

1. Negotiated Settlement
2. Ability to Pay
3. Other (explain)

C. Compliance History

No Previous Violations (0 – 10%) - 10 %

Similar Violation in Past 12 months (25 - 50%) + ____ %

Similar Violation within past 3 year (10 - 25%) + ____ %

Previous Unrelated Violation (5 – 25%) + ____ %

Total Penalty Adjustment Factors – sum of A, B, & C **-60 %**

IV. Recommended/Negotiated Fine

Penalty Adjustment:

$ 5,400	x	-60 %	=	$ -3,240
Penalty Subtotal (From Section II)		Total Adjustment Factors (From Section III)		Total Adjustment Value

Additional Credit for Environmental Investment/Training – N/A

Adjusted Penalty:

$ 5,400	-	$ 3,240	=	**$ 2,000**
Penalty Subtotal (From Section II)		Total Adjustment Value (From Section III + Credit)		**Negotiated Fine**

Dennis Cerfoglio
Air Quality Specialist

8-15-2013
Date

COMPLAINT INVESTIGATION REPORT

Washoe County Air Quality Management Division

Complaint Number: **CMP13-0099**

Complaint Status: NOV Source of Complaint: CITIZEN

Complaint Type: ASBESTOS Date Received: 07/11/2013 Time: 8:23:00 AM

Inspector: WPRICHARD Inspector Area: 3

Complaint Description: NOV CITATION 5278 CASE 1125 * NOV CITATION 5279 CASE 1126 - ASBESTOS WORK IN A COMMERCIAL BUILDING WITH NO AQ PERMITS - LOADIN

Address: 609 SIERRA ROSE DR RENO

Location: UNIT 3 OR 4

Parcel Number: 04094135

Related Permit Number:

Complainant:
ANONYMOUS

Responsible Party:
BISON CONSTRUCTION
JOHN MARTIN (OWNER)
P.O BOX 3198
CARSON CITY NV 89702
775-849-1850

Investigation:
Asbestos Work in a commercial building with no Air Quality permit. Also loading a truck with sheet rock.

The Air Quality Management Division (AQMD) of the Washoe County District Health Department is issuing Notice of Violation #5279 on July 11, 2013, to the company known as Bison Construction for removal and demolition of materials before an EPA NESHAP Notification OF DEMOLITION and RENOVATION
was issued.

On July 11, 2013 Washoe County Air Quality Management Division received a complaint from an anonymous caller regarding possible asbestos containing material being removed from Unit #3 at 609 Sierra Rose Drive, Reno. Complaint #CMP13-0099 was generated and assigned to investigator Air Quality Specialist Prichard.

AQ Specialist Prichard was dispatched to the above address and found that several walls had been removed from the interior of the Unit #3. The work had been initiated with removal of walls, electrical, and sheetrock by Greg A. Bailor's workmen. Greg A. Bailor is a subcontractor and was conducting the removal of materials that were then loaded into their truck and disposed of.

AQ Specialist Prichard contacted Bill Warner at the City of Reno to confirm if a building permit had been issued to Bison Construction for 609 Sierra Rose Drive, Unit #3. It was confirmed that no building permit had been issued by the City of Reno to Bison Construction. Also after checking the data base at Air Quality and speaking with Mr. John Martin, the owner of Bison Construction, investigation showed that there was no asbestos survey for the property submitted. Therefore, the Asbestos Assessment Acknowledgement Form was never issued from the Air Quality Mgmt office.

After being notified of the violation and that all work was to be ceased, Mr. Martin hired Lisa Monroe & Associates, Inc. Lisa Monroe's company conducted an asbestos bulk sampling analysis. The test was completed on 07/11/2013 and all samples were listed as no asbestos detected.

Mr. Martin obtained an Acknowledgment of Asbestos Assessment (ASB13-0593) from Washoe County Air Quality Management Division on July 15, 2013.

Based on the results of the Air Quality Management Division's investigation a Notice of Violation of Section 030.105 and 030.107 Asbestos/NESHAP, a Major Violation of National Emission Standards for Hazardous Air Pollutants a
Notice of Violation Citation #5279 has been issued on July 11, 2013.

Enforcement Activities

Warning Citation..:	Citation Number: 5278
NOV.....: 07/11/2013	NOV Number....: 5279
	Case Number.....: 1125
Settlement.....:	Amount.....: $0.00
Appealed.....:	
Upheld.....:	Amount.....: $0.00

Status Information

Initialized By.....: MAMES	Completed Date...:
Date Assigned.....: 07/11/2013	Completed By.....:

AIR QUALITY MANAGEMENT
ACKNOWLEDGEMENT OF ASBESTOS ASSESSMENT
FOR RENO DIAGNOSTICS - SUITE C, UNIT 3 LOCATED AT
609 SIERRA ROSE DRIVE, RENO

DATED: JULY 15, 2013

ACKNOWLEDGMENT OF ASBESTOS ASSESSMENT
Washoe County Air Quality Management Division

Permit Number: ASB13-0593

Property Owner: RIBEIRO COMPANY **Phone:** 775-825-4646

Property Being Evaluated: T.I. - FOR RENO DIAGNOSTICS SUITE C BLDG 3 - NEW BILLING CENTER.

Address: 609 SIERRA ROSE DR RENO

TYPE OF PROJECT	TYPE OF PROPERTY	PROPERTY BEING ASSESSED
RENO	NON-RES	PARTIAL*

FILING FEE: $62.00 ✓

*Note: If this project is a partial renovation and additional work is to be conducted later, additional asbestos assessment(s) will be required unless this assessment covers all pertinent representative asbestos suspected materials throughout the building.

General Contractor:
BISON CONSTRUCTION
JOHN MARTIN
PO BOX 3198
CARSON CITY, NV 89702

Consultant or Assessment Company:
LISA MONROE & ASSOCIATES

PO BOX 2252
SPARKS, NV 89431

Abatement Contractor:

Assessment Results: ACM ABSENT

Abatement Completed:

** Note: If asbestos present, abatement must be conducted in accordance with NESHAP and OSHA regulations before renovation or demolition work may proceed.

10-DAY NOTIFICATION MANDATORY FOR DEMOLITION _____
Owner / Representative's Name

Comments:
T.I. - Interior remodel for new Reno Diagnostics billing center. Sampling found NO ACM present. Use best methods of dust control during construction and dispose of waste properly.

Charlene Albee
Health District Representive

7/15/13
Date

Signature on this asbestos assessment document does NOT constitute full Health District approval for this project. Any additional Health permits such as are required for bar or restaurant operations, underground storage tanks, hazardous material disposal or air pollution sources must be obtained separately.

Signature by the Washoe County Health District does not warrant, nor should this report be taken to warrant, that asbestos was or was not present on stated property. Exposure to even small amounts of airborne asbestos fibers may cause cancer. For this reason the Health District recommends that all asbestos handling and abatement work be performed by certified asbestos contractors.

C

LISA MONROE & ASSOCIATES ASBESTOS SAMPLING AND TESTING REPORTS FOR RENO DIAGNOSTICS, SUITE C, UNIT 3 LOCATED AT 609 SIERRA ROSE DRIVE, RENO NEVADA

DATED: JULY 11, 2013

Lisa Monroe & Associates, Inc.
P.O. Box 2252
Sparks, NV 89432
Phone/Fax: 775-355-1011
Email Address: LM-ASSOCIATES@ATT.NET

Bulk Sample Asbestos Report

Date of Report: 7-15-13 Date of Inspection: 7-11-13

Company/Client: Bison Construction

Address: P.O. Box 3198

City, State & Zip: Carson City, NV 89702

Building Name:

Building Address: 609 Sierra Rose Drive, Reno, Nevada

Area of Building Inspected: Suite #3

A survey was performed at 609 Sierra Rose Drive on July 11, 2013. The inspection involved the collection of 6 bulk samples from the existing materials where the walls have been removed. The suspect asbestos containing materials that were sampled include wall texture and joint compound. The laboratory analysis shows no asbestos detected in the materials that were tested.

Asbestos Overview

Environmental regulatory agencies and health professionals consider any substance with an asbestos content of one percent or greater to pose a significant health hazard in the event of disturbance. Asbestos was used in a wide variety of building materials, such as thermal or acoustical insulators or as a binder for tensile strength. Some examples of where asbestos can be found include spray acoustic on ceilings, wall textures, joint compounds, floor tiles, linoleum flooring and the mastic used to adhere the flooring. Because asbestos containing building materials are still being manufactured, mainly in other countries, all building materials that will be disturbed by renovation or demolition activities should be tested for asbestos content.

The inspection that was performed involved only the areas that the client requested and the delivery of this report does not guarantee that all asbestos was identified or that all suspect asbestos containing materials were sampled within the building.

Submitted by:
Lisa D. Monroe, President
Lisa Monroe & Associates, Inc.
NV DIROSHES: IJPM0061
CAC: 92-0660

PRECISION MICRO-ANALYSIS INC

SPECIALISTS IN ASBESTOS-RELATED ANALYSIS

Bulk Sample Analysis (PLM) Report

Report# 130712001

Lisa Monroe & Associates
P.O. Box 2252
Sparks, NV 89432

Phone: (775) 355-1011

Date Collected: 07/11/13
Date Received: 07/12/13
Date Analyzed: 07/12/13

Job Information:
13-8791
609 Sierra Rose Drive, Suite 3

Sample Number	Sample Location	Sample Description	Analytical Results
13-8791-1 *Lab# 13-243453*	Northwest	White texture	No asbestos detected
13-8791-2 *Lab# 13-243454*	Southeast wall	White texture	No asbestos detected
13-8791-3 *Lab# 13-243455*	Southwest wall	White texture	No asbestos detected
13-8791-4 *Lab# 13-243456*	South wall	White joint compound	No asbestos detected
13-8791-5 *Lab# 13-243457*	East wall	White joint compound	No asbestos detected
13-8791-6 *Lab# 13-243458*	Northwest wall	White joint compound	No asbestos detected

OFFICIAL NOTICE: After 45 days, samples are disposed of through a licensed waste hauler, unless client requests their return.

Total number of samples: 6

Supervisor _____ Analyst _____

Note: The test result findings are made to the methodologies and parameters described on the reverse of this page.

3463 Ramona Ave., Suite 17 • Sacramento, CA 95826 • (916) 456-4892 • Fax (916) 456-1082

CITATION NOTIFICATION SENT CERTIFIED MAIL TO GREG A. BAILOR FROM WASHOE COUNTY AIR QUALITY MANGEMENT DIVISION, WALLACE PRICHARD

RECEIVED JULY 29, 2013

7011 2970 0004 2282 9134

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

AQFIA1300 OFFICIAL USE

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here
JUL 26 2013
CARSON CITY NV
USPS 89706

WP

Sent To: Mr Greg A Bailor
Street, Apt. No.; or PO Box No.: PO Box 21231
City, State, ZIP+4: Carson City NV 89721

PS Form 3800, August 2006 — See Reverse for Instructions

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Greg A. Bailor
P.O. Box 21231
Carson City, NV 89721

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☒ Addressee

B. Received by *(Printed Name)* | C. Date of Delivery

D. Is delivery address different from Item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

CARSON CITY NV JUL 29 2013 USPS 89706

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 2970 0004 2282 9134

WP

PS Form 3811, February 2004 — Domestic Return Receipt — 102595-02-M-1540

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

July 24, 2013

Mr. Greg A. Bailor
Nevada License #44094
P.O. Box 21231
Carson City, Nevada 89721

COPY

Re: 609 Sierra Rosa Drive, Unit #3, Reno, NV

Dear Mr. Bailor:

The Air Quality Management Division (AQMD) of the Washoe County District Health Department is issuing Notice of Violation **#5278** on July 11, 2013, to the company known as Greg A. Bailor for removal and demolition of materials before an **EPA NESHAP Notification OF DEMOLITION and RENOVATION** was issued to the general contractor Bison Construction.

On July 11,2013 Washoe County Air Quality Management Division received a complaint from an anonymous caller regarding possible asbestos containing material being removed from Unit #3 at 609 Sierra Rose Drive, Reno. Complaint #CMP13-0099 was generated and assigned to investigator Air Quality Specialist Prichard.

Specialist Prichard was dispatched to the above address and found that several walls had been removed from the interior of the Unit #3. The work had been initiated with removal of walls, electrical, and sheetrock by Greg A. Bailor's workmen and the materials were loaded into their truck and removed from the premise.

Specialist Prichard contacted Bill Warner at the City of Reno to confirm if a building permit had been issued to Bison Construction for 609 Sierra Rose Drive, Unit #3. It was confirmed that no building permit had been issued by the City of Reno to Bison Construction. Also after checking the data base at Air Quality and speaking with Mr. John Martin, the owner of Bison Construction, investigation showed that there was no asbestos survey for the property submitted. Therefore, the Asbestos Assessment Acknowledgement Form was never issue.

Based on the results of the Air Quality Management Division's investigation a Notice of Violation of **Section 030.105 and 030.107 Asbestos/NESHAP, a Major Violation of National Emission Standards for Hazardous Air Pollutants a Citation #5278** has been issued on **July 11, 2013**.

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

Following the issuance of a notice of violation (NOV), there are two (2) options for addressing the issues. These options include: 1) an appeal may be heard by the Air Pollution Control Hearing Board; or 2) a Memorandum of Understanding may be executed between the parties if a negotiated settlement can be arrived at.

An appeal form has been included for your convenience. Please contact either Dennis Cerfoglio, Permitting/Compliance Supervisor at 775-784-7232, or myself at 775-784-7212 to discuss your preference for the resolution of this matter.

Sincerely,

Wallace P. Prichard

COPY

Wallace P. Prichard Ph.D
Air Quality Specialist II

Enclosures

Appeal of Violation

Certified Mail # 7011 2970 0004 2282 9134

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

DATE: September 26, 2013

TO: District Board of Health

FROM: Daniel Inouye, Acting Director, Air Quality Management

SUBJECT: Bison Construction – Case No. 1126
Unappealed Citation No. 5279
Agenda Item: **8. A. 1. c.**

Recommendation

Air Quality Management Division Staff recommends that Citation No. 5279 be upheld and a fine of $2,500 be levied against Bison Construction for failure to have an asbestos survey performed by a qualified person and submitted to Air Quality for the issuance of an Acknowledgement of Asbestos Assessment prior to the demolition/renovation of a commercial facility. Conducting demolition/renovation activities without obtaining an asbestos survey and an Acknowledgement of Asbestos Assessment is a major violation of the District Board of Health Regulations Governing Air Quality Management, specifically Section 030.105(B)(10) National Emission Standards for Hazardous Air Pollutants (NESHAP), Subpart M - Asbestos, which is implemented through Section 030.107(A), Hazardous Air Pollutants, Asbestos Sampling and Notification. This is a negotiated settlement.

Recommended Fine: $5,400.00 Negotiated Fine: $2,500.00

Background

On July 11, 2013, Washoe County Air Quality Management Division received an anonymous citizen complaint regarding a commercial building located at 609 Sierra Rose Drive, Unit #3, in Reno. The complainant was concerned about the disturbance of possible asbestos containing materials associated with demolition/renovation activities at that address. A review of the Air Quality Management records determined an Asbestos Acknowledgement Form had not been completed for any renovation activities at that location.

Air Quality Specialist II Wallace Prichard was dispatched to the above address and found that several walls had been removed from the interior of Unit #3. During his investigation, AQ Specialist Prichard was able to determine the work had been initiated by Bailor Construction, acting as a subcontractor for Bison Construction. The suspect materials were illegally removed and hauled away for disposal utilizing pickup trucks on the jobsite. AQ Specialist Prichard made contact with Mr. Greg Bailor, owner of Bailor Construction, to inquire about the asbestos survey and Acknowledgement of Asbestos Assessment required for the removal of any suspect asbestos containing materials. Mr. Bailor informed AQ Specialist Prichard that he thought all of the permits had been obtained by the general contractor, Mr. John Martin, Bison Construction. AQ Specialist Prichard instructed Mr. Bailor to stop work immediately until a determination could be made regarding the status of the required permits.

AQ Specialist Prichard was able to confirm an asbestos survey had not been completed and submitted to Air Quality in order to obtain the required Acknowledgment of Asbestos Assessment. AQ Specialist Prichard also contacted Mr. Bill Warner, City of Reno Building Department, and confirmed a building permit had not been issued to Bison Construction for activities in Unit #3.

Specialist Prichard contacted Mr. John Martin, Bison Construction, regarding the required asbestos survey and Acknowledgement of Asbestos Assessment and did receive confirmation that neither had been completed. Specialist Prichard advised Mr. Martin that all work must stop until the required asbestos survey was completed and submitted to Air Quality Management in order to obtain the required Acknowledgement of Asbestos Assessment. Specialist Prichard advised Mr. Martin that if any asbestos was found it would have to be removed by a licensed abatement contractor. Mr. Martin contracted with Lisa Monroe & Associates and an asbestos survey was performed on July 11, 2013. The laboratory results from the survey found no asbestos detected. On July 15, 2013, Mr. Martin submitted a copy of the asbestos survey to Air Quality Management and obtained an Acknowledgement of Asbestos Assessment.

Based on the results of the file review and investigation, AQ Specialist Prichard issued Notice of Violation Citation No. 5279 to Bison Construction for a major violation of Section 030.107 (A), Asbestos Sampling and Notification. On July 24, 2013 the citation was delivered by certified mail to Mr. Martin in Carson City.

Settlement

On August 15, 2013, Senior AQ Specialist Dennis Cerfoglio conducted a negotiated settlement meeting attended by AQ Specialist Prichard and Mr. John Martin. After careful consideration of all the facts in the case, AQ Specialist Cerfoglio recommended that Citation No. 5279 be upheld with a fine of $2,500. A Memorandum of Understanding was signed by all parties.

Alternatives

1. The District Board of Health may determine that no violation of the Regulations has taken place and dismiss Citation No. 5279.

2. The Board may determine to uphold Citation No. 5279 but levy any fine in the range of $0 to $10,000 per day.

In the event the Board determines to change the proposed penalty, the matter should be continued so that Mr. Bailor and Bailor Construction may be properly noticed.

Daniel Inouye

Daniel Inouye, Acting Division Director
Air Quality Management

DI/DC: ma

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION
1001 EAST NINTH ST. • SUITE B171 • RENO NV 89512
(775) 784-7200

NOTICE OF VIOLATION

NOV 5279 DATE ISSUED: 7/11/2013

ISSUED TO: Bison Construction PHONE #: 849-1850

MAILING ADDRESS: 455 N US 395 CITY/ST: Washoe Valley NV ZIP: _____

NAME/OPERATOR: John Martin PHONE #: 720-1850

~~PERMIT NO~~. P.O. Box 3198 CC. 89702 COMPLAINT NO. CMP13-0099

YOU ARE HEREBY OFFICIALLY NOTIFIED THAT ON _____ (DATE) AT _____ (TIME), YOU ARE IN VIOLATION OF THE FOLLOWING SECTION(S) OF THE WASHOE COUNTY DISTRICT BOARD OF HEALTH REGULATIONS GOVERNING AIR QUALITY MANAGEMENT:

☐ **MINOR VIOLATION OF SECTION:**	☐ **MAJOR VIOLATION OF SECTION:**
☐ 040.030 __DUST CONTROL	☐ 030.000 OPERATING W/O PERMIT
☐ 040.055 __ ODOR/NUISANCE	☐ 030.2175 VIOLATION OF PERMIT CONDITION
☐ 040.200 __ DIESEL IDLING	☒ 030.105 ASBESTOS/NESHAP
☐ OTHER _____	☒ OTHER 030.107

VIOLATION DESCRIPTION: Failure to conduct an asbestos survey, or obtain a completed "Asbestos Assessment Acknowledgment Form"

LOCATION OF VIOLATION: 609 Sierra Rose Dr. Reno, NV

POINT OF OBSERVATION: Inside Unit #3

Weather: N/A Wind Direction From: N E ~~S~~ W

Emissions Observed: N/A
(If Visual Emissions Performed - See attached Plume Evaluation Record)

☐ **WARNING ONLY:** Effective _____ a.m./p.m. _____ (date) you are hereby ordered to abate the above violation within _____ hours/days. I hereby acknowledge receipt of this warning on the date indicated.

Signature N/A

☒ **CITATION:** You are hereby notified that effective on 7/11/13 (date) you are in violation of the section(s) cited above. You are hereby ordered to abate the above violation within 10:00 (hours/days. You may contact the Air Quality Management Division to request a negotiated settlement meeting by calling (775) 784-7200. You are further advised that within 10 working days of the date of this Notice of Violation, you may submit a written petition for appeal to the Washoe County Health District, Air Quality Management Division, P.O. Box 11130, Reno, Nevada 89520-0027. Failure to submit a petition within the specified time will result in the submission of this Notice of Violation to the District Board of Health with a recommendation for the assessment of an administrative fine.

SIGNING THIS FORM IS NOT AN ADMISSION OF GUILT

Signature: _____ Date: _____

Issued by: Wallace Pritchard Title: Air Quality Specialist

☐ **PETITION FOR APPEAL FORM PROVIDED**

H-AIR-09 (Rev. 04/12)

DISTRICT HEALTH DEPARTMENT
AIR QUALITY MANAGEMENT DIVISION

MEMORANDUM OF UNDERSTANDING

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Date: 08/15/2013

Company Name: Bison Construction (John Martin)

Address: P.O. Box 3198 Carson City, NV 89702

Notice of Violation No.: 5279 Case No.: 1126

The staff of the Air Quality Management Division of the Washoe County District Health Department issued the above referenced citation for the violation of Regulation: Section 030.105 and 030.107 Asbestos / NESHAP

A settlement of this matter has been negotiated between the undersigned parties resulting in a penalty amount of $ #2,500.00. This settlement will be submitted to the District Board of Health for review at the regularly scheduled meeting on September 26, 2013.

Martin
Signature of Company Representative

Dennis A. Cerfoglio
Signature of District Representative

John Martin
Print Name

DENNIS A. CERFOGLIO
Print Name

Sec Treas
Title

Sr. Air Quality Spec.
Title

Witness

Wallace Richard
Witness

Witness

Witness

AIR QUALITY MANAGEMENT - ADMINISTRATIVE PENALTY TABLE & RECOMMENDED FINE CALCULATION WORKSHEET

Administrative Penalty Table

Air Quality Management Division
Washoe County Health District

I. Minor Violations - Section 020.040(C)

Regulation		1st Violation	2nd Violation
040.005	Visible Emissions	$ 1,000	$ 2,500
040.030	Dust Control (fugitive)	250	750
040.035	Open Fires	500	1,000
040.040	Fire Training	500	1,000
040.050	Incinerator	1,000	2,000
040.051	Woodstoves	500	1,000
040.055	Odors	1,000	2,000
040.080	Gasoline Transfer (maintenance)	1,000	2,000
040.200	Diesel Idling	500	1,000
050.001	Emergency Episode	1,000	2,000

II. Major Violations - Section 020.040

		Source Category	
Regulation	Violation	Minimum	Maximum
030.000	Construction/Operating without Permit (per major process system or unit/day)	$ 5,000	$ 10,000
030.1402	Failure to Comply with Stop Work Order	10,000/day	10,000/day
030.2175	Operation Contrary to Permit Conditions (per day or event)	5,000	10,000
030.235	Failure to Conduct Source Test or Report (per Reporting Period for Each Unit)	2,500	5,000
	All other Major Violations (per day or event)	$10,000	$ 10,000
030.000	Construction Without a Dust Control Permit		
	Project Size – Less than 10 acres	$ 500 + $50 per acre	
	Project Size – 10 acres or more	$1,000 + $50 per acre	

III. Major Violations - Section 030.107 Asbestos

A. Asbestos Sampling & Notification	$ 2,000 - $10,000
B. Asbestos Control Work Practices (per day or event)	$ 5,000 - $10,000
C. Asbestos Containment & Abatement (per day or event)	$ 5,000 - $10,000

Washoe County Air Quality Management
Permitting & Enforcement Branch
Recommended Fine Calculation Worksheet

Company Name Bison Construction
Contact Name John Martin

Case #1126 NOV #5279 Complaint CMP13-0099

Violation of Section 030.107.A Asbestos Sampling & Notification

I. Base Penalty as specified in the Penalty Table = $ 5,000

II. Severity of Violation

A. Public Health Impact

1. Degree of Violation
(The degree of which the person/company has deviated from the regulatory requirements)
Minor – 0.5 Moderate – 0.75 Major – 1.0 **Adjustment Factor 1.0**

2. Toxicity of Release
Criteria Pollutant – 1x
Hazardous Air Pollutant – 2x **Adjustment Factor N/A**

3. Environmental/Public Health Risk **(Proximity to sensitive environment or group)**
Negligible – 1x Moderate – 1.5x Significant – 2x **Adjustment Factor 1.0**

Total Adjustment Factors (1 x 2 x 3) = **1.0**

B. Adjusted Base Penalty
Base Penalty 5,000 x Adjustment Factor 1.0 = **$ 5,000**

C. Multiple Days or Units in Violation

Adjusted Penalty 5,000 x Number of Days or Units 1.0 = **$ 5,000**

D. Economic Benefit
Avoided Costs $ 400 = **$ 400**
Average cost of an asbestos survey

Penalty Subtotal – Recommended Fine
Adjusted Base Penalty $ 5,000 + Economic Benefit $ 400 = **$ 5,400**

III. Penalty Adjustment Consideration

A. Degree of Cooperation (0 – 25%) - 25 %

B. Mitigating Factors (0 – 25%) - 25 %

1. Negotiated Settlement
2. Ability to Pay
3. Other (explain)

C. Compliance History

No Previous Violations (0 – 10%) - 5 %

Similar Violation in Past 12 months (25 - 50%) + ____ %

Similar Violation within past 3 year (10 - 25%) + ____ %

Previous Unrelated Violation (5 – 25%) + ____ %

Total Penalty Adjustment Factors – sum of A, B, & C **-55 %**

IV. Recommended/Negotiated Fine

Penalty Adjustment:

$ 5,400	x	-55 %	=	$ 2,970
Penalty Subtotal (From Section II)		Total Adjustment Factors (From Section III)		Total Adjustment Value

Additional Credit for Environmental Investment/Training – N/A

Adjusted Penalty:

$ 5,400	-	$ 2,970	=	**$ 2,500**
Penalty Subtotal (From Section II)		Total Adjustment Value (From Section III + Credit)		**Negotiated Fine**

Air Quality Specialist

Date

COMPLAINT INVESTIGATION REPORT

Washoe County Air Quality Management Division

Complaint Number: **CMP13-0099**

Complaint Status: NOV Source of Complaint: CITIZEN

Complaint Type: ASBESTOS Date Received: 07/11/2013 Time: 8:23:00 AM

Inspector: WPRICHARD Inspector Area: 3

Complaint Description: NOV CITATION 5278 CASE 1125 * NOV CITATION 5279 CASE 1126 - ASBESTOS WORK IN A COMMERCIAL BUILDING WITH NO AQ PERMITS - LOADIN

Address: 609 SIERRA ROSE DR RENO

Location: UNIT 3 OR 4

Parcel Number: 04094135

Related Permit Number:

Complainant:
ANONYMOUS

Responsible Party:
BISON CONSTRUCTION
JOHN MARTIN (OWNER)
P.O BOX 3198
CARSON CITY NV 89702
775-849-1850

Investigation:
Asbestos Work in a commercial building with no Air Quality permit. Also loading a truck with sheet rock.

The Air Quality Management Division (AQMD) of the Washoe County District Health Department is issuing Notice of Violation #5279 on July 11, 2013, to the company known as Bison Construction for removal and demolition of materials before an EPA NESHAP Notification OF DEMOLITION and RENOVATION
was issued.

On July 11, 2013 Washoe County Air Quality Management Division received a complaint from an anonymous caller regarding possible asbestos containing material being removed from Unit #3 at 609 Sierra Rose Drive, Reno. Complaint #CMP13-0099 was generated and assigned to investigator Air Quality Specialist Prichard.

AQ Specialist Prichard was dispatched to the above address and found that several walls had been removed from the interior of the Unit #3. The work had been initiated with removal of walls, electrical, and sheetrock by Greg A. Bailor's workmen. Greg A. Bailor is a subcontractor and was conducting the removal of materials that were then loaded into their truck and disposed of.

AQ Specialist Prichard contacted Bill Warner at the City of Reno to confirm if a building permit had been issued to Bison Construction for 609 Sierra Rose Drive, Unit #3. It was confirmed that no building permit had been issued by the City of Reno to Bison Construction. Also after checking the data base at Air Quality and speaking with Mr. John Martin, the owner of Bison Construction, investigation showed that there was no asbestos survey for the property submitted. Therefore, the Asbestos Assessment Acknowledgement Form was never issued from the Air Quality Mgmt office.

After being notified of the violation and that all work was to be ceased, Mr. Martin hired Lisa Monroe & Associates, Inc. Lisa Monroe's company conducted an asbestos bulk sampling analysis. The test was completed on 07/11/2013 and all samples were listed as no asbestos detected.

Mr. Martin obtained an Acknowledgment of Asbestos Assessment (ASB13-0593) from Washoe County Air Quality Management Division on July 15, 2013.

Based on the results of the Air Quality Management Division's investigation a Notice of Violation of Section 030.105 and 030.107 Asbestos/NESHAP, a Major Violation of National Emission Standards for Hazardous Air Pollutants a
Notice of Violation Citation #5279 has been issued on July 11, 2013.

Enforcement Activities

Warning Citation..:	Citation Number: 5278
NOV.....: 07/11/2013	NOV Number....: 5279
	Case Number.....: 1125
Settlement.....:	Amount.....: $0.00
Appealed.....:	
Upheld.....:	Amount.....: $0.00

Status Information

Initialized By.....: MAMES	Completed Date...:
Date Assigned.....: 07/11/2013	Completed By.....:

AIR QUALITY MANAGEMENT
ACKNOWLEDGEMENT OF ASBESTOS ASSESSMENT
FOR RENO DIAGNOSTICS - SUITE C, UNIT 3 LOCATED AT
609 SIERRA ROSE DRIVE, RENO

DATED: JULY 15, 2013

ACKNOWLEDGMENT OF ASBESTOS ASSESSMENT
Washoe County Air Quality Management Division

Permit Number: ASB13-0593

1 0715'13 A05077 THB CHECK $62.00

Property Owner: RIBEIRO COMPANY **Phone:** 775-825-4646

Property Being Evaluated: T.I. - FOR RENO DIAGNOSTICS SUITE C BLDG 3 - NEW BILLING CENTER.

Address: 6490 S MCCARRAN BLVD RENO

TYPE OF PROJECT	TYPE OF PROPERTY	PROPERTY BEING ASSESSED
RENO	NON-RES	PARTIAL*

FILING FEE: $62.00

*Note: If this project is a partial renovation and additional work is to be conducted later, additional asbestos assessment(s) will be required unless this assessment covers all pertinent representative asbestos suspected materials throughout the building.

General Contractor:
BISON CONSTRUCTION
JOHN MARTIN
PO BOX 3198
CARSON CITY, NV 89702

Consultant or Assessment Company:
LISA MONROE & ASSOCIATES

PO BOX 2252
SPARKS, NV 89431

Abatement Contractor:

Assessment Results: ACM ABSENT

Abatement Completed:

** Note: If asbestos present, abatement must be conducted in accordance with NESHAP and OSHA regulations before renovation or demolition work may proceed.

10-DAY NOTIFICATION MANDATORY FOR DEMOLITION JMarten
Owner / Representative's Name

Comments:
T.I. - Interior remodel for new Reno Diagnostics billing center. Sampling found NO ACM present. Use best methods of dust control during construction and dispose of waste properly.

Paula J Mendoza
Health District Representive

7/15/13
Date

Signature on this asbestos assessment document does NOT constitute full Health District approval for this project. Any additional Health permits such as are required for bar or restaurant operations, underground storage tanks, hazardous material disposal or air pollution sources must be obtained separately.

Signature by the Washoe County Health District does not warrant, nor should this report be taken to warrant, that asbestos was or was not present on stated property. Exposure to even small amounts of airborne asbestos fibers may cause cancer. For this reason the Health District recommends that all asbestos handling and abatement work be performed by certified asbestos contractors.

849-9052

ACKNOWLEDGMENT OF ASBESTOS ASSESSMENT
Washoe County Air Quality Management Division

Permit Number: ASB13-0593

Property Owner: RIBEIRO COMPANY **Phone:** 775-825-4646

Property Being Evaluated: T.I. - FOR RENO DIAGNOSTICS SUITE C BLDG 3 - NEW BILLING CENTER.

Address: 609 SIERRA ROSE DR RENO

TYPE OF PROJECT	TYPE OF PROPERTY	PROPERTY BEING ASSESSED
RENO	NON-RES	PARTIAL*

FILING FEE: $62.00 W

*Note: If this project is a partial renovation and additional work is to be conducted later, additional asbestos assessment(s) will be required unless this assessment covers all pertinent representative asbestos suspected materials throughout the building.

General Contractor:
BISON CONSTRUCTION
JOHN MARTIN
PO BOX 3198
CARSON CITY, NV 89702

Abatement Contractor:

Consultant or Assessment Company:
LISA MONROE & ASSOCIATES

PO BOX 2252
SPARKS, NV 89431

Assessment Results: ACM ABSENT

Abatement Completed:

** Note: If asbestos present, abatement must be conducted in accordance with NESHAP and OSHA regulations before renovation or demolition work may proceed.

10-DAY NOTIFICATION MANDATORY FOR DEMOLITION _____
Owner / Representative's Name

Comments:
T.I. - Interior remodel for new Reno Diagnostics billing center. Sampling found NO ACM present. Use best methods of dust control during construction and dispose of waste properly.

Charlene Albee
Health District Representive

7/15/13
Date

Signature on this asbestos assessment document does NOT constitute full Health District approval for this project. Any additional Health permits such as are required for bar or restaurant operations, underground storage tanks, hazardous material disposal or air pollution sources must be obtained separately.

Signature by the Washoe County Health District does not warrant, nor should this report be taken to warrant, that asbestos was or was not present on stated property. Exposure to even small amounts of airborne asbestos fibers may cause cancer. For this reason the Health District recommends that all asbestos handling and abatement work be performed by certified asbestos contractors.

* * * Communication Result Report (Jul. 15. 2013 4:20PM) * * *

1)
2)

Date/Time: Jul. 15. 2013 4:19PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
0851	Memory TX	Reno Building	P. 1	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

ACKNOWLEDGMENT OF ASBESTOS ASSESSMENT
Washoe County Air Quality Management Division

Permit Number: ASB13-0503

Property Owner: RIBEIRO COMPANY **Phone:** 775-825-4646

Property Being Evaluated: T.I. - FOR RENO DIAGNOSTICS SUITE C BLDG 3 - NEW BILLING CENTER.

Address: 609 SIERRA ROSE DR RENO

TYPE OF PROJECT	TYPE OF PROPERTY	PROPERTY BEING ASSESSED
RENO	NON-RES	PARTIAL*

FILING FEE: $62.00

*Note: If this project is a partial renovation and additional work is to be conducted later, additional asbestos assessment(s) will be required unless this assessment covers all pertinent representative asbestos suspected materials throughout the building.

General Contractor:
BISON CONSTRUCTION
JOHN MARTIN
PO BOX 3198
CARSON CITY, NV 89702

Consultant or Assessment Company:
LISA MONROE & ASSOCIATES
PO BOX 2252
SPARKS, NV 89431

Abatement Contractor:

Assessment Results: ACM ABSENT

Abatement Completed:

** Note: If asbestos present, abatement must be conducted in accordance with NESHAP and OSHA regulations before renovation or demolition work may proceed.

10-DAY NOTIFICATION MANDATORY FOR DEMOLITION _____
Owner / Representative's Name

Comments:
T.I. - Interior remodel for new Reno Diagnostics billing center. Sampling found NO ACM present. Use best methods of dust control during construction and dispose of waste properly.

Charlene Albee 7/15/13
Health District Representative Date

Signature on this asbestos assessment document does NOT constitute full Health District approval for this project. Any additional Health permits such as are required for bar or restaurant operations, underground storage tanks, hazardous material disposal or air pollution sources must be obtained separately.

Signature by the Washoe County Health District does not warrant, nor should this report be taken to warrant, that asbestos was or was not present on stated property. Exposure to even small amounts of airborne asbestos fibers may cause cancer. For this reason the Health District recommends that all asbestos handling and abatement work be performed by certified asbestos contractors.

LISA MONROE & ASSOCIATES ASBESTOS SAMPLING AND TESTING REPORTS FOR RENO DIAGNOSTICS, SUITE C, UNIT 3 LOCATED AT 609 SIERRA ROSE DRIVE, RENO NEVADA

DATED: JULY 11, 2013

Lisa Monroe & Associates, Inc.
P.O. Box 2252
Sparks, NV 89432
Phone/Fax: 775-355-1011
Email Address: LM-ASSOCIATES@ATT.NET

Bulk Sample Asbestos Report

Date of Report: 7-15-13 Date of Inspection: 7-11-13

Company/Client: Bison Construction

Address: P.O. Box 3198

City, State & Zip: Carson City, NV 89702

Building Name:

Building Address: 609 Sierra Rose Drive, Reno, Nevada

Area of Building Inspected: Suite #3

A survey was performed at 609 Sierra Rose Drive on July 11, 2013. The inspection involved the collection of 6 bulk samples from the existing materials where the walls have been removed. The suspect asbestos containing materials that were sampled include wall texture and joint compound. The laboratory analysis shows no asbestos detected in the materials that were tested.

Asbestos Overview

Environmental regulatory agencies and health professionals consider any substance with an asbestos content of one percent or greater to pose a significant health hazard in the event of disturbance. Asbestos was used in a wide variety of building materials, such as thermal or acoustical insulators or as a binder for tensile strength. Some examples of where asbestos can be found include spray acoustic on ceilings, wall textures, joint compounds, floor tiles, linoleum flooring and the mastic used to adhere the flooring. Because asbestos containing building materials are still being manufactured, mainly in other countries, all building materials that will be disturbed by renovation or demolition activities should be tested for asbestos content.

The inspection that was performed involved only the areas that the client requested and the delivery of this report does not guarantee that all asbestos was identified or that all suspect asbestos containing materials were sampled within the building.

Submitted by:
Lisa D. Monroe, President
Lisa Monroe & Associates, Inc.
NV DIROSHES: IJPM0061
CAC: 92-0660

PRECISION MICRO-ANALYSIS INC

SPECIALISTS IN ASBESTOS-RELATED ANALYSIS

Bulk Sample Analysis (PLM) Report

Report# 130712001

Lisa Monroe & Associates
P.O. Box 2252
Sparks, NV 89432

Phone: (775) 355-1011

Date Collected: 07/11/13
Date Received: 07/12/13
Date Analyzed: 07/12/13

Job Information:
13-8791
609 Sierra Rose Drive, Suite 3

Sample Number	Sample Location	Sample Description	Analytical Results
13-8791-1 *Lab# 13-243453*	Northwest	White texture	No asbestos detected
13-8791-2 *Lab# 13-243454*	Southeast wall	White texture	No asbestos detected
13-8791-3 *Lab# 13-243455*	Southwest wall	White texture	No asbestos detected
13-8791-4 *Lab# 13-243456*	South wall	White joint compound	No asbestos detected
13-8791-5 *Lab# 13-243457*	East wall	White joint compound	No asbestos detected
13-8791-6 *Lab# 13-243458*	Northwest wall	White joint compound	No asbestos detected

OFFICIAL NOTICE: After 45 days, samples are disposed of through a licensed waste hauler, unless client requests their return.

Total number of samples: 6

Supervisor _____ Analyst _____

Note: The test result findings are made to the methodologies and parameters described on the reverse of this page.

3463 Ramona Ave., Suite 17 • Sacramento, CA 95826 • (916) 456-4892 • Fax (916) 456-1082

CITATION NOTIFICATION SENT CERTIFIED MAIL TO JOHN MARTIN FROM WASHOE COUNTY AIR QUALITY MANAGEMENT DIVISION, WALLACE PRICHARD

RECEIVED AUGUST 1, 2013

7011 2970 0004 2282 9141

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

AQFIT2300 OFFICIAL USE

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here
CARSON CITY NV 89703
AUG 1 2013

WP

Sent To: Mr John Martin
Street, Apt. No.; or PO Box No.: PO Box 3198
City, State, ZIP+4: Carson City NV 89702

PS Form 3800, August 2006 — See Reverse for Instructions

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr John Martin
PO Box 3198
Carson City NV 89702

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Martin ☒ Agent ☒ Addressee

B. Received by *(Printed Name)*: Terrie Martin
C. Date of Delivery: 8-1-13

D. Is delivery address different from Item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

CARSON CITY NV 89703 AUG 1 2013

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 2970 0004 2282 9141

WP

PS Form 3811, February 2004 — Domestic Return Receipt — 102595-02-M-1540

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

July 24, 2013

Mr. John Martin
P.O. Box 3198
Carson City, Nevada 89702

COPY

Re: 609 Sierra Rosa Drive, Unit #3, Reno, NV

Dear Mr. Martin:

The Air Quality Management Division (AQMD) of the Washoe County District Health Department is issuing Notice of Violation **#5279** on July 11, 2013, to the company known as Bison Construction for removal and demolition of materials before an **EPA NESHAP Notification OF DEMOLITION and RENOVATION** was issued.

On July 11, 2013 Washoe County Air Quality Management Division received a complaint from an anonymous caller regarding possible asbestos containing material being removed from Unit #3 at 609 Sierra Rose Drive, Reno. Complaint #CMP13-0099 was generated and assigned to investigator Air Quality Specialist Prichard.

Specialist Prichard was dispatched to the above address and found that several walls had been removed from the interior of the Unit #3. The work had been initiated with removal of walls, electrical, and sheetrock by Greg A. Bailor's workmen. Greg A. Bailor is a subcontractor and was conducting the removal of materials that were then loaded into their truck and disposed of.

Specialist Prichard contacted Bill Warner at the City of Reno to confirm if a building permit had been issued to Bison Construction for 609 Sierra Rose Drive, Unit #3. It was confirmed that no building permit had been issued by the City of Reno to Bison Construction. Also after checking the data base at Air Quality and speaking with Mr. John Martin, the owner of Bison Construction, investigation showed that there was no asbestos survey for the property submitted. Therefore, the Asbestos Assessment Acknowledgement Form was never issue.

After being notified of the violation and that all work was to be ceased Mr. Martin hired Lisa Monroe & Associates, Inc. Lisa Monroe's company conduct an asbestos bulk sampling analysis. The test was completed on 07/11/2013 and all samples were listed as no asbestos detected.

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

Mr. Martin obtained an Acknowledgment of Asbestos Assessment (**ASB13-0593**) from Washoe County Air Quality Management Division on July 15, 2013.

Based on the results of the Air Quality Management Division's investigation a Notice of Violation of **Section 030.105 and 030.107 Asbestos/NESHAP, a Major Violation of National Emission Standards for Hazardous Air Pollutants a Citation #5279** has been issued on **July 11, 2013**.

Following the issuance of a notice of violation (NOV), there are two (2) options for addressing the issues. These options include: 1) an appeal may be heard by the Air Pollution Control Hearing Board; or 2) a Memorandum of Understanding may be executed between the parties if a negotiated settlement can be arrived at.

An appeal form has been included for your convenience. Please contact either Dennis Cerfoglio, Permitting/Compliance Supervisor at 775-784-7232, or myself at 775-784-7212 to discuss your preference for the resolution of this matter.

Sincerely,

Wallace P. Prichard

Wallace P. Prichard Ph.D
Air Quality Specialist II

COPY

Enclosures:

Notice of Violation #5279 (Pink Sheet)

Appeal of Violation

Certified Mail # 7011 2970 0004 2282 9141

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

DATE: September 26, 2013

TO: District Board of Health

FROM: Daniel Inouye, Acting Director, Air Quality Management

SUBJECT: Boys and Girls Club of Truckee Meadows – Case No. 1128
Unappealed Citation No. 5274
Agenda Item: **8. A. 1. d.**

Recommendation

Air Quality Management Staff recommends that Citation No. 5274 be upheld and a fine of $1,000 be levied against Fred Taeubel, Project Manager for the Boys and Girls Club of Truckee Meadows, for violation of Conditions No. 10 and 11 of Conditional Dust Control Permit No. DCP13-0047. Condition No. 10 requires the owner or general contractor to erect an informational sign at the main entrance to the project site prior to initiation of disturbance of the ground surface. Condition No. 11 requires a log book be maintained on-site documenting all dust control activities on a daily basis. Failure to comply with the conditions of Dust Control Permit No. DCP-13-0047 is a Major Violation of the District Board of Health Regulations Governing Air Quality Management, specifically Section 030.2175, Operations Contrary to Permit. This is a negotiated settlement.

Recommended Fine: $1,500 Negotiated Fine: $1,000

Background

On July 17, 2013, Air Quality Specialist II Suzanne Dugger was conducting a routine inspection of Dust Control Permit No. DCP13-0047 issued for the future Boys and Girls Club to be located at 1300 Foster Drive in Reno. During the inspection, AQ Specialist Dugger discovered a dust control sign had not been posted at the entrance to the project site as required by Condition No. 10 of the permit. AQ Specialist Dugger contacted Mr. Jeff Forsyth, Project Manager for United Construction, to inquire about the status of the dust control sign. During this contact, AQ Specialist Dugger also found there were no dust control water truck logs on site as required by Condition No. 11 of the permit. AQ Specialist Dugger informed Mr. Forsyth of the dust control permit requirements to erect a dust control sign and maintain water truck logs on-site at all times.

On July 26, 2013, AQ Specialist Dugger conducted a follow up inspection to determine if the project was in compliance with the conditions of Dust Control Permit No. DCP13-0047. The results of the follow up inspection confirmed a dust control sign had not been erected and no water truck logs were on site. Upon review of the dust control permit, AQ Specialist Dugger determined the responsible party for the project was Mr. Fred Taeubel, Project Manager for the Boys and Girls Club. AQ Specialist Dugger contacted Mr. Taeubel to inform him of the noncompliance issues.

Based on the results of the original and follow up inspections and the failure to comply with the permit conditions regarding signage and water truck logs, Specialist Dugger issued Notice of Violation Citation No. 5274 for a major violation of Section 030.2175 for Operations Contrary to Permit.

Settlement

On August 22, 2013, Senior AQ Specialist Dennis Cerfoglio conducted a negotiated settlement meeting attended by AQ Specialist Dugger and Mr. Fred Taeubel, Project Manager for the Boys and Girls Club of Truckee Meadows. After careful consideration of all the facts presented in the case, Senior AQ Specialist Cerfoglio proposed that Citation No. 5274 be upheld with a fine of $1,000 dollars. A Memorandum of Understanding was signed by all parties.

Alternatives

1. The District Board of Health may determine that no violation of the regulations has taken place and dismiss Citation No. 5274.

2. The Board may determine to uphold Citation No. 5274 and levy a fine in the range of $0 to $10,000 per day.

   In the event the Board determines to change the penalty, the matter should be continued so that Mr. Fred Taeubel and the Boys and Girls Club of Truckee Meadows may be properly noticed.

Daniel Inouye, Acting Division Director
Air Quality Management

DI/DC: ma

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION
1001 EAST NINTH ST. • SUITE B171 • RENO NV 89512
(775) 784-7200

NOTICE OF VIOLATION

NOV 5274 DATE ISSUED: 7-26-2013

ISSUED TO: FRED THEUBEL PHONE #: 690-1434

MAILING ADDRESS: 2680 E. 9TH ST. CITY/ST: RENO ZIP: 89512

NAME/OPERATOR: PEAVINE CONSTRUCTION PHONE #: 691-5766

PERMIT NO. DCP13-0047 JOHN HEDGCORTH COMPLAINT NO. CMP13-0107 UNITED CONSTRUCTION JEFF FORSYTHE

YOU ARE HEREBY OFFICIALLY NOTIFIED THAT ON 7-26-2013 (DATE) AT 9:30 (TIME), YOU ARE IN VIOLATION OF THE FOLLOWING SECTION(S) OF THE WASHOE COUNTY DISTRICT BOARD OF HEALTH REGULATIONS GOVERNING AIR QUALITY MANAGEMENT:

☐ MINOR VIOLATION OF SECTION:	☒ MAJOR VIOLATION OF SECTION:
☐ 040.030 __DUST CONTROL	☐ 030.000 OPERATING W/O PERMIT
☐ 040.055 __ ODOR/NUISANCE	☒ 030.2175 VIOLATION OF PERMIT CONDITION
☐ 040.200 __ DIESEL IDLING	☐ 030.105 ASBESTOS/NESHAP
☐ OTHER _____	☐ OTHER _____

VIOLATION DESCRIPTION: NO DUST CONTROL SIGN. NO DUST CONTROL LOGS ON SITE. SEC. 3 (c)

LOCATION OF VIOLATION: 1300 FOSTER DR RENO NV 89509

POINT OF OBSERVATION: ON SITE / PROJECT AREA

Weather: CLEAR Wind Direction From: N E S W

Emissions Observed: _____
(If Visual Emissions Performed - See attached Plume Evaluation Record)

☐ **WARNING ONLY:** Effective _____ a.m./p.m. _____ (date) you are hereby ordered to abate the above violation within _____ hours/days. I hereby acknowledge receipt of this warning on the date indicated.

Signature _____

☒ **CITATION:** You are hereby notified that effective on 7-26-2013 (date) you are in violation of the section(s) cited above. You are hereby ordered to abate the above violation within IMMEDIATELY hours/days. You may contact the Air Quality Management Division to request a negotiated settlement meeting by calling (775) 784-7200. You are further advised that within 10 working days of the date of this Notice of Violation, you may submit a written petition for appeal to the Washoe County Health District, Air Quality Management Division, P.O. Box 11130, Reno, Nevada 89520-0027. Failure to submit a petition within the specified time will result in the submission of this Notice of Violation to the District Board of Health with a recommendation for the assessment of an administrative fine.

SIGNING THIS FORM IS NOT AN ADMISSION OF GUILT

Signature: _____ Date: 7/26/13

Issued by: _____ Title: AQS II

☐ **PETITION FOR APPEAL FORM PROVIDED**

H-AIR-09 (Rev. 04/12)

DISTRICT HEALTH DEPARTMENT
AIR QUALITY MANAGEMENT DIVISION

MEMORANDUM OF UNDERSTANDING

AIR QUALITY MANAGEMENT DIVISION
WASHOE COUNTY HEALTH DISTRICT

Date: August 23, 2013

Company Name: Boys & Girls Club - Truckee Meadows

Company Address: 2680 East Ninth Street

Notice of Violation No.: 5274 Case No.: 1128

Location of Violation: 1300 Foster Drive

The staff of the Air Quality Management Division of the Washoe County Health District issued the above referenced Citation for the violation of Regulation: 030.2175 for a violation of permit conditions. No dust control sign plus no water truck logs on site

A settlement of this matter has been negotiated between the undersigned parties resulting in a penalty amount of $ 1,000.00. This settlement will be submitted to the District Board of Health for review at the regularly scheduled meeting on September 26, 2013.

Signature of Company Representative

Signature of District Representative

FRED TAEVER
Print Name

DENNIS A. CERFOGLIO
Print Name

Owner's Rep.
Title

Sr. Air Quality Spec.
Title

Witness

Suzanne Dugger
Witness

Witness

SUZANNE DUGGER
Witness

AIR QUALITY MANAGEMENT – ADMINISTRATIVE PENALTY TABLE & RECOMMENDED FINE CALCULATION WORKSHEET

Administrative Penalty Table

Air Quality Management Division
Washoe County Health District

I. Minor Violations - Section 020.040(C)

Regulation		1st Violation	2nd Violation
040.005	Visible Emissions	$ 1,000	$ 2,500
040.030	Dust Control (fugitive)	250	750
040.035	Open Fires	500	1,000
040.040	Fire Training	500	1,000
040.050	Incinerator	1,000	2,000
040.051	Woodstoves	500	1,000
040.055	Odors	1,000	2,000
040.080	Gasoline Transfer (maintenance)	1,000	2,000
040.200	Diesel Idling	500	1,000
050.001	Emergency Episode	1,000	2,000

II. Major Violations - Section 020.040

		Source Category	
Regulation	Violation	Minimum	Maximum
030.000	Construction/Operating without Permit (per major process system or unit/day)	$ 5,000	$ 10,000
030.1402	Failure to Comply with Stop Work Order	10,000/day	10,000/day
030.2175	Operation Contrary to Permit Conditions (per day or event)	2,500	10,000
030.235	Failure to Conduct Source Test or Report (per Reporting Period for Each Unit)	2,500	5,000
	All other Major Violations (per day or event)	$ 5,000	$ 10,000
030.000	Construction Without a Dust Control Permit		
	Project Size – Less than 10 acres	$ 500 + $50 per acre	
	Project Size – 10 acres or more	$1,000 + $50 per acre	

III. Major Violations - Section 030.107 Asbestos

A. Asbestos Sampling & Notification	$ 2,000 - $10,000
B. Asbestos Control Work Practices (per day or event)	$ 5,000 - $10,000
C. Asbestos Containment & Abatement (per day or event)	$ 5,000 - $10,000

Washoe County Air Quality Management
Permitting & Enforcement Branch
Recommended Fine Calculation Worksheet

Company Name Boys & Girls Club of Truckee Meadows
Contact Name Fred Taeubel

Case #1128 NOV #5274 Complaint CMP13-0107

Violation of Section 030.2175 Operations Contrary to Permit

I. Base Penalty as specified in the Penalty Table = $ 2,500

II. Severity of Violation

A. Public Health Impact

1. Degree of Violation
(The degree of which the person/company has deviated from the regulatory requirements)
Minor – 0.5 Moderate – 0.75 Major – 1.0 **Adjustment Factor** 1.0

2. Toxicity of Release
Criteria Pollutant – 1x
Hazardous Air Pollutant – 2x **Adjustment Factor** N/A

3. Environmental/Public Health Risk **(Proximity to sensitive environment or group)**
Negligible – 1x Moderate – 1.5x Significant – 2x **Adjustment Factor** 1.0

Total Adjustment Factors (1 x 2 x 3) = **1.0**

B. Adjusted Base Penalty
Base Penalty 2,500 x Adjustment Factor 1.0 = **$ 2,500**

C. Multiple Days or Units in Violation

Adjusted Penalty 2,500 x Number of Days or Units 1.0 = **$ 2,500**

D. Economic Benefit
Avoided Costs $ = **$ N/A**
No cost benefit was determined for this administrative violation

Penalty Subtotal – Recommended Fine
Adjusted Base Penalty $ 2,500 + Economic Benefit $ 0 = **$ 2,500**

III. Penalty Adjustment Consideration

A. Degree of Cooperation (0 – 25%) - 25 %

B. Mitigating Factors (0 – 25%) - 25 %

1. Negotiated Settlement
2. Ability to Pay
3. Other (explain)

C. Compliance History

No Previous Violations (0 – 10%) - 10 %

Similar Violation in Past 12 months (25 - 50%) + ____ %

Similar Violation within past 3 year (10 - 25%) + ____ %

Previous Unrelated Violation (5 – 25%) + ____ %

Total Penalty Adjustment Factors – sum of A, B, & C **-60 %**

IV. Recommended/Negotiated Fine

Penalty Adjustment:

$ 2,500	x	-60 %	=	$ 1,500
Penalty Subtotal (From Section II)		Total Adjustment Factors (From Section III)		Total Adjustment Value

Additional Credit for Environmental Investment/Training – N/A

Adjusted Penalty:

$ 2,500	-	$ 1,500	=	**$ 1,000**
Penalty Subtotal (From Section II)		Total Adjustment Value (From Section III + Credit)		**Negotiated Fine**

Dennis Cerfoglio
Air Quality Specialist

8-22-2013
Date

AIR QUALITY MANAGEMENT
DUST PERMIT # DCP13-0047
APPLICATION SUBMITTED BY BOYS & GIRLS CLUB OF TRUCKEE MEADOWS

WASHOE COUNTY HEALTH DISTRICT

AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

Dust Control Permit #: DCP13-0047

Name of Development: BOYS & GIRLS CLUB OF TRUCKEE MEADOWS

Location of Development: 1300 FOSTER DRIVE, RENO NV 89509

Acres: 4 **# of Water Trucks:** 1

Issued Date: 06/04/2013 **Expiration Date:** 12/04/2014
Issued To: BOYS AND GIRLS CLUB

The following requirements are special conditions of approval for this dust control permit in addition to the standard conditions noted in the permit application. The special conditions noted below must be followed in all activities covered in this permit.

1. The required number of water trucks will be assigned and available for operation 24 HOURS A DAY, 7 DAYS A WEEK for the purpose of water application for control of fugitive dust. If the required number cannot control fugitive dust emissions from equipment operations and/or gusty wind conditions, the applicant shall immediately provide additional water trucks. CESSATION OF OPERATIONS IS REQUIRED IF DUST CANNOT BE CONTROLLED DUE TO EQUIPMENT OPERATIONS AND/OR GUSTY WIND CONDITIONS. IF CESSATION OF OPERATIONS IS USED AS A DUST CONTROL MEASURE, CONTINUED WATERING OF THE PROJECT IS REQUIRED.
2. Dust emissions generated on any entrance or exit haul roads due to equipment operations or gusty wind conditions must be controlled 24 hours a day, 7 days a week, by the use of water application or an environmentally safe dust palliative (District Regulation 040.030, Section C. 2. a. and b.) Any palliative used must comply with state and local regulations and not provide a noxious odor or contaminate ground water.
3. All projects importing or exporting dirt, rock or other fill materials must comply with the work practice standards in District Regulation 040.030, Section C. 4., including load tarping, watering or Freeboard. Any soil tracked onto adjoining paved roadways will be promptly removed by wet broom or washing. Regular vacuum or wet sweeping will be performed at least daily, and more often if necessary or if ordered by the Control Officer due to a violation. Any materials tracked out or spilled which cause visible fugitive dust for a period of five (5) minutes in any hour period shall be cleaned up immediately.
4. Any soil or fill storage piles operated or maintained as a part of this construction lot will be covered or wetted down sufficiently to prevent wind blown dust. Dust emissions from screening operations will be controlled by the use of a water truck or other control measure that prevents fugitive dust.

5. The applicant shall implement additional dust control measures, such as extra water trucks, water cannons, re-vegetation, environmentally safe dust palliatives (which comply with all applicable regulations and do not emit a noxious odor and do not contaminate ground water), wind fencing, and/or cessation of operations should these measures fail to control fugitive dust emissions from this project.

6. Once final grade has been completed, and if no structures are being constructed, the owner/developer shall be required to establish a long-term stable surface. This shall include re-vegetation or covering the disturbed soil with rock or crushed asphalt products within 30 days of completion of final grade. The use of an approved palliative is an option, but must be approved by the Air Quality Management Division (AQMD) prior to application.

7. The applicant shall provide a Material Safety Data Sheet (MSDS) and dilution ratio to AQMD staff for any dust palliative selected for use as a dust control measure at this site.

8. A copy of this dust control permit shall be maintained at the construction project site and available to any sub-contractor or Air Quality Management Division inspector to review upon request.

9. ANY CHANGES MADE TO THE PROPOSED OPERATIONS, SCOPE OF WORK OR SURFACE DISTURBANCES UNDER THIS DUST CONTROL PERMIT shall be submitted to the Washoe County Health District, AQMD in writing and must receive approval from the Control Officer prior to implementation.

10. The owner or the general contractor shall erect an informational sign at the main entrance to the project site. The sign shall be a minimum of 4 ft by 4 ft in size, and shall be in place prior to initiation of disturbance of the ground surface. The sign lettering shall be at least 4 inches high and shall be bold and easily readable by the public. The sign shall remain in place for the life of the project. The sign shall include the following information, also see attached example:

    a) The name of the project.
    b) A statement identifying the General Contractor.
    c) A statement proclaiming that "All operators at this site are required to control dust emissions from their operations. The General Contractor is required to oversee and control project wide dust emissions."
    d) A statement proclaiming that "For dust related problems coming from this site, or to make a dust complaint, call this phone number 24 hours per day, seven days per week: (775) 784-7200. A 24-hour phone number for both the Contractor/Developer and the Air Quality Management Division shall also be posted. The 24-hour phone number for complaints to the Air Quality Management Division is (775) 784-7200.

11. A log book of all dust control operations, containing all information as required by the Control Officer in the standard "**WASHOE COUNTY DUST CONTROL LOG**" must be maintained on a daily basis (copies of blank log sheets are available at the Air Quality Management Division Office). Required information includes, but is not limited to, the number of **OPERATING** water trucks/pulls, the size of **OPERATING** water trucks/pulls (gallons capacity of each truck/pull), and the condition of the surface crust on disturbed areas. The operator shall record in the logbook all dust control efforts and the compliance level of the site with dust control requirements. The logbook shall be kept at the project site and made available to District representatives upon request.

12. Visible dust may not be emitted into the air from any operations or disturbed areas of this project for more than 5 minutes in any hour period (Regulation 040.030, Section C. 1). All disturbed areas must maintain a visible surface crust or other cover in compliance with Regulation 040.030, Section C.2.c. Compliance shall be determined using US Environmental Protection Agency Reference Method 22, with an observation period of not less than 5 minutes in any hour period. Copies of District Regulations, enforcement policies and USEPA Reference Testing Methods may be obtained by contacting the Air Quality Management Division at (775) 784-7200.

13. Failure to comply with all of the requirements of this Dust Control Permit shall be considered a citable violation of District Regulations and this dust control permit. Citations may be issued for each day of violation, in amounts up to $10,000 per day as stated in District Regulations.

14. Any use of recycled wastewater from a public or private sewer treatment plant must take into account the protection of public heath.

NOTE: All operators who clear more than one (1) acre of land also need an NPDES permit addressing water quality issues related to storm run-off from the Nevada Division of Environmental Protection. Contact the Bureau of Water Pollution Control at (775) 687-9418 for further information.

Charlene Albee
Control Officer

THIS IS NOT A GRADING PERMIT. THESE CONDITIONS ADDRESS DUST CONTROL ONCE THE GRADING PERMIT HAS BEEN OBTAINED. IF THE GRADING PERMIT IS DENIED THIS PERMIT IS VOID.

DUST CONTROL PERMIT APPLICATION

AIR QUALITY MANAGEMENT DIVISION
PO Box 11130, Reno NV 89520-0027 * (775) 784-7200 * Fax (775) 784-7225

F 465.00 CHECK 1 0603'13 N050397 TND $465.00 V

13-066

FEE as of July 1, 2012: **$108.00 *per acre*** – **plus a $33.00 administration fee per permit**
(Less than .5 acres round down; .5 and greater round up)

THE "APPLICANT" IS RESPONSIBLE FOR ALL DUST CONTROL *24 HOURS A DAY, SEVEN DAYS A WEEK*, Including weekends and holidays, from commencement of project to completion.

*The Applicant must be the Property Owner/Developer, and signed by the Applicant or his Attorney in Fact. Fill in the application **completely** or it will be returned for completion.*

To be filled in by AQ Staff
Permit No.: DCP13-0047
Area: 3
Water Truck(s): 1
Hydro Basin: (Yes) No

1. Name of Development: Boys and Girls Club of Truckee Meadows
2. Development Address: 1300 Foster Drive, Reno, NV 89509
3. Size of Project (disturbed acres): 3.8 Acre
4. Type of Project (choose one):

Residential – Single Family		Residential – Multi Family		Commercial with Residential	
Road Construction – New		Road Construction – Maintenance/Rehabilitation			
Commercial / Industrial		Municipal/Utilities	X		

6. If renewing an existing permit, list permit number: _____

NOTE - - *The Dust Control Permit is valid for eighteen (18) months from the date of approval. If the project is not complete or has not commenced by the expiration date, the Applicant must submit a renewal application to the Air Quality Management Division. Failure to do so will result in the Permit expiring and could result in a citation.*

7. **APPLICANT -- Name and current Address of Property Owner/Developer:**
Owner/Developer: Boys and Girls Club Contact: Mike Wurm
Address: 2680 E. Ninth Street
City: Reno State: NV Zip: 89512
Phone Number: (775) 331-5437 Email: mwurm@bgctm.com

8. **Name and current Address of Project Engineer/Consultant:**
Engineer/Consultant: Odyssey Engineering Contact: Jerry Walsh
Address: 895 Roberta Lane Suite 104
City: Sparks State: NV Zip: 89431
Phone Number: (775) 359-3303 Email: jerry@odysseyreno.com

9. **Name and Address of General Contractor:**
Contractor: United Construction Contact: _____
Address: 5300 Mill street
City: Reno State: NV Zip: 89502
Phone Number: (775) 858-8090 Email: _____

10. **Name and Address of Grading/Excavating Contractor:**
Contractor: Peavine Construction, Inc. Contact: Michael Borden
Address: 2332 Larkin Circle
City: Sparks State: NV Zip: 89431
Phone Number: (775) 359-2288 Email: borden@peavineconst.com

11. Proposed Construction Dates – Per Phase: *** provide grading and phasing maps ***

On-Site Grading/Excavation:	**Start:**	June 3, 2013 (4)	**Complete:**	December 31, 2013
Building Construction:	**Start:**		**Complete:**	

12. Will fill material be required? Yes _____ yd³ _____; No X
13. Will there be an excess of native material as a result of excavation? Yes X yd³ 2500 cy No _____
14. Amount of Material to be excavated (yd³): 15,000
15. Is there a soil analysis report available? Yes X No _____
16. On-Site soil type: Silty Sand
17. Method of dust control to be utilized (per phase): (attach a map showing dust control strategy-utilize scale with contours)

Water Truck(s) 1-3 depending on operation (number of trucks)
Chemical Sealant _____ (type – attach MSDS Sheets)
Sprinklers/Water Cannons _____ (locations)
Compaction 90% (percent)
Enclosure _____ (fences, windbreaks)
Revegetation _____ (type – attach seeding schedule)
Will temporary irrigation be supplied? Yes _____ No _____
Water Source: TMWA Fill Stand
Speed Limits _____ Other _____

NOTE - Permanent stabilization methods such as construction/landscaping, revegetation, chemical sealant/palliative, or other approved method(s) of dust suppression must occur "within 30 days of grading completion". Dust suppression must continue regardless of construction status.

18. Method to control mud and soil being tracked onto adjacent paved roadways: Rock trackout
19. Frequency of daily street cleaning: As needed.
20. Describe the methods (fences, barriers, etc.) to prevent unauthorized traffic on the construction site(s): Perimeter fence.
21. **Persons to be contacted during non-working hours in case of dust problems:**
Name & Phone no: JEFF FORSYTH Email: forsythc@unitedconstruction.com ✓
Name & Phone no: MIKE BRUNSON 775-771-3776 Email: MBRUNSON@UNITEDCONSTRUCTION.COM ✓

7.75 9149 142-

22. The **Applicant's (Owner/Developer) signature or that of his/her Attorney in fact** on this application shall constitute agreement by the Applicant to accept responsibility for meeting the "Conditions of Plan" (attached):

[signature]	6/2/13
Signature	**Date**
FRED TRAVISO	OWNERS Rep.
Print or type name	**Title**
BOY'S & GIRLS CLUB OF TRUCKEE-MEMORIAL	690 - 1439
Company Name	**Phone Number**

TO BE COMPLETED BY STAFF UPON SUBMITTAL

Plan Review Fee Paid:

AMOUNT PAID: $465.00 ✓ CHECK#: 23606 CC: _____

DATE: 6/3/2013 COMPANY: PEAVINE CONSTRUCTION INC

Permit Approved: 6/4/2013
Date

Permit Expires: 12/4/2014
Date

Plan Denied: _____
Date

Reason: _____

Change to permit: _____ Date _____ Date _____ Date

CLOSING INFORMATION

Date Received: _____

Date Complete: _____ See attached fax/letter – YES NO

Contact Person/Company: _____

Project Results: _____

COMPLAINT INVESTIGATION REPORT

Washoe County Air Quality Management Division

Complaint Number: **CMP13-0107**

Complaint Status: NOV Source of Complaint: INVESTIGATOR

Complaint Type: DUSTPLAN Date Received: 07/26/2013 Time: 9:30 A.M.

Inspector: SDUGGER Inspector Area: 3

Complaint Description: NOV CITATION 5274 - CASE 1128 - VIOLATION OF 040.030 DUST CONTROL PLAN - NO SIGN POSTED OR LOGS ON SITE

Address: 1300 FOSTER DR RENO

Location:

Parcel Number: 01017130

Related Permit Number: DCP13-0047

Complainant:
SUZANNE DUGGER
AIR QUIALITY SPECIALIST II
1001 EAST NINTH STREET #B171
RENO NV 89512
784-7217

Responsible Party:
BOYS AND GIRLS CLUB
2680 E. 9TH STREET
RENO NV
89512
690-1434

Investigation:
7-26-2013 As a follow up to an earlier site visit performed on July 17, 2013 AQS Dugger arrived on site of the Boys and Girls Club future location located at 1300 Foster Dr. in Reno, Nevada. On site AQS Dugger spoke again with Mr. Jeff Forsyth, Project Manager of United Construction, to inquire about the dust control sign and the dust control logs. Both the sign and logs were not on site on the previous site visit. Mr. Forsyth stated that the sign was still not up and that the dust control logs were also not on site. AQS Dugger reviewed Dust Control Permit #DCP13-0047 and determined that the RP who signed the permit was Mr. Fred Taeubel, project manager for the Boys and Girls Club. AQS Dugger contacted Mr. Taeubel and informed him that not having a dust control sign on site and not having dust control logs on site were both violations of 040.030 Sec.3 (c). Due to violation of 040.030 Sec. (c), AQS Dugger issued NOV Citation #5274. An appeal form was given with the NOV.

Enforcement Activities

Warning Citation..: 07/26/2013
NOV.....:

Citation Number: 5274
NOV Number....: 0
Case Number.....: 1128

Settlement.....:		Amount.....:	$0.00
Appealed.....:			
Upheld.....:		Amount.....:	$0.00

Status Information

Initialized By.....: TBURTON	Completed Date...:
Date Assigned.....: 07/26/2013	Completed By.....:

AIR QUALITY MANAGEMENT
CONSTRUCTION SITE INSPECTION FORM
FOR BOYS & GIRLS CLUB

DATED 7-26-2013 AT 9:30 AM

WASHOE COUNTY AIR QUALITY MANAGEMENT DIVISION
PO Box 11130, Reno, NV 89520-0027
Office (775) 784-7200 * Fax (775) 784-7225

CONSTRUCTION SITE INSPECTION FORM

Enforcement Officer: SUZANNE DUGGER Date/Time: 7-26-2013 / 9:30
Permit No.: DCP 13-6047 Responsible Party: BOYS & GIRLS CLUB
Project Name: BOYS & GIRLS CLUB Location: 1300 FOSTER DR.

Weather: ☑ Clear ☐ Partly Cloudy ☐ Cloudy ☑ Recent Rain Temp: Wind/mph: 0 Direction:
Site: ☑ Active ☐ Inactive ☐ Project Complete **Workers Present:** ☑ Yes ☐ No
Activities Occurring: ☐ None

☐ Clearing/Grubbing	☐ Backfilling	☐ Abrasive Blasting	☐ Clearing Forms	☐ Crushing/Screening
☐ Cut & Fill	☐ Importing/Exporting	☐ Explosive Blasting	☑ General Construction	☑ Subgrade Prep
☐ Trenching	☑ Stockpiling	☐ Demolition (mech)	☐ Landscaping	☐ Paving

EMISSIONS COMPLIANCE ☑ **Yes** ☐ **No**

Fugitive Dust Emissions: ☐ Yes ☑ No If yes, source: Plume Length:
Opacity: %

Project Soils: (Stable) ☑ Moist ☐ Gravel ☐ Palliative ☐ Crust ☐ Other:
Unstable: ☐ Dry ☐ Loose ☐ Powdery

Interior Roads: ☑ None Stable: ☐ Paved ☐ Type II ☐ Moist ☐ Dust Suppressant
Unstable: ☐ Dry ☐ Loose ☐ Powdery

Track-out: ☐ Yes ☑ No **Dust from vehicles:** ☐ Yes ☑ No If yes, ☐ Interior ☐ Access
Water Source: ☐ Hydrant ☐ Stand Tank ☐ Reservoir ☐ None Observed ☑ Other: H_2O TRUCK ①
Mitigation Equipment: ☐ Hose ☐ Pull(s) ☑ Truck(s) ☐ None Observed ☐ Other:
Mitigation Equipment Ratio: ☑ Adequate ☐ Inadequate
Track-out device present: ☐ Yes, functional ☐ Yes, not functional ☑ No, needed ☐ No, not needed

ADMINISTRATIVE COMPLIANCE ☐ **Yes** ☑ **No**

Acreage Permitted: 4 Project Size: ☑ Equal to ☐ Greater than
Staging/Parking area(s): ☐ N/A ☑ On-Site ☐ Off-Site, included in acreage ☐ Off-Site, not included in acreage
Stationary Source Permits: ☑ No Equipment ☐ Screen ☐ Crusher ☐ Batch Plant ATC#:
DCP Sign: ☐ Yes ☑ No DCP On-Site: ☐ Yes ☐ No ☐ Not Verified
Spoke with: FRED THEUBEL **Title:** PROJECT MANAGE ☑ **in person** / ☐ **phone**

Actions Taken: ☐ **None** ☐ **Verbal Warning**
☐ **Notice of Violation – Warning:** ☑ **Notice of Violation – Citation:** #5274

Deficiencies to be corrected: ISSUED NOV. #5274 FOR NO DUST CONTROL SIGN & NO DUST CONTROL LOGS ON SITE, C90-1434

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION

Public Health
Prevent. Promote. Protect.

DATE: September 26, 2013

TO: District Board of Health

FROM: Daniel Inouye, Acting Director, Air Quality Management

SUBJECT: Montane Building Group – Case No. 1131
Unappealed Citation No. 5383
Agenda Item: **8. A. 1. e.**

Recommendation

Air Quality Management Division Staff recommends that Citation No. 5383 be upheld and a fine of $2,500.00 dollars be levied against Montane Building Group for failure to have an asbestos survey performed by a qualified person and submitted to Air Quality for the issuance of an Acknowledgement of Asbestos Assessment prior to the demolition/renovation of a commercial facility. Conducting demolition/renovation activities without obtaining an asbestos survey and an Acknowledgement of Asbestos Assessment is a major violation of the District Board of Health Regulations Governing Air Quality Management, specifically Section 030.105(B)(10) National Emission Standards for Hazardous Air Pollutants (NESHAP), Subpart M - Asbestos, which is implemented through Section 030.107(A), Hazardous Air Pollutants, Asbestos Sampling and Notification. This is a negotiated settlement.

Recommended Fine: $5,000.00 Negotiated Fine: $2,500.00

Background

On August 13, 2013, at approximately 9:20 a.m., Air Quality Specialist II Michael Osborn was driving south on Vista Boulevard when he observed a 30-yard dumpster positioned in front of 650 Vista Boulevard, Suite 100, in Sparks. AQ Specialist Osborn pulled into the parking area to investigate the need for a waste container at that location. Shortly after his arrival, AQ Specialist Osborn observed a worker throwing vinyl floor tile, a suspect asbestos containing material, into the container. AQ Specialist Osborn then entered the building and identified himself to the two workmen performing the removal. The two workmen were identified as Isreal Garcia and Filiberto Muro. AQ Specialist Osborn inquired about any asbestos sampling that may have been performed and if an Acknowledgement of Asbestos Assessment had been obtained from Washoe County Air Quality Management. Mr. Muro was unsure if the testing and Acknowledgement Form had been completed and referred AQ Specialist Osborn to Mr. Paul Slocum, owner of Montane Building Group. AQ Specialist Osborn immediately contacted Mr. Slocum who stated the asbestos sampling had been completed but that he had not yet received the test results. AQ Specialist Osborn asked Mr. Slocum to please meet him at the job site so they could discuss the vinyl floor tile and linoleum removal.

Upon arrival, Mr. Slocum informed AQ Specialist Osborn that the asbestos testing had actually not been completed prior to the disturbance of the suspect flooring materials. AQ Specialist Osborn instructed Mr. Slocum to stop work immediately until a licensed Asbestos Consultant could perform a survey of all suspect materials associated with the demolition/renovation activities scheduled for the project. Specialist Osborn advised Mr. Slocum that if any asbestos was detected it would have to be removed by a licensed abatement contractor. Mr. Slocum stated that he was very familiar with the asbestos regulations since he formerly worked for Marcor Environmental, a licensed asbestos abatement contractor.

Mr. Slocum contracted with Ms. Jill Smith of Air Tranquility, a licensed asbestos consultant, to perform the survey that afternoon. On August 14, 2013, the results of the laboratory analysis found no asbestos detected in any of the samples. Mr. Slocum submitted the asbestos survey to Air Quality Management and obtained the required Acknowledgement of Asbestos Assessment on August 15, 2013.

Based on the results of the investigation, Specialist Osborn issued Notice of Violation Citation No. 5383 for a major violation of Section 030.107 (A), Asbestos Sampling and Notification.

Settlement

On August 21, 2013, Senior AQ Specialist Dennis Cerfoglio conducted a negotiated settlement meeting attended by Specialist Osborn and Mr. Paul Slocum, Montane Building Group. After careful consideration of all the facts in the case, Specialist Cerfoglio recommended that Citation No. 5383 be upheld with a fine of $2,500. A Memorandum of Understanding was signed by all parties.

Alternatives

1. The District Board of Health may determine that no violation of the Regulations has taken place and dismiss Citation No. 5383.

2. The Board may determine to uphold Citation No. 5383 but levy any fine in the range of $0 to $10,000 per day.

In the event the Board determines to change the proposed penalty, the matter should be continued so that Montane Building Group may be properly noticed.

Daniel Inouye, Acting Division Director
Air Quality Management

DI/DC: ma

WASHOE COUNTY HEALTH DISTRICT
AIR QUALITY MANAGEMENT DIVISION
1001 EAST NINTH ST. • SUITE B171 • RENO NV 89512
(775) 784-7200

NOTICE OF VIOLATION

NOV 5383 DATE ISSUED: 8/13/2013

ISSUED TO: Western Building Mgr PHONE #: 775-624-3966

MAILING ADDRESS: 5310 Kietzke CITY/ST: Reno, NV ZIP: 89511

NAME/OPERATOR: Paul O'Neill PHONE #: Same

PERMIT NO. None COMPLAINT NO. COMAR13-0119

YOU ARE HEREBY OFFICIALLY NOTIFIED THAT ON 8/13/2013 (DATE) AT 1600 hrs (TIME), YOU ARE IN VIOLATION OF THE FOLLOWING SECTION(S) OF THE WASHOE COUNTY DISTRICT BOARD OF HEALTH REGULATIONS GOVERNING AIR QUALITY MANAGEMENT:

☐ **MINOR VIOLATION OF SECTION:**	☐ **MAJOR VIOLATION OF SECTION:**
☐ 040.030 __DUST CONTROL	☐ 030.000 OPERATING W/O PERMIT
☐ 040.055 __ ODOR/NUISANCE	☐ 030.2175 VIOLATION OF PERMIT CONDITION
☐ 040.200 __ DIESEL IDLING	☒ 030.105 ASBESTOS/NESHAP
☐ OTHER _____	☐ OTHER 030.107A

VIOLATION DESCRIPTION: Failure to conduct a survey and submit an evaluation as required prior to disturbing flooring materials

LOCATION OF VIOLATION: 650 Vista Ste 100, Sparks NV

POINT OF OBSERVATION: On site / See photos

Weather: Warm / Calm Wind Direction From: N E S W

Emissions Observed: None
(If Visual Emissions Performed - See attached Plume Evaluation Record)

☐ **WARNING ONLY:** Effective _____ a.m./p.m. _____ (date) you are hereby ordered to abate the above violation within _____ hours/days. I hereby acknowledge receipt of this warning on the date indicated.

Signature _____

☐ **CITATION:** You are hereby notified that effective on 8/13/13 (date) you are in violation of the section(s) cited above. You are hereby ordered to abate the above violation within 10 A.M., hours/days. You may contact the Air Quality Management Division to request a negotiated settlement meeting by calling (775) 784-7200. You are further advised that within 10 working days of the date of this Notice of Violation, you may submit a written petition for appeal to the Washoe County Health District, Air Quality Management Division, P.O. Box 11130, Reno, Nevada 89520-0027. Failure to submit a petition within the specified time will result in the submission of this Notice of Violation to the District Board of Health with a recommendation for the assessment of an administrative fine.

SIGNING THIS FORM IS NOT AN ADMISSION OF GUILT

Signature: _____ Date: 8-13-13

Issued by: _____ Title: AQ Sr

☐ **PETITION FOR APPEAL FORM PROVIDED**

H-AIR-09 (Rev. 04/12)

DISTRICT HEALTH DEPARTMENT
AIR QUALITY MANAGEMENT DIVISION

MEMORANDUM OF UNDERSTANDING

AIR QUALITY MANAGEMENT DIVISION
WASHOE COUNTY HEALTH DISTRICT

Date: Aug 21, 2013

Company Name: Monrane Building Group, Inc

Company Address: 5310 Kietzke Lane, Ste 206, Reno, NV 89511

Notice of Violation No.: 5383 Case No.: CMP13-0119

Location of Violation: 650 Vista Blvd. Ste 100, Sparks, NV

The staff of the Air Quality Management Division of the Washoe County Health District issued the above referenced Citation for the violation of Regulation: 030.107A No Asbestos Survey & Sampling and No Asbestos Assesment Forms.

A settlement of this matter has been negotiated between the undersigned parties resulting in a penalty amount of $ $2,500^{00}$. This settlement will be submitted to the District Board of Health for review at the regularly scheduled meeting on September 26, 2013.

Signature of Company Representative

Signature of District Representative

Paul Stocum
Print Name

DENNIS A. CERFOGLIO
Print Name

OWNER
Title

Sr. Air Quality Spec.
Title

Witness

Witness

Witness

Witness

AIR QUALITY MANAGEMENT - ADMINISTRATIVE PENALTY TABLE & RECOMMENDED FINE CALCULATION WORKSHEET

Administrative Penalty Table

Air Quality Management Division
Washoe County Health District

I. Minor Violations - Section 020.040(C)

Regulation		1st Violation	2nd Violation
040.005	Visible Emissions	$ 1,000	$ 2,500
040.030	Dust Control (fugitive)	250	750
040.035	Open Fires	500	1,000
040.040	Fire Training	500	1,000
040.050	Incinerator	1,000	2,000
040.051	Woodstoves	500	1,000
040.055	Odors	1,000	2,000
040.080	Gasoline Transfer (maintenance)	1,000	2,000
040.200	Diesel Idling	500	1,000
050.001	Emergency Episode	1,000	2,000

II. Major Violations - Section 020.040

		Source Category	
Regulation	Violation	Minimum	Maximum
030.000	Construction/Operating without Permit (per major process system or unit/day)	$ 5,000	$ 10,000
030.1402	Failure to Comply with Stop Work Order	10,000/day	10,000/day
030.2175	Operation Contrary to Permit Conditions (per day or event)	2,500	10,000
030.235	Failure to Conduct Source Test or Report (per Reporting Period for Each Unit)	2,500	5,000
	All other Major Violations (per day or event)	$ 5,000	$ 10,000
030.000	Construction Without a Dust Control Permit		
	Project Size – Less than 10 acres	$ 500 + $50 per acre	
	Project Size – 10 acres or more	$1,000 + $50 per acre	

III. Major Violations - Section 030.107 Asbestos

A. Asbestos Sampling & Notification	$ 2,000 - $10,000
B. Asbestos Control Work Practices (per day or event)	$ 5,000 - $10,000
C. Asbestos Containment & Abatement (per day or event)	$ 5,000 - $10,000

Washoe County Air Quality Management
Permitting & Enforcement Branch
Recommended Fine Calculation Worksheet

Company Name Montane Building Group
Contact Name Paul Slocum

Case #1131 NOV #5383 Complaint CMP13-0119

Violation of Section 030.107.A Asbestos Sampling & Notification

I. Base Penalty as specified in the Penalty Table = $ 5,000

II. Severity of Violation

A. Public Health Impact

1. Degree of Violation
(The degree of which the person/company has deviated from the regulatory requirements)
Minor – 0.5 Moderate – 0.75 Major – 1.0 **Adjustment Factor 1.0**

2. Toxicity of Release
Criteria Pollutant – 1x
Hazardous Air Pollutant – 2x **Adjustment Factor N/A**

3. Environmental/Public Health Risk **(Proximity to sensitive environment or group)**
Negligible – 1x Moderate – 1.5x Significant – 2x **Adjustment Factor 1.0**

Total Adjustment Factors (1 x 2 x 3) = **1.0**

B. Adjusted Base Penalty
Base Penalty 5,000 x Adjustment Factor 1.0 = **$ 5,000**

C. Multiple Days or Units in Violation

Adjusted Penalty 5,000 x Number of Days or Units 1.0 = **$ 5,000**

D. Economic Benefit
Avoided Costs $ 400 = **$ 400**
Average cost of an asbestos survey

Penalty Subtotal – Recommended Fine
Adjusted Base Penalty $ 5,000 + Economic Benefit $ 400 = **$ 5,400**

III. Penalty Adjustment Consideration

A. Degree of Cooperation (0 – 25%) - 25 %

B. Mitigating Factors (0 – 25%) - 25 %

1. Negotiated Settlement
2. Ability to Pay
3. Other (explain)

C. Compliance History

No Previous Violations (0 – 10%) - 5 %

Similar Violation in Past 12 months (25 - 50%) + ____ %

Similar Violation within past 3 year (10 - 25%) + ____ %

Previous Unrelated Violation (5 – 25%) + ____ %

Total Penalty Adjustment Factors – sum of A, B, & C **-55 %**

IV. Recommended/Negotiated Fine

Penalty Adjustment:

$ 5,400	x	-55 %	=	$ 2,970
Penalty Subtotal (From Section II)		Total Adjustment Factors (From Section III)		Total Adjustment Value

Additional Credit for Environmental Investment/Training – N/A

Adjusted Penalty:

$ 5,400	-	$ 2,970	=	**$ 2,500**
Penalty Subtotal (From Section II)		Total Adjustment Value (From Section III + Credit)		**Negotiated Fine**

Dennis Corfoglia
Air Quality Specialist

8-21-2013
Date

COMPLAINT INVESTIGATION REPORT

Washoe County Air Quality Management Division

Complaint Number: **CMP13-0119**

Complaint Status: NOV Source of Complaint: INVESTIGATOR

Complaint Type: ASBESTOS Date Received: 08/13/2013 Time: 9:33 a.m.

Inspector: MOSBORN Inspector Area: 2

Complaint Description: NOV CITATION 5383 - CASE 1131 - VIOLATION OF 030.107A, FAILURE TO COMPLETED ASBESTOS SURVERY AND ASSESSMENT PRIOR TO DISTURBANC

Address: 650 VISTA BLVD SPKS

Location: SUITE 100

Parcel Number:

Related Permit Number:

Complainant:
MICHAEL OSBORN - AQ SPECIALIST II
AIR QUALITY MANAGEMENT DIVISION
1001 E 9TH ST STE B171
RENO NV 89512
775-772-7923

Responsible Party:
MONTANE BUILDING GROUP INC
PAUL SLOCUM
5310 KIETZKE LANE STE 206
RENO NV 89511
775-624-3966

Investigation:
On August 13th, 2013 at approximately 0920 a.m., Specialist Osborn while driving South on Vista Blvd. observed a 30 yard container in front of 650 Vista Blvd. Ste 100. Experience has shown that this size container is usually used for demolitions or remodels. On contacting Washoe County Air Quality it was learned that there had been no survey or assessments received for this address. Shortly thereafter Specialist Osborn observed an unidentified individual throwing what appeared to be vinyl tile into the container.

Specialist Osborn entered into the building and presented a business card and introduction to Israel Garcia and Filiberto Muro who were removing tile, mastic and other building systems from the interior of Suite 100. On making an inquiry into the sampling survey and asbestos notification Mr. Muro was unsure if it had been done. Mr. Muro referred Specialist Osborn to Paul Slocum of Montane Building Group.

On contacting Mr. Slocum via telephone initially he stated that the sampling was done but he hadn't received the results as of yet. He told Osborn that he would get them and immediately go down to Air Quality. He stated that the samples had been taken by Air Tranquility, a company Osborn was unfamiliar with at that time. I asked Mr. Slocum to come down to Vista Blvd. so I could speak with him. On his arrival I asked him for his sampling results and he explained that the sampling hadn't been done yet. He further explained that he had told the guys to start work yesterday at 3:00 p.m.

so they could get a head start on the project. It should be noted that neither employee was wearing any type of PPE. It was further noted that approximately 3,000 ft. plus of tile had been removed. (Specialist Osborn's estimate.) Linoleum had been disturbed in the bathroom along with cove base around the floor areas. There were two types of tiles observed with yellow mastic. Carpet/mastic had also been removed from some areas which covered the tiles. Mr. Slocum when advised of sampling procedures stated that he was very familiar these procedures due to have been employed with MACOR asbestos abatement Company of Reno. Mr. Slocum was issued Notice of Violation Citation #5383 for violation of 030.107A sampling and survey required. Mr. Slocum was further presented with a Petition for appeal and instructed not to continue working until a survey has been completed and taken to the Washoe County Air Quality Office.

Michael R. Osborn, AQS II
Washoe County Air Quality
Washoe County Health District

Enforcement Activities

Warning Citation..:	Citation Number: 0
NOV.....: 08/13/2013	NOV Number....: 5383
	Case Number.....: 1131
Settlement.....:	Amount.....: $0.00
Appealed.....:	
Upheld.....:	Amount.....: $0.00

Status Information

Initialized By.....: MOSBORN	Completed Date...:
Date Assigned.....: 08/13/2013	Completed By.....:

AIR TRANQUILITY LLC - BULK SAMPLE ASBESTOS REPORT
DATED AUGUST 13, 2013

AND

ASBESTOS TEM LABORATORIES INC REPORT
DATED AUGUST 14, 2013

BOTH FOR 650 VISTA BOULEVARD, UNIT 100, SPARKS NV

Air Tranquility, LLC
PO Box 18476
Reno, NV 89511
Phone: 775-771-8897
Email:jill@airtranquility.com

Bulk Sample Asbestos Report

Date of Inspection: 8-13-13

Client: Montane Building Group

Address: 5310 Kietzke Ln., Ste. 206, Reno, NV 89511

Project #: 13010

Project Address: 650 Vista Blvd., Suite 100, Sparks, Nevada 89431

Area of Building Inspected: Single Level Floor-Demolition Area

An asbestos survey was conducted at 650 Vista Blvd., Suite 100 on August 13th, 2013. This site was red tagged by Washoe County due to the demolition starting without an asbestos survey or demolition permit. There were enough remnant materials from the demolition area to obtain samples. Eight bulk samples were collected from the demolition area of this building. The suspect containing materials that were collected included VCT tile w/mastic, vinyl flooring w/mastic, joint compound, acoustic ceiling tile, carpet mastic and drywall. The laboratory analysis detected no asbestos in the materials that were tested.

Asbestos Synopsis

Asbestos is a naturally occurring mineral that has been used in literally hundreds of products. It gained widespread use due to being plentiful, readily available, low in cost, and having extremely unique properties. It does not burn, is incredibly strong, conducts heat and electricity poorly, and can withstand chemical corrosion. Asbestos therefore proved to be well suited for many uses in the construction field. For example, asbestos emerged as an insulating component in thermal system insulation for boilers and as a reinforcement material for a variety of products. These building materials are in fact still being manufactured mainly in other countries. This is why all building materials that will be disturbed by demolition or renovation should be tested for asbestos Environmental regulatory agencies and health professionals consider any substance with an asbestos content of one percent or greater to pose a significant health hazard in the event of disturbance. Some examples of where asbestos can be found include acoustic ceiling tiles, joint compound sheet rock, and the mastic used to seal carpet or vinyl flooring.

The survey that was performed involved only the areas of the building that the client requested. This report does not guarantee that all suspect asbestos containing materials were identified or that all were sampled within the building.

Sincerely,

Jill Smith
Owner

ASBESTOS TEM LABORATORIES, INC.

EPA Method 600/R-93/116
Polarized Light Microscopy
Analytical Report

Report No. 123147

1350 Freeport Blvd., Unit 104
Sparks, NV 89431
(775) 359-3377
FAX (775) 359-2798

With Main Office Located At:
630 Bancroft Way, Berkeley, CA 94710
Ph. (510) 704-8930 Fax (510) 704-8929

ASBESTOS TEM LABORATORIES, INC

Accredited by
NVLAP
NVLAP Lab Code 200104-0

Aug-14-13

Ms. Jill Smith
Air Tranquility, LLC
P.O. Box 18476
Reno, NV 89511

RE: LABORATORY JOB # 9052-010
Polarized light microscopy analytical results for 8 bulk sample(s) with 5 sample split(s)
Job Site: 650 Vista Blvd., Sparks, NV
Job No.: 13010
Report No.: 123147

Enclosed please find the bulk material analytical results for one or more samples submitted for asbestos analysis. The analyses were performed in accordance with EPA Method 600/R-93/116 or 600/M4-82-020 for the determination of asbestos in bulk building materials by polarized light microscopy (PLM). Please note that while PLM analysis is commonly performed on non-friable and fine grained materials such as floor tiles and dust, the EPA method recognizes that PLM is subject to limitations. In these situations, accurate results may only be obtainable through the use of more sophisticated and accurate techniques such as transmission electron microscopy (TEM) or X-ray diffraction (XRD).

Prior to analysis, samples are logged-in and all data pertinent to the sample recorded. The samples are checked for damage or disruption of any chain-of-custody seals. A unique laboratory ID number is assigned to each sample. A hard copy log-in sheet containing all pertinent information concerning the sample is generated. This and all other relevant paper work are kept with the sample throughout the analytical procedures to assure proper analysis.

Each sample is opened in a class 100 HEPA negative air hood. A representative sampling of the material is selected and placed onto a glass microscope slide containing a drop of refractive index oil. The glass slide is placed under a polarizing light microscope where standard mineralogical techniques are used to analyze and quantify the various materials present, including asbestos. The data is then compiled into standard report format and subjected to a thorough quality assurance check before the information is released to the client.

For possible future reference, samples are normally kept on file for one year.

Sincerely Yours,

Laboratory Analyst
ASBESTOS TEM LABORATORIES, INC.

Accredited by NVLAP
NVLAP Lab Code 200104-0

POLARIZED LIGHT MICROSCOPY ANALYTICAL REPORT

EPA Method 600/R-93/116 or 600/M4-82-020

Contact: Ms. Jill Smith

Address: Air Tranquility, LLC
P.O. Box 18476
Reno, NV 89511

Samples Indicated: 8
Reg. Samples Analyzed: 8
Split Layers Analyzed: 5

Job Site / No. 650 Vista Blvd., Sparks, NV 13010

Report No. 123147
Date Submitted: Aug-14-13
Date Reported: Aug-14-13

SAMPLE ID	ASBESTOS % TYPE	OTHER DATA (1) Non-Asbestos Fibers (2) Matrix Materials (3) Date/Time Collected (4) Date Analyzed	DESCRIPTION FIELD / LAB
13010-1.	None Detected	1) 2-10% Cellulose, Fiberglass 2) 90-98% Gyp, Other m.p.	Drywall, East Wall of Room 1
Lab ID # 9052-00010-001		3) 4) Aug-14-13	Drywall-White
13010-2.	None Detected	1) 1-5% Cellulose 2) 95-99% Calc, Gyp, Other m.p.	Joint Compound, East Wall of Room 1
Lab ID # 9052-00010-002		3) 4) Aug-14-13	JointCom-White
13010-3.	None Detected	1) 1-5% Cellulose 2) 95-99% Plast, Calc, Qtz, Other m.p.	Blue VCT Tile W/ Mastic, South Entry to Room 2
Lab ID # 9052-00010-003A		3) 4) Aug-14-13	Floor Tile-Blue
13010-3.	None Detected	1) 1-5% Cellulose 2) 95-99% Calc, Gyp, Other m.p.	Blue VCT Tile W/ Mastic, South Entry to Room 2
Lab ID # 9052-00010-003B		3) 4) Aug-14-13	Mastic-Clear/Grey
13010-3.	None Detected	1) 5-10% Cellulose 2) 90-95% Plast, Calc, Qtz, Other m.p.	Blue VCT Tile W/ Mastic, South Entry to Room 2
Lab ID # 9052-00010-003C		3) 4) Aug-14-13	LevelCmpd-Grey
13010-3.	None Detected	1) 1-5% Cellulose 2) 95-99% Calc, Gyp, Other m.p.	Blue VCT Tile W/ Mastic, South Entry to Room 2
Lab ID # 9052-00010-003D		3) 4) Aug-14-13	Mastic-Yellow
13010-4.	None Detected	1) 1-5% Cellulose 2) 95-99% Plast, Calc, Qtz, Other m.p.	Multi Colored VCT Tile W/ Mastic, Floor of Room 3
Lab ID # 9052-00010-004A		3) 4) Aug-14-13	Floor Tile-Grey
13010-4.	None Detected	1) 1-5% Cellulose 2) 95-99% Calc, Gyp, Other m.p.	Multi Colored VCT Tile W/ Mastic, Floor of Room 3
Lab ID # 9052-00010-004B		3) 4) Aug-14-13	Mastic-Yellow
13010-5.	None Detected	1) 2-10% Cellulose, Synthetics 2) 90-98% Calc, Gyp, Other m.p.	Carpet Mastic, Floor of Room 3
Lab ID # 9052-00010-005		3) 4) Aug-14-13	Mastic-Yellow
13010-6.	None Detected	1) <1% Cellulose 2) 100-100% Calc, Gyp, Other m.p.	Rubber Base Mastic, Outside North Wall of Room 4
Lab ID # 9052-00010-006		3) 4) Aug-14-13	Mastic-White

Limit of Quantitation of Method is Estimated to be 1% Asbestos Using a Visual Area Estimation Technique

Laboratory Analyst Greg Hanes

ASBESTOS TEM LABORATORIES, INC. **1350 Freeport Blvd., Unit 104, Sparks, NV 89431** **(775) 359-3377**
With Main Office in Berkeley, CA (510) 704-8930

Accredited by NVLAP
NVLAP Lab Code 200104-0

POLARIZED LIGHT MICROSCOPY ANALYTICAL REPORT

EPA Method 600/R-93/116 or 600/M4-82-020

Contact: Ms. Jill Smith

Address: Air Tranquility, LLC
P.O. Box 18476
Reno, NV 89511

Samples Indicated: 8
Reg. Samples Analyzed: 8
Split Layers Analyzed: 5

Job Site / No. 650 Vista Blvd., Sparks, NV 13010

Report No. 123147
Date Submitted: Aug-14-13
Date Reported: Aug-14-13

SAMPLE ID	ASBESTOS % TYPE	OTHER DATA (1) Non-Asbestos Fibers (2) Matrix Materials (3) Date/Time Collected (4) Date Analyzed	DESCRIPTION FIELD / LAB
13010-7.	None Detected	1) 50-70% Cellulose,Fiberglass 2) 30-50% GlassFoam, Bndr, Other m.p.	Acoustic Ceiling Tile, Ceiling in Room 5
Lab ID # 9052-00010-007		3) 4) Aug-14-13	Ceiling Tile-Grey/White
13010-8.	None Detected	1) 30-50% Cellulose,Fiberglass 2) 50-70% Plast, Gyp, Other m.p.	Spotted Vinyl Flooring w/Mastic, Floor in Restroom 1
Lab ID # 9052-00010-008A		3) 4) Aug-14-13	Sheet Floor/Backing-Grey
13010-8.	None Detected	1) 1-5% Fiberglass,Cellulose 2) 95-99% Calc, Gyp, Other m.p.	Spotted Vinyl Flooring w/Mastic, Floor in Restroom 1
Lab ID # 9052-00010-008B		3) 4) Aug-14-13	Mastic-Yellow
Lab ID #		1) 2) 3) 4)	
Lab ID #		1) 2) 3) 4)	
Lab ID #		1) 2) 3) 4)	
Lab ID #		1) 2) 3) 4)	
Lab ID #		1) 2) 3) 4)	
Lab ID #		1) 2) 3) 4)	
Lab ID #		1) 2) 3) 4)	

Limit of Quantitation of Method is Estimated to be 1% Asbestos Using a Visual Area Estimation Technique

Laboratory Analyst Greg Hanes

ASBESTOS TEM LABORATORIES, INC. 1350 Freeport Blvd., Unit 104, Sparks, NV 89431 (775) 359-3377
With Main Office in Berkeley, CA (510) 704-8930

Air Tranquility, LLC

P.O. Box 18476, Reno, Nevada 89511 – (775) 771-8897

Bulk Sample
Chain of Custody Form

DATE SUBMITTED:	SUBMIT TO:
August 13th, 2013	Asbestos TEM Laboratories, Inc. 1350 Freeport Blvd., Unit 104 Sparks, NV 89431 (775) 359-3377

PROJECT NAME:	RESULTS TO:
Rinnai-Montane	Email: jill@airtranquility.com

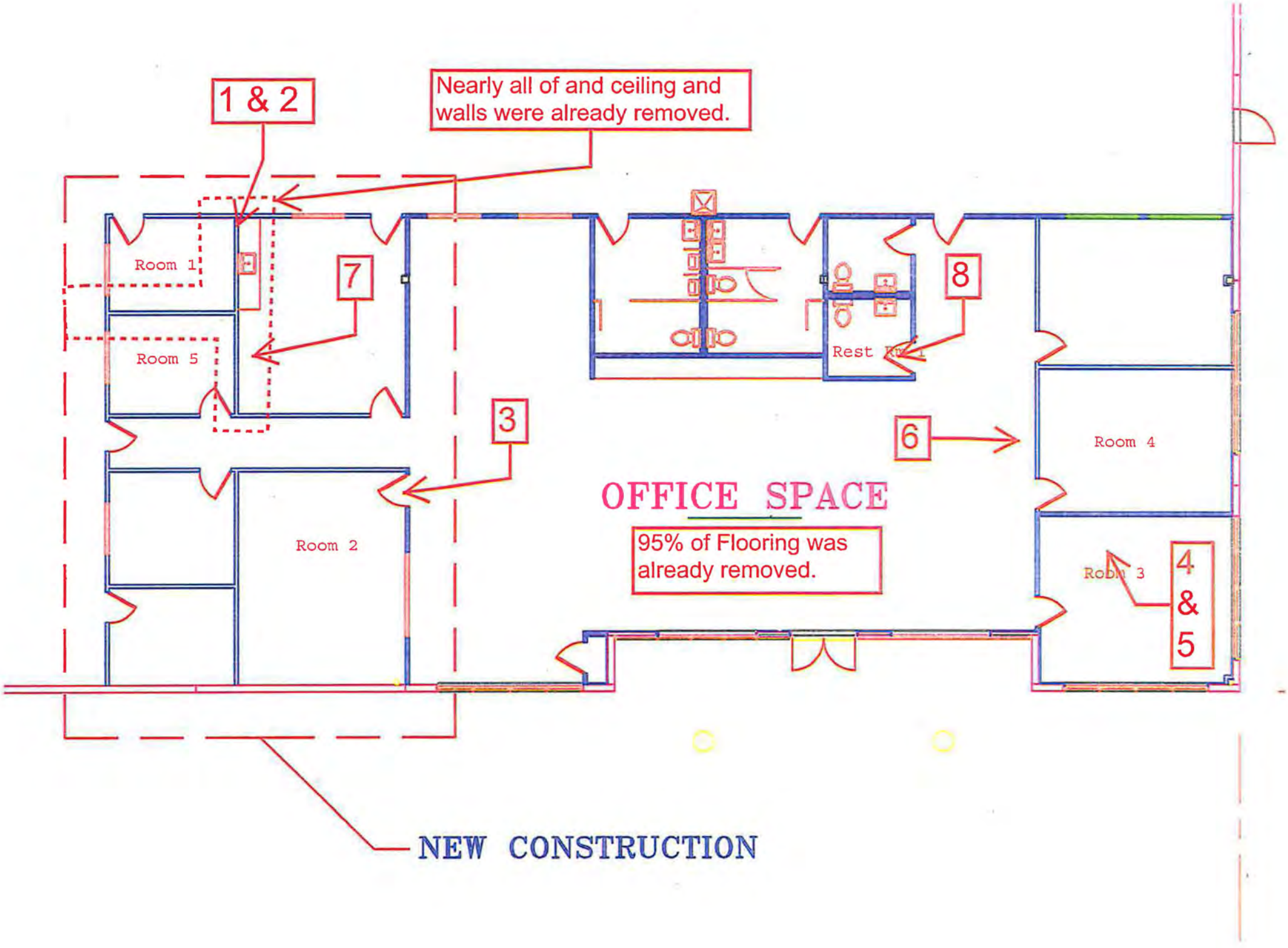
Project #: 13010	Address: 650 Vista Blvd., Sparks, Nevada	Copy To:
Tel: 560-4815(Paul w/Montane)	Email:	
Number of Samples: 8	Date Required:	Check Priority: ☑ Rush ☐ Reg.

SAMPLE#	SAMPLE LOCATION	SAMPLE DESCRIPTION
13010-1	East wall of Room 1	drywall
13010-2	East wall of Room 1	joint compound
13010-3	South entry to Room 2	blue VCT tile w/Masti
13010-4	floor of Room 3	Multi-colored VCT tile w/masti
13010-5	floor of Room 3	Carpet mastic
13010-6	Outside north wall of Rm 4	rubber base Mastic
13010-7	Ceiling in Room 5	acoustic ceiling tile
13010-8	floor in Restroom 1	Spotted Vinyl flooring w/ma

Special Instructions:

Date:

Relinquished By	Date/Time	Received By	Date/Time
Name/Company: Air Tranquility, LLC.	8/14/13	Name/Company: Asbestos TEM Lab	8/14/13
Signature: Jill E Mott	9:15 am	Signature: Dave Ehrlich	9:15am


1 & 2
Nearly all of and ceiling and walls were already removed.
Room 1
Room 5
7
8
Rest Rm 1
3
6
Room 4
OFFICE SPACE
95% of Flooring was already removed.
Room 2
Room 3
4 & 5
NEW CONSTRUCTION

AIR QUALITY MANAGEMENT
ACKNOWLEDGEMENT OF ASBESTOS ASSESSMENT
FOR 650 VISTA BOULEVARD, UNIT 100, SPARKS NV

DATED: AUGUST 15, 2013

ACKNOWLEDGMENT OF ASBESTOS ASSESSMENT
Washoe County Air Quality Management Division

Permit Number: ASB13-0706

Property Owner: BRE/NV INDUSTRIAL PROPERTY LLC **Phone:**

Property Being Evaluated: UNIT #100 - REMOVE EXISTING WALLS TO RECONFIGURE BREAKROOM AND REPLACE FLOORING

Address: 650 VISTA BLVD SPKS

TYPE OF PROJECT	TYPE OF PROPERTY	PROPERTY BEING ASSESSED
RENO	NON-RES	PARTIAL*

FILING FEE: $62.00

*Note: If this project is a partial renovation and additional work is to be conducted later, additional asbestos assessment(s) will be required unless this assessment covers all pertinent representative asbestos suspected materials throughout the building.

General Contractor:
MONTANE BUILDING GROUP INC
PAUL SLOCUM
5310 KIETZKE LANE STE 206
RENO, NV 89511

Consultant or Assessment Company:
AIR TRANQUILITY LLC

PO BOX 19476
RENO, NV 89511

Abatement Contractor:

Assessment Results: ACM ABSENT

Abatement Completed:

** Note: If asbestos present, abatement must be conducted in accordance with NESHAP and OSHA regulations before renovation or demolition work may proceed.

10-DAY NOTIFICATION MANDATORY FOR DEMOLITION

Owner / Representative's Name

Comments:
T.I. - remodel existing breakroom. Demo existing walls and replace flooring throughout office. Sampling found NO ACM present. Use best methods of dust control during construction and dispose of waste properly.

Mauri O Mendoza
Health District Representative

8/15/13
Date

Signature on this asbestos assessment document does NOT constitute full Health District approval for this project. Any additional Health permits such as are required for bar or restaurant operations, underground storage tanks, hazardous material disposal or air pollution sources must be obtained separately.

Signature by the Washoe County Health District does not warrant, nor should this report be taken to warrant, that asbestos was or was not present on stated property. Exposure to even small amounts of airborne asbestos fibers may cause cancer. For this reason the Health District recommends that all asbestos handling and abatement work be performed by certified asbestos contractors.

PHOTOS TAKEN BY AQ SPECIALIST II, MICHAEL OSBORN
OF 650 VISTA BOULEVARD, UNIT 100 IN SPARKS NV

DATED AUGUST 15, 2013

08/13/2013 9:33:51 AM

08/13/2013 9:34:02 AM

Violation of 030.107A; Failure to conduct an asbestos survey prior to disturbing vinyl tiles and mastic from a public building.

08/13/2013 9:34:15 AM

08/13/2013 9:34:32 AM

08/13/2013 9:34:47 AM

08/13/2013 9:35:07 AM

08/13/2013 9:35:29 AM

08/13/2013 9:52:21 AM

08/13/2013 9:52:50 AM

08/13/2013 9:53:35 AM

08/13/2013 9:54:01 AM

08/13/2013 9:54:21 AM

08/13/2013 9:55:14 AM

08/13/2013 9:55:30 AM

08/13/2013 9:55:54 AM

Washoe County Health District

Public Health
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STAFF REPORT
BOARD MEETING DATE: September 26, 2013

DATE: September 6, 2013

TO: District Board of Health

FROM: Patsy Buxton, Fiscal Compliance Officer, Washoe County Health District
775-328-2418, pbuxton@washoecounty.us

THROUGH: Eileen Stickney, Administrative Health Services Officer
775-328-2417, estickney@washoecounty.us

SUBJECT: Approve termination of the Interlocal Agreement between the Washoe County Health District and the University of Nevada School of Medicine Integrated Clinical Services, Inc., and University of Nevada School of Medicine Multispecialty Group Practice North, Inc., dba MEDSchool Associates North (MSAN), to provide a faculty physician to serve as a consultant on pediatric Tuberculosis cases effective October 31, 2013.

SUMMARY

The Washoe County District Board of Health must approve and execute, or direct the Health Officer to execute, contracts in excess of $50,000, Interlocal Agreements and amendments to the adopted budget.

PREVIOUS ACTION

The District Board of Health ratified the Interlocal Agreement with MSAN to provide a faculty physician to serve as a consultant on pediatric Tuberculosis cases in the total amount of $2,000 per year for the period July 1, 2011 through June 30, 2014 at the June 23, 2011 meeting. A copy of this Agreement is attached.

BACKGROUND

The Washoe County Health District received notice from Dr. Sonia Budecha that she is no longer affiliated with MSAN and is working through Renown effective September 3, 2013. It is our understanding that the only other pediatric respiratory specialist is Dr. Lokshin and he is not affiliated with MSAN either. As such, we are proposing to terminate the contract with the University of Nevada School of Medicine Integrated Clinical Services, Inc., and University of Nevada School of Medicine Multispecialty Group Practice North, Inc., dba MEDSchool Associates North (MSAN) for the period July 1, 2011 through June 30, 2014. The contract rate is $500 per quarter, not to exceed a total annual amount of $2,000.

The Interlocal Agreement provided for: medical consultation services related to the diagnosis and treatment of active tuberculosis cases and latent tuberculosis infection in pediatric patients (0-14 years) by record review or office visit; discussion and review of progress and concerns related to pediatric tuberculosis patients; and approval of pediatric treatment protocols and clinical evaluations performed by District nurses.

Should the Board approve the termination of this Agreement, a letter will be sent (copy attached) notifying MSAN of this action.

FISCAL IMPACT

Should the Board approve to terminate this Interlocal Agreement, there will be no additional impact to the adopted FY14 budget.

RECOMMENDATION

Staff recommends that the Washoe County District Board of Health approve termination of the Interlocal Agreement between the Washoe County Health District and the University of Nevada School of Medicine Integrated Clinical Services, Inc., and University of Nevada School of Medicine Multispecialty Group Practice North, Inc., dba MEDSchool Associates North (MSAN), to provide a faculty physician to serve as a consultant on pediatric Tuberculosis cases effective October 31, 2013.

POSSIBLE MOTION

Move to approve termination of the Interlocal Agreement between the Washoe County Health District and the University of Nevada School of Medicine Integrated Clinical Services, Inc., and University of Nevada School of Medicine Multispecialty Group Practice North, Inc., dba MEDSchool Associates North (MSAN), to provide a faculty physician to serve as a consultant on pediatric Tuberculosis cases effective October 31, 2013.

Washoe County Health District

Public Health
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September 26, 2013

Gail Smith, MBA
UNSOM MSAN
1664 N. Virginia Street M/S 1332
Reno, NV 89557-1332

Dear Ms. Smith,

The Washoe County Health District ("Health District") has enjoyed its working relationship with MSAN for many years, and hope to continue to do so with other services. However, due to the departure of your assigned consultant for Pediatric Tuberculosis, Dr. Sonia Budhecha, we will be terminating our contract for these services.

This letter serves as the written notification required under the "TERMINATION" paragraph attached of the "Agreement" between the Health District and MSAN for pediatric tuberculosis consultation services. The termination of the Agreement shall be effective October 31, 2013.

With your permission, the Health District will keep your information on file in the event circumstances change, and your specialized services could be utilized in the future.

If you have any questions please feel free to contact Steve Kutz at (775) 328-3759.

Sincerely,

Matt Smith
Chairman, Washoe County District Board of Health

cc: Steve Kutz
Candy Hunter
Lisa Lottritz
Patsy Buxton
File

INTERLOCAL AGREEMENT

THIS AGREEMENT is made and entered into between the WASHOE COUNTY HEALTH DISTRICT, hereinafter referred to as "District," and the University of Nevada School of Medicine Integrated Clinical Services, Inc., and University of Nevada School of Medicine Multi-Specialty Group Practice North, Inc., dba MEDSchool Associates North, hereinafter referred to as "MSAN."

WHEREAS, the District conducts several public health programs which require the services of a physician consultant; and

WHEREAS, MSAN has faculty physicians who are licensed to practice medicine in the State of Nevada, and specialize in pediatric pulmonary medicine; and

WHEREAS, MSAN agrees to provide a faculty member to serve as a consultant on pediatric Tuberculosis cases;

Now therefore, in consideration of the mutual promises contained herein, the parties agree as follows:

The MSAN agrees to:

1. Provide medical consultation services related to the diagnosis and treatment of active tuberculosis cases and latent tuberculosis infection in pediatric patients (0-14 years) by record review or office visit.
2. Discuss and review progress and concerns related to pediatric tuberculosis patients and approve pediatric treatment protocols and clinical evaluations performed by District nurses.
3. Bill the District quarterly for consultative services provided.
4. Ensure that the physician consultant has submitted to a full background investigation pursuant to NRS 179.180 et seq., which includes a criminal history check and fingerprinting, and authorize the District to receive the records. The discovery of a) an undisclosed conviction for a sexual offense or a conviction based on an arrest or initial charge for a sexual offense, b) an undisclosed pending arrest or initial charge for a sexual offense, or c) two or more incidents resulting in arrest or initial charge of sexual offense which have not resulted in conviction and were not disclosed may be grounds for immediate termination of this Agreement without prior notice by the District, as may the arrest, initial charge or conviction of physician for a sexual offense during the term of this Agreement.

The District agrees to:

1. Reimburse MSAN $2,000 per year in four (4) quarterly payments of $500 for services described herein.
2. Be responsible for all fiscal and program responsibilities, records and reports for patients provided services through District programs.
3. Provide physician(s) with appropriate forms to obtain fingerprints at the Washoe County Sheriff's Office.

4. Provide no payment in advance of services. Payments are to be mailed to the following address:

MEDSchool Associates North
Nelson Building – MS 353
Attn: Accounts Receivable
401 West Second Street, Suite 237
Reno, NV 89503-5353

HIPAA: The parties acknowledge that they are subject to the provisions of the Health Insurance Portability and Accountability Act and the regulations promulgated there under (hereinafter "HIPAA"), pertaining to the maintenance, handling, retention, confidentiality and availability of records and data containing protected health information, as that term is defined by 45 C.F.R.§164.501. It is agreed that in addition to maintaining such records and data in accordance with HIPAA and any more restrictive provisions of state law, including but not limited to, chapters 441A of the Nevada Revised Statutes and the Nevada Administrative Code, the parties will require that all employees, contractors, and agents with whom they share the records and data provide comparable protections to those provided by the parties.

INDEMNIFICATION.

a. Consistent with the Limited Liability provision stated below, each party shall indemnify, hold harmless and defend, not excluding the other's right to participate, the other party from and against all liability, claims, actions, damages, losses, and expenses, including but not limited to reasonable attorneys' fees and costs, arising out of any alleged negligent or willful acts or omissions of the indemnifying party, its officers, employees and agents. Such obligation shall not be construed to negate, abridge, or otherwise reduce any other right or obligation of indemnity, which would otherwise exist as to any party or person, described in this paragraph.

b. The indemnification obligation under this paragraph is conditioned upon receipt of written notice by the indemnifying party within 30 days of the indemnified party's actual notice of any actual or pending claim or cause of action. The indemnifying party shall not be liable to hold harmless any attorneys' fees and costs for the indemnified party's chosen right to participate with legal counsel.

c. In the event that the provisions of NRS Chapter 41 do not apply to a party, the party not covered by Chapter 41 agrees to indemnify the other party for any amount of damages in excess of the capped amount contained in Chapter 41 that may be awarded.

LIMITED LIABILITY. The parties will not waive and intend to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both parties shall not be subject to punitive damages. To the extent applicable, actual contract damages for any breach shall be limited by NRS 353.260 and NRS 354.626.

TERM. The term of this Agreement is from July 1, 2011 through June 30, 2012 unless extended by the mutual agreement of the Parties. The Agreement will automatically be renewed for two successive one-year periods for a total of 3 years on the same terms unless either party gives the other written notice of nonrenewal at least 60 days prior to June 30 of each year. The automatic renewal provision of this section shall not affect the right of the Health District to terminate the Agreement as provided below.

TERMINATION. Either party may terminate this Agreement and any amendments at any time, without cause or penalty upon 30 days written notice to the other party. The District shall reimburse MSAN for any services still owing prior to the termination date of this Agreement but reserves the right to withhold payment if it is determined that the services were not provided.

NON-APPROPRIATION. In the event funds are not appropriated for this purposes specified in this Agreement, MSAN hereby consents to the termination of this Agreement. In such event, District will notify provider in writing and the agreement will terminate on the date specified in the notice. Both parties understand that this funding out provision is required by N.R.S. 354.626.

SEVERABILITY. The provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of the Agreement shall be in effect and binding upon the parties.

WAIVER OF PROVISION. Any waiver of any terms or conditions hereof must be in writing and signed by the parties hereto. A waiver of any of the terms or conditions hereof shall not be construed as a waiver of any other terms of conditions hereof.

AMENDMENTS. This Agreement may be amended at any time by mutual agreement of the parties without additional consideration, provided that before any amendment shall be operative or valid it shall be reduced to writing and signed by the parties. .Ratification by the governing bodies shall be a condition precedent to its entry into force. This Agreement may be reviewed at any time by both parties to determine whether the Agreement is appropriate as it relates to individuals referred from the District.

ENTIRE AGREEMENT. This Agreement contains the entire agreement between the parties and shall be binding upon the parties and no other agreements, oral or written, have been entered into with respect to the subject of this Agreement.

ASSIGNMENT. Nothing contained in this Agreement shall be construed to permit assignment by MSAN of any rights, duties or obligations under this Agreement and such assignment is expressly prohibited.

NOTICES. Official notices required under this Agreement shall be sent to the parties by certified or registered mail, return receipt requested, postage prepaid in the United States Postal Service to the addresses set forth below, or to such other addresses as the parties may designate in writing from time to time by notice given in accordance with the provisions of this section.

Notices to MSAN shall be addressed to:

Gail Smith, MBA
UNSOM
1664 N. Virginia Street, M/S 1332
Reno, NV 89557-1332

Notices to the District shall be addressed to:

District Health Officer
Washoe County Health District
P O Box 11130
Reno NV 89520-0027

Witness whereof, the parties hereto or a representative of either have set their hands and subscribed their signatures as of the date and year indicated.

District Board of Health

By: _____ Date: 6-23-11
Chairman

University of Nevada School of Medicine Integrated Clinical Services, Inc., and University of Nevada School of Medicine Multispecialty Group Practice North, Inc., dba MEDSchool Associates North

By: _____ Date: 7/13/11
Cheryl Hug-English, MD, MPH
ICS President

By: _____ Date: 7.7.11
Nevin Wilson, MD, MSAN President

EXHIBIT A

Washoe County Health District
OSHA Bloodborne Pathogen Requirements for Independent Contractors

Although the OSHA Standard for bloodborne pathogens covers employees, the Washoe County Health District (WCHD) wishes to insure that all individuals working on site (independent contractor) at risk for exposure will adhere to the recommendations outline in the WCDHD Bloodborne Pathogens Exposure Control Plan. Copies of the plan are available in the Divisions within the Department.

Your signature below indicates your agreement that:

You have reviewed a current copy of the WCHDH Bloodborne Pathogen Exposure Control Plan as of the date below.

You will abide by those policies.

You have designated a health care provider to provide you post exposure evaluation and prophylaxis at your own expense in the event you are exposed to blood or body fluids.

The WCDHD offers independent contractors initial and annual blood borne pathogen training. Should you decline this training, you agree to comply with any OSHA requirements for Bloodborne Pathogen training that might apply to you under Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard, 29 CFR 1910.1030, enacted in December, 1991, to reduce occupational exposure to Hepatitis B Virus (HBV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens.

NAME Dr. Budhecha

DATE 7/25/11

Washoe County Health District

Public Health
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STAFF REPORT
BOARD MEETING DATE: September 26, 2013

DATE: September 5, 2013

TO: District Board of Health

FROM: Patsy Buxton, Fiscal Compliance Officer, Washoe County Health District
775-328-2418, pbuxton@washoecounty.us

THROUGH: Eileen Stickney, Administrative Health Services Officer, Washoe County Health District, 775-328-2417, estickney@washoecounty.us

SUBJECT: **Authorize Travel and Travel Reimbursements for two Centers for Disease Control and Prevention (CDC) Assignees (Jessica Ponce and Andrew Stutman), for the period of July 29, 2013 through August 1, 2015 in a total amount not to exceed $2,500.**

SUMMARY:

On June 14, 2011, the Washoe Board of County Commissioners (BCC) delegated the authority to the Washoe County District Board of Health (DBOH) to make final decisions regarding approval of non-employee travel.

District Board of Health strategic priority: Experience a low rate of communicable diseases.

BCC Strategic Objective supported by this item: Safe, secure and healthy communities.

Approval of the non-employee travel also supports the District's Community & Clinical Health Service Divisions Sexual Health program's mission to provide comprehensive prevention education, treatment , and surveillance activities in Washoe County that reduce the incidence of STD infection including HIV. The Sexual Health Program emphasizes strategies that empower individuals to decrease risk-related behaviors, thereby decreasing the incidence of new STD and HIV infections in the community.

PREVIOUS ACTION:

On June 27, 2013, the Board of Health approved a request to Authorize Travel and Travel Reimbursements for a Non-County Employee (Patrick Russell) in the approximate amount of $1,200 in support of the HIV Prevention Grant Program (IO 10013).

BACKGROUND:

The Washoe County Health District submitted an application to the CDC to be a host site for a Public Health Associate to work in our community. CDC agreed and assigned two individuals (Jessica Ponce and Andrew Stutman) to work with us for a two (2) year assignment. As a host site we provide the Associate(s) first-hand experience in the implementation of public health programs at the Health District level.

The Agreement with CDC stipulates that Associates will have the same rights, responsibilities, and supervision as comparably situated employees of the host agency including receiving reimbursement for local travel expenses, participating in host site training, and receiving technical direction and mentoring from host site employees.

It is anticipated travel expenses will mainly be local mileage reimbursement; however if required training opportunities are outside of the Tahoe Basin the amount being requested should be sufficient to cover travel expenses.

FISCAL IMPACT:

Should the Board approve the non-county employee travel, there will be a fiscal impact, however, this impact is minimal and will be absorbed within the Community and Clinical Health Services division operating expenditures.

RECOMMENDATION:

Staff recommends that the District Board of Health authorize Travel and Travel Reimbursements for two Centers for Disease Control and Prevention (CDC) Assignees (Jessica Ponce and Andrew Stutman), for the period of July 29, 2013 through August 1, 2015 in a total amount not to exceed $2,500.

POSSIBLE MOTION:

Move to authorize Travel and Travel Reimbursements for two Centers for Disease Control and Prevention (CDC) Assignees (Jessica Ponce and Andrew Stutman), for the period of July 29, 2013 through August 1, 2015 in a total amount not to exceed $2,500.

Washoe County Health District

Public Health
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STAFF REPORT
BOARD MEETING DATE: September 26, 2013

DATE: September 9, 2013

TO: District Board of Health

FROM: Patsy Buxton, Fiscal Compliance Officer, Washoe County Health District
775-328-2418, pbuxton@washoecounty.us

THROUGH: Eileen Stickney, Administrative Health Services Officer
775-328-2417, estickney@washoecounty.us

SUBJECT: Approval of Subgrant Amendment #2 from the Nevada State Health Division for the Women, Infants and Children (WIC) Clinic Program for the period October 1, 2012 through September 30, 2014 in the total amount of $2,143,996 in support of Salaries and Benefits, Travel and Training, and Operating Expenditures; and if approved authorize the Chairman to execute.

SUMMARY

The Washoe County District Board of Health must approve and execute, or direct the Health Officer to execute, contracts in excess of $50,000, Interlocal Agreements and amendments to the adopted budget. The Washoe County Health District has received a Notice of Subgrant Award from the Nevada State Health Division that provides funding for the period October 1, 2012 through September 30, 2014 in the amount of $2,143,996 ($1,071,998 per year) in support of the Special Supplemental Nutrition Program for Women, Infants and Children. A copy of the Subgrant Amendment #2 is attached.

District Board of Health strategic priority: Be assured that mandates are met and needed services are delivered.

BCC Strategic Objective supported by this item: Safe, secure and healthy communities.

It also supports the Washoe County Health District's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) mission. It is to provide supplemental nutritious foods, nutrition education and referrals to other health and social services to eligible pregnant and postpartum women, infants and children up to age five in Washoe County to prevent the occurrence of health problems and to improve the health status of these persons.

PREVIOUS ACTION

The District Board of Health approved last year's base Notice of Subgrant Award for the period October 1, 2012 through September 30, 2013 in the total amount of $1,071,998 on September 27, 2012.

BACKGROUND

The Washoe County Health District agrees to provide a level of service sufficient to provide WIC food instruments to an estimated 6,576 participants per month for a total of 78,911 participants per year during the term of this Subgrant Award.

This document has been revised to reflect the correct funding levels in each budget category per year: Personnel = $1,007,089; Travel = $5,750.00 and Operating = $59,159. The total award amount will remain at $1,071,998.

FISCAL IMPACT

No budget amendments are necessary at this time.

RECOMMENDATION

Staff recommends that the Washoe County District Board of Health approve Subgrant Amendment #2 from the Nevada State Health Division for the Women, Infants and Children (WIC) Clinic Program for the period October 1, 2012 through September 30, 2014 in the total amount of $2,143,996 in support of Salaries and Benefits, Travel and Training, and Operating Expenditures; and if approved authorize the Chairman to execute.

POSSIBLE MOTION

Move to approve Subgrant Amendment #2 from the Nevada State Health Division for the Women, Infants and Children (WIC) Clinic Program for the period October 1, 2012 through September 30, 2014 in the total amount of $2,143,996 in support of Salaries and Benefits, Travel and Training, and Operating Expenditures; and if approved authorize the Chairman to execute.

Department of Health and Human Services
DIVISION of Public and Behavioral Health
(hereinafter referred to as the DIVISION)

HD Amendment #: 2
HD Contract #: 12031
Budget Account #: 3214
Category #: 04
GL #: 8516

SUBGRANT AMENDMENT #2

Program Name:
Women, Infants and Children (WIC)
Bureau of Child, Family, and Community Wellness
Nevada State Health Division

Address:
4126 Technology Way, Suite #102
Carson City, NV 89706-2009

Original Subgrant Period:
October 1, 2012 – September 30, 2013

Amended Subgrant Period:
October 1, 2012 – September 30, 2014

Subgrantee Name:
Washoe County Health District

Address:
1009 East 9th Street
PO Box 11130
Reno, NV 89520

Subgrantee EIN#: 88-6000138
Subgrantee Vendor#: T41107900

Dun & Bradstreet#: 073-78-6998

Source of Funds:	% of Funds:	CFDA#:	Federal Grant #:
WIC Nutrition Services/Administration	100	10.577	7NV700NV7

Amendment : This change is to increase the total dollar amount for a two (2) year term of the subgrant from $1,071,998.00 to $2,143,996.00. Annual reimbursement will not exceed $1,071,998.00. Scope of work remains the same. WIC funding levels are subject to change dependent on yearly grant allocation from USDA. The WIC program is discretionary and subject to Sequestration cuts which may affect funding levels. Funding adjustments could be necessary and dependent of these factors.

Change from:		**Change to:**	
Personnel:	$ 1,007,089.00	Personnel:	$ 2,014,178.00
Operating:	$ 59,159.00	Operating:	$ 118,318.00
Travel:	$ 5,750.00	Travel:	$ 11,500.00
Total:	$ 1,071,998.00	Total:	$ 2,143,996.00

By signing this Amendment, the Authorized Subgrantee Official or their designee, Program Manager, Bureau Chief, and Health Division Administrator acknowledge the above as the new standard of practice for the above referenced Subgrant. Further, the undersigned understand this amendment does not alter, in any substantial way, the non-referenced contents of the Original Subgrant Award and all of its Attachments.

Authorized Sub-grantee Official Title:	Signature	Date
Michelle Walker Program Manager	Michelle Walker	8/14/13
Deborah Harris, MA, CPM Bureau Chief		8/19/13
Richard Whitley, MS Administrator, Health Division		

Washoe County Health District

Public Health
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STAFF REPORT
BOARD MEETING DATE: September 26, 2013

DATE: September 16, 2013

TO: District Board of Health

FROM: Patsy Buxton, Fiscal Compliance Officer, Washoe County Health District
775-328-2418, pbuxton@washoecounty.us

THROUGH: Eileen Stickney, Administrative Health Services Officer
775-328-2417, estickney@washoecounty.us

SUBJECT: Approve Subgrant Amendment #2 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health for the period January 1, 2013 through December 31, 2013 in the amount of $99,227, bringing total CY 2013 funding for the Immunization Program Grant (IOs 10028 & 10029), to $297,673; and if approved authorize the Chairman to execute.

SUMMARY

The Washoe County District Board of Health must approve and execute, or direct the Health Officer to execute, contracts in excess of $50,000, Interlocal Agreements and amendments to the adopted budget.

The Health District received Subgrant Amendment #2 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health which provides for grant funding for the on-going Immunization Program, IOs 10028 & 10029. A copy of Amendment #2 is attached.

District Board of Health strategic priority: Be assured that mandates are met and needed services are delivered.

BCC Strategic Objective supported by this item: Safe, secure, and healthy communities.

Approval of Subgrant Amendment #2 also supports the Health District Immunization Program Mission to promote public health by reducing vaccine preventable disease through immunization, with an emphasis on collaboration and cooperation with community partners.

PREVIOUS ACTION

The Washoe County District Board of Health approved a Notice of Subgrant Award in the amount of $99,223, representing "Round 1" of funding, in support of the Immunization Program on February 28, 2013.

The Washoe County District Board of Health approved a Notice of Subgrant Award in the amount of $99,223, representing "Round 2" of funding, in support of the Immunization Program on July 25, 2013.

BACKGROUND

The NSHD has received "Round 3" of funding from the Centers for Disease Control and Prevention (CDC). As such, the Amendment reflects the subgrant period of January 1, 2013 through December 31, 2013, with additional funding of $99,227.

FISCAL IMPACT

No budget amendments are necessary as sufficient budget authority is available through 6/30/14.

RECOMMENDATION

Staff recommends that the District Board of Health approve Subgrant Amendment #2 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health for the period January 1, 2013 through December 31, 2013 in the amount of $99,227, bringing total CY 2013 funding for the Immunization Program Grant (IOs 10028 & 10029), to $297,673; and if approved authorize the Chairman to execute.

POSSIBLE MOTION

Move to approve Subgrant Amendment #2 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health for the period January 1, 2013 through December 31, 2013 in the amount of $99,227, bringing total CY 2013 funding for the Immunization Program Grant (IOs 10028 & 10029), to $297,673; and if approved authorize the Chairman to execute.

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
(hereinafter referred to as the DIVISION)

HD Amendment #: 13128-2

HD Contract #: 13128
Budget Account #: 3213
Category #: 20
GL #: 8516
Job Number: 9326813

SUBGRANT AMENDMENT #2

Program Name:
Immunization Program
Bureau of Child, Family & Community Wellness
Nevada State Division of Public and Behavioral Health

Address:
4150 Technology Way, Suite #210
Carson City, NV 89706-2009

Subgrantee Name:
Washoe County Health District (WCHD)

Address:
PO Box 11130
Reno, NV 89520

Original Subgrant Period:
1/1/2013 through 12/31/2013

Amended Subgrant Period:
1/1/2013 through 12/31/2013

Subgrantee EIN#: 88-6000138

Subgrantee Vendor#: T40283400 Q

Dunn and Bradstreet #: 73786998

Source of Funds:	% of Funds:	CFDA#:	Federal Grant #:
1.Centers for Disease Control & Prevention	100%	93.268	1H23IP000727-01

Amendment #2: The Nevada State Immunization Program received Round 3 funding from the CDC issued on 8/27/2013. It is necessary for the Nevada State Immunization Program to increase the subgrant award so that the subgrantee can accomplish the scope of work set out in the original subgrant. This amendment does not affect the subgrant scope of work. This amendment increases the approved subgrant budget by $99,227, from $198,446 to $297,673.

Change to:
Total Approved Budget Categories & Funding Sources

CATEGORIES	FUNDING SOURCE				
	VFC OPS (01)	VFC/AFIX (04)	317 OPS (00)	PAN FLU (05)	TOTAL
1. Personnel	$169,211		$108,042		$277,253
2. Travel	$600		$6,800		$7,400
3. Operating	$1,300				$1,300
4. Equipment					
5. Contractual/Consultant					
6. Training					
7. Other	$11,720				$11,720
TOTAL	$182,831		$114,842		$297,673

Any categorical adjustments must be approved through the Immunization Program Manager. Written permission must be obtained and can be done via email. Please note that funding cannot be moved between funding sources (example – moving funds from VFC Ops to 317 Ops), but funds can be moved within a funding source (example – from Personnel to Travel).

Disbursement of funds will be as follows:
Payment will be made upon receipt and acceptance of Reimbursement Request and supporting documentation specifically requesting reimbursement for actual expenditures specific to this subgrant. Total reimbursement will not exceed $297,673 during the subgrant period.

By signing this Amendment, the Authorized Subgrantee Official or their designee, Program Manager, Bureau Chief, and Health Division Administrator acknowledge the above as the new standard of practice for the above referenced Subgrant. Further, the undersigned understand this amendment does not alter, in any substantial way, the non-referenced contents of the Original Subgrant Award and all of its Attachments.

	Signature	Date
Kevin Dick Interim District Health Officer		
Karissa Loper, MPH State Immunization Program Manager	Karissa Loper	9/4/13
Deborah A. Harris, MA, CPM CFCW Bureau Chief		9/6/13
Richard Whitley, MS Administrator, Health Division		

nF 9/9/13

gH 9/4/13

Washoe County Health District

Public Health
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STAFF REPORT
BOARD MEETING DATE: September 26, 2013

DATE: September 16, 2013

TO: District Board of Health

FROM: Patsy Buxton, Fiscal Compliance Officer, Washoe County Health District
775-328-2418, pbuxton@washoecounty.us

THROUGH: Eileen Stickney, Administrative Health Services Officer, Washoe County Health District, 775-328-2417, estickney@washoecounty.us

SUBJECT: Approve Notice of Subgrant Award for the period August 1, 2013 through July 31, 2014 in the total amount of $136,833 in support of the Centers for Disease Control and Prevention (CDC) Epidemiology and Laboratory Capacity (ELC) Affordable Care Act Federal Grant Program, IO 10984; and if approved authorize the Chairman to execute.

SUMMARY

The Washoe County District Board of Health must approve and execute, or direct the Health Officer to execute, contracts in excess of $50,000, Interlocal Agreements and amendments to the adopted budget.

The Washoe County Health District received a Notice of Subgrant Award from the Division of Public and Behavioral Health for the period August 1, 2013 through July 31, 2014 in the total amount of $136,833 in support of the Epidemiology and Laboratory Capacity Grant Program. A copy of Subgrant Award is attached.

District Board of Health strategic priority: Experience a low rate of communicable diseases.

BCC Strategic Objective supported by this item: Safe, secure and healthy communities.

This item supports the Epidemiology and Public Health Preparedness (EPHP) Division's mission to strengthen the capacity of public health infrastructure to detect, assess, and respond decisively to control the public health consequences of bioterrorism events or any public health emergency.

PREVIOUS ACTION

The District Board of Health approved amendments totaling an increase of $62,216 in both revenue and expense to the FY13 CDC ELC grant program (IO 10984) on January 24, 2013.

BACKGROUND

The Nevada State Health Division has awarded the Epidemiology Program $136,833 for the period August 1, 2013 through July 31, 2014. Funds will be used to support personnel, travel, operating expenditures.

FISCAL IMPACT

No budget amendments are necessary as sufficient budget authority is available through June 30, 2014. The Notice of Grant Award includes $16,474 indirect federal revenue.

RECOMMENDATION

Staff recommends that the Washoe County District Board of Health approve the Notice of Subgrant Award for the period August 1, 2013 through July 31, 2014 in the total amount of $136,833 in support of the Centers for Disease Control and Prevention (CDC) Epidemiology and Laboratory Capacity (ELC) Affordable Care Act Federal Grant Program, IO 10984; and if approved authorize the Chairman to execute.

POSSIBLE MOTION

Move to approve the Notice of Subgrant Award for the period August 1, 2013 through July 31, 2014 in the total amount of $136,833 in support of the Centers for Disease Control and Prevention (CDC) Epidemiology and Laboratory Capacity (ELC) Affordable Care Act Federal Grant Program, IO 10984; and if approved authorize the Chairman to execute.

Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
(hereinafter referred to as the DIVISION)

Division #: S-14187
Budget Account # 3219
Category#: 16
GL #: 8516
Job Number:

NOTICE OF SUBGRANT AWARD

Program Name:	**Subgrantee Name:**
Office of Public Health Informatics and Epidemiology Community Services Section Division of Public and Behavioral Health	Washoe County Health District (WCHD)
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	**Address:** 1001 East Ninth Street Reno, NV 89502
Subgrant Period: August 1, 2013 through July 31, 2014	**Subgrantee's EIN#:** 88-6000138 **Vendor#:** T41107900 **Dun & Bradstreet#:** 73-786-998

Reason for Award: This award is funded through the *Epidemiology and Laboratory Capacity (ELC) Program - Building and Strengthening Epidemiology, Laboratory and Health Information System grant* from the CDC. The WCHD will use these funds to complete health information system development and exchange activities.

County(ies) to be served: ( ) Statewide (X) Specific county or counties: Washoe County

Approved Budget Categories:

1. Personnel	$	**111,611**
2. Travel	$	**6,969**
3. Operating	$	**979**
4. Equipment	$	**-**
5. Contractual/Consultant	$	**-**
6. Other	$	**800**
7. Indirect	$	**16,474**
Total Cost	$	**136,833**

Subgrantee may make categorical funding adjustments up to ten percent (10%) of the total subgrant amount without amending the agreement, so long as the adjustment is reasonable to support the activities described within the Scope of Work and the adjustment does not alter the Scope of Work.

Disbursement of funds will be as follows:
Payment will be made upon receipt and acceptance of an invoice and supporting documentation specifically requesting reimbursement for actual expenditures *specific to this subgrant.* Total reimbursement will not exceed $136,833 .00 during the subgrant period.

Source of Funds:	**% of Funds:**	**CFDA#:**	**Federal Grant #:**
1. Centers for Disease Control and Prevention	73.89%	93.521	3U50CI000900-02S4
2. Centers for Disease Control and Prevention	26.11%	93.283	3U50CI000900-02S5

Terms and Conditions
In accepting these grant funds, it is understood that:
1. Expenditures must comply with appropriate state and/or federal regulations.
2. This award is subject to the availability of appropriate funds.
3. Recipient of these funds agrees to stipulations listed in Sections A through E of this subgrant award.

	Signature	Date
Washoe County Health District		
Judy DuMonte Program Manager		9/29/2013
Mary Wherry Deputy Administrator		9.5.13
Richard Whitley, MS Administrator, Division of Public and Behavioral Health		

JF 9/4/13

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD
SECTION A
Assurances

As a condition of receiving subgranted funds from the Nevada Division of Public and Behavioral Health, the Subgrantee agrees to the following conditions:

1. Subgrantee agrees grant funds may not be used for other than the awarded purpose. In the event Subgrantee expenditures do not comply with this condition, that portion not in compliance must be refunded to the Division of Public and Behavioral Health.

2. Subgrantee agrees to submit reimbursement requests for only expenditures approved in the spending plan. Any additional expenditures beyond what is allowable based on approved categorical budget amounts, without prior written approval by the Division of Public and Behavioral Health, may result in denial of reimbursement.

3. Approval of subgrant budget by the Division of Public and Behavioral Health constitutes prior approval for the expenditure of funds for specified purposes included in this budget. Unless otherwise stated in the Scope of Work the transfer of funds between budgeted categories without written prior approval from the Division of Public and Behavioral Health is not allowed under the terms of this subgrant. Requests to revise approved budgeted amounts must be made in writing and provide sufficient narrative detail to determine justification.

4. Recipients of subgrants are required to maintain subgrant accounting records, identifiable by subgrant number. Such records shall be maintained in accordance with the following:
    a. Records may be destroyed not less than three years (unless otherwise stipulated) after the final report has been submitted if written approval has been requested and received from the Administrative Services Officer of the Division of Public and Behavioral Health. Records may be destroyed by the Subgrantee five (5) calendar years after the final financial and narrative reports have been submitted to the Division of Public and Behavioral Health.
    b. In all cases an overriding requirement exists to retain records until resolution of any audit questions relating to individual subgrants.

    Subgrant accounting records are considered to be all records relating to the expenditure and reimbursement of funds awarded under this Subgrant Award. Records required for retention include all accounting records and related original and supporting documents that substantiate costs charged to the subgrant activity.

5. Subgrantee agrees to disclose any existing or potential conflicts of interest relative to the performance of services resulting from this subgrant award. The Division of Public and Behavioral Health reserves the right to disqualify any grantee on the grounds of actual or apparent conflict of interest. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest will automatically result in the disqualification of funding.

6. Subgrantee agrees to comply with the requirements of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, P.L. 93-112, as amended, and any relevant program-specific regulations, and shall not discriminate against any employee or offeror for employment because of race, national origin, creed, color, sex, religion, age, disability or handicap condition (including AIDS and AIDS-related conditions).

7. Subgrantee agrees to comply with the Americans with Disabilities Act of 1990 (P.L. 101-136), 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 CFR 26.101-36.999 inclusive, and any relevant program-specific regulations.

8. Subgrantee agrees to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. 160, 162 and 164, as amended. If the subgrant award includes functions or

activities that involve the use or disclosure of Protected Health Information, the Subgrantee agrees to enter into a Business Associate Agreement with the Division of Public and Behavioral Health, as required by 45 C.F.R 164.504 (e).

9. Subgrantee certifies, by signing this subgrant, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. This certification is made pursuant to regulations implementing Executive Order 12549, Debarment and Suspension, 28 C.F.R. pt. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal Register (pp.19150-19211). This provision shall be required of every Subgrantee receiving any payment in whole or in part from federal funds.

10. Subgrantee agrees, whether expressly prohibited by federal, state, or local law, or otherwise, that no funding associated with this subgrant will be used for any purpose associated with or related to lobbying or influencing or attempting to lobby or influence for any purpose the following:
    a. any federal, state, county or local agency, legislature, commission, council, or board;
    b. any federal, state, county or local legislator, commission member, council member, board member, or other elected official; or
    c. any officer or employee of any federal, state, county or local agency, legislature, commission, council, or board.

11. Division of Public and Behavioral Health subgrants are subject to inspection and audit by representatives of the Division of Public and Behavioral Health, Nevada Department of Health and Human Services, the State Department of Administration, the Audit Division of the Legislative Counsel Bureau or other appropriate state or federal agencies to
    a. verify financial transactions and determine whether funds were used in accordance with applicable laws, regulations and procedures;
    b. ascertain whether policies, plans and procedures are being followed;
    c. provide management with objective and systematic appraisals of financial and administrative controls, including information as to whether operations are carried out effectively, efficiently and economically; and
    d. determine reliability of financial aspects of the conduct of the project.

12. Any audit of Subgrantee's expenditures will be performed in accordance with Generally Accepted Government Auditing Standards to determine there is proper accounting for and use of subgrant funds. It is the policy of the Division of Public and Behavioral Health (as well as a federal requirement as specified in the Office of Management and Budget (OMB) Circular A-133 [Revised June 27th, 2003]) that each grantee annually expending $500,000 or more in federal funds have an annual audit prepared by an independent auditor in accordance with the terms and requirements of the appropriate circular. A COPY OF THE FINAL AUDIT REPORT MUST BE SENT TO THE NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH, ATTN: ADMINISTRATIVE SERVICES OFFICER IV, 4150 TECHNOLOGY WAY,SUITE 300, CARSON CITY, NEVADA 89706-2009, within nine (9) months of the close of the Subgrantee's fiscal year. T**o ensure this requirement is met Section D of this subgrant must be filled out and signed.**

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD
SECTION B
Description of services, scope of work, deliverables and reimbursement

Washoe County Health District (WCHD), hereinafter referred to as Subgrantee, agrees to provide the following services and reports according to the identified timeframes:

- The Senior Epidemiologist will assist with communicable disease reporting, tracking, follow up, and analysis. Support to include sample size determination, data collection instrument development, analytical statistical analyses, report review, epidemiological software training, development, and implementation, outbreak response timeliness evaluation for Nevada Division of Public and Behavioral Health.

- The WCHD will submit written progress reports to the Nevada Division of Public and Behavioral Health electronically as required for the grant progress and annual reports. This report must have updates on current project progress as well as the future funding year project proposal and budget.

- Additional information may be requested by the Nevada Division of Public and Behavioral Health, as needed, due to evolving state and federal reporting requirements.

- Identify the source of funding on all printed documents purchased or produced within the scope of this subgrant, using a statement similar to: "This publication (journal, article, etc.) was supported by the Nevada Division of Public and Behavioral Health through Grant Numbers 3U50CI000900-02S4 and 3U50CI000900-02S5 from Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Nevada Division of Public and Behavioral Health nor Centers for Disease Control and Prevention (CDC)."

- Any activities performed under this subgrant shall acknowledge the funding was provided through the Nevada Division of Public and Behavioral Health by Grant Number s 3U50CI000900-02S4 and 3U50CI000900-02S5 from the Centers for Disease Control and Prevention.

- Report detailed influenza data to include age of individual, date tested, type of test, subtyping of influenza (A, B) if available, and county of residence to the Nevada Division of Public and Behavioral Health on a weekly basis.

(continued on next page)

Subgrantee agrees to adhere to the following budget:

1. Personnel	$	111,611	To cover the salary and fringe for Lei Chen, Senior Epidemiologist
2. Travel	$	6,969	Local travel and to allow WCHD staff to attend the following out-of-state trainings/travel: CSTE Conference, West Coast Epi Conference, Epi In Action Course, Public Health Surveillance Course, and other related conferences/trainings.
3. Operating	$	979	To cover purchase of reference books and materials
4. Equipment	$	0	
5. Contractual/Consultant	$	0	
6. Other	$	800	To cover subscriptions to the Journal of Infectious Diseases, Journal of Clinical Infectious Diseases, etc.
7. Indirect	$	16,474	Calculated at 20% of salary only
Total Cost	$	136,833	

- Subgrantee may make categorical funding adjustments up to ten percent (10%) of the total subgrant amount without amending the agreement, so long as the adjustment is reasonable to support the activities described within the Scope of Work and the adjustment does not alter the Scope of Work.

- Equipment purchased with these funds belongs to the federal program from which this funding was appropriated and shall be returned to the program upon termination of this agreement.

- Travel expenses, per diem, and other related expenses must conform to the procedures and rates allowed for State officers and employees. It is the Policy of the Board of Examiners to restrict contractors/Subgrantees to the same rates and procedures allowed State Employees. The State of Nevada reimburses at rates comparable to the rates established by the US General Services Administration, with some exceptions (State Administrative Manual 0200.0 and 0320.0).

Subgrantee agrees to request reimbursement according to the schedule specified below for the actual expenses incurred related to the Scope of Work during the subgrant period.

- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred, summarizing the total amount and type of expenditures made during the reporting period.

- Requests for Reimbursements will be submitted monthly.

- Submit monthly Requests for Reimbursement no later than 15 days following the end of the month.

- Additional expenditure detail will be provided upon request from the Division.

Additionally, the Subgrantee agrees to provide:

- A complete financial accounting of all expenditures to the Division of Public and Behavioral Health within 30 days of the CLOSE OF THE SUBGRANT PERIOD. Any un-obligated funds shall be returned to the Division of Public and Behavioral Health at that time, or if not already requested, shall be deducted from the final award.

The Nevada Division of Public and Behavioral Health agrees:

- Review and approve activities through programmatic and fiscal reports and conduct site visits at the Subgrantee's physical site as necessary.

- Provide reimbursements, not to exceed a total of $136,833, for the entire subgrant period.

- Provide technical assistance, upon request from the Subgrantee.

- The Nevada Division of Public and0 Behavioral Health reserves the right to hold reimbursement under this subgrant until any delinquent forms, reports, and expenditure documentation are submitted to and accepted by the Nevada Division of Public and Behavioral Health.

- The Nevada Division of Public and Behavioral Health reserves the right to hold reimbursement under this subgrant until any delinquent forms, reports, and expenditure documentation are submitted to and accepted by the Division of Public and Behavioral Health.

Both parties agree:

- Based on the bi-annual narrative progress and financial reporting forms, as well as site visit findings, if it appears to the Nevada Division of Public and Behavioral Health that activities will not be completed in time specifically designated in the Scope of Work, or project objectives have been met at a lesser cost than originally budgeted, the Nevada Division of Public and Behavioral Health may reduce the amount of this subgrant award and reallocate funding to other preparedness priorities within the state. This includes but is not limited to:

    - Reallocating funds between the subgrantee's categories, and

Reallocating funds to another subgrantee or funding recipient to address other identified Nevada Division of Public and Behavioral Health priorities, by removing it from this agreement through a subgrant amendment.

All reports of expenditures and requests for reimbursement processed by the Nevada Division of Public and Behavioral Health are SUBJECT TO AUDIT.

This subgrant agreement may be TERMINATED by either party prior to the date set forth on the Notice of Subgrant Award, provided the termination shall not be effective until 30 days after a party has served written notice upon the other party. This agreement may be terminated by mutual consent of both parties or unilaterally by either party without cause. The parties expressly agree that this Agreement shall be terminated immediately if for any reason the Nevada Division of Public and Behavioral Health, state, and/or federal funding ability to satisfy this Agreement is withdrawn, limited, or impaired.

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

NOTICE OF SUBGRANT AWARD
SECTION C
Financial Reporting Requirements

- A Request for Reimbursement is due on a monthly or quarterly basis, based on the terms of the subgrant agreement, no later than the 15th of the month.
- Reimbursement is based on actual expenditures incurred during the period being reported.
- Payment will not be processed without all reporting being current.
- Reimbursement may only be claimed for expenditures approved within the Notice of Subgrant Award.

Provide the following information on the top portion of the form: Subgrantee name and address where the check is to be sent, Division (subgrant) number, Bureau program number, draw number, employer I.D. number (EIN) and Vendor number.

An explanation of the form is provided below. The cells are pre-programed and will auto populate when data is entered.

A. Approved Budget: List the approved budget amounts in this column by category.

B. Total Prior Requests: List the total expenditures for all previous reimbursement periods in this column, for each category, by entering the numbers found on Lines 1-8, Column D on the **previous** Request for Reimbursement/Advance Form. If this is the first request for the subgrant period, the amount in this column equals zero.

C. Current Request: List the current expenditures requested at this time for reimbursement in this column, for each category.

D. Year to Date Total: Add Column B and Column C for each category.

E. Budget Balance: Subtract Column D from Column A for each category.

F. Percent Expended: Divide Column D by Column A for each category and total. Monitor this column; it will help to determine if/when an amendment is necessary. Amendments MUST be completed (including all approving signatures) 30 days **prior** to the end of the subgrant period.

An Expenditure Report/Backup that summarizes, by expenditure GL, the amounts being claimed in column 'C' is required.

Nevada Department of Health and Human Services

Division # 14095

PUBLIC and BEHAVIORAL HEALTH

Bureau Program #

GL # 8516

Draw #:

REQUEST FOR REIMBURSEMENT

Program Name:	**Subgrantee Name:**
Office of Public Health Informatics and Epidemiology Nevada Division of Public and Behavioral Health	Washoe County Health District (WCHD)
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	**Address:** 1001 East Ninth Street Reno, NV 89502
Subgrant Period: August 1, 2013 through July 31, 2014	**Subgrantee EIN#:** 88-6000138 **Subgrantee Vendor#:** T41107900

FINANCIAL REPORT AND REQUEST FOR FUNDS

(must be accompanied by expenditure report/back-up)

Month(s): **Calendar Year:**

	Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year To Date Total	E Budget Balance	F Percent Expended
1	Personnel	$ 111,611	$ 0	$ 0	$ 0	$ 111,611	0%
2	Travel	$ 6,969	$ 0	$ 0	$ 0	$ 6,969	0%
3	Operating	$ 979	$ 0	$ 0	$ 0	$ 979	0%
4	Equipment	$ 0	$ 0	$ 0	$ 0	$ 0	-
5	Contract/Consultant	$ 0	$ 0	$ 0	$ 0	$ 0	-
6	Other	$ 800	$ 0	$ 0	$ 0	$ 800	0%
7	Indirect	$ 16,474	$ 0	$ 0	$ 0	$ 16,474	0%
8	**Total**	$ 136,833	$ 0	$ 0	$ 0	$ 136,833	0%

This report is true and correct to the best of my knowledge.

Authorized Signature Title Date

Reminder: Request for Reimbursement cannot be processed without an expenditure report/backup. Reimbursement is only allowed for items contained within Subgrant Award documents. If applicable, travel claims must accompany report.

FOR DIVISION USE ONLY

Program contact necessary? _____ Yes _____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____ Signed: _____

Scope of Work review/approval date: _____ Signed: _____

ASO or Bureau Chief (as required): _____ Date: _____

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD
SECTION D

NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
AUDIT INFORMATION REQUEST

1. Non-Federal entities that **expend** $500,000.00 or more in total Federal Awards are required to have a single or program-specific audit conducted for that year, in accordance with *OMB Circular A-133*. A COPY OF THE FINAL AUDIT REPORT MUST BE SENT TO THE NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH, ATTN: ADMINISTRATIVE SERVICES OFFICER IV, 4150 TECHNOLOGY WAY, SUITE 300, CARSON CITY, NEVADA 89706-2009, within nine (9) months of the close of your fiscal year.

2. Did your organization expend $500,000.00 or more in all Federal Awards during your most recent fiscal year? YES ____ NO ____

3. When does your fiscal year end? _____

4. Official name of organization? _____

5. How often is your organization audited? _____

6. When was your last audit performed? _____

7. What time period did it cover? _____

8. Which accounting firm conducted the audit? _____

_____

SIGNATURE TITLE DATE

SECTION E

BUSINESS ASSOCIATE ADDENDUM

BETWEEN

Nevada Division of Public and Behavioral Health
Hereinafter referred to as the "Covered Entity"

and

Washoe County Health District
Hereinafter referred to as the "Business Associate".

PURPOSE. In order to comply with the requirements of HIPAA and the HITECH Act, this Addendum is hereby added and made part of the Contract between the Covered Entity and the Business Associate. This Addendum establishes the obligations of the Business Associate and the Covered Entity as well as the permitted uses and disclosures by the Business Associate of protected health information it may possess by reason of the Contract. The Covered Entity and the Business Associate shall protect the privacy and provide for the security of protected health information disclosed to the Business Associate pursuant to the Contract and in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-5 ("the HITECH Act"), and regulation promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws.

WHEREAS, the Business Associate will provide certain services to the Covered Entity, and, pursuant to such arrangement, the Business Associate is considered a business associate of the Covered Entity as defined in HIPAA, the HITECH Act, the Privacy Rule and Security Rule; and

WHEREAS, Business Associate may have access to and/or receive from the Covered Entity certain protected health information, in fulfilling its responsibilities under such arrangement; and

WHEREAS, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule require the Covered Entity to enter into a contract containing specific requirements of the Business Associate prior to the disclosure of protected health information, as set forth in, but not limited to, 45 CFR Parts 160 & 164 and Public Law 111-5.

THEREFORE, in consideration of the mutual obligations below and the exchange of information pursuant to this Addendum, and to protect the interests of both Parties, the Parties agree to all provisions of this Addendum.

I. DEFINITIONS. The following terms shall have the meaning ascribed to them in this Section. Other capitalized terms shall have the meaning ascribed to them in the context in which they first appear.

1. **Breach** means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of the protected health information. The full definition of breach can be found in 42 USC 17921 and 45 CFR 164.402.
2. **Business Associate** shall mean the name of the organization or entity listed above and shall have the meaning given to the term under the Privacy and Security Rule and the HITECH Act. For full definition refer to 45 CFR 160.103.
3. **CFR** stands for the Code of Federal Regulations.
4. **Contract** shall refer to this Addendum and that particular Contract to which this Addendum is made a part.
5. **Covered Entity** shall mean the name of the Division listed above and shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to 45 CFR 160.103.
6. **Designated Record Set** means a group of records that includes protected health information and is maintained by or for a covered entity or the Business Associate that includes, but is not limited to, medical, billing, enrollment, payment, claims adjudication, and case or medical management records. Refer to 45 CFR 164.501 for the complete definition.

7. **Disclosure** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information as defined in 45 CFR 160.103.
8. **Electronic Protected Health Information** means individually identifiable health information transmitted by electronic media or maintained in electronic media as set forth under 45 CFR 160.103.
9. **Electronic Health Record** means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. Refer to 42 USC 17921.
10. **Health Care Operations** shall have the meaning given to the term under the Privacy Rule at 45 CFR 164.501.
11. **Individual** means the person who is the subject of protected health information and is defined in 45 CFR 160.103.
12. **Individually Identifiable Health Information** means health information, in any form or medium, including demographic information collected from an individual, that is created or received by a covered entity or a business associate of the covered entity and relates to the past, present, or future care of the individual. Individually identifiable health information is information that identifies the individual directly or there is a reasonable basis to believe the information can be used to identify the individual. Refer to 45 CFR 160.103.
13. **Parties** shall mean the Business Associate and the Covered Entity.
14. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 CFR Parts 160 and 164, Subparts A, D and E.
15. **Protected Health Information** means individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Refer to 45 CFR 160.103 for the complete definition.
16. **Required by Law** means a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law. This includes, but is not limited to: court orders and court-ordered warrants; subpoenas, or summons issued by a court; and statues or regulations that require the provision of information if payment is sought under a government program providing public benefits. For the complete definition refer to 45 CFR 164.103.
17. **Secretary** shall mean the Secretary of the federal Department of Health and Human Services (HHS) or the Secretary's designee.
18. **Security Rule** shall mean the HIPAA regulation that is codified at 45 CFR Parts 160 and 164 Subparts A and C.
19. **Unsecured Protected Health Information** means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued in Public Law 111-5. Refer to 42 USC 17932 and 45 CFR 164.402.
20. **USC** stands for the United States Code.

II. OBLIGATIONS OF THE BUSINESS ASSOCIATE.

1. **Access to Protected Health Information.** The Business Associate will provide, as directed by the Covered Entity, an individual or the Covered Entity access to inspect or obtain a copy of protected health information about the Individual that is maintained in a designated record set by the Business Associate or, its agents or subcontractors, in order to meet the requirements of the Privacy Rule, including, but not limited to 45 CFR 164.524 and 164.504(e) (2) (ii) (E). If the Business Associate maintains an electronic health record, the Business Associate or, its agents or subcontractors shall provide such information in electronic format to enable the Covered Entity to fulfill its obligations under the HITECH Act, including, but not limited to 42 USC 17935.
2. **Access to Records.** The Business Associate shall make its internal practices, books and records relating to the use and disclosure of protected health information available to the Covered Entity and to the Secretary for purposes of determining Business Associate's compliance with the Privacy and Security Rule in accordance with 45 CFR 164.504(e)(2)(ii)(H).
3. **Accounting of Disclosures.** Promptly, upon request by the Covered Entity or individual for an accounting of disclosures, the Business Associate and its agents or subcontractors shall make available to the Covered Entity or the individual information required to provide an accounting of disclosures in accordance with 45 CFR 164.528, and the HITECH Act, including, but not limited to 42 USC 17935. The accounting of disclosures, whether electronic or other media, must include the requirements as outlined under 45 CFR 164.528(b).
4. **Agents and Subcontractors.** The Business Associate must ensure all agents and subcontractors to whom it provides protected health information agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to all protected health information accessed, maintained, created, retained, modified, recorded, stored, destroyed, or otherwise held, transmitted, used or disclosed by the agent or subcontractor. The Business Associate must implement and maintain sanctions against agents and

subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation as outlined under 45 CFR 164.530(f) and 164.530(e)(1).

5. **Amendment of Protected Health Information.** The Business Associate will make available protected health information for amendment and incorporate any amendments in the designated record set maintained by the Business Associate or, its agents or subcontractors, as directed by the Covered Entity or an individual, in order to meet the requirements of the Privacy Rule, including, but not limited to, 45 CFR 164.526.
6. **Audits, Investigations, and Enforcement.** The Business Associate must notify the Covered Entity immediately upon learning the Business Associate has become the subject of an audit, compliance review, or complaint investigation by the Office of Civil Rights or any other federal or state oversight agency. The Business Associate shall provide the Covered Entity with a copy of any protected health information that the Business Associate provides to the Secretary or other federal or state oversight agency concurrently with providing such information to the Secretary or other federal or state oversight agency. The Business Associate and individuals associated with the Business Associate are solely responsible for all civil and criminal penalties assessed as a result of an audit, breach, or violation of HIPAA or HITECH laws or regulations. Reference 42 USC 17937.
7. **Breach or Other Improper Access, Use or Disclosure Reporting.** The Business Associate must report to the Covered Entity, in writing, any access, use or disclosure of protected health information not permitted by the Contract, Addendum or the Privacy and Security Rules. The Covered Entity must be notified immediately upon discovery or the first day such breach or suspected breach is known to the Business Associate or by exercising reasonable diligence would have been known by the Business Associate in accordance with 45 CFR 164.410, 164.504(e)(2)(ii)(C) and 164.308(b) and 42 USC 17921. The Business Associate must report any improper access, use or disclosure of protected health information by: the Business Associate or its agents or subcontractors. In the event of a breach or suspected breach of protected health information, the report to the Covered Entity must be in writing and include the following: a brief description of the incident; the date of the incident; the date the incident was discovered by the Business Associate; a thorough description of the unsecured protected health information that was involved in the incident; the number of individuals whose protected health information was involved in the incident; and the steps the Business Associate is taking to investigate the incident and to protect against further incidents. The Covered Entity will determine if a breach of unsecured protected health information has occurred and will notify the Business Associate of the determination. If a breach of unsecured protected health information is determined, the Business Associate must take prompt corrective action to cure any such deficiencies and mitigate any significant harm that may have occurred to individual(s) whose information was disclosed inappropriately.
8. **Breach Notification Requirements.** If the Covered Entity determines a breach of unsecured protected health information by the Business Associate has occurred, the Business Associate will be responsible for notifying the individuals whose unsecured protected health information was breached in accordance with 42 USC 17932 and 45 CFR 164.404 through 164.406. The Business Associate must provide evidence to the Covered Entity that appropriate notifications to individuals and/or media, when necessary, as specified in 45 CFR 164.404 and 45 CFR 164.406 has occurred. The Business Associate is responsible for all costs associated with notification to individuals, the media or others as well as costs associated with mitigating future breaches. The Business Associate must notify the Secretary of all breaches in accordance with 45 CFR 164.408 and must provide the Covered Entity with a copy of all notifications made to the Secretary.
9. **Breach Pattern or Practice by Covered Entity.** Pursuant to 42 USC 17934, if the Business Associate knows of a pattern of activity or practice of the Covered Entity that constitutes a material breach or violation of the Covered Entity's obligations under the Contract or Addendum, the Business Associate must immediately report the problem to the Secretary.
10. **Data Ownership.** The Business Associate acknowledges that the Business Associate or its agents or subcontractors have no ownership rights with respect to the protected health information it accesses, maintains, creates, retains, modifies, records, stores, destroys, or otherwise holds, transmits, uses or discloses.
11. **Litigation or Administrative Proceedings.** The Business Associate shall make itself, any subcontractors, employees, or agents assisting the Business Associate in the performance of its obligations under the Contract or Addendum, available to the Covered Entity, at no cost to the Covered Entity, to testify as witnesses, or otherwise, in the event litigation or administrative proceedings are commenced against the Covered Entity, its administrators or workforce members upon a claimed violation of HIPAA, the Privacy and Security Rule, the HITECH Act, or other laws relating to security and privacy.
12. **Minimum Necessary.** The Business Associate and its agents and subcontractors shall request, use and disclose only the minimum amount of protected health information necessary to accomplish the purpose of the request, use or disclosure in accordance with 42 USC 17935 and 45 CFR 164.514(d)(3).
13. **Policies and Procedures.** The Business Associate must adopt written privacy and security policies and procedures and documentation standards to meet the requirements of HIPAA and the HITECH Act as described in 45 CFR 164.316 and 42 USC 17931.
14. **Privacy and Security Officer(s).** The Business Associate must appoint Privacy and Security Officer(s) whose responsibilities shall include: monitoring the Privacy and Security compliance of the Business

Associate; development and implementation of the Business Associate's HIPAA Privacy and Security policies and procedures; establishment of Privacy and Security training programs; and development and implementation of an incident risk assessment and response plan in the event the Business Associate sustains a breach or suspected breach of protected health information.

15. **Safeguards.** The Business Associate must implement safeguards as necessary to protect the confidentiality, integrity, and availability of the protected health information the Business Associate accesses, maintains, creates, retains, modifies, records, stores, destroys, or otherwise holds, transmits, uses or discloses on behalf of the Covered Entity. Safeguards must include administrative safeguards (e.g., risk analysis and designation of security official), physical safeguards (e.g., facility access controls and workstation security), and technical safeguards (e.g., access controls and audit controls) to the confidentiality, integrity and availability of the protected health information, in accordance with 45 CFR 164.308, 164.310, 164.312, 164.316 and 164.504(e)(2)(ii)(B). Sections 164.308, 164.310 and 164.312 of the CFR apply to the Business Associate of the Covered Entity in the same manner that such sections apply to the Covered Entity. Technical safeguards must meet the standards set forth by the guidelines of the National Institute of Standards and Technology (NIST). The Business Associate agrees to only use, or disclose protected health information as provided for by the Contract and Addendum and to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate, of a use or disclosure, in violation of the requirements of this Addendum as outlined under 45 CFR 164.530(e)(2)(f).
16. **Training.** The Business Associate must train all members of its workforce on the policies and procedures associated with safeguarding protected health information. This includes, at a minimum, training that covers the technical, physical and administrative safeguards needed to prevent inappropriate uses or disclosures of protected health information; training to prevent any intentional or unintentional use or disclosure that is a violation of HIPAA regulations at 45 CFR 160 and 164 and Public Law 111-5; and training that emphasizes the criminal and civil penalties related to HIPAA breaches or inappropriate uses or disclosures of protected health information. Workforce training of new employees must be completed within 30 days of the date of hire and all employees must be trained at least annually. The Business Associate must maintain written records for a period of six years. These records must document each employee that received training and the date the training was provided or received.
17. **Use and Disclosure of Protected Health Information.** The Business Associate must not use or further disclose protected health information other than as permitted or required by the Contract or as required by law. The Business Associate must not use or further disclose protected health information in a manner that would violate the requirements of the HIPAA Privacy and Security Rule and the HITECH Act.

III. PERMITTED AND PROHIBITED USES AND DISCLOSURES BY THE BUSINESS ASSOCIATE. The Business Associate agrees to these general use and disclosure provisions:

1. **Permitted Uses and Disclosures:**
   a. Except as otherwise limited in this Addendum, the Business Associate may use or disclose protected health information to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the HIPAA Privacy and Security Rule or the HITECH Act, if done by the Covered Entity in accordance with 45 CFR 164.504(e) (2) (i) and 42 USC 17935 and 17936.
   b. Except as otherwise limited by this Addendum, the Business Associate may use or disclose protected health information received by the Business Associate in its capacity as a Business Associate of the Covered Entity, as necessary, for the proper management and administration of the Business Associate, to carry out the legal responsibilities of the Business Associate, as required by law or for data aggregation purposes in accordance with 45 CFR 164.504(e)(2)(A), 164.504(e)(4)(i)(A), and 164.504(e)(2)(i)(B).
   c. Except as otherwise limited in this Addendum, if the Business Associate discloses protected health information to a third party, the Business Associate must obtain, prior to making any such disclosure, reasonable written assurances from the third party that such protected health information will be held confidential pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to the third party. The written agreement from the third party must include requirements to immediately notify the Business Associate of any breaches of confidentiality of protected health information to the extent it has obtained knowledge of such breach. Refer to 45 CFR 164.502 and 164.504 and 42 USC 17934.
   d. The Business Associate may use or disclose protected health information to report violations of law to appropriate federal and state authorities, consistent with 45 CFR 164.502(j)(1).
2. **Prohibited Uses and Disclosures:**
   a. Except as otherwise limited in this Addendum, the Business Associate shall not disclose protected health information to a health plan for payment or health care operations purposes if the patient has required this special restriction, and has paid out of pocket in full for the health care item or service to which the protected health information relates in accordance with 42 USC 17935.

b. The Business Associate shall not directly or indirectly receive remuneration in exchange for any protected health information, as specified by 42 USC 17935,unless the Covered Entity obtained a valid authorization, in accordance with 45 CFR 164.508 that includes a specification that protected health information can be exchanged for remuneration.

IV. OBLIGATIONS OF COVERED ENTITY

1. The Covered Entity will inform the Business Associate of any limitations in the Covered Entity's Notice of Privacy Practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of protected health information.
2. The Covered Entity will inform the Business Associate of any changes in, or revocation of, permission by an individual to use or disclose protected health information, to the extent that such changes may affect the Business Associate's use or disclosure of protected health information.
3. The Covered Entity will inform the Business Associate of any restriction to the use or disclosure of protected health information that the Covered Entity has agreed to in accordance with 45 CFR 164.522 and 42 USC 17935, to the extent that such restriction may affect the Business Associate's use or disclosure of protected health information.
4. Except in the event of lawful data aggregation or management and administrative activities, the Covered Entity shall not request the Business Associate to use or disclose protected health information in any manner that would not be permissible under the HIPAA Privacy and Security Rule and the HITECH Act, if done by the Covered Entity.

V. TERM AND TERMINATION

1. **Effect of Termination**:
   a. Except as provided in paragraph (b) of this section, upon termination of this Addendum, for any reason, the Business Associate will return or destroy all protected health information received from the Covered Entity or created, maintained, or received by the Business Associate on behalf of the Covered Entity that the Business Associate still maintains in any form and the Business Associate will retain no copies of such information.
   b. If the Business Associate determines that returning or destroying the protected health information is not feasible, the Business Associate will provide to the Covered Entity notification of the conditions that make return or destruction infeasible. Upon a mutual determination that return or destruction of protected health information is infeasible, the Business Associate shall extend the protections of this Addendum to such protected health information and limit further uses and disclosures of such protected health information to those purposes that make return or destruction infeasible, for so long as the Business Associate maintains such protected health information.
   c. These termination provisions will apply to protected health information that is in the possession of subcontractors, agents, or employees of the Business Associate.
2. **Term**. The Term of this Addendum shall commence as of the effective date of this Addendum herein and shall extend beyond the termination of the contract and shall terminate when all the protected health information provided by the Covered Entity to the Business Associate, or accessed, maintained, created, retained, modified, recorded, stored, or otherwise held, transmitted, used or disclosed by the Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it not feasible to return or destroy the protected health information, protections are extended to such information, in accordance with the termination.
3. **Termination for Breach of Contract**. The Business Associate agrees that the Covered Entity may immediately terminate the Contract if the Covered Entity determines that the Business Associate has violated a material part of this Addendum.

VI. MISCELLANEOUS

1. **Amendment.** The parties agree to take such action as is necessary to amend this Addendum from time to time for the Covered Entity to comply with all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law No. 104-191 and the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, Public Law No. 111-5.
2. **Clarification.** This Addendum references the requirements of HIPAA, the HITECH Act, the Privacy Rule and the Security Rule, as well as amendments and/or provisions that are currently in place and any that may be forthcoming.
3. **Indemnification.** Each party will indemnify and hold harmless the other party to this Addendum from and against all claims, losses, liabilities, costs and other expenses incurred as a result of, or arising directly or indirectly out of or in conjunction with:

a. Any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the party under this Addendum; and
b. Any claims, demands, awards, judgments, actions, and proceedings made by any person or organization arising out of or in any way connected with the party's performance under this Addendum.

4. **Interpretation.** The provisions of the Addendum shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Addendum shall be resolved to permit the Covered Entity and the Business Associate to comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule.
5. **Regulatory Reference.** A reference in this Addendum to a section of the HITECH Act, HIPAA, the Privacy Rule and Security Rule means the sections as in effect or as amended.
6. **Survival.** The respective rights and obligations of Business Associate under Effect of Termination of this Addendum shall survive the termination of this Addendum.

IN WITNESS WHEREOF, the Business Associate and the Covered Entity have agreed to the terms of the above written agreement as of the effective date set forth below.

COVERED ENTITY	BUSINESS ASSOCIATE
Division of Public and Behavioral Health (Enter Division Name)	_____ (Enter Business Name)
4150 Technology Way (Enter Division Address)	_____ (Enter Business Address)
Carson City, NV 89706 (Enter Division City, State and Zip Code)	_____ (Enter Business City, State and Zip Code)
775-684-4200 (Enter Division Phone Number)	_____ (Enter Business Phone Number)
775-684-4211 (Enter Division Fax Number)	_____ (Enter Business Fax Number)
_____ (Authorized Signature)	_____ (Authorized Signature)
Richard Whitley (Print Name)	_____ (Print Name)
Administrator (Title)	_____ (Title)

Washoe County Health District

Public Health
Prevent. Promote. Protect.

STAFF REPORT
BOARD MEETING DATE: September 26, 2013

DATE: September 16, 2013

TO: District Board of Health

FROM: Patsy Buxton, Fiscal Compliance Officer, Washoe County Health District PB
775-328-2418, pbuxton@washoecounty.us

THROUGH: Eileen Stickney, Administrative Health Services Officer, Washoe County Health District, 775-328-2417, estickney@washoecounty.us PB for ES

SUBJECT: Approval of Subgrant Amendment #2 from the Division of Public and Behavioral Health in the total amount of $623,386.50 (with $62,338.65 or 10% match) for the budget period July 1, 2012 through December 31, 2013 in support of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program; approve amendments totaling an increase of $37,058 in both revenue and expense to the FY14 ASPR Hospital Preparedness Federal Grant Program, IO 10708; Authorize travel and travel reimbursements for non-County employees (individuals to be determined) in the approximate amount of $3,000 specific to the Northern Nevada Disaster Victim Recovery Team Project, supported by the grant award; and if approved authorize the Chairman to execute.

SUMMARY

The Washoe County District Board of Health must approve and execute, or direct the Health Officer to execute, contracts in excess of $50,000, Interlocal Agreements and amendments to the adopted budget.

The Washoe County Health District received a Notice of Subgrant Award from the Nevada State Health Division for the period July 1, 2012 through December 31, 2013 in the total amount of $623,386.50 in support of the Public Health Preparedness ASPR Grant Program. A copy of the Subgrant Amendment #2 is attached.

District Board of Health strategic priority: Protect population from health problems and health hazards.

BCC Strategic Objective supported by this item: Safe, Secure and Healthy Communities.

This item supports the Epidemiology and Public Health Preparedness (EPHP) Division's mission to strengthen the capacity of public health infrastructure to detect, assess, and respond decisively to control the public health consequences of bioterrorism events or any public health emergency.

PREVIOUS ACTION
The District Board of Health approved the Notice of Subgrant Award from the Nevada State Health Division in the amount of $404,044 for the period July 1, 2012 to June 30, 2013 insupport of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program at their August 23, 2012 meeting.

BACKGROUND
The Nevada State Health Division has awarded the Public Health Preparedness Program $623,386.50 for the budget period July 1, 2012 through December 31, 2013. Funds will be used to support personnel, travel, other professional services, and operating expenditures. Items include but are not limited to: hydration and nutrition (water/juice/coffee and snacks/light lunch) to be provided for participants in training exercises, meetings and other grant activities to ensure continuity of active participation; Incentives (non-cash value gift cards such as Walmart, Starbucks, etc) to be provided to preparedness training facilitators, etc. who volunteer their time training staff; incentives for meeting and training participants; and MRC program supplies to maintain operations of the MRC unit include signage, binders, certificates, hats, lapel pins, badges, go-bags, first-aid kits, etc.

Included in the award is $20,934 in funding for a Registered Environmental Health Specialist to work on overtime status to complete a Potable Water Project. A Regional Water Emergency Response Guide will be written and will provide the entire region an outline of what happens during a water emergency, to include timeframes of water restoration. The guidance will also include question packets for regional hospitals that would be used in creating annexes to facility Emergency Operations Plans in the event of a water emergency.

The Northern Nevada Disaster Victim Recovery Team project funded by this award is in the second year of development. The focus this year will be on team member development. Trainings will be available for medical examiner's offices, coroner's offices, law enforcement personnel, medical field personnel, and search and rescue personnel on recovery operations. The training will review the systematic approach for recovery procedures to include: gridding, search techniques, photography, numbering, mapping, and packaging of recovered remains. After the trainings a tabletop exercise will be conducted to test the plan that was written during FY13.

The FY14 ASPR Budget was projected at $404,040. Budget period 2 only reflects six months of authority. It is anticipated that a second round of funding in the amount of $219,346.50 will be awarded after the next Interim Finance Committee meeting scheduled for October 22, 2013. There was $13,687 in unspent funds from budget period 1. The budget amendment takes into account receiving the second round of funding and will bring the Notice of Subgrant Award into alignment with the program budget.

This award currently includes $20,913 of indirect revenue. No budget adjustment is needed for the indirect revenue.

This budget amendment will also require Board of County Commissioners approval.

FISCAL IMPACT

Should the Board approve these budget amendments, the adopted FY 14 budget will be **increased by $37,058** in the following accounts:

Account Number	Description	Amount of Increase/(Decrease)
2002-IO-10708-431100	**Federal Revenue**	**$37,058**
	Total Revenue	**$37,058**
2002-IO-10708-701300	Overtime	20,934
2002-IO-10708-701412	Salary Adjustment	(6,584)
2002-IO-10708-705360	Benefit Adjustment	(3,747)
2002-IO-10708-710100	Professional Svcs	19,274
2002-IO-10708-710110	Contracted/Temp Services	(12,500)
2002-IO-10708-710334	Copy Machine Expense	150
2002-IO-10708-710350	Office Supplies	500
2002-IO-10708-710355	Books and Subscriptions	(350)
2002-IO-10708-710360	Postage	(50)
2002-IO-10708-710502	Printing	360
2002-IO-10708-710508	Telephone Land Lines	1,340
2002-IO-10708-710509	Seminars and Meetings	800
2002-IO-10708-710512	Auto Expense	(300)
2002-IO-10708-710872	Food Purchases	(100)
2002-IO-10708-711210	Travel	1,725
2002-IO-10708-711504	Equipment nonCapital	15,606
	Total Expenditures	**$37,058**

RECOMMENDATION

Staff recommends that the Washoe County District Board of Health approve Subgrant Amendment #2 from the Division of Public and Behavioral Health in the total amount of $623,386.50 (with $62,338.65 or 10% match) for the budget period July 1, 2012 through December 31, 2013 in support of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program; approve amendments totaling an increase of $37,058 in both revenue and expense to the FY14 ASPR Hospital Preparedness Federal Grant Program, IO 10708; Authorize travel and travel reimbursements for non-County employees (individuals to be determined) in the approximate amount of $3,000, supported by the grant award; and if approved authorize the Chairman to execute.

POSSIBLE MOTION

Move to approve Subgrant Amendment #2 from the Division of Public and Behavioral Health in the total amount of $623,386.50 (with $62,338.65 or 10% match) for the budget period July 1, 2012 through December 31, 2013 in support of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program; approve amendments totaling an increase of $37,058 in both revenue and expense to the FY14 ASPR Hospital Preparedness Federal Grant Program, IO 10708; Authorize travel and travel reimbursements for non-County employees (individuals to be determined) in the approximate amount of $3,000, supported by the grant award; and if approved authorize the Chairman to execute.

Department of Health and Human Services
Division Public & Behavioral Health
(hereinafter referred to as the DIVISION)

Division #:	13008-2
Program #:	ASPR07-13
Budget Account #:	3218
Category #:	22
GL #:	8516
Job #:	9388913

SUBGRANT AMENDMENT #2

Program Name: Public Health Preparedness Health Planning & Emergency Response Division Public & Behavioral Health	**Subgrantee Name:** Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite #200 Carson City, NV 89706-2009	**Address:** 1001 East Ninth Street Reno, NV 89520
Subgrant Period: July 1, 2012 through June 30, 2017 **Subgrant Budget Period:** July 1, 2012 through December 31, 2013	**Subgrantee's** **EIN#: 88-6000138** **Vendor#: T40283400Q** **Dun & Bradstreet#: 073786998**

Source of Funds:	% of Funds:	CFDA#:	Federal Grant #:
1. ASPR Hospital Preparedness Program	100%	93.889	5U90TP000534-02

Amendment #2:

The purpose of this amendment is to increase the funding by $219,346.50 to cover expenses incurred during six months of Budget Period 2 (July 1, 2013 through December 31, 2013) and to add a new Scope of Work for Budget Period 2 as detailed in Attachment A and B. The new grand total for this subgrant award is $623,386.50.

	Budget Period 1 (7/1/12-6/30/13)	Budget Period 2 (7/1/13-12/31/13)	Grand Total (7/1/12-12/31/13)
1. Personnel	$ 235,762	$ 139,421.00	$ 375,183.00
2. Contractual/Consultant	$ 81,450	$ 32,017.00	$ 113,467.00
3. Travel	$ 9,563	$ 7,862.50	$ 17,425.50
4. Equipment	$ 9,750	$ 14,303.00	$ 24,053.00
5. Supplies	$ 22,006	$ 1,125.00	$ 23,131.00
6. Other	$ 19,053	$ 3,705.00	$ 22,758.00
7. Indirect	$ 26,456	$ 20,913.00	$ 47,369.00
Total Cost	**$ 404,040**	**$ 219,346.50**	**$ 623,386.50**

By signing this Amendment, the Authorized Subgrantee Official or their designee, Program Manager, Bureau Chief, and Health Division Administrator acknowledge the above as the new scope of work for the above referenced Subgrant. Further, the undersigned understand this amendment does not alter, in any substantial way, the non-referenced contents of the Original Subgrant Award and all of its Attachments.

	Signature	Date
Authorized Sub-grantee Official Title		
Erin Seward Health Program Manager II, PHP	Erin Seward	9/5/13
Chad Westom Bureau Chief	Chad Westom	9/6/13
Richard Whitley, MS Administrator, Division of Public and Behavioral Health	Vanessa Alpers for	9.11.13

4 HF 9/6/13 POM 9/11/13

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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD

SECTION A
Assurances

- All original terms and conditions remain unchanged.

SECTION B
Description of services, scope of work, deliverables and reimbursement

- The attached Scope of Work is for Budget Period 2, July 1, 2013 through June 30, 2014 and is broken down by capability, task and function. Attachment A: Capability Summary, shows the estimated allocation of awarded funds and proposed subgrantee effort by capability. Attachment B contains the capabilities under this subgrant award including, but not limited to, the subgrantee planned activities and performance measure planned activities.
- Achievement of Capability Objectives for Budget Period 2 to be completed by June 30, 2014. Outcome of the funded Capabilities will be measured by Division of Public and Behavioral Health. Each funded capability requires substantial achievement and demonstration of completion as specified in the Scope of Work of the funded functions and resource elements. If objectives are not met, Division of Public and Behavioral Health may reduce the amount of this subgrant award and reallocate funding to other preparedness priorities within the state.
- Submit written Progress Reports to the Division of Public & Behavioral Health electronically according to the following schedule. This schedule may change due to availability of reporting templates and scheduled site visits. The Quarterly Reports are cumulative progress reports and should be submitted with the Request for Reimbursement at the end of the month.

  - October 31, 2014 Quarterly Progress Report – Year 2 (For the period of 07/01/13 - 9/30/13)
  - January 31, 2014 Mid Year Progress Report – Year 2 (For the period of 07/01/13 - 12/31/13)
  - April 30, 2014 Quarterly Progress Report – Year 2 (For the period of 07/01/13 – 3/31/14)
  - July 31, 2014 Annual Progress Report – Year 2 (For the period of 07/01/13 - 06/30/14)
  - October 31, 2015 Quarterly Progress Report – Year 3 (For the period of 07/01/14 - 9/30/14)
  - January 31, 2015 Mid Year Progress Report – Year 3 (For the period of 07/01/14 - 12/31/14)
  - April 30, 2015 Quarterly Progress Report – Year 3 (For the period of 07/01/14 – 3/31/15)
  - July 31, 2015 Annual Progress Report – Year 3 (For the period of 07/01/14 – 06/30/15)
  - October 31, 2015 Quarterly Progress Report – Year 4 (For the period of 07/01/15 - 9/30/15)
  - January 15, 2016 Mid Year Progress Report – Year 4 (For the period of 07/01/15 – 12/31/15)
  - April 30, 2016 Quarterly Progress Report – Year 4 (For the period of 07/01/15 – 3/31/16)
  - July 31, 2016 Annual Progress Report – Year 4 (For the period of 07/01/15 – 06/30/16)
  - October 31, 2016 Quarterly Progress Report – Year 5 (For the period of 07/01/16 - 9/30/16)
  - January 15, 2017 Mid Year Progress Report – Year 5 (For the period of 07/01/16 – 12/31/16)
  - April 30, 2017 Quarterly Progress Report – Year 5 (For the period of 07/01/16 – 3/31/17)
  - July 31, 2017 Final Progress Report – Year 5 (For the period of 07/01/16 – 06/30/17)

- Schedule of Quarterly Match/Cost Sharing Reports remains unchanged.

(continued on next page)

Subgrantee agrees to adhere to the following Year 2 budget through December 31, 2013:

1. Personnel	$ 139,431.00		
		Director, Epidemiology & Health Preparedness	5%
		Public Health Preparedness Manager	30%
		Administrative Secretary	50%
		Public Health Emergency Response Coordinator	95%
		Health Educator II	25%
		MRC Program Coordinator	50%
		Public Information Officer	5%
		Public Health Emergency Response Coordinator	5%
		Fringe Benefits (40.75%)	
2. Contractual/ Contract Services	$ 32,017.00	Part-Time Clerical Assistant, Translation/Interpretation Services, Consultant/Contract Services: MRC Training Classes, Northern Nevada Disaster Victim Recovery Team Project (NNDVRT), Continuity of Operations Planning (COOP) Project, NNDVRT Training, Call Center Training and Media Buy.	
3. Travel	$ 7,862.50	In State Travel and Out of State Travel – In compliance with Federal GSA rates	
4. Equipment	$ 14,303.00	WebEOC Annual Maint. Fee for WCHD Instance, WebEOC Annual Maint. Fee for WCHD Resource Manager, Air Purifier Systems, Prox Reader and installation, and Medical Examiner Equipment.	
5. Supplies	$ 1,125.00	Office Supplies and Operating Supplies	
6. Other	$ 3,705.00	Telephone Services, Postage, Copy Machine, Educational Supplies, MRC Program Supplies, Rental Space / Meeting room, and Printing	
7. Indirect	$ 20,913.00	Indirect Costs (15%)	
Total Cost	$ 219,346.50		

- The maximum approved funding under this subgrant has increased by $219,346.50 for six months of Year 2 budget period which covers July 1, 2013 through December 31, 2013. The grand total for this subgrant award is $623,386.50.

- Requests for Reimbursement will be accompanied by supporting documentation, including the Reimbursement Worksheet and any required invoice copies. All Budget Period 1 and Budget Period 2 expenses will be submitted separately. The Budget Period 2 Request for Reimbursement is included in Section C. Requests for Reimbursement are due on or before the 30th of the following month.

- At the end of this budget period WCHD may submit a written request for carry-over of unexpended funding into the next budget period. The carry-over request may not exceed 10% of the current budget period awarded amount or a total equal to or less than $21,934.65. The request to carry-over must be submitted by April 30, 2014 and include a breakdown of estimated carry-over funding by category and by capability, reason or barriers which resulted in the carry-over and the planned scope of work to be completed with these carry-over funds. Please note that a Carry-Over request is not a guarantee.

- Costs associated with food or meals are NOT permitted unless included with per diem as a apart of official travel. Meals cannot be claimed within 50 miles of the official workstation.

- Subgrantee agrees to cost share/match a nonfederal contribution in the amount of 10% ($1 for each $10 of federal funds provided in this subgrant). The Cost Sharing/Match for Budget Year 2 will be $21,934.65 for a grand total Cost Sharing/Match of $62,338.65. This match may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services. Amounts provided by the federal government or services assisted or subsidized to any significant extent by the federal government may not be included in determining the amount of such nonfederal contributions. Documentation of match, including methods and sources must be available upon request of Division Public & Behavioral Health. Subgrantee will sign attached Match Certification (Attachment 1).

- Reimbursement Worksheet will be submitted along with each Request for Reimbursement:
  - Insert detailed breakdown of all monthly expenditures included in the attached reimbursement request (column c).
  - Provide complete travel detail including purpose of travel and attach copies of travel claim summary (if available).
  - Attached invoice copies for all items listed in Contract/Consultant and Equipment. Also attach invoices for all Supplies and Other purchases that are over $500 per item. **NOTE:** Supplies are items which have a consumable live of less than 1 year and Equipment are items over $5,000 per item OR have a consumable live of over 1 year (ie: laptops, iPads, printers, etc...).
  - Return document along with the monthly reimbursement request.

- Budget Request and Justification Form will be submitted along with each Request for Reimbursement:
  - Insert your total monthly expenditure amount from your attached reimbursement request in column a.
  - Provide the percentage of the capabilities these funds are to be applied against in column b.
  - If utilizing an electronic copy, this will auto-populate the dollar amount in column c.
  - Return document along with the monthly reimbursement request.

DIVISION PUBLIC & BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD
SECTION C
Financial Reporting Requirements

Request for Reimbursement form

- A Request for Reimbursement is due on a **monthly** basis, based on the terms of the subgrant agreement, no later than the **30th** of the month.
- Reimbursement is based on **actual** expenditures incurred during the period being reported.
- Payment will not be processed without all reporting being current and without the Reimbursement Worksheet.
- Reimbursement may only be claimed for expenditures approved within the Notice of Subgrant Award.
- **PLEASE REPORT IN DOLLARS and CENTS (No Rounding)**

Provide the following information on the top portion of the form: Subgrantee name and address where the check is to be sent, Health Division (subgrant) number, Bureau program number, draw number, employer I.D. number (EIN) and Vendor number.

An explanation of the form is provided below.

A. Approved Budget: List the approved budget amounts in this column by category.

B. Total Prior Requests: List the **total** expenditures for all previous reimbursement periods in this column, for each category, by entering the numbers found on Lines 1-8, Column D on the **previous** Request for Reimbursement/Advance Form. If this is the first request for the subgrant period, the amount in this column equals zero.

C. Current Request: List the **current** expenditures requested at this time for reimbursement in this column, for each category.

D. Year to Date Total: Add Column B and Column C for each category.

E. Budget Balance: Subtract Column D from Column A for each category.

F. Percent Expended: Divide Column D by Column A for each category and total. Monitor this column; it will help to determine if/when an amendment is necessary. Amendments MUST be completed (including all approving signatures) 30 days **prior** to the end of the subgrant period.

Nevada Department of Health and Human Services

Division Public & Behavioral Health

Public Health Preparedness Program

GRAND TOTAL

Division #: 13008-2
Program #: ASPR07-13
GL #: 8516
Job #: 9388913
Draw #: _____

REQUEST FOR REIMBURSEMENT

Program Name:	**Subgrantee Name:**
Public Health Preparedness Health Planning & Emergency Response Nevada State Health Division	Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite 200 Carson City, NV 89706	**Address:** 1001 East Ninth Street Reno, NV 89520
Subgrant Period: July 1, 2012 through June 30, 2017 **Subgrant Budget Period:** July 1, 2012 through December 31, 2013	**Subgrantee EIN #:** 88-6000138 **Subgrantee Vendor #:** T40283400Q **Dun & Bradstreet #:** 073786998

FINANCIAL REPORT AND REQUEST FOR FUNDS

(report in dollars and cents; must be accompanied by expenditure report/back-up)

Month(s): **Calendar Year:**

	Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year To Date Total	E Budget Balance	F Percent Expended
1	Personnel	$ 375,183.00	$ 235,761.68	$ 0.00	$ 235,761.68	$ 139,421.32	63%
2	Contract/Consultant	$ 113,467.00	$ 75,385.94	$ 0.00	$ 75,385.94	$ 38,081.06	0%
3	Travel	$ 17,425.50	$ 8,850.11	$ 0.00	$ 8,850.11	$ 8,575.39	51%
4	Supplies	$ 22,131.00	$ 17,718.40	$ 0.00	$ 17,718.40	$ 5412 WH 4,412.60	80%
5	Equipment	$ 24,053.00	$ 9,750.00	$ 0.00	$ 9,750.00	$ 14,303.00	0%
6	Other	$ 22,758.00	$ 17,156.35	$ 0.00	$ 17,156.35	$ 5,601.65	0%
7	Indirect	$ 47,369.00	$ 25,730.89	$ 0.00	$ 25,730.89	$ 21,638.11	0%
8	**Total**	$ 622,386.50	$ 390,353.37	$ 0.00	$ 390,353.37	$ 232,033.13	63%

This report is true and correct to the best of my knowledge.

Authorized Signature Title Date

Reminder: Request for Reimbursement cannot be processed without an expenditure report/backup. Reimbursement is only allowed for items contained within Subgrant Award documents. If applicable, travel claims must accompany report.

FOR HEALTH DIVISION USE ONLY

Program contact necessary? _____ Yes _____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____ Signed: _____

Scope of Work review/approval date: _____ Signed: _____

ASO or Bureau Chief (as required): _____ Date: _____

Nevada Department of Health and Human Services

Division Public & Behavioral Health

Public Health Preparedness Program

BUDGET PERIOD 1

Division #: 13008-1
Program #: ASPR07-12
GL #: 8516
Job #: 9388912B
Draw #: _____

REQUEST FOR REIMBURSEMENT

Program Name:	**Subgrantee Name:**
Public Health Preparedness Health Planning & Emergency Response Nevada State Health Division	Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite 200 Carson City, NV 89706	**Address:** 1001 East Ninth Street Reno, NV 89520
Subgrant Period: July 1, 2012 through June 30, 2017 **Subgrant Budget Period:** July 1, 2012 through June 30, 2013	**Subgrantee EIN #:** 88-6000138 **Subgrantee Vendor #:** T40283400Q **Dun & Bradstreet #:** 073786998

FINANCIAL REPORT AND REQUEST FOR FUNDS

(report in dollars and cents; must be accompanied by expenditure report/back-up)

Month(s): **Calendar Year:**

	Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year To Date Total	E Budget Balance	F Percent Expended
1	Personnel	$ 235,762.00	$ 235,761.68	$ 0.00	$ 235,761.68	$ 0.32	100%
2	Contract/Consultant	$ 81,450.00	$ 75,385.94	$ 0.00	$ 75,385.94	$ 6,064.06	0%
3	Travel	$ 9,563.00	$ 8,850.11	$ 0.00	$ 8,850.11	$ 712.89	93%
4	Supplies	$ 22,006.00	$ 17,718.40	$ 0.00	$ 17,718.40	$ 4,287.60	81%
5	Equipment	$ 9,750.00	$ 9,750.00	$ 0.00	$ 9,750.00	$ 0.00	0%
6	Other	$ 19,053.00	$ 17,156.35	$ 0.00	$ 17,156.35	$ 1,896.65	0%
7	Indirect	$ 26,456.00	$ 25,730.89	$ 0.00	$ 25,730.89	$ 725.11	0%
8	**Total**	$ 404,040.00	$ 390,353.37	$ 0.00	$ 390,353.37	$ 13,686.63	97%

This report is true and correct to the best of my knowledge.

Authorized Signature Title Date

Reminder: Request for Reimbursement cannot be processed without an expenditure report/backup. Reimbursement is only allowed for items contained within Subgrant Award documents. If applicable, travel claims must accompany report.

FOR HEALTH DIVISION USE ONLY

Program contact necessary? _____ Yes _____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____ Signed: _____

Scope of Work review/approval date: _____ Signed: _____

ASO or Bureau Chief (as required): _____ Date: _____

Nevada Department of Health and Human Services

Division Public & Behavioral Health

Public Health Preparedness Program

BUDGET PERIOD 2

Division #: 13008-2
Program #: ASPR07-13
GL #: 8516
Job #: 9388913
Draw #: _____

REQUEST FOR REIMBURSEMENT

Program Name: Public Health Preparedness Health Planning & Emergency Response Nevada State Health Division	**Subgrantee Name:** Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite 200 Carson City, NV 89706	**Address:** 1001 East Ninth Street Reno, NV 89520
Subgrant Period: July 1, 2012 through June 30, 2017 **Subgrant Budget Period:** July 1, 2013 through December 31, 2013	**Subgrantee EIN #:** 88-6000138 **Subgrantee Vendor #:** T40283400Q **Dun & Bradstreet #:** 073786998

FINANCIAL REPORT AND REQUEST FOR FUNDS

(report in dollars and cents; must be accompanied by expenditure report/back-up)

Month(s): **Calendar Year:**

	Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year To Date Total	E Budget Balance	F Percent Expended
1	Personnel	$ 139,421.00	$ 0.00	$ 0.00	$ 0.00	$ 139,421.00	0%
2	Contract/Consultant	$ 32,017.00	$ 0.00	$ 0.00	$ 0.00	$ 32,017.00	0%
3	Travel	$ 7,862.50	$ 0.00	$ 0.00	$ 0.00	$ 7,862.50	0%
4	Supplies	$ 125.00	$ 0.00	$ 0.00	$ 0.00	$ 125.00	0%
5	Equipment	$ 14,303.00	$ 0.00	$ 0.00	$ 0.00	$ 14,303.00	0%
6	Other	$ 3,705.00	$ 0.00	$ 0.00	$ 0.00	$ 3,705.00	0%
7	Indirect	$ 20,913.00	$ 0.00	$ 0.00	$ 0.00	$ 20,913.00	0%
8	**Total**	$ 218,346.50	$ 0.00	$ 0.00	$ 0.00	$ 218,346.50	0%

This report is true and correct to the best of my knowledge. 218346.50

Authorized Signature Title Date

Reminder: Request for Reimbursement cannot be processed without an expenditure report/backup. Reimbursement is only allowed for items contained within Subgrant Award documents. If applicable, travel claims must accompany report.

FOR HEALTH DIVISION USE ONLY

Program contact necessary? _____ Yes _____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____ Signed: _____

Scope of Work review/approval date: _____ Signed: _____

ASO or Bureau Chief (as required): _____ Date: _____

Washoe County Health District (WCHD)
Reimbursement Worksheet
July 1 - July 31, 2013

Personnel	Title	Description	Amount
		TOTAL	

Contract / Consultant	Description	Amount
	TOTAL	

Travel (Name of Traveler)	Travel Dates	To	Mileage @ $0.565/mi	Lodging & Per Diem	AirFare & Misc	Purpose/ Description	Amount
						TOTAL	

Supplies	Description	Amount
	TOTAL	

Equipment	Description (attach invoice copies for all items)	Amount
	TOTAL	

Other	Description	Amount
	TOTAL	

Indirect	Description	Amount
	TOTAL	
	TOTAL EXPENDITURES	

Division Public & Behavioral Health : Public Health Preparedness
Assistant Secretary for Preparedness and Response: Hospital Preparedness Program
Budget Request and Justification Form
Washoe County Health District
July 1, 2013 through June 30, 2014

Contact Name: Jeff Whitesides
Phone Number: 775-328-6130
E-Mail Address: jwhitesides@washoecounty.us
Applicant/Agency Name: WCHD
Total Agency Request: $438,693 -- Year 2

** Insert your total monthly expenditure amount below from your attached reimbursement request in column a. Provide the percentage of the capabilities these funds are to be applied against in column b. If utilizing an electronic copy this will auto-populate the dollar amount in column c. Return this document along with your monthly reimbursement request. This will provide a tracking to expedite the mid- and end-of-year progress reporting.
**Please contact us if you have any questions.

Budget Summary

	(a)	(b)	(c)
Monthly Expenditure:		Current % Utilized	Current $ Utilized
1. Healthcare System Preparedness			
F1: Develop, refine, or sustain Healthcare Coalitions			$ -
F2: Coordinate healthcare planning to prepare the healthcare system for a disaster			$ -
F3: Indentify and prioritize essential healthcare assets and services.			$ -
F4: Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps			$ -
F5: Coordinate training to assist healthcare responders to develop the necessary skills in order to respond			$ -
F6: Improve healthcare response capabilities through coordinated exercise and evaluation			$ -
F7: Coordinate with planning for at-risk individuals and those with special medical needs			$ -
2. Healthcare System Recovery:			
F1: Develop recovery processes for the healthcare delivery system			$ -
F2: Assist healthcare organizations to implement Continuity of Operations (COOP)			$ -
3. Emergency Operations Coordination:			
F1: Healthcare organization multi-agency representation and coordination with emergency operations			$ -
F2: Assess and notify stakeholders of healthcare delivery status			$ -
F3: Support healthcare response efforts through coordination of resources			$ -
F4: Demobilize and evaluate healthcare operations			

5. Fatality Management:		
F1: Coordinate surges of deaths and human remains at healthcare organizations with community fatality management operations	_____	$ -
F2: Coordinate surges of concerned citizens with community agencies responsible for family assistance	_____	$ -
F3: Mental/behavioral support at the healthcare organization level	_____	$ -
6. Information Sharing:		
F1: Provide healthcare situational awareness that contributes to the incident common operating picture.	_____	$ -
F2: Develop, refine, and sustain redudant, interaperable communication systems	_____	$ -
10. Medical Surge:		
F1: The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge	_____	$ -
F2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services	_____	$ -
F3: Assist healthcare organizations with surge capacity and capability	_____	$ -
F4: Develop Crisis Standards of Care guidance	_____	$ -
F5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations	_____	$ -
14. Responder Safety and Health		
F1: Assist healthcare organizations with additional pharmaceutical protection for healthcare workers	_____	$ -
F2: Provide assistance to healthcare organizations with access to additional Personal Protective Equipment.		
15. Volunteer Management:		
F1: Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations	_____	$ -
F2: Volunteer notification for healthcare response needs	_____	$ -
F3: Organization and assignment of volunteers	_____	$ -
F4: Volunteer notification for healthcare response needs	_____	
		$ -

ATTACHMENT 1

ASPR07-13

Nevada State / Division Public & Behavioral Health
Public Health Preparedness Program
Match Certification

Date: 9/16/13

External Funding Source: 2012 ASPR Hospital Preparedness Program (HPP)

A mandatory cost sharing/matching cost contribution is required for the following proposal:

Funding Recipient: Washoe County Health District (WCHD)

Project Title: HPP and PHEP Cooperative Agreement

Project Grant #: 5U90TP000534-02

Duration: **From:** July 1, 2013 **To:** December 31, 2013

Total cost sharing/matching cost contribution: $21,934.65 / Percentage: 10%

Source of cost sharing/matching cost contribution:

Name: Washoe County Health District

Account # (if applicable):

Funding recipient hereby certifies that the identified cost sharing/matching cost contribution is not being used to match any other funding source.

Washoe County Health District		9/16/13
Name and Title (Funding Recipient)	**Signature**	**Date**

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Attachment A: Capability Summary

Washoe County Health District (WCHD)
ASPR Hospital Preparedness Program (BP2) Subgrant # ASPR07-13
July 1, 2013 - June 30, 2014
Funding - Budget Perod 2: $ 438,693

Budget %	Fund Allocation	Capability / Function Name				
30.24%	$132,666	1	Healthcare System Preparedness			
		Build	F1	Determine risks to the health of the jurisdiction		
			Sustain	T1	Form a collaborative preparedness planning group that provides integration, coordination, and organization for the purpose of regional healthcare preparedness activities and response coordination.	
			Build	T2	Provide a regional healthcare multi-agency coordination function to share incident specific healthcare situational awareness to assist with resource coordination during response and recovery activities	
				Build	P1	Healthcare Coalition regional boundaries
				Build	P2	Healthcare Coalition primary members
				Build	P3	Healthcare Coalition essential partner memberships
				Build	P4	Additional Healthcare Coalition partnerships/memberships
				Build	P5	Healthcare Coalition organization and structure
				Build	P6	Multi-agency coordination during response
		Build	F2	Coordinate healthcare planning to prepare the healthcare system for a disaste		
			Build	T1	Engage relevant response and healthcare partners to assess the probability of hazards deemed likely to affect the healthcare delivery capability within a geographic area and prioritize response and mitigation activities given available resources.	
			No Activity	T2	Engage healthcare partners to coordinate healthcare planning efforts with local and state emergency operations planning to integrate healthcare organization priorities and unique needs into response and recovery operations.	
				Build	P1	Healthcare system situational assessments
				Build	P2	Healthcare System disaster planning
		Build	F3	Identify and prioritize essential healthcare assets and services.		
			Build	T1	Identify and prioritize the essential healthcare assets and services of the community	
			No Activity	T2	Coordinate planning and preventative measures to assist with the protection of prioritized healthcare assets and essential services.	
				Build	P1	Identify and prioritize critical healthcare assets and essential services
				No Activity	P2	Priority healthcare assets and essential services planning
				Build	P3	Equipment to assist healthcare organizations with the provision of critical services

Attachment A: Capability Summary

		Build	F4		Determine gaps in the healthcare preparedness and identify resources for mitigation of	
			Sustain	T1	Perform a resource assessment by analyzing healthcare organization needs and evaluating exercises, training, and actual incidents or events to determine gaps and corrective action.	
			Build	T2	Deconflict resources by ensuring response resources are not over allocated to multiple stakeholders within the community	
				Build	P1	Healthcare resource assessment
				Build	P2	Healthcare resource coordination
				No Activity	P3	Address healthcare information gaps
		Sustain	F5	Coordinate training to assist healthcare responders to develop the necessary skills in order to respond.		
			Sustain	T1	Assist with the provision of National Incident Management System training for healthcare organizations in order to refine and improve response knowledge, skills, and abilities in accordance with the National Response Framework (NRF).	
			Sustain	T2	Assist with the provision of training for healthcare organizations based on existing response gaps in order to improve and refine required response knowledge, skills, and abilities.	
				Sustain	P1	Healthcare organization — National Incident Management System (NIMS) training.
				No Activity	P2	Training to address healthcare gaps and corrective actions.
		Sustain	F6	Improve healthcare response capabilities through coordinated exercise and evaluation		
			Sustain	T1	Coordinate and implement capability based exercises that test disaster planning efforts .	
			Build	T2	Utilize a coordinated evaluation method to evaluate exercises and actual incident responses	
			Sustain	T3	Address findings from gap analysis and subsequent corrective actions to revise planning, training, and exercises to minimize response gaps.	
				Build	P1	Exercise plans
				Build	P2	Exercise implementation and coordination
				Build	P3	Evaluation and improvement plans
				Build	P4	Best practice and lessons learned sharing
				Build	S1	Evaluation and improvement plans
		Build	F7	Coordinate with planning for at-risk individuals and those with special medical needs.		
			Build	T1	Participate in the planning process that identifies and determines multiple care options for individuals with special medical needs that are not suitable for mass care shelters and require care at medical facilities during incidents.	
			No Activity	T2	Participate in coordinated planning with public health and ESF#6 agencies to determine protocols for the transfer of patients between mass care and healthcare settings during a disaster.	
				Build	P1	Healthcare planning for at-risk individuals and functional needs.
				Build	P2	Special medical needs planning

Attachment A: Capability Summary

7.87%	**$34,512**	**2**	Healthcare System Recovery			
		Build	**F1**	Develop recovery processes for the healthcare delivery system		
			Build	**T1**	Assess the impact of an incident on the healthcare systems ability to deliver essential services to the community and prioritize healthcare recovery needs	
			No Activity	**T2**	Promote healthcare organization participation in state and/or local pre- and post-disaster recovery planning activities as described in the National Disaster Recovery Framework (NRDF) in order to leverage recovery resources, programs, projects, and activities	
				Build	**P1**	Healthcare recovery planning
				Build	**P2**	Assessment of healthcare delivery recovery needs post disaster
				No Activity	**P3**	Healthcare organization recovery assistance and participation
		Build	**F2**	Assist healthcare organizations to implement Continuity of Operations		
			Build	**T1**	Identify the healthcare essential services that must be continued to maintain healthcare delivery following a disaster	
			Build	**T2**	Encourage healthcare organizations to identify the components of a fully functional COOP and develop corresponding plans for implementation.	
			No Activity	**T3**	If a disaster notice can be provided, alert healthcare organizations within communities threatened by disaster and if requested and feasible, assist them with the activation of COOP such that healthcare delivery to the community is minimally impacted.	
			No Activity	**T4**	Develop coordinated healthcare strategies to assist healthcare organizations transition from COOP operations to normalcy or the new norm for healthcare operations	
				Build	**P1**	COOP planning assistance for healthcare organizations
				Build	**P2**	Healthcare organization COOP implementation assistance
				Build	**P3**	Healthcare organization recovery assistance
8.54%	**$37,475**	**3**	Emergency Operations Coordination			
		Sustain	**F1**	Conduct preliminary assessment to determine need for public activation.		
			Sustain	**T1**	Determine the process for healthcare organizations representation with local and state emergency operations during an incident response	
				Sustain	**P1**	Healthcare organization multi-agency coordination during response
				No Activity	**P2**	Healthcare organization and emergency operations decision coordination
		Sustain	**F2**		Assess and notify stakeholders of healthcare delivery status	
			Sustain	**T1**	During an incident, implement information sharing processes that supports ongoing communication to inform local incident management of the operational status and resource needs of healthcare organizations	
			Sustain	**T2**	During an incident, implement information sharing processes that supports ongoing communication to inform healthcare organizations about the status of the incident and of healthcare delivery in the community	

			No Activity	T3	During an incident, implement coordinated information sharing processes that provide relevant and timely healthcare messages to the community and other stakeholders through a Joint Information System (JIS)	
				Build	P1	Healthcare organization resource needs assessment
				Build	P2	Incident information sharing
				No Activity	P3	Community notification of healthcare delivery status
		No Activity	F3		Support healthcare response efforts through coordination of resources	
		No Activity	F4	Demobilize and evaluate healthcare operations		
24.58%	**$107,835**	**5**	Fatality Management			
		Sustain	F1	Coordinate surges of deaths and human remains at healthcare organizations with		
			Sustain	T1	Prior to an incident, assist healthcare organizations with determining the amount of morgue space that is available to them duringperiods of death surges and develop the processes to request support from local and state agencies.	
			Sustain	T2	Prior to an incident, coordinate with healthcare organizations to identify alternate storage and disposal options for human remains	
				Build	P1	Anticipate storage needs for a surge of human remains
				Build	P2	Healthcare organization human remain surge plans
				Build	E1	Mortuary storage equipment and supplies
		Build	F2	Coordinate surges of concerned citizens with community agencies responsible for family assistance		
			Build	T1	Prior to an incident, assist healthcare organizations by coordinating options for surges of concerned citizens and their direction to the appropriate location for family assistance when these surges arrive at the facility seeking family member information.	
				Build	P1	Procedures for a surge of concerned citizens
		Build	F3	Mental/behavioral support at the healthcare organization level.		
			Build	T1	Coordinate the options for mental/Behavioral support for healthcare organizations during disasters which cause a death surge involving a large amount of human remains.	
				Build	P1	Mental/behavioral health support
8.86%	**$38,880**	**6**	Information Sharing			
		Build	F1	Provide healthcare situational awareness that contributes to the incident common		
			Build	T1	Before an incident, identify the essential elements of incident specific healthcare information that are timely, relevant, actionable, and can be reasonably delivered during the response.	
			Build	T2	Before, during, and after an incident, utilize coordinated information sharing protocols to receive and transmit timely, relevant, and actionable incident specific healthcare information to incident management during response and recovery.	

Attachment A: Capability Summary

				Build	P1	Healthcare information sharing plan
				Build	P2	Healthcare essential elements of information
				Build	P3	Healthcare incident information validation
				No Activity	P4	Healthcare information sharing with the public
				No Activity	P5	Bed tracking
				No Activity	P6	Patient tracking
				No Activity	P7	Patient record tracking
				Build	E1	Healthcare information systems
				No Activity	E2	Bed tracking system
				No Activity	E3	Patient tracking system
				Build	S1	Bed tracking system training
		Build	F2	Develop, refine, and sustain redundant, interoperable communication systems		
			Sustain	T1	Before, during, and after an incident or event, have redundant processes and systems to communicate with the appropriate multijurisdictional and multidisciplinary emergency responders	
			Build	T2	Before, during, and after an incident or event, have redundant processes and systems to communicate the status of the incident and the status of the community healthcare delivery to healthcare organizations.	
				Build	P1	Interoperable communications plans
				No Activity	E1	Interoperable communication system
				No Activity	S1	Communication training
2.22%	$9,756	10	Medical Surge			
		No Activity	F1	The Healthcare Coalition assists with the coordination of the healthcare organization		
		Build	F2	Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical		
			Build	T1	Promote information sharing processes that enable healthcare organizations to track the status and transport of patients from EMS during medical surge incidents.	
			Build	T2	Provide training and guidance to encourage healthcare organizations to understand EMS disaster triage protocols and CBRNE treatment protocols that assist with the transition of disaster patients from the field to the facility.	
				Build	P1	Healthcare organization coordination with EMS during response
				Build	P2	Coordinated disaster protocols for triage, transport, documentation, CBRNE
				Build	S1	Training on local EMS disaster triage methodologies
				No Activity	S2	Coordinated CBRNE training
		No Activity	F3	Assist healthcare organizations with surge capacity and capability		
		No Activity	F4	Develop Crisis Standards of Care guidance		
		No Activity	F5	Provide assistance to healthcare organizations regarding evacuation and shelter in place		

3.81%	$16,713	14	Responder Safety and Health			
		Build	F1	Assist healthcare organizations with additional pharmaceutical protection for healthcare		
			Build	T1	Identify the pharmaceuticals needed to safeguard healthcare workers and their families when indicated by a biological infectious disease or during a likely exposure incident identified through risk assessments, hazards vulnerability assessments (HVAs), and resource needs.	
			Build	T2	Assess the need for developing pharmaceutical caches that can be accessed by healthcare organizations when requested and available during an exposure/incident.	
			Build	T3	Establish the appropriate processes to deliver caches of pharmaceuticals to healthcare organizations during an exposure requiring prophylaxis and treatment when requested and available.	
				Build	P1	Pharmaceutical needs assessment
				Build	P2	Pharmaceutical cache storage, rotation, replacement, and distribution
				Build	P3	Medical Countermeasure dispensing
				Build	E1	Pharmaceutical cache protection
				Build	S1	Pharmaceutical cache training
		Build	F2	Provide assistance to healthcare organizations with access to additional Personal Protective Equipment		
			Build	T1	Prior to an incident, and as applicable during an incident, work with subject matter experts to identify responder safety and health resource requirements	
			Build	T2	Prior to an incident, and as applicable during an incident, and in conjunction with subject matter experts, formulate recommendations to public health responders regarding personal protective equipment that are consistent with local jurisdictional requirements.	
				Build	P1	Personal protective equipment needs assessment
				Build	P2	Personal protective equipment caches
				No Activity	P3	Personal protective equipment supply and dispensing
				Build	E1	Personal Protective Equipment for healthcare workers
				Build	S1	Personal protective equipment training
13.87%	$60,856	15	Volunteer Management			
		Sustain	F1	Participate with volunteer planning processes to determine the need for volunteers in		
			Sustain	T1	Assess which situations would necessitate the need for the use of volunteers in healthcare organizations during response and participate in the planning that would provide this as an option when needed.	
			Sustain	T2	Identify the type and quantity of volunteers most likely needed to support healthcare response based on the risk assessments, hazard vulnerability assessments, resource assessments and other data that may provide clarity into anticipated needs.	

Attachment A: Capability Summary

			Sustain	T3	Prior to an incident or event, participate with volunteer planning for pre-incident screening and verification of volunteers' credentials for healthcare professionals that may be used in healthcare organizations.		
			Sustain	T4	Prior to an incident or event, participate with training initiatives for the planning of initial and ongoing emergency response training for registered volunteers that may be used in healthcare organizations during response.		
				Sustain	P1	Volunteer needs assessment for healthcare organizations response.	
				Sustain	P2	Collect, assemble, maintain, and utilize volunteer information	
				Sustain	E1	Electronic volunteer registration system	
		Sustain	F2	Volunteer notification for healthcare response needs			
			Sustain	T1	At the time of an incident, determine the volunteers needed to assist the healthcare organization response including the role and quantity of volunteers needed; communicate requests using the established volunteer request process.		
				Sustain	P1	Process to contact registered volunteers	
				Sustain	P2	Process to confirm credentials of responding volunteers	
				Sustain	P3	Volunteer request process	
		Sustain	F3	Organization and assignment of volunteers			
			Sustain	T1	Develop a process to assist healthcare organizations with volunteer placement during an incident that includes multi-agency coordination between healthcare organizations in order to deconflict the needs of multiple healthcare organizations with the availability of volunteers.		
			Sustain	T2	Develop a process to assist healthcare organizations with the provision of deployment briefings, tracking and rotation of volunteers, spontaneous volunteer management, safety and incident-specific training.		
				Sustain	P1	Volunteer deployment protocols	
				Sustain	P2	Briefing template for healthcare volunteers	
				Sustain	P3	Volunteer support services	
		Build	F4	Coordinate the demobilization of volunteers			
			Build	T1	Coordinate with incident management and the appropriate jurisdictional volunteer organizations to ensure the proper outprocessing of volunteers.		
			Build	T2	Coordinate with incident management and the appropriate jurisdictional volunteer organizations to identify community resources that can support volunteer post-deployment medical screening, stress, well-being assessments and, when requested or indicated, have a process to refer volunteers to medical and mental/behavioral health services.		
				Sustain	P1	Volunteer release processes	
				Sustain	P2	Volunteer exit screening protocols	
100.00%	**$438,693**	**TOTAL (Must equal 100%)**					

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Washoe County Health District
ASPR Hospital Preparedness Program (BP2) Subgrant # ASPR07-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

HPP Capability # 1: Healthcare System Preparedness

Description: Healthcare system preparedness is the ability of a community's healthcare system to prepare, respond, and recover from incidents that have a public health and medical impact in the short and long term. The healthcare system role in community preparedness involves coordination with emergency management, public health, mental/behavioral health providers, community and faith based
partners, state, local, and territorial governments to do the following:
- Provide and sustain a tiered, scalable, and flexible approach to attain needed disaster response and recovery capabilities while not jeopardizing services to individuals in the community
- Provide timely monitoring and management of resources
- Coordinate the allocation of emergency medical care resources
- Provide timely and relevant information on the status of the incident and healthcare system to key stakeholders

Healthcare system preparedness is achieved through a continuous cycle of planning, organizing and equipping, training, exercises, evaluations and corrective actions.

Goal: Build resilience through collaboration with community partners. Hold discussions and formalize significant decisions affecting collaboration among coalition members as part of preparedness activities. Avoid ambiguities that would otherwise burden responders and slow down a health response.

Performance Measures: Percent of healthcare coalitions (HCCs) that have established formalized agreements and demonstrate their ability to function and execute the capabilities for healthcare preparedness, response, and recovery as defined in Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness. Below are the data elements that must be reported on for this capability at mid-year and end of year.

Allocated funding: **$132,666**

Performance Measure Data Element:
HPP 1.1: Are there formal documents such as: Memoranda of Understanding (MOUs), Mutual Aid Agreements (MAAs), Interagency Agreement (IAAs), articles of incorporation, letters of agreement, contracts, charters, or other supporting formal documents that define:
1.1.1 - The member organizations of the HCC?
1.1.2 - Formal agreement to aid coalition members and to share resources and information
1.1.3 - A process to allow representation of subject matter experts (SMEs) to the HCC?
1.1.4 - Joint or cooperative activities with non-healthcare constituencies?
1.1.5 - Formal agreements to prepare to respond as part of the HCC?
HPP 1.2: Has the HCC established a formal self-governance structure (e.g., By-laws for the board of directors and a charter that is multidisciplinary and representative of all members of the coalition)?
HPP 1.3: Please estimate the total percentage of the State population covered by each HCC within the State.
HPP 1.4: Does the HCC include emergency management and public health as integral partners?
HPP 1.5: Has the HCC and its members participated in at least one HSEEP-compliant exercise to test State, regional and facility-level healthcare disaster plans considering scenarios identified by a Hazard Vulnerability Assessment (HVA) within the past year
1.5.1 - If so, did the HCC achieve its established exercise participation goals for its member organizations' engagement in exercises or real events to test State, regional and

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

facility-level healthcare disaster plan?
1.5.2 - If so, did the exercises or real events to test State, regional and facility-level healthcare disaster plans demonstrate the HCC capabilities to function as a coordinated entity?
HPP 1.6: Has the HCC successfully implemented "lesson learned" and corrective actions from an exercise or event within the past year?

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
The WCHD will continue to sustain current activities that assist with healthcare preparedness while building new capabilities within the region.	Through the current activities and planning process, an electronic patient tracking system will be designed as well as a regional potable water plan.	• Electronic patient tracking system • Potable water plan • Resource list for Access & Functional Needs citizens • Community Assessment of healthcare assets and equipment • Revised hospital mass fatality annex • Revised healthcare requesting procedures

Function #1: Determine risks to the health of the jurisdiction

Objective

WCHD will continue to participate and administratively support the existing healthcare coalition, the Inter-Hospital Coordinating Council (IHCC) to include reviewing and revising response and recovery procedures as identified by the IHCC.

Task 1: Form a collaborative preparedness planning group that provides integration, coordination, and organization for the purpose of regional healthcare preparedness activities and response coordination (See Pg 1)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$4,866	Continue to participate in and administratively support the IHCC and the Skilled Nursing Facility Emergency Preparedness Committee	June 30, 2014	• Attend monthly IHCC meetings and provide agenda and meeting minute support. • Attend quarterly Skilled Nursing Facility meetings and provide agenda and meeting minute support.

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Attachment B: Scope of Work by Capability

Task 2: Provide a regional healthcare multi-agency coordination function to share incident specific healthcare situational awareness to assist with resource coordination during response and recovery activities (See Pg 1)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$13,922	Continue to work with the Inter-Hospital Coordinating Council to create a healthcare coalition that will assist with response and recovery during an incident.	June 30, 2014	▫ Update IHCC bylaws to incorporate regional boundaries represented and the primary/essential members. ▫ Revised hospital requesting procedures

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare Coalition regional boundaries (See Pg 2)	Build	WCHD will continue to participate in and administratively support the Inter-Hospital Coordinating Council.	Updated IHCC bylaws to incorporate regional boundaries represented and the primary/essential members
Planning Resource Element 2: Healthcare Coalition primary members (See Pg 2)	Build	WCHD will continue to participate in and administratively support the Inter-Hospital Coordinating Council.	Updated IHCC bylaws to incorporate the primary/essential members
Planning Resource Element 3: Healthcare Coalition essential partner memberships (See Pg 2)	Build	WCHD will continue to participate in and administratively support the Inter-Hospital Coordinating Council.	Updated IHCC bylaws to incorporate the primary/essential members
Planning Resource Element 4: Additional Healthcare Coalition partnerships/memberships (See Pg 2)	Build	WCHD will continue to participate in and administratively support the Inter-Hospital Coordinating Council.	Updated IHCC bylaws to incorporate the primary/essential members
Planning Resource Element 5: Healthcare Coalition Organization and Structure (See Pg 3)	Build	WCHD will continue to participate in and administratively support the Inter-Hospital Coordinating Council.	Updated IHCC bylaws to reflect the organizational structure and member information
Planning Resource Element 6: Multi-agency coordination during response (See Pg 3)	Build	WCHD will design and build an electronic patient tracking system within WebEOC to be utilized by regional healthcare partners.	Development of electronic patient tracking system.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Function #2: Coordinate healthcare planning to prepare the healthcare system for a disaster.

Objective

By the end of Budget Period 2, WCHD will have coordinated planning efforts that had previously been identified as gaps to prepare the healthcare organizations for an emergency.

Task 1: Engage relevant response and healthcare partners to assess the probability of hazards deemed likely to affect the healthcare delivery capability within a geographic area and prioritize response and mitigation activities given available resources. (See Pg 4)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$29,810	As identified through a community exercise, the WCHD will facilitate the development of a Regional Water Emergency Restoration Plan.	June 30, 2014	• Regional Water Emergency Restoration Plan • Regional healthcare template to utilize for individual organizational planning.

Task 2: Engage healthcare partners to coordinate healthcare planning efforts with local and state emergency operations planning to integrate healthcare organization priorities and unique needs into response and recovery operations. (See Pg 4)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare system situational assessments. (See Pg 4)	Build	WCHD will work in collaboration with Carson City Health and Human Services to develop a list of resources within Northern Nevada that serve citizens with Access or Functional Needs.	• Work through the Northern Nevada Access and Functional Needs workgroup to develop a list of services available to citizens within the region. • Reach out to the identified organizations to get them involved in the workgroup.

Planning Resource Element 2: Healthcare System disaster planning. (See Pg 5)	Build	WCHD will write a Regional Water Emergency Restoration Plan.	◦ All regional hospitals will be involved in the review of the Regional Water Emergency Restoration Plan relating specifically to healthcare organizations. ◦ Regional Water Emergency Restoration Plan

Function #3: Identify and prioritize essential healthcare assets and services.

Objective

Beginning in Budget Period 2 and completing by mid-year of Budget Period 3, WCHD will have identified critical care and equipment assets within the region for use by healthcare organizations during an incident.

Task 1: Identify and prioritize the essential healthcare assets and services of the community (See Pg 4)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$8,717	WCHD will perform a community assessment to identify and prioritize healthcare assets and essential services imperative to healthcare delivery during an emergency.	June 30, 2014	A list of key resources to include: ◦ Critical Medical Services ◦ Critical medical support services ◦ Critical facility management services ◦ Critical healthcare information systems

Task 2: Coordinate planning and preventative measures to assist with the protection of prioritized healthcare assets and essential services (See Pg 4)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Identify and prioritize critical healthcare assets and essential services (See Pg 6)	Build	Beginning in Budget Period 2, WCHD will perform a community assessment to identify and prioritize healthcare assets and essential services imperative to healthcare delivery during an emergency.	Develop a list of key resources to include: ◦ Critical Medical Services ◦ Critical medical support services ◦ Critical facility management services ◦ Critical healthcare information systems

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Planning Resource Element 2: Priority healthcare assets and essential services planning (See Pg 6)	No Activity		
Equipment & Technology 1: Equipment to assist healthcare organizations with the provision of critical services (See Pg 6)	Build	By the end of Budget Period 2, WCHD will develop a list of equipment that can be used to assist healthcare organizations with essential services in a disaster.	Develop a key list of equipment to include: • Specialty medical services • Equipment that can provide power, HVAC, potable water, etc. • Redundant communications systems • Pharmaceutical supplies

Function #4: Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps

Objective

By the end of Budget Period 2, WCHD will review and revise the Mass Fatality Hospital Annex developed during FY 10-11 based on items identified as gaps.

Task 1: Perform a resource assessment by analyzing healthcare organization needs and evaluating exercises, training, and actual incidents or events to determine gaps and corrective action. (See Pg 7)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$2,502	Throughout the budget period, WCHD will work with healthcare organizations during the planning and evaluation of exercises and the after-action reviews of regional events to identify opportunities for improvement.	June 30, 2014	AAR/IPs of exercises and events

Task 2: Deconflict resources by ensuring response resources are not over allocated to multiple stakeholders within the community (See Pg 7)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$7,087	During Budget Period 2, WCHD will work in collaboration with Emergency Management to expand the Resource Management Requesting Procedures, which were developed during Budget Period 1, to coordinate with the Hospital Requesting Procedures for items that are not SNS (Strategic National Stockpile) resources.	June 30, 2014	Updated requesting procedures.

Attachment B: Scope of Work by Capability

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare resource assessment (See Pg 7)	Build Build Build	• During Budget Period 2, WCHD will work with the Inter-Hospital Coordinating Council to update the Hospital Requesting Procedures based on items identified during the drill during Budget Period 1. • During Budget Period 2, WCHD will work in collaboration with Emergency Management to expand the Resource Management Requesting Procedures, which were developed during Budget Period 1, to coordinate with the Hospital Requesting Procedures for items that are not SNS (Strategic National Stockpile) resources. • WCHD will work with the Medical Examiner's Office to revise the hospital annex to the regional mass fatality plan.	• All regional hospitals will participate in the reviewing process relating to the Hospital Requesting Procedures. • All regional hospitals will receive training on hospital requesting procedures. • Washoe County Resource Unit Leader will work with WCEM and WCHD to ensure the Resource Management Requesting Procedures identify processes for healthcare organizations to request resources other than SNS items. • Updated mass fatality annex specifically relating to hospitals.
Planning Resource Element 2: Healthcare resource coordination. (See Pg 8)	Build	• During Budget Period 2, WCHD will work in collaboration with Emergency Management to expand the Resource Management Requesting Procedures, which were developed during Budget Period 1, to coordinate with the Hospital Requesting Procedures for items	• Washoe County Resource Unit Leader will work with WCEM and WCHD to ensure the Resource Management Requesting Procedures identify processes for healthcare organizations to request resources other than SNS items.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

	Build	that are not SNS (Strategic National Stockpile) resources. • WCHD will work with the Medical Examiner's Office to revise the hospital annex to the regional mass fatality plan.	• Updated mass fatality annex specifically relating to hospitals
Planning Resource Element 3: Address healthcare information gaps (See Pg 8)	No Activity		

Function #5: Coordinate training to assist healthcare responders to develop the necessary skills in order to respond.

Objective

WCHD will continue to provide ICS and HSEEP training opportunities to Health District staff, hospital representatives, Medical Reserve Corps volunteers, and regional partners.

Task 1: Assist with the provision of National Incident Management System training for healthcare organizations in order to refine and improve response knowledge, skills, and abilities in accordance with the National Response Framework (NRF) (See Pg 8)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$11,288	Continue to provide training opportunities through to the Medical Reserve Corps and healthcare professionals.	June 30, 2014	Training sign-in sheets

Task 2: Assist with the provision of training for healthcare organizations based on existing response gaps in order to improve and refine required response knowledge, skills, and abilities. (See Pg 8)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$11,288	Continue to provide training opportunities through to the Medical Reserve Corps and healthcare professionals.	June 30, 2014	Training sign-in sheets

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare organization — National Incident Management System (NIMS) training. (See Pg 8)	Sustain	By the end of Budget Period 2, WCHD will coordinate ICS 300, ICS 400 and HSEEP training courses for healthcare system partners and WCHD staff.	• Sign in sheets • Course evaluations
Planning Resource Element 2: Training to address healthcare gaps and corrective actions. (See Pg 9)	No Activity		

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Function #6: Improve healthcare response capabilities through coordinated exercise and evaluation

Objective
WCHD will continue to participate in regional Training, Exercise, Planning Workshops (TEPW) that are held to ensure community collaboration and healthcare organizational needs are met.

Task 1: Coordinate and implement capability based exercises that test disaster planning efforts (See Pg 9)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$12,027	Participate in regional exercises on the planning team to ensure the healthcare needs are represented and met during the exercise objectives.	June 30, 2014	Exercise documentation
Build		WCHD will develop a HSEEP toolkit specific to healthcare exercise planning.	December 31, 2013	Exercise kit

Task 2: Utilize a coordinated evaluation method to evaluate exercises and actual incident responses (See Pg 9)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$9,892	Identify critical equipment that can be used to provide healthcare organizations with essential services during a disaster.	June 30, 2014	Equipment list

Task 3: Address findings from gap analysis and subsequent corrective actions to revise planning, training, and exercises to minimize response gaps (See Pg 9)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$1,795	Through the exercise process and the AAR/IP, WCHD will support the healthcare organizations in revising and training on items identified as corrective actions.	June 30, 2014	AAR/IP

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Exercise plans (See Pg 10)	Sustain	• Throughout Budget Period 2, WCHD will participate in regional TEPW from the planning stages through the exercise or drill to ensure healthcare response capabilities have an opportunity to be tested.	• WCHD will participate in regional Washoe County Emergency Management TEPW • WCHD will participate in Statewide TEPW

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

	Build	• By mid-year of Budget Period 2, WCHD will develop and distribute an HSEEP exercise kit to regional hospitals and healthcare organizations, as the need was identified through the Nevada Hospital Association gap analysis	• WCHD will provide tool kit to regional hospitals and healthcare organizations • WCHD will provide training on the tool kit
Planning Resource Element 2: Exercise implementation and coordination (See Pg 10)	Sustain Build	• Throughout Budget Period 2, WCHD will participate in regional TEPW from the planning stages through the exercise or drill to ensure healthcare response capabilities have an opportunity to be tested. • By mid-year of Budget Period 2, WCHD will develop and distribute an HSEEP exercise kit to regional hospitals and healthcare organizations, as the need was identified through the Nevada Hospital Association gap analysis	• WCHD will participate in regional Washoe County Emergency Management TEPW • WCHD will participate in Statewide TEPW • WCHD will provide tool kit to regional hospitals and healthcare organizations • WCHD will provide training on the tool kit
Planning Resource Element 3: Evaluation and improvement plans (See Pg 10)	Sustain Build	• Throughout Budget Period 2, WCHD will participate in regional TEPW from the planning stages through the exercise or drill to ensure healthcare response capabilities have an opportunity to be tested. • By mid-year of Budget Period 2, WCHD will develop and distribute an HSEEP exercise kit to regional hospitals and healthcare	• WCHD will participate in regional Washoe County Emergency Management TEPW • WCHD will participate in Statewide TEPW • WCHD will provide tool kit to regional hospitals and healthcare organizations • WCHD will provide training on the tool kit

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

		organizations, as the need was identified through the Nevada Hospital Association gap analysis	
Planning Resource Element 4: Best practice and lessons learned sharing (See Pg 10)	Sustain Build	• Throughout Budget Period 2, WCHD will participate in regional TEPW from the planning stages through the exercise or drill to ensure healthcare response capabilities have an opportunity to be tested. • By mid-year of Budget Period 2, WCHD will develop and distribute an HSEEP exercise kit to regional hospitals and healthcare organizations, as the need was identified through the Nevada Hospital Association gap analysis •	• WCHD will participate in regional Washoe County Emergency Management TEPW • WCHD will participate in Statewide TEPW • WCHD will provide tool kit to regional hospitals and healthcare organizations • WCHD will provide training on the tool kit
Skills & Training 1: Exercise and evaluation training (See Pg 10)	Build	By mid-year of Budget Period 2, WCHD will develop and distribute an HSEEP exercise kit to regional hospitals and healthcare organizations, as the need was identified through the Nevada Hospital Association gap analysis	• WCHD will provide tool kit to regional hospitals and healthcare organizations • WCHD will provide training on the tool kit

Function #7: Coordinate with planning for at-risk individuals and those with special medical needs.

Objective

WCHD will partner with Carson City Health and Human Services to enhance the Northern Nevada Access and Functional Needs workgroup and address the gaps identified by the workgroup.

Task 1: Participate in the planning process that identifies and determines multiple care options for individuals with special medical needs that are not suitable for mass care shelters and require care at medical facilities during incidents. (See Pg 11)

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$19,471	WCHD will work in collaboration with Carson City Health and Human Services to develop a list of resources within Northern Nevada that serve citizens with Access or Functional Needs.	December 31, 2013	Organization resource list.

Task 2: Participate in coordinated planning with public health and ESF#6 agencies to determine protocols for the transfer of patients between mass care and healthcare settings during a disaster. (See Pg 11)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity.	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare planning for at-risk individuals and functional needs. (See Pg 11)	Build	WCHD will work in collaboration with Carson City Health and Human Services to develop a list of resources within Northern Nevada that serve citizens with Access or Functional Needs.	• Work through the Northern Nevada Access and Functional Needs workgroup to develop a list of services available to citizens within the region. • Distribute the list to regional partners. • Reach out to the identified organizations to get them involved in the workgroup.
Planning Resource Element 2: Special medical needs planning (See Pg 11)	Build	WCHD will work in collaboration with Carson City Health and Human Services to develop a list of resources within Northern Nevada that serve citizens with Access or Functional Needs.	• Work through the Northern Nevada Access and Functional Needs workgroup to develop a list of services available to citizens within the region. • Distribute the list to regional partners. • Reach out to the identified organizations to get them involved in the workgroup.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Washoe County Health District
ASPR Hospital Preparedness Program (BP2) Subgrant # ASPR07-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

HPP Capability # 2 : Healthcare System Recovery

Definition: Healthcare system recovery involves the collaboration with Emergency Management and other community partners, (e.g., public health, business, and education) to develop efficient processes and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible.
The focus is an effective and efficient return to normalcy or a new standard of normalcy for the provision of healthcare delivery to the community.

Goal: Determine whether recovery is planned for as part of the preparedness process as well as response. Communities think through how they can reinstate a level of functioning comparable to pre-incident levels, and improved levels where possible, in the aftermath of a disaster.

Performance Measures: Percent of healthcare coalitions (HCCs) that have developed processes for short-term recovery of healthcare service delivery and continuity of business operations. Below are the data elements that must be reported on for this capability at mid-year and end of year.

Allocated funding: $34,512

Performance Measure Data Element:
HPP 2.1: Has a risk-based regional/jurisdictional Hazard Vulnerability Analysis (HVA) been conducted within the past 3 years that identifies events and incidents that may impact the ability of an HCC's hospitals and other healthcare organizations (HCOs) to deliver healthcare?
HPP 2.2: If yes, have those identified events or incidents been assessed as to their potential impacts on the hospital and other HCC members, such as power outages, water outages, road outages and supply chain disruptions?
HPP 2.3: If yes, have healthcare recovery needs been identified and prioritized based on those potential impacts?
HPP 2.4: Does the HCC ensure that its hospitals and other HCOs are integrated in the jurisdiction's Emergency Operations Plan that is intended to meet prioritized essential health care recovery needs?
HPP 2.5: COOP Planning
HPP 2.6: Has the HCC, its hospitals, and other HCO members implemented AND tested plans and processes for continuing and sustaining operations (e.g., hardening facilities) within the past three years?
HPP 2.7: Does the HCC coordinate with each of its hospitals and other HCOs to enhance member support in planning for continuity of operations plans?
HPP 2.8: Has the HCC coordinated with the State and with its HCOs to develop a regional recovery and continuity of operations plan?
HPP 2.9: Does the HCC coordinate its hospitals' and other HCOs' use of Electronic Medical Records, and link their use in their continuity of operations plans?
HPP 2.10: Do HCC hospitals and other HCOs incorporate guidance on messaging to their workforce into their continuity of operations plans?
HPP 2.11: Can HCC hospitals and other HCOs maintain essential functions (e.g. continue to bill for payment with healthcare insurers) to sustain revenues to operate during and after an emergency?
HPP 2.12: Has the HCC successfully tested processes for short-term recovery of healthcare service delivery and continuity of business operations in an exercise or event within the past year?
HPP 2.13: If yes, has the HCC successfully implemented lessons learned and corrective actions from this exercise or event?

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Short–term Goal	Planned Outcome	Output ¶ Documentation
WCHD will continue to coordinate efforts with the Skilled Nursing Committee to build their capabilities to recover from an emergency with limited impact to their patient population through plan development assistance and training opportunities.	Enhance Skilled Nursing Facility and Memory Care Facility's ability to recover from an emergency.	Business Continuity worksheet.

Function #1: Develop recovery processes for the healthcare delivery system

Objective

During Budget Period 2, WCHD will support the identified needs of the regional Skilled Nursing Facilities by coordinating training opportunities or providing assistance with emergency response plan development.

Task 1: Assess the impact of an incident on the healthcare systems ability to deliver essential services to the community and prioritize healthcare recovery needs (See Pg 12)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$13,911	Assist Skilled Nursing Facilities with any identified needs relating to training or emergency response plans.	June 30, 2014	• Minutes identifying need • Training documentation

Task 2: Promote healthcare organization participation in state and/or local pre- and post-disaster recovery planning activities as described in the National Disaster Recovery Framework (NRDF) in order to leverage recovery resources, programs, projects, and activities (See Pg 12)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare recovery planning(See Pg 12)	Build	During Budget Period 2, WCHD will coordinate training and/or assist with plan development to regional Skilled Nursing Facilities.	• Training documentation based on trainings requested
Planning Resource Element 2: Assessment of healthcare delivery recovery needs post disaster (See Pg 13)	Build	During Budget Period 2, WCHD will coordinate training and/or assist with plan development to regional Skilled Nursing Facilities.	• Training documentation based on trainings requested
Planning Resource Element 3: Healthcare organization recovery assistance and participation (See Pg 13)	No Activity		

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Function #2: Assist healthcare organizations to implement Continuity of Operations (COOP)

Objective

By the end of Budget Period 2, there will be a Continuity of Operations worksheet developed to assist Washoe County Skilled Nursing Facilities in the development of their Business Continuity Plans.

Task 1: Identify the healthcare essential services that must be continued to maintain healthcare delivery following a disaster (See Pg 14)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$10,301	Creation of a worksheet to assist Skilled Nursing Facilities in the development of business continuity plans to ensure they are able to remain operational.	June 30, 2014	Worksheet relating to business continuity

Task 2: Encourage healthcare organizations to identify the components of a fully functional COOP and develop corresponding plans for implementation. (See Pg 14)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$10,301	Creation of a worksheet to assist Skilled Nursing Facilities in the development of business continuity plans to ensure they are able to remain operational.	June 30, 2014	Worksheet relating to business continuity

Task 3: If a disaster notice can be provided, alert healthcare organizations within communities threatened by disaster and if requested and feasible, assist them with the activation of COOP such that healthcare delivery to the community is minimally impacted. (See Pg 14)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Task 4: Develop coordinated healthcare strategies to assist healthcare organizations transition from COOP operations to normalcy or the new norm for healthcare operations (See Pg 14)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: COOP planning assistance for healthcare organizations (See Pg 14)	Build	By June 30th 2014, WCHD will develop a Continuity of Operations worksheet/check list that will outline the essential functions and items to consider when developing Business Continuity plans.	• All seven Skilled Nursing Facilities will receive training on the worksheet/check list. • All seven Skilled Nursing Facilities will begin working on Business

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Attachment B: Scope of Work by Capability

			Continuity Plans
Planning Resource Element 2: Healthcare organization COOP implementation assistance (See Pg 14)	Build	By June 30th 2014, WCHD will develop a Continuity of Operations worksheet/check list that will outline the essential functions and items to consider when developing Business Continuity plans.	• All seven Skilled Nursing Facilities will receive training on the worksheet/check list. • All seven Skilled Nursing Facilities will begin working on Business Continuity Plans
Planning Resource Element 3: Healthcare organization recovery assistance (See Pg 15)	Build	By June 30th 2014, WCHD will develop a Continuity of Operations worksheet/check list that will outline the essential functions and items to consider when developing Business Continuity plans.	• All seven Skilled Nursing Facilities will receive training on the worksheet/check list. • All seven Skilled Nursing Facilities will begin working on Business Continuity Plans

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HPP Capability # 3 : Emergency Operations Coordination

Definition: Emergency operations coordination regarding healthcare is the ability for healthcare organizations to engage with incident management at the Emergency Operations Center or with on-scene incident management during an incident to coordinate information and resource allocation for affected healthcare organizations. This is done through multi-agency coordination representing
healthcare organizations or by integrating this coordination into plans and protocols that guide incident management to make the appropriate decisions. Coordination ensures that the healthcare organizations, incident management, and the public have relevant and timely information about the status and needs of the healthcare delivery system in the community. This enables healthcare organizations to coordinate their response with that of the community response and according to the framework of the National Incident Management System (NIMS).

Goal: To assess the level at which healthcare coalitions are organized around an integrated Incident Command Structure and make use of this structure to coordinate the most effective use of resources in a disaster situation.

Performance Measures: Percent of healthcare coalitions (HCCs) that use an integrated Incident Command Structure (ICS) to coordinate operations and sharing of critical resources among HCC organizations (including emergency management and public health) during disasters. Below are the data elements that must be reported on for this capability at mid-year and end of year.

Allocated funding: $37,475

Performance Measure Data Element:
HPP 3.1: Have the HCC and its members successfully exercised protocols for notifying non-partner support agencies to activate mutual aid agreements for resource support within the last year?
HPP 3.2: Has the HCC planned with partner hospitals and other HCOs to identify each hospital and other HCO's maximum patient capacity to establish its baseline as a coalition?
HPP 3.3: Has the HCC coordinated healthcare response operations with appropriate patient transport operations within the community, in an exercise or event, within the past year?
HPP 3.4: If yes, which of the following functions were successfully demonstrated by the HCC's hospitals and other HCOs in the exercise or event in which the HCC participated?
3.4.1 - Triage
3.4.2 - Treatment
3.4.3 - Transport
3.4.4 - Tracking of patients
3.4.5 - Documentation of care
3.4.6 - Off-loading
HPP 3.5: Has there been an HCC--triggered activation of the HCC incident response within the last year, in an event or exercise? Has the HCC successfully exercised notification protocols for its hospitals and other HCOs within the last year?
HPP 3.6: Are HCC members integrated into an HCC incident command structure such that the members are included in HCC Regional Plans?

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
WCHD will continue to assist in the expansion of existing plans to include healthcare organizations to ensure the continued consideration of healthcare needs within Incident Command or Emergency Operations Center.	Healthcare organizations will have a revised hospital requesting procedures and resource management plans to utilize during emergency responses.	• Revised hospital requesting procedures • Revised resource requesting procedures.

Function #1: Conduct preliminary assessment to determine need for public activation.

Objective

WCHD will continue to test the Standard Operating Procedures developed during FY 12-13 that details the interface between the Regional Emergency Operations Center and the Hospital Command Centers.

Task 1: Determine the process for healthcare organizations representation with local and state emergency operations during an incident response (See Pg 16)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$9,701	Continue to exercise the Standard Operating Procedures relating to the integration of the hospital command center and the emergency operations center.	June 30, 2014	Exercise documentation.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare organization multi-agency coordination during response (See Pg 16)	Sustain	Throughout Budget Period 2, WCHD will test the communication between the Emergency Operations Center and Hospital Command Centers at available exercises and drills.	• Exercise documentation • SOPs will be revised based on AAR/IP identified items.
Planning Resource Element 2: Healthcare organization and emergency operations decision coordination	No Activity		

Function #2: Assess and notify stakeholders of healthcare delivery status

Objective

- During Budget Period 2, WCHD will continue to test the Standard Operating Procedures developed during Budget Period 1 that outlines the interaction between the Emergency Operations Center and the Hospital Command Centers.

Attachment B: Scope of Work by Capability

- By the end of Budget Period 2, WCHD will have revised and trained the regional hospitals and Skilled Nursing Facilities on requesting resources. These procedures are utilized during an emergency as a tool for regional healthcare organizations to request items needed during their incident response.
- WCHD will work in collaboration with Emergency Management to expand the Resource Management Requesting Procedures, which were developed during Budget Period 1, to coordinate with the Hospital Requesting Procedures for items that are not SNS (Strategic National Stockpile) resources.
- **Personnel; Web EOC Resource Manager??**

Task 1: During an incident, implement information sharing processes that supports ongoing communication to inform local incident management of the operational status and resource needs of healthcare organizations (See Pg 17)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$21,509	By the end of Budget Period 2, WCHD will have revised and trained the regional hospitals and Skilled Nursing Facilities on requesting resources. These procedures are utilized during an emergency as a tool for regional healthcare organizations to request items needed during their incident response.	June 30, 2014	◦ Revised requesting procedures ◦ Training documentation

Task 2: During an incident, implement information sharing processes that supports ongoing communication to inform healthcare organizations about the status of the incident and of healthcare delivery in the community (See Pg 17)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$6,264	During Budget Period 2, WCHD will continue to test the Standard Operating Procedures developed during Budget Period 1 that outlines the interaction between the Emergency Operations Center and the Hospital Command Centers.	June 30, 2014	Exercise documentation

Task 3: During an incident, implement coordinated information sharing processes that provide relevant and timely healthcare messages to the community and other stakeholders through a Joint Information System (JIS) (See Pg 17)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Attachment B: Scope of Work by Capability

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare organization resource needs assessment (See Pg 17)	Build	During Budget Period 2, WCHD will work with the Inter-Hospital Coordinating Council to update the Hospital Requesting Procedures based on items identified during the drill during Budget Period 1.	• All regional hospitals will participate in the reviewing process relating to the Hospital Requesting Procedures • All regional hospitals will receive training on hospital requesting procedures
	Build	During Budget Period 2, WCHD will work in collaboration with Emergency Management to expand the Resource Management Requesting Procedures, which were developed during Budget Period 1, to coordinate with the Hospital Requesting Procedures for items that are not SNS (Strategic National Stockpile) resources.	• Washoe County Resource Unit Leader will work with WCEM and WCHD to ensure the Resource Management Requesting Procedures identify processes for healthcare organizations to request resources other than SNS items.
Planning Resource Element 2: Incident information sharing (See Pg 17)	Build	During Budget Period 2, WCHD will work with the Inter-Hospital Coordinating Council to update the Hospital Requesting Procedures based on items identified during the drill during Budget Period 1.	• All regional hospitals will participate in the reviewing process relating to the Hospital Requesting Procedures. • All regional hospitals will receive training on hospital requesting procedures.

Planning Resource Element 2: Incident information sharing (See Pg 17) – Con't	Build	During Budget Period 2, WCHD will work in collaboration with Emergency Management to expand the Resource Management Requesting Procedures, which were developed during Budget Period 1, to coordinate with the Hospital Requesting Procedures for items that are not SNS (Strategic National Stockpile) resources.	▫ Washoe County Resource Unit Leader will work with WCEM and WCHD to ensure the Resource Management Requesting Procedures identify processes for healthcare organizations to request resources other than SNS items.
Planning Resource Element 3: Community notification of healthcare delivery status (See Pg 18)	No Activity		

Function #3: Support healthcare response efforts through coordination of resources.

Objective

No activities planned for this budget period.

Task 1: Implement processes that assists local and state incident management to identify resource gaps and allocate available resources for healthcare organizations when requested during a response (See Pg 18)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Task 2: Implement the Healthcare Coalition's process to allocate resources, if any, and coordinate with emergency management and other response partners (See Pg 18)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Identify available healthcare resources (See Pg 18)	No Activity		
Planning Resource Element 2: Resource management implementation (See Pg 18)	No Activity		

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Planning Resource Element 3: Public health resource support to healthcare organizations (See Pg 19)	No Activity		
Planning Resource Element 4: Template for producing incident action plans (See Pg 19)	No Activity		
Equipment & Technology 1: Inventory management system (See Pg 19)	No Activity		

Function #4: Demobilize and evaluate healthcare operations

Objective

No activities planned for this budget period.

Task 1: Develop a process to assist healthcare organizations with the return of shared healthcare owned resources to a condition of "the normal state of operations". (See Pg 19)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Task 2: Engage in evaluation processes that ensure the timely implementation of corrective actions and refine best practices to enhance preparedness for the healthcare delivery during response (See Pg 19)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Process to ensure continued performance of pre-identified essential functions (See Pg 20)			
Planning Resource Element 2: Evaluation and continuous program improvement (See Pg 20)			
Skills & Training 1: Evaluation training (See Pg 20)			

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HPP Capability # 5 : Fatality Management

Definition: Fatality management is the ability to coordinate with organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services for family members, responders, and survivors of an incident. Coordination also includes the proper and culturally sensitive storage of human remains during periods of increased deaths at healthcare organizations during an incident.
Goal: To determine whether healthcare coalitions coordinate with leaders/officials who manage fatalities, as well as other jurisdictional partners, to develop a shared understanding of roles and responsibilities related to fatality management.
Performance Measures: Percent of healthcare coalitions (HCCs) that have systems and processes in place to manage mass fatalities consistent with their defined roles and responsibilities. Below are the data elements that must be reported on for this capability at mid-year and end of year.
Allocated funding: **$107,835**
Performance Measure Data Element:
HPP 5.1: Has the HCC identified the roles and responsibilities of member organizations and other key partners for managing mass fatalities, including but not limited to the following:
5.1.1 - Identifying response actions of HCC members, including local health departments, local emergency management, hospitals, other HCOs, and other key partners (e.g., funeral directors, coroners, medical examiners)
5.1.2 - Identifying who is responsible for each of the Fatality Management functions
5.1.3 - Identifying legal/regulatory authority of member organizations and key partners that govern fatality management in the local jurisdiction, including any necessary waivers (e.g. determining cause of death, identification and storage of remains, family notification, burial permits and vital records, etc.)
HPP 5.2: Has the HCC established systems and processes to manage mass fatalities consistent with its defined roles and responsibilities, including but not limited to the following:
5.2.1 - Ensuring that systems and processes are aligned with the local jurisdictional EOP or fatality management plan
5.2.2 - Identifying critical pathways/trigger points for response actions
5.2.3 - Providing training on fatality management coordination
5.2.4 - Establishing communication systems among members and key partners, including mental/behavioral health professionals
5.2.5 - Developing concepts of operations and standard operating procedures
HPP 5.3: Has the HCC established systems and processes to manage a surge of concerned citizens requesting information about missing family members, including how to contact the responsible agency for family support, and protocols to ensure its HCOs can connect with family assistance and/or family reception centers?
HPP 5.4: Has the HCC successfully tested its systems and processes for managing mass fatalities during an exercise or event within the past year?
HPP 5.5: Has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Short–term Goal	Planned Outcome	Output Documentation
WCHD will collaborate with WCMECO (Washoe County Medical Examiner Coroner's Office) to continue to developing fatality management capabilities within the region with the continued development of the Northern Nevada Disaster Victim Recovery Team and community Family Assistance Centers.	Washoe County will have a cache of personnel specially trained in fatality response to be able to assist whether it is within the Family Assistance Center or the recovery of human remains.	• Family Assistance Center Annex • Training documentation of NNDVRT

Function #1: Coordinate surges of deaths and human remains at healthcare organizations with community fatality management operations

Objective

1. WCHD will review and revise the Mass Fatality Hospital Annex developed during FY 10-11. The annex outlines each hospitals capability to store human remains including the equipment and supplies needed.
2. WCHD will continue to support the objectives of the Medical Examiner's Office and the development of the Northern Nevada Disaster Victim Recovery Team.

Task 1: Prior to an incident, assist healthcare organizations with determining the amount of morgue space that is available to them during periods of death surges and develop the processes to request support from local and state agencies.

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$28,599	Continue to test the hospital mass fatality response annex that details morgue space at each regional hospital.	June 30, 2014	Exercise documentation

Task 2: Prior to an incident, coordinate with healthcare organizations to identify alternate storage and disposal options for human remains.

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$28,599	Continue to test the hospital mass fatality response annex that details morgue space at each regional hospital.	June 30, 2014	Exercise documentation

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Anticipate storage needs for a surge of human remains. (See Pg 21)	Build	WCHD and Washoe County Medical Examiner Coroner's Office will work together to revise the Mass Fatality Hospital Annex to address items indentified during the Operation Urgent	All regional hospitals will receive training on the new Mass Fatality Hospital Annex

		Solidarity community exercise.	
Planning Resource Element 2: Healthcare organization human remain surge plans. (See Pg 22)	Build	WCHD and Washoe County Medical Examiner Coroner's Office will work together to revise the Mass Fatality Hospital Annex to address items indentified during the Operation Urgent Solidarity community exercise.	All regional hospitals will receive training on the new Mass Fatality Hospital Annex
Equipment & Technology 1: Mortuary storage equipment and supplies. (See Pg 22)	Build	Medical Examiner's Office equipment to help support a response to a mass fatality event within Washoe County.	Equipment

Function #2: Coordinate surges of concerned citizens with community agencies responsible for family assistance

Objective

WCHD will develop an annex to the Statewide Family Assistance Center Plan, developed during Budget Period 1, to have specific regional considerations identified.

Task 1: Prior to an incident, assist healthcare organizations by coordinating options for surges of concerned citizens and their direction to the appropriate location for family assistance when these surges arrive at the facility seeking family member information. (See Pg 22)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$30,458	WCHD will update the Statewide FAC plan to have an operational regional FAC plan with identified command team members.	June 30, 2014	Operational FAC plan.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Procedures for a surge of concerned citizens. (See Pg 22)	Build	• WCHD will work with regional partners to develop an annex to the Statewide Family Assistance Center (FAC) plan to include the coordination with hospital FACs.	• FAC Annex relating specifically to the coordination with hospitals for information and logistical support for family members of the missing/deceased. • FAC Annex training with identified community and hospital FAC personnel to ensure accuracy of information. • FAC tabletop exercise with regional partners.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Function #3: Mental/behavioral support at the healthcare organization level.

Objective

WCHD will update and revise the hospital requesting procedures to include a "personnel" sheet that can be utilized to request mental/behavioral support at the healthcare organizations.

Task 1: Coordinate the options for mental/Behavioral support for healthcare organizations during disasters which cause a death surge involving a large amount of human remains. (See Pg 23)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$20,180	Work with NNAMHS to determine what capabilities they have and the response procedures as it relates to Washoe County.	June 30, 2014	MOA with NNAMHS for support within an FAC.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Mental/behavioral health support. (See Pg23)	Build	Determine the activation procedures for NNAMHS for supporting a Family Assistance Center.	MOA with NNAMHS.
	Build	Revise hospital requesting procedures to allow for the requesting of personnel or mental/behavioral support.	Revised healthcare requesting procedures.

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HPP Capability # 6: Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of public health and medical related information and situational awareness between the healthcare system and local, state, Federal, tribal, and territorial levels of government and the private sector. This includes the sharing of healthcare information through routine coordination with the Joint Information System for dissemination to the local, state, and Federal levels of government and the community in preparation for and response to events or incidents of public health and medical significance.

Goal: To determine whether healthcare coalitions have the capability to maintain a Common Operating Picture during surge operations.

Performance Measures: The Performance Measures that will be used to capture awardee progress toward building this capability is:

- HPP-Specific Performance Measure: Percent of healthcare coalitions (HCCs) that can continuously monitor Essential Elements of Information (EEIs) and demonstrate the ability to electronically send data to and receive data from coalition members to inform a Common Operating Picture
- Joint HPP-PHEP Performance Measure: Percent of local partners that reported requested Essential Elements of Information (EEI) to health and medical lead within the requested timeframe.

Below are the data elements that must be reported on for this capability at mid-year and end of year.

Allocated funding: $38,880

Performance Measure Data Element:
HPP 6.1: Has the HCC identified essential elements of information (EEIs) that the HCC members must report for specific types of events to inform the common operating procedure? Examples of EEI data include: -Facility operating status -Facility structural integrity -Status of evacuations/shelter in place operations -Critical medical services (e.g., critical care, trauma) -Critical service status (e.g., electric, water, sanitation, heating, ventilation, air conditioning) -Critical healthcare delivery status (e.g., surge status, bed status, deaths, medical and pharmaceutical supply and medical equipment) -Staffing status -Emergency Medical Services status involving patient transport, tracking and availability -Electronic patient tracking -Electronic bed tracking
HPP 6.2: If EEI data has been identified, has the HCC defined data usage and access policies for the EEI data?
HPP 6.3: Does the HCC have redundant systems and processes in place to electronically send and receive the EEI data?
HPP 6.4: Can the HCC share basic epidemiological and/or clinical data with relevant local health departments?
HPP 6.5: Are the HCC members able to report the identified EEIs electronically within the timeframe requested as evidenced by performance during exercises or events?
HPP 6.6: Is the HCC able to receive and quickly process the EEI data to provide timely, relevant, and actionable healthcare information to the common operating picture as evidenced by performance during exercises or events?
HPP 6.7: Has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

-- JOINT PERFORMANCE MEASURES --
HPP-PHEP 6.2: On each incident/planned event/exercise reported for demonstration of the Information Sharing Capability, please answer the following information:
HPP-PHEP 6.2.1: This incident /planned event/exercise utilized or demonstrated one or more function(s) within the:
HPP-PHEP 6.2.2: The number of local partners that received a request for EEI (denominator)
HPP-PHEP 6.2.3: The number of local partners that reported requested EEI to the health and medical lead within the requested timeframe (numerator)
HPP-PHEP 6.2.4: The request for EEI occurred during a (select one):
HPP-PHEP 6.2.5: The type of incident/exercise/planned event upon which the request for EEI was based
HPP-PHEP 6.2.6: Other Specified
HPP-PHEP 6.2.7: The name of the incident/planned event/exercise.
HPP-PHEP 6.2.8: The date of the incident/planned event/exercise
HPP-PHEP 6.2.9: The number of each type of local partner that responded to the request
HPP-PHEP 6.2.10: Healthcare Organizations
HPP-PHEP 6.2.11: Healthcare Coalitions
HPP-PHEP 6.2.12: Local Health Departments
HPP-PHEP 6.2.13: Other Specified
HPP-PHEP 6.2.14: Other numeric
HPP-PHEP 6.2.15: The requesting entity (e.g., health and medical lead at the State, sub-state regional, or local level).
HPP-PHEP 6.2.16: Other requesting entity specified
HPP-PHEP 6.2.17: The type(s) of EEI requested.
HPP-PHEP 6.2.19: The type of IT or other communication system used by local partners to report requested EEI
HPP-PHEP 6.2.20: Barriers /challenges to submitting requested EEI within the requested timeframe (please describe types of local partners experiencing challenges and types of EEI not submitted within requested timeframe).

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
WCHD will collaborate with regional partners to research and develop tools for regional information sharing. This will enable continued communication during emergency responses.	A Public Warning/Public Information regional plan that has an annex specifically for health and medical communications.	• Health and medical annex • Electronic patient tracking system

Function #1: Provide healthcare situational awareness that contributes to the incident common operating picture.

Attachment B: Scope of Work by Capability

Objective
1. WCHD will participate in the Nevada Public Warning/Public Information Task Force. 2. WCHD will build an electronic patient tracking system and train healthcare representatives on the system. 3. WCHD will continue to test the Standard Operating Procedures developed during Budget Period 1 that outlines the interaction between the Emergency Operations Center and the Hospital Command Centers.

Task 1: Before an incident, identify the essential elements of incident specific healthcare information that are timely, relevant, actionable, and can be reasonably delivered during the response. (See Pg 24)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$11,465	Through the Public Warning/Public Information Task Force, WCHD will assist in the development of a regional plan that addresses before, during and after an incident communications.	June 30, 2014	PW/PI Regional Plan

Task 2: Before, during, and after an incident, utilize coordinated information sharing protocols to receive and transmit timely, relevant, and actionable incident specific healthcare information to incident management during response and recovery. (See Pg 24)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$24,226	Through the Public Warning/Public Information Task Force, WCHD will assist in the development of a regional plan that addresses before, during and after an incident communications.	June 30, 2014	PW/PI Regional Plan

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare information sharing plans (See Pg 24)	Build	▫ WCHD will participate in the Nevada Public Warning/Public Information Task Force. The task force will be developing templates for information sharing to the public and regional partners in the event of an incident.	▫ Participation in Task Force meetings and applicable sub-committee meetings. ▫ Development of Public Health and Medical Public Warning and Information Annex to the Washoe County Public Warning Public Information plan
	Build	▫ WCHD will design and build an electronic patient tracking system within WebEOC to be utilized by regional healthcare partners.	▫ Development of electronic patient tracking system. ▫ Training for all regional hospitals on electronic patient tracking system.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Planning Resource Element 1: Healthcare information sharing plans (See Pg 24) – Con't	Sustain	• Throughout Budget Period 2, WCHD will test the communication between the Emergency Operations Center and Hospital Command Centers at available exercises and drills.	Exercise AARIPs detailing the testing of the SOP
Planning Resource Element 2: Healthcare essential elements of information (See Pg 25)	Build Sustain	• WCHD will participate in the Nevada Public Warning/Public Information Task Force. The task force will be developing templates for information sharing to the public and regional partners in the event of an incident. • Throughout Budget Period 2, WCHD will test the communication between the Emergency Operations Center and Hospital Command Centers at available exercises and drills.	• Participation in Task Force meetings and applicable sub-committee meetings. • Development of Public Health and Medical Public Warning and Information Annex to the Washoe County Public Warning Public Information plan Exercise AARIPs detailing the testing of the SOP
Planning Resource Element 3: Healthcare incident information validation (See Pg 25)	Build Sustain	• WCHD will participate in the Nevada Public Warning/Public Information Task Force. The task force will be developing templates for information sharing to the public and regional partners in the event of an incident. • Throughout Budget Period 2, WCHD will test the communication between the Emergency Operations Center and Hospital Command Centers at available exercises and drills.	• Participation in Task Force meetings and applicable sub-committee meetings. • Development of Public Health and Medical Public Warning and Information Annex to the Washoe County Public Warning Public Information plan Exercise AARIPs detailing the testing of the SOP

Planning Resource Element 4: Healthcare information sharing with the public (See Pg 26)	No Activity		
Planning Resource Element 5: Bed tracking (See Pg 26)	No Activity		
Planning Resource Element 6: Patient tracking (See Pg 27)	No Activity		
Planning Resource Element 7: Patient record tracking (See Pg 28)	No Activity		
Equipment & Technology 1: Healthcare information systems (See Pg 26)	Build	WCHD will design and build an electronic patient tracking system within WebEOC to be utilized by regional healthcare partners.	◦ Development of electronic patient tracking system. ◦ Training for all regional hospitals on electronic patient tracking system.
Equipment & Technology 2: Bed tracking system (See Pg 27)	No Activity		
Equipment & Technology 3: Patient tracking system (See Pg 27)	No Activity		
Skills & Training 1: Bed tracking system training (See Pg 27)	Build	WCHD will design and build an electronic patient tracking system within WebEOC to be utilized by regional healthcare partners.	◦ Development of electronic patient tracking system. ◦ Training for all regional hospitals on electronic patient tracking system.

Function #2: Develop, refine, and sustain redundant, interoperable communication systems.

Objective

WCHD will work to develop and sustain redundant interoperable communication systems within the regional Skilled Nursing Facilities.

Task 1: Before, during, and after an incident or event, have redundant processes and systems to communicate with the appropriate multijurisdictional and multidisciplinary emergency responders (See Pg 28)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$0	WCHD will continue to build upon the purchase of 800 MHz radios for regional partners and have monthly communication drills, which include	June 30, 2014	Monthly test documentation.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

		emergency responders.		

Task 2: Before, during, and after an incident or event, have redundant processes and systems to communicate the status of the incident and the status of the community healthcare delivery to healthcare organizations. (See Pg 28)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$3,188	WCHD will develop a Standard Operating Procedure for the use of 800 MHz radios and the Skilled Nursing Facilities.	June 30, 2014	SOP on redundant communications.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Interoperable communications plans (See Pg 28)	Build	WCHD will develop a Standard Operation Procedure for Skilled Nursing Facilities relating to the 800 MHz radio training conducted during Budget Period 1	Develop a protocol for Skilled Nursing Facilities relating to the use 800 MHz radios for redundant communication during a disaster.
Equipment & Technology 1: Interoperable communications systems (See Pg 29)	No Activity		
Skills & Training 1: Communication Training (See Pg 29)	No Activity		

Washoe County Health District
ASPR Hospital Preparedness Program (BP2) Subgrant # ASPR07-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

HPP Capability # 10 : Medical Surge

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Goal: To determine whether healthcare coalitions are prepared to provide healthcare in the immediate aftermath of a disaster.

Performance Measures: Percent of healthcare coalitions that have a coordinated mechanism established that supports their members' ability both to deliver appropriate levels of care to all patients (including pre-existing patients [both inpatient and outpatient], non-disaster-related patients, and disaster-specific patients), as well as to provide no less than 20% bed availability of staffed members' beds, within 4 hours of a disaster. Below are the data elements that must be reported on for this capability at mid-year and end of year.

Allocated funding: $9,756

Performance Measure Data Element:
HPP 10.1: Do the surge plans of the HCC hospitals and other HCC members include written clinical practice guidelines for Crisis Standards of Care for use in an incident, including triggers that delineate shifts in the continuum of care from conventional to crisis standards of care?
HPP 10.2: Has the HCC successfully tested its coordinated mechanism to both deliver appropriate levels of care to all patients, as well as to provide no less than 20% bed availability of staffed members' beds, within 4 hours of a disaster?
10.2.1 - If yes, has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?
HPP 10.3: Has the HCC demonstrated the ability to communicate regional healthcare surge status in an exercise or event within the past year?
HPP 10.4: Does the HCC have the ability to expand its coalition-wide surge capacity according to the scope and magnitude of the incident
HPP 10.5: Does the HCC have the ability to communicate and coordinate support to its member organizations so that members can perform surge functions and coordinate distribution of resources to support those functions?

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
WCHD will work with regional pre-hospital Emergency Medical Services and hospitals to update protocols that coordinate the transportation decisions during a medical surge incident.	WCHD will have an updated medical evacuation plan that will account for the evacuation of more than one facility.	Evacuation Annex to the Multiple Casualty Incident Plan

Function #1: The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge.

Objective
The healthcare coalition needs to be fully developed prior to the identification of how the coordination of efforts can addressed.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Task 1: Provide healthcare coordination for healthcare emergency preparedness activities and surge planning that guide incidentmanagement decisions during response.

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Task 2: Develop, refine, and sustain a method to ensure that healthcare organizations are adequately represented during medical surge incidents in order to provide incident management with information and assist with decisions regarding the allocation of resources to healthcare organizations. (See Pg 30)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare Coalition preparedness activities (See Pg 31)	No Activity		
Planning Resource Element 2: Multi-agency coordination during response (See Pg 31).	No Activity		

Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations.

Objective

1. WCHD will review and update the regional Multi-Casualty Incident Plan.
2. WCHD will begin to review and update the regional Mutual Aid Evacuation Annex of the Washoe County Multi-Casualty Incident Plan.

Task 1: Promote information sharing processes that enable healthcare organizations to track the status and transport of patients (situational awareness) from EMS during medical surge incidents. (See Pg 31)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$9,756	WCHD will update the regional Multi-Casualty Incident Plan, which includes the notification of hospitals on transporting of patients.	June 30, 2014	Revised MCI plan with notification information.

Task 2: Provide training and guidance to encourage healthcare organizations to understand EMS disaster triage protocols and CBRNE treatment protocols that assist with the transition of disaster patients from the field to the facility. (See Pg 31)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$0	WCHD will work with community partners to identify a new triage tag system for multi-casualty incidents.	June 30, 2014	Revised MCI plan with triage tag information included.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Attachment B: Scope of Work by Capability

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare organization coordination with EMS during response. (See Pg 32)	Build	◦ WCHD will review and update the regional Multi-Casualty Incident Plan, to include newly selected Emergency Medical Services (EMS) triage tags	◦ Participation from regional EMS partners and hospitals on the review of changes to the Multi-Casualty Incident Plan. ◦ Training provided to regional EMS partners and hospitals on the changes made to the protocols. ◦ Training provided to the regional EMS partners and hospitals on the EMS triage tags.
	Build	◦ WCHD will review and update the regional Mutual Aid Evacuation Annex of the Washoe County Multi-Casualty Incident Plan.	◦ Participation from regional hospitals and EMS on the need to address the evacuation of more than one facility. ◦ Workshop for regional partners, to include subgroups, to discuss and outline evacuation policies.
Planning Resource Element 2: Coordinated disaster protocols for triage, transport, documentation, CBRNE (See Pg 32)	Build	◦ WCHD will review and update the regional Multi-Casualty Incident Plan, to include newly selected Emergency Medical Services (EMS) triage tags	◦ Participation from regional EMS partners and hospitals on the review of changes to the Multi-Casualty Incident Plan. ◦ Training provided to regional EMS partners and hospitals on

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Planning Resource Element 2: Coordinated disaster protocols for triage, transport, documentation, CBRNE (See Pg 32) (con't)	Build	• WCHD will review and update the regional Mutual Aid Evacuation Annex of the Washoe County Multi-Casualty Incident Plan.	the changes made to the protocols. • Training provided to the regional EMS partners and hospitals on the EMS triage tags. • Participation from regional hospitals and EMS on the need to address the evacuation of more than one facility. • Workshop for regional partners, to include subgroups, to discuss and outline evacuation policies.
Skills & Training 1: Training on local EMS disaster triage methodologies (See Pg 32)	Build	• WCHD will review and update the regional Multi-Casualty Incident Plan, to include newly selected Emergency Medical Services (EMS) triage tags	• Participation from regional EMS partners and hospitals on the review of changes to the Multi-Casualty Incident Plan. • Training provided to regional EMS partners and hospitals on the changes made to the protocols. • Training provided to the regional EMS partners and hospitals on the EMS triage tags.

Skills & Training 1: Training on local EMS disaster triage methodologies (See Pg 32) – (con't)	Build	• WCHD will review and update the regional Mutual Aid Evacuation Annex of the Washoe County Multi-Casualty Incident Plan.	• Participation from regional hospitals and EMS on the need to address the evacuation of more than one facility. • Workshop for regional partners, to include subgroups, to discuss and outline evacuation policies.
Skills & Training 2: Coordinated CBRNE training (See Pg 32)	No Activity		

Function #3: Assist healthcare organizations with surge capacity and capability

Objective

No Activity

Task 1: Assist healthcare organizations with decisions regarding surge management by ensuring processes exist to provide healthcare organizations with ongoing communication regarding the status of the incident and the status of medical surge operations when requested. (See Pg 33)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Task 2: Develop a process for healthcare organizations to provide multi-agency coordination regarding resource decisions during medical surge operations. (See Pg 33)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Task 3: Develop, refine, and sustain processes that assist healthcare organizations to maximize medical surge capacity and capability during response operations. (See Pg 33)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Attachment B: Scope of Work by Capability

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Medical surge planning (See Pg 33)	No Activity		
Planning Resource Element 2: Medical surge emergency operations coordination (See Pg 34)	No Activity		
Planning Resource Element 3: Assist healthcare organizations maximize surge capacity (See Pg 34)	No Activity		
Planning Resource Element 4: Assist healthcare organizations maximize surge capability (See Pg 36)	No Activity		
Planning Resource Element 5: Medical surge information sharing (See Pg 37)	No Activity		
Planning Resource Element 6: Healthcare organization patient transport assistance (See Pg 37)	No Activity		
Planning Resource Element 7: Medical surge considerations for at-risk individuals and those with special medical needs	No Activity		
Planning Resource Element 8: Mobile medical assets for surge operations (See Pg 38)	No Activity		
Planning Resource Element 9: Medical surge considerations for at-risk individuals and those with special medical needs	No Activity		
Planning Resource Element 10: Medical surge considerations for at-risk individuals and those with special medical needs (See Pg 40)	No Activity		
Equipment & Technology 1: Specialty equipment to increase medical surge capacity and capability (See Pg 38)	No Activity		
Equipment & Technology 2: Medical surge considerations for at-risk individuals and those with special medical needs (See Pg 39)	No Activity		
Equipment & Technology 3: Medical surge considerations for at-risk individuals and those with special medical needs (See Pg 40)	No Activity		
Skills & Training 1: Special training to maximize medical surge competency (See Pg 38)	No Activity		
Skills & Training 2: Development and execution of healthcare coalition plans (See Pg 40)	No Activity		

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Function #4: Develop Crisis Standards of Care guidance

Objective

No Activity at this time

Task 1: Identify the current status of crisis standards of care planning to determine the future implementation requirements for use by the healthcare organizations (See Pg 41)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Task 2: Identify the guidelines for crisis standards of care, including the effective allocation of scarce resources. (See Pg 41)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Task 3: Identify the appropriate legal authorities and protections for healthcare providers and institutions for implementation of crisis standards of care. (See Pg 41)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description		Output Documentation
Planning Resource Element 1: State crisis standards of care guidance (See Pg 41)	No Activity			
Planning Resource Element 2: Indicators for crisis standards of care (See Pg 42)	No Activity			
Planning Resource Element 3: Legal protections for healthcare practitioners and institutions (See Pg 42)	No Activity			
Planning Resource Element 4: Provide guidance for crisis standards of care implementation processes (See Pg 42)	No Activity			
Planning Resource Element 5: Provide guidance for the management of scarce resources (See Pg 43)	No Activity			
Skills & Training 1: Crisis standards of care training (See Pg 44)	No Activity			

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Function #5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations

Objective
No Activity at this time
Task 1: Before, during, and after an incident ensure there are processes to provide resource assistance to healthcare organizations and providers for evacuation and shelter-in-place operations (See Pg 44)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
No Activity	$0			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Healthcare organization evacuation and shelter-in-place plans (See Pg 44)	No Activity		
Planning Resource Element 2: Healthcare organization preparedness to receive evacuation surge (See Pg 45)	No Activity		
Planning Resource Element 3: Transportation options for evacuation (See Pg 45)	No Activity		
Equipment & Technology 1: Specialized equipment needed to evacuate patients (See Pg 45)	No Activity		

Washoe County Health District
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HPP Capability # 14 : Responder Safety and Health

Definition: The responder safety and health capability describes the ability of healthcare organizations to protect the safety and health of healthcare workers from a variety of hazards during emergencies and disasters. This includes processes to equip, train, and provide other resources needed to ensure healthcare workers at the highest risk for adverse exposure, illness, and injury are adequately protected from all hazards during response and recovery operations.

Goal: To determine whether healthcare coalitions have access to sufficient protection to keep healthcare staff working effectively for the duration of a healthcare crisis.

Performance Measure: Percent of healthcare coalitions that have systems and processes in place to preserve healthcare system functions and to protect all of the coalition member employees (including healthcare and non-healthcare employees). Below are the data elements that must be reported on for this capability at mid-year and end of year.

Allocated funding: $16,713

Performance Measure Data Element:
HPP 14.1: Has the HCC implemented an occupational safety and health plan to protect employees of the organizations within the HCC and their families, based on a Hazard Vulnerability Analysis (HVA) conducted within the last 3 years?
HPP 14.2: If yes, do HCC member organizations have access to the elements of an occupational safety and health program that include:
14.2.1 - Pharmaceutical caches
14.2.2 - PPE
14.2.3 - Medical countermeasures
14.2.4 - Risk communications
14.2.5 - Family member protections and considerations
14.2.6 - Social distancing protocols
14.2.7 - Behavioral health
14.2.8 - Security
HPP 14.3: Has the HCC successfully tested its systems and processes to preserve healthcare system functions and to enhance support of all HCC member employees (including healthcare and non-healthcare employees) in an exercise or event within the past year?
HPP 14.4: If yes, has the HCC successfully implemented lessons learned and corrective actions from the exercise or event within the past year?

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Short–term Goal	Planned Outcome	Output Documentation
By the end of BP2, WCHD staff will identify responder health and safety resources that address responder safety and health risks and needs in an effort to better protect responders in the event of a public health emergency.	All public health responders will have access to a Health and Safety Plan as it relates to public health emergencies.	A Safety and Health Plan which contains: 1. Lists/Fact sheets/Risk assessment identifying: • medical health risks • environmental exposures • mental/behavioral health risks 2. Matrices that address identified risks and: • Resources • Acute and chronic health conditions • PPE needs • Safety needs

Function #1: Assist healthcare organizations with additional pharmaceutical protection for healthcare workers.

Objective

By end of year, WCHD staff will develop MOUs with all area hospitals (as they are willing) to ensure the prompt provision of medical countermeasures to all staff and their families in the event of a public health emergency.

Task 1: Identify the pharmaceuticals needed to safeguard healthcare workers and their families when indicated by a biological infectious disease or during a likely exposure incident identified through risk assessments, hazards vulnerability assessments (HVAs), and resource needs. (See Pg 46)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$876	Identification of needed pharmaceuticals in the event of a public health emergency.	December 31, 2013	Matrix of pharmaceuticals as they relate to identified risks.

Task 2: Assess the need for developing pharmaceutical caches that can be accessed by healthcare organizations when requested and available during an exposure/incident. (See Pg 46)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$10,682	Determine the need for developing pharmaceutical caches.	June 30, 2014	Needs Assessment

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Task 3: Establish the appropriate processes to deliver caches of pharmaceuticals to healthcare organizations during an exposure requiring prophylaxis and treatment when requested and available. (See Pg 46)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$1,020	Develop MOUs (as they are willing) with area hospitals for SNS medical countermeasures in the event of a public health emergency.	June 30, 2014	MOUs

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Pharmaceutical needs assessment (See Pg 46)	Build	Conduct a needs assessment to determine the types of pharmaceuticals that may be needed to protect healthcare workers from priority threats.	Needs Assessment
Planning Resource Element 2: Pharmaceutical cache storage, rotation, replacement, and distribution (See Pg 47)	Build	1. Develop security plans with Washoe County Sheriff's Office in the distribution of pharmaceuticals during a public health emergency. 2. Create a supply chain management chart for pharmaceutical distribution in the event of a public health emergency.	Updated Medical Countermeasures Distribution and Dispensing Plan.
Planning Resource Element 3: Medical Countermeasure dispensing (See Pg 47)	Build	Develop MOUs (as they are willing) with area hospitals for SNS medical countermeasures in the event of a public health emergency.	MOUs
Equipment & Technology 1: Pharmaceutical cache protection (See Pg 47)	Build	Identify and purchase (as budget allows) security devices and environmental storage devices for caches of medical supplies.	Equipment purchased.
Skills & Training 1: Pharmaceutical cache training (See Pg 48)	Build	Develop a training curriculum for healthcare workers as it related to SNS requesting procedures.	Sign-in sheet from training

Function #2: Identify safety and personal protective needs

Objective

By end of year, WCHD staff will create Responder Health and Safety Facts Sheets which include safety and health recommendations as they relate to identified risks.

Task 1: Prior to an incident, and as applicable during an incident, work with subject matter experts (e.g., state environmental health, state occupational health and safety, hazard-specific subject matter experts, and emergency managers) to identify responder safety and health resource requirements (e.g., equipment needs). (See Pg 129)

Note: The page #'s listed in this table correspond to ASPR's "Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness", January 2012

Attachment B: Scope of Work by Capability

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$3,258	Identify safety and PPE needs as they relate to identified risks.	December 31, 2013	Matrix of safety and PPE needs as they relate to identified risks.

Task 2: Prior to an incident, and as applicable during an incident, and in conjunction with subject matter experts, formulate recommendations to public health responders regarding personal protective equipment that are consistent with local jurisdictional requirements. (See Pg 129)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$876	Create Fact Sheets that list recommendations to public health responders regarding PPE.	June 30, 2014	Fact Sheets

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Personal protective equipment needs assessment (See Pg 48)	Build	Conduct a needs assessment to determine additional levels and types of PPE based on estimated resource needs.	Needs Assessment
Planning Resource Element 2: Personal protective equipment caches (See Pg 48)	Build	Assess the need for additional caches of PPE based on estimated resource needs.	Needs Assessment
Planning Resource Element 3: Personal protective equipment supply and dispensing (See Pg 49)	No Activity	N/A	
Equipment & Technology 1: Personal Protective Equipment for healthcare workers (See Pg 49)	Build	Purchase PPE equipment consistent with identified risks.	Purchased equipment
Skills & Training 1: Personal protective equipment training. (See Pg 49)	Build	Identify training opportunities related to PPE caches.	List of training opportunities.

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HPP Capability # 15 : Volunteer Management

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, engagement, and retention of volunteers to support healthcare organizations with the medical preparedness and response to incidents and events.

Goal: Ensure that the healthcare coalitions have or have access to plans, processes, and procedures to manage volunteers, including rapid verification of credentials and affiliation with deployed entities. To determine whether awardees are able to meet requests for volunteers in a timely manner.

Performance Measure: The Performance Measures that will be used to capture awardee progress toward building this capability are:
•HPP-Specific Performance Measure: Percent of healthcare coalitions (HCCs) that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident.
•Joint HPP-PHEP Performance Measure: Proportion of volunteers deployed to support a public health/medical incident within an appropriate timeframe.
Below are the data elements that must be reported on for this capability at mid-year and end of year.

Allocated funding: $60,856

Performance Measure Data Element:
HPP 15.1: Does the HCC have procedures for identifying the type and quantity of volunteers needed to support healthcare response?
HPP 15.2: Does the HCC have or have access to an electronic registration system for recording and managing volunteer information that is compliant with the current guidelines of the HHS ESAR-VHP program?
HPP 15.3: Has the HCC coordinated with the State and HCC members to develop plans, processes and procedures to manage volunteers that address the following areas:
15.3.1 - Receiving volunteers
15.3.2 - Determining volunteer affiliation, including procedures for integrating or referring non-registered or spontaneous volunteers
15.3.3 - Confirming volunteer credentials
15.3.4 - Assigning roles and responsibilities to volunteers
15.3.5 - Providing just in time training for volunteers
15.3.6 - Tracking volunteers
15.3.7 - Out-processing volunteers
HPP 15.4: Has the HCC successfully tested its plans, processes and procedures for managing volunteers during an exercise or event within the past year?
HPP 15.5: If yes, has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?

– JOINT PERFORMANCE MEASURES –
HPP-PHEP 15.2: On each incident/planned event/exercise reported for demonstration of the Volunteer Management Capability, please answer the following information:
HPP-PHEP 15.2.1: This incident /planned event/exercise utilized or demonstrated one or more function(s) within the:
HPP-PHEP 15.2.2: The request for volunteers occurred during a (select one):
HPP-PHEP 15.2.3: The type of incident/exercise/planned event upon which the request for volunteers was based (select all that apply):

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

HPP-PHEP 15.2.4: Biological hazard or disease or other specified
HPP-PHEP 15.2.5: The name of the incident/planned event/exercise
HPP-PHEP 15.2.6: The date of the incident/planned event/exercise
HPP-PHEP 15.2.7: The date/time when request for volunteers was received by health/medical lead.
HPP-PHEP 15.2.8: The number of volunteers requested to deploy from the originating requestor (denominator)
HPP-PHEP 15.2.9: The entity that made the original request for volunteers (drop-down)
HPP-PHEP 15.2.10: Other entity specified
HPP-PHEP 15.2.11: The date/time when volunteers were requested to arrive at staging area or on scene by health and medical lead
HPP-PHEP 15.2.12: The requested location for the deployment (select one):
HPP-PHEP 15.2.13: The number of volunteers who were notified to deploy ("activated")
HPP-PHEP 15.2.14: The date/time when the last volunteer was notified to deploy (i.e., "activated")
HPP-PHEP 15.2.15: The number of volunteers who arrived at staging area/on scene within requested timeframe (numerator)
HPP-PHEP 15.2.16: Number of deployed volunteers registered in ESAR-VHP
HPP-PHEP 15.2.17: Number of deployed volunteers registered in other systems
HPP-PHEP 15.2.18: Date/time that last volunteer arrived at staging area/on scene within requested timeframe
HPP-PHEP 15.2.19: Barriers /challenges to deploying volunteers to support a public health/medical incident within requested timeframe

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
Ensure that Renown, St. Mary's, Northern Nevada and Incline Village Health Center and other healthcare organizations have or have access to plans, processes, and procedures to contact the MRC Program Coordinator to utilize MRC volunteers; including rapid verification of credentials and affiliation with deployed entities. To assure that WCHD's MRC program will be able to meet requests for volunteers in a timely manner. Additionally, ongoing training opportunities will be scheduled and made available for MRC Volunteers to improve skill by the end of BP2s.	MOU's or agreements will be developed to ensure that in the occurrence of the need to utilize MRC-volunteers; Renown, St. Mary's, Northern Nevada and Incline Village Health Centers will be the target. Additionally, the American Red Cross will also be included in the process.	Written MOU's or agreements that outlines the process with each of the healthcare facilities identified.

Function #1: Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations

Objective

Prior to an incident or event the MRC Coordinator will develop written plans along with WC hospitals to determine which situations would warrant the use of MRC volunteers. Once the "need responses" for volunteers are determined training initiatives will be developed to address these situations by the end of BP2.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

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Task 1: Assess which situations would necessitate the need for the use of volunteers in healthcare organizations during response and participate in the planning that would provide this as an option when needed. (See Pg 50)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$4,325	MRC coordinator will utilize information obtained from local healthcare agencies and the American Red Cross to develop written plans to establish what situations would warrant the use of MRC-volunteers. MRC volunteer information in E- Coordinator, which is the WCHD's electronic volunteer registration system, will be used to update and identify volunteers to respond to the new written response plans.	Ongoing during budget period	The revised written response plans.

Task 2: Identify the type and quantity of volunteers most likely needed to support healthcare response based on the risk assessments, hazard vulnerability assessments, resource assessments and other data that may provide clarity into anticipated needs. (See Pg 50)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$10,728	MRC Coordinator will update E-Coordinator with volunteers who would most likely be able to support a health care response based upon the risk assessment needs data information that will be gathered from the local healthcare organizations.	Ongoing during budget period	The number volunteers needed based upon the risk assessment needs data.

Task 3: Prior to an incident or event, participate with volunteer planning for pre-incident screening and verification of volunteers' credentials for healthcare professionals that may be used in healthcare organizations. (See Pg 50)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$9,650	MRC Coordinator will recruit new volunteers through media and participate in events that will promote MRC mission. E-Coordinator will also be updated with new volunteers and existing volunteers credentialed information.	Ongoing during budget period	Number of MRC volunteers information that is updated and sustained.

Task 4: Prior to an incident or event, participate with training initiatives for the planning of initial and ongoing emergency response training for registered volunteers that may be used in healthcare organizations during response. (See Pg 50)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$7,762	MRC coordinator will plan training programs for MRC volunteers in the areas of: ICS 100, 200 & 700, Shelter Training, CPR First/Aid, Basic Disaster Life Support and Psychological First Aid. Additional relevant training opportunities may also be identified for volunteers.	Ongoing during budget period	Number of training programs made available to MRC volunteers and the actual number that attends.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Volunteer needs	Sustain	MRC Coordinator will update E-Coordinator	The Number of volunteers

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

assessment for healthcare organizations response. (See Pg 50)		with volunteers who would most likely be able to support a health care response based upon the risk assessment needs data information that will be gathered from the WC Hospitals/healthcare organizations.	identified to support a healthcare risk from the needs risk assessment data.
Planning Resource Element 2: Collect, assemble, maintain, and utilize volunteer information. (See Pg 51)	Sustain	MRC Coordinator will recruit new volunteers through media and participate in events that will promote MRC mission. E-Coordinator will also be updated with new volunteers and existing volunteers credentialed information.	Number of MRC volunteers information that is updated and sustained.
Equipment & Technology 1: Electronic volunteer registration system. (See Pg 51)	Sustain	MRC volunteer information in E- Coordinator, which is the WCHD's electronic volunteer registration system, will be used to update and identify volunteers to respond to the new written response plans	The newly developed written response plans and updated information in E-Coordinator

Function #2: Volunteer notification for healthcare response needs

Objective

MRC Coordinator will review and revise the current MRC volunteer request process to ensure that prospective volunteers are mobilized in the appropriate health professional role for WCHD's response by the end of BP2.

Task 1: At the time of an incident, determine the volunteers needed to assist the healthcare organization response including the role and quantity of volunteers needed; communicate requests using the established volunteer request process. (See Pg 51)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$4,181	MRC coordinator will review and revise where needed the current healthcare organization's written request procedure at the time of an incident for volunteers needed to assist. The role and quantity of volunteers needed will also be assessed which will be aided with the use of E-Coordinator (computerized volunteer system).	Ongoing during budget period	The written request process that will ensure proper volunteer response.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Process to contact registered volunteers. (See Pg 51)	Sustain	MRC coordinator will edit the current written draft "call down" procedure that at the time of an incident determines the MRC volunteers needed to assist the WC Hospitals or healthcare organizations response	The number of MRC volunteers identified and able to respond and assist in the event of a "call down process."

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

		including the role and quantity of volunteers needed with along with the use of E-Coordinator; communicate requests using the State's established volunteer request process.	
Planning Resource Element 2: Process to confirm credentials of responding volunteers. (See Pg 51)	Sustain	MRC coordinator will check with State licensing Departments and/or also request copies of certifications licenses from new and current volunteers.	The number of MRC volunteers credentials that are confirmed.
Planning Resource Element 3: Volunteer request process. (See Pg 51)	Sustain	MRC coordinator will use State's established volunteer request process.	The use of Nevada's established volunteer request process.

Function #3: Organization and assignment of volunteers

Objective

MRC Coordinator will develop a written protocol for allocating MRC volunteers that are needed simultaneously across several healthcare organizations. This process will include the placement of volunteers through the appropriate deployment channels and match the assignment of volunteers to the needs of the requesting WC healthcare organizations that will be based on volunteer availability by the end of BP2.

Task 1: Develop a process to assist healthcare organizations with volunteer placement during an incident that includes multi-agency coordination between healthcare organizations in order to deconflict the needs of multiple healthcare organizations with the availability of volunteers. (See Pg 52)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$10,122	MRC Coordinator will revise current standard operating procedures on the written a call down procedure to minimize conflict of MRC Volunteers availability during an incident. The "healthcare requesting procedure" data will be used to help identify healthcare organizations needs.	Ongoing during budget period	The written multi-agency coordination plan.

Task 2: Develop a process to assist healthcare organizations with the provision of deployment briefings, tracking and rotation of volunteers, spontaneous volunteer management, safety and incident-specific training. (See Pg 52)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain	$5,726	MRC Coordinator will revise and create written protocols for the deployment of registered volunteers; tracking and handling of spontaneous volunteers, and ensuring all volunteer personal safety in responding to incidents. This may require a simulated exercise of volunteers to test the effectiveness of the process along instituting a just in time exercise.	Ongoing during budget period	The written protocol for deployment.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned ActivityType	Planned Activity Description	Output Documentation
Planning Resource Element 1: Volunteer deployment protocols. (See Pg 52)	Sustain	MRC Coordinator will develop written protocols for the deployment of registered volunteers; tracking and handling of spontaneous volunteers, and ensuring all volunteer personal safety in responding to incidents. This may require training of volunteers in the process.	The written protocols.
Planning Resource Element 2: Briefing template for healthcare volunteers. (See Pg 52)	Sustain	MRC Coordinator will develop written protocols.	The written protocol.
Planning Resource Element 3: Volunteer support services. (See Pg 52)	Sustain	MRC Coordinator will provide training and information to MRC volunteers.	The kind of training and or information that volunteers are provided.

Function #4: Coordinate the demobilization of volunteers

Objective

MRC Coordinator will Coordinate the demobilization of MRC volunteers based on evolving incident requirements or incident status. This includes coordination with the appropriate partner agencies to ensure provision of medical and mental/behavioral health support needed for the volunteers' physical and mental well-being by the end of BP2.

Task 1: Coordinate with incident management and the appropriate jurisdictional volunteer organizations to ensure the proper out processing of volunteers. (See Pg 53)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$4,181	MRC Coordinator will collaborate and work with select incident management personnel and localher health care coalition organizations, along with the MRC Volunteers to ensure the proper documentation on the out-processing of volunteers will be developed in written plans.	Ongoing during budget period	The development of the written plans.

Task 2: Coordinate with incident management and the appropriate jurisdictional volunteer organizations to identify community resources that can support volunteer post-deployment medical screening, stress, well-being assessments and, when requested or indicated, have a process to refer volunteers to medical and mental/behavioral health services. (See Pg 138)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Build	$4,181	MRC Coordinator will collaborate in the coordination and participate with select incident management personnel and the MRC volunteers to identify the kinds and types of community resources that can support volunteer post-deployment medical screening, stress, and well-being assessments; while also establishing a process to refer volunteers to medical and mental/behavioral	Ongoing during budget period	An informational list on the kinds and types of deployment services that are made available to volunteers.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

		health services.		

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Volunteer Release Processes. (See Pg 53)	Sustain	MRC Coordinator will help in the coordination and participate with incident management and the MRC volunteers to identify community resources that can support volunteer post-deployment medical screening, stress, and well-being assessments and when requested or indicated, have a process to refer volunteers to medical and mental/behavioral health services.	The written kinds and types of deployment services that are made available to volunteers.
Planning Resource Element 2: Volunteer exit screening protocols. (See Pg 53)	Sustain	MRC Coordinator will help in the coordination and participate with incident management personnel and the MRC volunteers to identify community resources that can support volunteer exit screening process and medical screening, stress, and well-being assessments and when requested or indicated, have a process to refer volunteers to medical and mental/behavioral health services.	The written kinds and types of deployment services that are made available to volunteers

Washoe County Health District

Public Health
Prevent. Promote. Protect.

STAFF REPORT
BOARD MEETING DATE: September 26, 2013

DATE: September 17, 2013

TO: District Board of Health

FROM: Patsy Buxton, Fiscal Compliance Officer, Washoe County Health District PB
775-328-2418, pbuxton@washoecounty.us

THROUGH: Eileen Stickney, Administrative Health Services Officer, Washoe County Health District, 775-328-2417, estickney@washoecounty.us PB AS

SUBJECT: Approval of Subgrant Amendment #2 from the Division of Public and Behavioral Health in the total amount of $1,045,473 (with $104,547.30 or 10% match) for the budget period July 1, 2012 through December 31, 2013 in support of the Centers for Disease Control and Prevention (CDC) Public Health Preparedness Program; approve amendments totaling an increase of $128,275 in both revenue and expense to the FY14 CDC Public Health Preparedness Federal Grant Program, IO 10713; and if approved authorize the Chairman to execute.

SUMMARY

The Washoe County District Board of Health must approve and execute, or direct the Health Officer to execute, contracts in excess of $50,000, Interlocal Agreements and amendments to the adopted budget.

The Washoe County Health District received a Subgrant Amendment #2 from the Division of Public and Behavioral Health for the period July 1, 2012 (corrected from 7/1/13) through December 31, 2013 in the total amount of $1,045,473 in support of the CDC Public Health Preparedness Grant Program. A copy of the Subgrant Amendment #2 is attached.

District Board of Health strategic priority: Protect population from health problems and health hazards.

BCC Strategic Objective supported by this item: Safe, Secure and Healthy Communities.

This item supports the Epidemiology and Public Health Preparedness (EPHP) Division's mission to strengthen the capacity of public health infrastructure to detect, assess, and respond decisively to control the public health consequences of bioterrorism events or any public health emergency.

PREVIOUS ACTION
The District Board of Health approved the Notice of Subgrant Award from the Nevada State Health Division in the amount of $665,000 for the period July 1, 2012 to June 30, 2013 insupport of the CDC Public Health Preparedness Program at their August 23, 2012 meeting.

BACKGROUND
The Nevada State Health Division has awarded the Public Health Preparedness Program $1,045,473 for the budget period July 1, 2012 through December 31, 2013. Funds will be used to support personnel, travel, other professional services, and operating expenditures. Items include but are not limited to: hydration and nutrition (water/juice/coffee and snacks/light lunch) to be provided for participants in training exercises, meetings and other grant activities to ensure continuity of active participation; Incentives (non-cash value gift cards such as Walmart, Starbucks, etc) to be provided to preparedness training facilitators, etc. who volunteer their time training staff; incentives for meeting and training participants.

The FY14 CDC Budget was projected at $665,000. Budget period 2 only reflects six months of authority. It is anticipated that a second round of funding in the amount of $380,473 will be awarded after the next Interim Finance Committee meeting scheduled for October 22, 2013. There was $63,773 in unspent funds from budget period 1. The budget amendment takes into account receiving the second round of funding and will bring the Notice of Subgrant Award into alignment with the program budget.

This award currently includes $40,376 of indirect revenue. No budget adjustment is needed for the indirect revenue.

This budget amendment will also require Board of County Commissioners approval.

FISCAL IMPACT
Should the Board approve these budget amendments, the adopted FY 14 budget will be **increased by $128,275** in the following accounts:

Account Number	Description	Amount of Increase/(Decrease)
2002-IO-10713-431100	**Federal Revenue**	**$128,275**
	Total Revenue	**$128,275**
2002-IO-10713-701130	Pooled Positions	1,955
2002-IO-10713-701412	Salary Adjustment	18,982
2002-IO-10713-705360	Benefit Adjustment	(13,398)
2002-IO-10713-710100	Professional Svcs	94,720
2002-IO-10713-710110	Contracted/Temp Services	24,809
2002-IO-10713-710205	Repairs and Maintenance	(500)
2002-IO-10713-710300	Operating Supplies	(1,950)
2002-IO-10713-710334	Copy Machine Expense	50
2002-IO-10713-710350	Office Supplies	3,000
2002-IO-10713-710355	Books and Subscriptions	325
2002-IO-10713-710360	Postage	(50)
2002-IO-10713-710361	Express and Courier	(50)

2002-IO-10713-710500	Other Expense	750
2002-IO-10713-710502	Printing	(200)
2002-IO-10713-710505	Rental Equipment	127
2002-IO-10713-710508	Telephone Land Lines	950
2002-IO-10713-710509	Seminars and Meetings	1,300
2002-IO-10713-710512	Auto Expense	(300)
2002-IO-10713-710529	Dues	35
2002-IO-10713-710872	Food Purchases	800
2002-IO-10713-711010	Utilities	(180)
2002-IO-10713-711114	Equip Srv O & M	26
2002-IO-10713-711210	Travel	(2,676)
2002-IO-10713-711504	Equipment nonCapital	(250)
	Total Expenditures	**$128,275**

RECOMMENDATION

Staff recommends that the Washoe County District Board of Health approve Subgrant Amendment #2 from the Division of Public and Behavioral Health in the total amount of $1,045,473 (with $104,547.30 or 10% match) for the budget period July 1, 2012 through December 31, 2013 in support of the Centers for Disease Control and Prevention (CDC) Public Health Preparedness Program; approve amendments totaling an increase of $128,275 in both revenue and expense to the FY14 CDC Public Health Preparedness Federal Grant Program, IO 10713; and if approved authorize the Chairman to execute.

POSSIBLE MOTION

Move to approve Subgrant Amendment #2 from the Division of Public and Behavioral Health in the total amount of $1,045,473 (with $104,547.30 or 10% match) for the budget period July 1, 2012 through December 31, 2013 in support of the Centers for Disease Control and Prevention (CDC) Public Health Preparedness Program; approve amendments totaling an increase of $128,275 in both revenue and expense to the FY14 CDC Public Health Preparedness Federal Grant Program, IO 10713; and if approved authorize the Chairman to execute.

Department of Health and Human Services
Division Public & Behavioral Health
(hereinafter referred to as the DIVISION)

Division #:	**13015-2**
Program #:	CDC08-13
Budget Account #:	3218
Category #:	22
GL #:	8501
Job #:	9306913

SUBGRANT AMENDMENT #2

Program Name:	**Subgrantee Name:**
Public Health Preparedness Health Planning & Emergency Response Division Public & Behavioral Health	Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite #200 Carson City, NV 89706-2009	**Address:** 1001 East Ninth Street Reno, NV 89520
Subgrant Period: July 1, 2012 through June 30, 2017 **Subgrant Budget Period:** July 1, 2012 through December 31, 2013	**Subgrantee's** **EIN#:** 88-6000138 **Vendor#:** T40283400Q **Dun & Bradstreet#:** 073786998

Source of Funds:	**% of Funds:**	**CFDA#:**	**Federal Grant #:**
1. Center for Disease Control and Prevention	**100%**	**93.069**	**5U90TP000534-02**

Amendment #2:

The purpose of this amendment is to increase the funding by $380,473 to cover expenses incurred during six months of Budget Period 2 (July 1, 2012 through December 31, 2013) and to add a new Scope of Work for Budget Period 2 as detailed in Attachment A and B. The new grand total for this subgrant award is $1,045,473.00.

	Budget Period 1 (7/1/12-6/30/13)	**Budget Period 2 (7/1/13-12/31/13)**	**Grand Total (7/1/12-12/31/13)**
1. Personnel	$ 425,585	$ 269,172.50	$ 694,757.50
2. Contractual/Consultant	$ 115,634	$ 57,112.00	$ 172,746.00
3. Travel	$ 10,200	$ 5,062.00	$ 15,262.00
4. Equipment	$ 0	$ 0	$ 0
5. Supplies	$ 18,936	$ 2,625.00	$ 21,561.00
6. Other	$ 45,823	$ 6,125.50	$ 51,948.50
7. Indirect	$ 48,822	$ 40,376.00	$ 89,198.00
Total Cost	**$ 665,000**	**$ 380,473.00**	**$ 1,045,473.00**

By signing this Amendment, the Authorized Subgrantee Official or their designee, Program Manager, Bureau Chief, and Health Division Administrator acknowledge the above as the new scope of work for the above referenced Subgrant. Further, the undersigned understand this amendment does not alter, in any substantial way, the non-referenced contents of the Original Subgrant Award and all of its Attachments.

	Signature	Date
Authorized Sub-grantee Official Washoe County Health District		
Erin Seward Health Program Manager II, PHP	Erin Seward	9/5/13
Chad Westom Bureau Chief	Chad Westom	9/6/13
Richard Whitley, MS Administrator, Division of Public and Behavioral Health	Vanessa Delpes	9.11.13

4 AF 9/10/13 POW 9/10/13

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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD

SECTION A
Assurances

- All original terms and conditions remain unchanged.

SECTION B
Description of services, scope of work, deliverables and reimbursement

- The attached Scope of Work is for Budget Period 2, July 1, 2013 through June 30, 2014 and is broken down by capability, task and function. Attachment A: Capability Summary, shows the estimated allocation of awarded funds and proposed subgrantee effort by capability. Attachment B contains the 15 capabilities under this subgrant award including, but not limited to, the subgrantee planned activities and performance measure planned activities.
- Achievement of Capability Objectives for Budget Period 2 to be completed by June 30, 2014. Outcome of the funded Capabilities will be measured by Division of Public and Behavioral Health. Each funded capability requires substantial achievement and demonstration of completion as specified in the Scope of Work of the funded functions and resource elements. If objectives are not met, Division of Public and Behavioral Health may reduce the amount of this subgrant award and reallocate funding to other preparedness priorities within the state.
- Submit written Progress Reports to the Division of Public & Behavioral Health electronically according to the following schedule. This schedule may change due to availability of reporting templates and scheduled site visits. The Quarterly Reports are cumulative progress reports and should be submitted with the Request for Reimbursement at the end of the month.

  - October 31, 2014 Quarterly Progress Report – Year 2 (For the period of 07/01/13 - 9/30/13)
  - January 31, 2014 Mid Year Progress Report – Year 2 (For the period of 07/01/13 - 12/31/13)
  - April 30, 2014 Quarterly Progress Report – Year 2 (For the period of 07/01/13 – 3/31/14)
  - July 31, 2014 Annual Progress Report – Year 2 (For the period of 07/01/13 - 06/30/14)
  - October 31, 2015 Quarterly Progress Report – Year 3 (For the period of 07/01/14 - 9/30/14)
  - January 31, 2015 Mid Year Progress Report – Year 3 (For the period of 07/01/14 - 12/31/14)
  - April 30, 2015 Quarterly Progress Report – Year 3 (For the period of 07/01/14 – 3/31/15)
  - July 31, 2015 Annual Progress Report – Year 3 (For the period of 07/01/14 – 06/30/15)
  - October 31, 2015 Quarterly Progress Report – Year 4 (For the period of 07/01/15 - 9/30/15)
  - January 15, 2016 Mid Year Progress Report – Year 4 (For the period of 07/01/15 – 12/31/15)
  - April 30, 2016 Quarterly Progress Report – Year 4 (For the period of 07/01/15 – 3/31/16)
  - July 31, 2016 Annual Progress Report – Year 4 (For the period of 07/01/15 – 06/30/16)
  - October 31, 2016 Quarterly Progress Report – Year 5 (For the period of 07/01/16 - 9/30/16)
  - January 15, 2017 Mid Year Progress Report – Year 5 (For the period of 07/01/16 – 12/31/16)
  - April 30, 2017 Quarterly Progress Report – Year 5 (For the period of 07/01/16 – 3/31/17)
  - July 31, 2017 Final Progress Report – Year 5 (For the period of 07/01/16 – 06/30/17)

- Schedule of Quarterly Match/Cost Sharing Reports remains unchanged.

(continued on next page)

Subgrantee agrees to adhere to the following Year 2 budget through December 31, 2013:

1.	Personnel	$ 269,172.50	Director, Epidemiology and Public Health Prep 75% Public Health Preparedness Manager 70% Administrative Secretary 50% Public Health Emergency Response Coordinator 95% Health Educator II 75% Public Information Officer 65% Public Health Emergency Response Coordinator 5% MRC Program Coordinator 50% Epidemiologist - Intermittent Hrly Position 100% Fringe Benefits (39.17%).
2.	Contractual/ Contract Services	$ 57,112.00	Regional Planner, Environmental Health Consultant, Pharmacist, Administrative Analysts and Administrative Support.
3.	Travel	$ 5,062.00	In-State and Out-of-State Travel in accordance with Federal GSA Rates.
4.	Equipment	$ 0	
5.	Supplies	$ 2,625.00	Office Supplies and Operating Supplies.
6.	Other	$ 6,125.50	Telephone Services; Postage; Copy Machine; Printing Books, Publications, Subscriptions; Membership Dues; Educational Supplies; Equipment Repair; Minor Furniture and Equipment; Rental Space/Meeting Incentives; Rental Space – Antiviral Storage; Equipment Services – Vehicle asset Management Fee / Operating and Maintenance /Charge (for truck) and Satellite phones.
7.	Indirect	$ 40,376.00	15.0% Direct Costs excluding capital expenditures, sub-awards and flow through funds.
	Total Cost	$ 380,473.00	

- The maximum approved funding under this subgrant has increased by $380,473.00 for six months of Year 2 budget period which covers July 1, 2013 through December 31, 2013. The grand total for this subgrant award is $1,045,473.00.

- Requests for Reimbursement will be accompanied by supporting documentation, including the Reimbursement Worksheet and any required invoice copies. All Budget Period 1 and Budget Period 2 expenses will be submitted separately. The Budget Period 2 Request for Reimbursement is included in Section C. Requests for Reimbursement are due on or before the 30th of the following month.

- At the end of this budget period WCHD may submit a written request for carry-over of unexpended funding into the next budget period. The carry-over request may not exceed 10% of the current budget period awarded amount or a total equal to or less than $38,047.30. The request to carry-over must be submitted by April 30, 2014 and include a breakdown of estimated carry-over funding by category and by capability, reason or barriers which resulted in the carry-over and the planned scope of work to be completed with these carry-over funds. Please Note that a Carry-Over request is not a guarantee.

- Costs associated with food or meals are NOT permitted unless included with per diem as a apart of official travel. Meals cannot be claimed within 50 miles of the official workstation.

- Subgrantee agrees to cost share/match a nonfederal contribution in the amount of 10% ($1 for each $10 of federal funds provided in this subgrant). The Cost Sharing/Match for Budget Year 2 will be $38,047.30 for a grand total Cost Sharing/Match of $104,547.30. This match may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services. Amounts provided by the federal government or services assisted or subsidized to any significant extent by the federal government may not be included in determining the amount of such nonfederal contributions. Documentation of match, including methods and sources must be available upon request of Division Public & Behavioral Health. Subgrantee will sign attached Match Certification (Attachment 1).

- Reimbursement Worksheet will be submitted along with each Request for Reimbursement:
  - Insert detailed breakdown of all monthly expenditures included in the attached reimbursement request (column c).
  - Provide complete travel detail including purpose of travel and attach copies of travel claim summary (if available).
  - Attached invoice copies for all items listed in Contract/Consultant and Equipment. Also attach invoices for all Supplies and Other purchases that are over $500 per item. **NOTE:** Supplies are items which have a consumable live of less than 1 year and Equipment are items over $5,000 per item OR have a consumable live of over 1 year (ie: laptops, iPads, printers, etc...).
  - Return document along with the monthly reimbursement request.

- Budget Request and Justification Form will be submitted along with each Request for Reimbursement:
  - Insert your total monthly expenditure amount from your attached reimbursement request in column a.
  - Provide the percentage of the capabilities these funds are to be applied against in column b.
  - If utilizing an electronic copy, this will auto-populate the dollar amount in column c.
  - Return document along with the monthly reimbursement request.

Request for Reimbursement form

- A Request for Reimbursement is due on a **monthly** basis, based on the terms of the subgrant agreement, no later than the **30th** of the month.
- Reimbursement is based on **actual** expenditures incurred during the period being reported.
- Payment will not be processed without all reporting being current and without the Reimbursement Worksheet.
- Reimbursement may only be claimed for expenditures approved within the Notice of Subgrant Award.
- **PLEASE REPORT IN DOLLARS and CENTS (No Rounding)**

Provide the following information on the top portion of the form: Subgrantee name and address where the check is to be sent, Health Division (subgrant) number, Bureau program number, draw number, employer I.D. number (EIN) and Vendor number.

An explanation of the form is provided below.

A. Approved Budget: List the approved budget amounts in this column by category.

B. Total Prior Requests: List the **total** expenditures for all previous reimbursement periods in this column, for each category, by entering the numbers found on Lines 1-8, Column D on the **previous** Request for Reimbursement/Advance Form. If this is the first request for the subgrant period, the amount in this column equals zero.

C. Current Request: List the **current** expenditures requested at this time for reimbursement in this column, for each category.

D. Year to Date Total: Add Column B and Column C for each category.

E. Budget Balance: Subtract Column D from Column A for each category.

F. Percent Expended: Divide Column D by Column A for each category and total. Monitor this column; it will help to determine if/when an amendment is necessary. Amendments MUST be completed (including all approving signatures) 30 days **prior** to the end of the subgrant period.

Nevada Department of Health and Human Services

Division Public & Behavioral Health

Public Health Preparedness Program

Division # 13015-2
Program # CDC08-13
GL # 8516
Job #: 9306913
Draw #: _____

Grand Total

REQUEST FOR REIMBURSEMENT

Program Name:	**Subgrantee Name:**	
Public Health Preparedness Health Planning & Emergency Response Nevada State Health Division	Washoe County Health District (WCHD)	
Address: 4150 Technology Way, Suite 200 Carson City, NV 89706	**Address:** 1001 East Ninth Street Reno, NV 89520	
Subgrant Period: July 1, 2012 through June 30, 2017 **Subgrant Budget Period:** July 1, 2013 through December 31, 2013	**Subgrantee EIN #:** **Subgrantee Vendor #:** **Dun & Bradstreet #:**	88-6000138 T40283400Q 73786998

FINANCIAL REPORT AND REQUEST FOR FUNDS

(report in dollars and cents; must be accompanied by expenditure report/back-up)

Month(s): **Calendar Year:**

	Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year To Date Total	E Budget Balance	F Percent Expended
1	Personnel	$ 694,758	$ 415,234.05	$ 0.00	$ 415,234.05	$ 279,523.45	60%
2	Contract/Consultant	$ 172,746	$ 73,184.87	$ 0.00	$ 73,184.87	$ 99,561.13	42%
3	Travel	$ 15,262	$ 8,194.81	$ 0.00	$ 8,194.81	$ 7,067.19	54%
4	Supplies	$ 21,561	$ 18,935.69	$ 0.00	$ 18,935.69	$ 2,625.31	88%
5	Equipment	$ 0	$ 0.00	$ 0.00	$ 0.00	$ 0.00	0%
6	Other	$ 51,949	$ 44,360.42	$ 0.00	$ 44,360.42	$ 7,588.08	85%
7	Indirect	$ 89,198	$ 41,316.81	$ 0.00	$ 41,316.81	$ 47,881.19	0%
8	**Total**	$ 1,045,473	$ 601,226.65	$ 0.00	$ 601,226.65	$ 444,246.35	58%

This report is true and correct to the best of my knowledge.

Authorized Signature Title Date

Reminder: Request for Reimbursement cannot be processed without an expenditure report/backup. Reimbursement is only allowed for items contained within Subgrant Award documents. If applicable, travel claims must accompany report.

FOR HEALTH DIVISION USE ONLY

Program contact necessary? _____ Yes _____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____ Signed: _____

Scope of Work review/approval date: _____ Signed: _____

ASO or Bureau Chief (as required): _____ Date: _____

Nevada Department of Health and Human Services

Division Public & Behavioral Health

Public Health Preparedness Program

Division # 13015-1
Program # CDC08-12
GL # 8516
Job #: 9306912B
Draw #: _____

Budget Period 1

REQUEST FOR REIMBURSEMENT

Program Name: Public Health Preparedness Health Planning & Emergency Response Nevada State Health Division	**Subgrantee Name:** Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite 200 Carson City, NV 89706	**Address:** 1001 East Ninth Street Reno, NV 89520
Subgrant Period: July 1, 2012 through June 30, 2017 **Subgrant Budget Period:** July 1, 2012 through June 30, 2013	**Subgrantee EIN #:** 88-6000138 **Subgrantee Vendor #:** T40283400Q **Dun & Bradstreet #:** 73786998

FINANCIAL REPORT AND REQUEST FOR FUNDS

(report in dollars and cents; must be accompanied by expenditure report/back-up)

Month(s): **Calendar Year:**

	Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year To Date Total	E Budget Balance	F Percent Expended
1	Personnel	$ 425,585	$ 415,234.05	$ 0.00	$ 415,234.05	$ 10,350.95	98%
2	Contract/Consultant	$ 115,634	$ 73,184.87	$ 0.00	$ 73,184.87	$ 42,449.13	63%
3	Travel	$ 10,200	$ 8,194.81	$ 0.00	$ 8,194.81	$ 2,005.19	80%
4	Supplies	$ 18,936	$ 18,935.69	$ 0.00	$ 18,935.69	$ 0.31	100%
5	Equipment	$ 0	$ 0.00	$ 0.00	$ 0.00	$ 0.00	0%
6	Other	$ 45,823	$ 44,360.42	$ 0.00	$ 44,360.42	$ 1,462.58	97%
7	Indirect	$ 48,822	$ 41,316.81	$ 0.00	$ 41,316.81	$ 7,505.19	0%
8	**Total**	$ 665,000	$ 601,226.65	$ 0.00	$ 601,226.65	$ 63,773.35	90%

This report is true and correct to the best of my knowledge.

Authorized Signature Title Date

Reminder: Request for Reimbursement cannot be processed without an expenditure report/backup. Reimbursement is only allowed for items contained within Subgrant Award documents. If applicable, travel claims must accompany report.

FOR HEALTH DIVISION USE ONLY

Program contact necessary? _____ Yes _____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____ Signed: _____

Scope of Work review/approval date: _____ Signed: _____

ASO or Bureau Chief (as required): _____ Date: _____

Nevada Department of Health and Human Services

Division Public & Behavioral Health

Public Health Preparedness Program

Budget Period 2

Division # 13015-2
Program # CDC08-13
GL # 8516
Job #: 9306913
Draw #: _____

REQUEST FOR REIMBURSEMENT

Program Name: Public Health Preparedness Health Planning & Emergency Response Nevada State Health Division	**Subgrantee Name:** Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite 200 Carson City, NV 89706	**Address:** 1001 East Ninth Street Reno, NV 89520
Subgrant Period: July 1, 2012 through June 30, 2017 **Subgrant Budget Period:** July 1, 2013 through December 31, 2013	**Subgrantee EIN #:** 88-6000138 **Subgrantee Vendor #:** T40283400Q **Dun & Bradstreet #:** 73786998

FINANCIAL REPORT AND REQUEST FOR FUNDS

(report in dollars and cents; must be accompanied by expenditure report/back-up)

Month(s): **Calendar Year:**

	Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year To Date Total	E Budget Balance	F Percent Expended
1	Personnel	$ 269,173	$ 0.00	$ 0.00	$ 0.00	$ 269,172.50	0%
2	Contract/Consultant	$ 57,112	$ 0.00	$ 0.00	$ 0.00	$ 57,112.00	0%
3	Travel	$ 5,062	$ 0.00	$ 0.00	$ 0.00	$ 5,062.00	0%
4	Supplies	$ 2,625	$ 0.00	$ 0.00	$ 0.00	$ 2,625.00	0%
5	Equipment	$ 0	$ 0.00	$ 0.00	$ 0.00	$ 0.00	0%
6	Other	$ 6,126	$ 0.00	$ 0.00	$ 0.00	$ 6,125.50	0%
7	Indirect	$ 40,376	$ 0.00	$ 0.00	$ 0.00	$ 40,376.00	0%
8	**Total**	$ 380,473	$ 0.00	$ 0.00	$ 0.00	$ 380,473.00	0%

This report is true and correct to the best of my knowledge.

Authorized Signature Title Date

Reminder: Request for Reimbursement cannot be processed without an expenditure report/backup. Reimbursement is only allowed for items contained within Subgrant Award documents. If applicable, travel claims must accompany report.

FOR HEALTH DIVISION USE ONLY

Program contact necessary? _____ Yes _____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____ Signed: _____

Scope of Work review/approval date: _____ Signed: _____

ASO or Bureau Chief (as required): _____ Date: _____

Washoe County Health District (WCHD)
Reimbursement Worksheet
July 1 - July 31, 2013

Personnel	Title	Description	Amount
		TOTAL	

Contract / Consultant	Description	Amount
	TOTAL	

Travel (Name of Traveler)	Travel Dates	To	Mileage @ $0.565/mi	Lodging & Per Diem	AirFare & Misc	Purpose/ Description	Amount
						TOTAL	

Supplies	Description	Amount
	TOTAL	

Equipment	Description (attach invoice copies for all items)	Amount
	TOTAL	

Other	Description	Amount
	TOTAL	

Indirect	Description	Amount
	TOTAL	
	TOTAL EXPENDITURES	

Nevada State Division of Public & Behavioral Health: Public Health Preparedness
Centers for Disease Control and Prevention (CDC)
Budget Request and Justification Form
Washoe County Health District (WCHD)
July 1, 2013 through June 30, 2014

Contact Name:	Jeff Whiteside
Phone Number:	775-328-6130
E-Mail Address:	jwhitesides@washoecounty.us
Applicant/Agency Name:	WCHD
Total Agency Request:	$760,946 - Year 2

** Insert your total monthly expenditure amount below from your attached reimbursement request in column a. Provide the percentage of the capabilities these funds are to be applied against in column b. If utilizing an electronic copy this will auto-populate the dollar amount in column c. Return this document along with your monthly reimbursement request. This will provide a tracking to expedite the mid- and end-of-year progress reporting.
**Please contact us if you have any questions.

Budget Summary

	(a)	(b)	(c)
Monthly Expenditure:		Current % Utilized	Current $ Utilized
CDC Capabilities:			
1. Community Preparedness:			
F1: Determine risks to the health of the jurisdiction			$ -
F2: Build community partnerships to support health preparedness			$ -
F3: Engage with community organizations to foster public health, medical, and mental/behavioral health social networks			$ -
F4: Coordinate training or guidance to ensure commur engagement in preparedness efforts			$ -
2. Community Recovery:			
F1: Identify and monitor public health, medical, and mental/ behavioral health system recovery needs			$ -
F2: Coordinate community public health, medical, and mental/ behavioral health system recovery operations			$ -
F3: Implement corrective actions to mitigate damages incidents			$ -
3. Emergency Operations Coordination:			
F1: Conduct preliminary assessment to determine need for public activation			$ -
F2: Activate public health emergency operations			$ -
F3: Develop incident response strategy			$ -
F4: Manage and sustain the public health response			$ -
F5: Demobilize and evaluate public health Emergency operations			$ -
4. Emergency Public Information and Warning:			
F1: Activate the emergency public information system			$ -
F2: Determine the need for a joint public information system			$ -
F3: Establish and participate in information system operations			$ -
F4: Establish avenue for public interaction and information exchange			$ -
F5: Issue public information, alerts, warnings, and notifications			$ -

	(a)	(b)	(c)
Monthly Expenditure:		Current % Utilized	Current $ Utilized
CDC Capabilities:			
5. Fatality Management:			
F1: Determine role for public health in fatality management			$ -
F2: Activate public health fatality management operations			$ -
F3: Assist in the collection and dissemination of antemortem data			$ -
F4: Participate in survivor mental/behavior health services			$ -
F5: Participate in fatality processing and storage operations			$ -
6. Information Sharing:			
F1: Identify stakeholders to be incorporated into information flow			$ -
F2: Identify and develop rules and data elements for sharing			$ -
F3: Exchange information to determine a commmon operating picture			$ -
7. Mass Care: **No Activity**			
8. Medical Countermeasure Dispensing:			
F1: Identify and initiate medical countermeasure dispensing strategies			$ -
F2: Receive medical countermeasurers			$ -
F3: Activate dispensing modalities			$ -
F4: Dispense medical countermeasures to identified population			$ -
F5: Report adverse events			$ -
9. Medical Material Management and Distribution:			
F1: Direct and activate medical material management and distribution			$ -
F2: Acquire medical material			$ -
F3: Maintain updated inventory management and reporting system			$ -
F4: Estabish and maintain security			$ -
F5: Distribute medical material			$ -
F5: Recover medical material and demobilize distribution operations			$ -
10. Medical Surge:			
F1: Assess the nature and scope of the incident			$ -
F2: Support activation of medical surge			$ -
F3: Support jusrisdictional medical surge operations			$ -
F4: Support demobilization of medical surge operations			$ -
11. Non-Pharmaceutical Interventions:			
F1: Engage partners and identify factors that impact non-pharmaceutical interventions			$ -
F2: Determine non-pharmaceutical intervention			$ -
F3: Implement non-pharmaceutical interventions			$ -
F5: Monitor non-pharmaceutical interventions			$ -
12. Public Health Laboratory Testing: **No Activity**			
13. Public Health Surveillance and Epi Investigation:			
F1: Conduct public health surveillance and detection			$ -
F2: Conduct public health and epidemiological investigations			$ -
F3: Recommend, monitor, and analyze mitigation actions			$ -
F4: Improve public health surveillance and epidemiological investigation systems			$ -

Budget Summary - Page 3

	(a)	(b)	(c)
Monthly Expenditure:		Current % Utilized	Current $ Utilized
CDC Capabilities:			
14. Responder Safety and Health:			
F1: Identify responder safety and health risks			$ -
F2: Identify safety and personal protective needs			$ -
F3: Coordinate with partners to facilitate risk-specific safety and health training			$ -
F3: Exchange information to determine a commmon operating picture			$ -
15. Volunteer Management:			
F1: Coordinate volunteers			$ -
F2: Notify volunteers			$ -
F3: Organize, assemble, and dispatch volunteers			$ -
F4: Demobilize volunteers			$ -
			$ -

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ATTACHMENT 1

CDC08-13

Nevada State / Division Public & Behavioral Health
Public Health Preparedness Program
Match Certification

Date: _____

External Funding Source: Centers for Disease Control (CDC)- Public Health Emergency Preparedness (PHEP)

A mandatory cost sharing/matching cost contribution is required for the following proposal:

Funding Recipient: Washoe County Health District (WCHD)

Project Title: HPP and PHEP Cooperative Agreement

Project Grant #: 5U90TP000534-02

Duration: **From:** July 1, 2013 **To:** December 31, 2013

Total cost sharing/matching cost contribution: $38,047.30 / Percentage: 10%

Source of cost sharing/matching cost contribution:

Name: _____

Account # (if applicable): _____

Funding recipient hereby certifies that the identified cost sharing/matching cost contribution is not being used to match any other funding source.

Washoe County Health District

Name and Title (Funding Recipient) **Signature** **Date**

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Attachment A: Capability Summary

Washoe County Health District (WCHD)
CDC Public Health Emergency Preparedness (BP2) Subgrant # CDC 08-13
July 1, 2013 - June 30, 2014
Funding - Budget Perod 2: $760,946

Budget %	Fund Allocation	Capability / Function Name				
9.2%	$69,954	1	Community Preparedness			
		Sustain	F1	Determine risks to the health of the jurisdiction		
			Sustain	T1	Utilize jurisdictional risk assessment to identify for which the jurisdiction needs to have access to mitigate identified disaster health risks.	
			Sustain	T2	Utilize jurisdictional risk assessment to identify within the jurisdiction that currently support the mitigation of identified disaster health risks.	
				Sustain	P1	Identification of vulnerable populations.
				Sustain	P2	Jurisdictional risk assessment related to public health, medical, and mental/behavioral health.
				Sustain	S1	Person(s) with expertise in GIS to assist in locating/mapping at-risk populations.
		Build	F2	Build community partnerships to support health preparedness.		
			Sustain	T1	Identify community sector groups to be engaged for partnership based upon the jurisdictional risk assessment.	
			Sustain	T2	Create and implement strategies for ongoing engagement with community partners who may be able to provide services to mitigate identified public health threats or incidents	
			Build	T3	Utilize community agencies to help assure the community's ability to deliver public health, medical, and mental/behavioral health services in both short and long term settings during and after an incident.	
			Sustain	T4	Utilize a continuous quality improvement process to incorporate feedback from community and faith-based partners into jurisdictional emergency operations plans.	
			Build	T5	Identify community leaders that can act as trusted spokespersons to deliver public health messages.	
				Build	P1	Participation in existing or new partnerships representing the listed community sectors.
				Sustain	P2	Protocol to encourage or promote medical personnel to register and participate with MRC or
		Build	F3	Engage with community organizations to foster public health, medical, and mental/behavioral health social networks.		
			Build	T1	Ensure that community constituency groups understand how to connect to public health to participate in public health and community partner preparedness efforts.	
			Sustain	T2	Ensure that public health, medical, and mental/behavioral health service agencies that provide essential health services to the community are connected to jurisdictional public health preparedness plans and efforts.	
			Build	T3	Create jurisdictional networks for public health, medical, and mental/behavioral health information dissemination before, during, and after the incident.	
				Sustain	P1	Public health approaches to address children's medical and mental/behavioral health needs.
				Sustain	P2	Building and sustaining volunteer opportunities for community residents.

Attachment A: Capability Summary

		Build	F4	Coordinate training or guidance to ensure community engagement in Preparedness Efforts		
			Build	T1	Integrate information on resilience into existing training and educational programs related to crisis and disaster preparedness and response.	
			Build	T2	Promote training to community partners that may have a supporting role to public health, medical, and mental/behavioral health sectors	
			Build	T3	Provide guidance to community partners to assist them in educating their own constituency groups regarding plans for addressing preparedness for and recovery from the jurisdiction's identified risks and for access to health services that may apply to the incident.	
				Build	P1	Public health approaches to address children's medical and mental/behavioral health needs.
				Sustain	P2	Building and sustaining volunteer opportunities for community residents.
14%	$109,656	2	Community Recovery			
		Build	F1	Identify and monitor public health, medical, and mental/behavioral health system recovery needs.		
			Sustain	T1	In collaboration with jurisdictional partners, document short-term and long-term health service delivery priorities and goals.	
			Sustain	T2	Identify the services that can be provided by the public health agency and by community and faith-based partners that were identified prior to the incident as well as by new community partners that may arise during the incident response.	
			Sustain	T3	Activate plans previously created with neighboring jurisdictions to provide identified services that the jurisdiction does not have the ability to provide during and after an incident.	
			Build	T4	In conjunction with healthcare organizations determine the community's health service priorities and goals that are the responsibility of public health.	
				Sustain	P1	Identify recovery needs
				Sustain	P2	Community assessment
				Build	P3	Operational plans
		Build	F2	Coordinate community public health, medical, and mental/behavioral health system recovery operations.		
			Build	T1	Participate with the recovery lead jurisdictional agencies to ensure that the jurisdiction can provide health services needed to recover from a physical or mental/behavioral injury, illness, or exposure sustained as a result of the incident, with particular attention to the functional needs of at-risk persons.	
			Build	T2	Inform the community of the availability of mental/behavioral, psychological first aid, and medical services within the community, with particular attention to how these services affect the functional needs of at-risk persons	
			Build	T3	Notify the community via community partners of the health agency's plans for restoration of impacted public health, medical, and mental/behavioral health services.	
			Build	T4	Solicit community input via community partners regarding health service recovery needs during and after the acute phase of the incident.	
			Build	T5	Partner with public health, medical, and mental/behavioral health professionals and other social networks from within and outside the jurisdiction to educate their constituents regarding applicable health interventions being recommended by public health.	

Attachment A: Capability Summary

		Build	F3	Implement corrective actions to mitigate damages from future incidents		
			Sustain	T1	Conduct post-incident assessment and planning as part of the after action report process that affects short and long-term recovery for those corrective actions including the mitigation of damages from future incidents.	
			Build	T2	Collaborate with sector leaders to facilitate collection of community feedback to determine corrective actions.	
			Sustain	T3	Implement corrective actions for items that are within the scope or control of public health to affect short and long-term recovery, including the mitigation of damages from future incidents.	
			Build	T4	Facilitate and advocate for collaborations among government agencies and community partners so that these agencies can fulfill their respective roles in completing the corrective actions to protect the health of the public.	
6%	$45,898	3	Emergency Operations Coordination			
		Build	F1	Conduct preliminary assessment to determine need for public activation.		
			Build	T1	To analyze data, assess emergency conditions and determine the activation levels based on the complexity of the event or incident.	
			Sustain	T2	At the time of an incident and as applicable during an incident, determine whether public health has the lead role, a supporting role, or no role.	
			Build	T3	Define incident command and emergency management structure for the public health event or incident according to one of the Federal Emergency Management Agency (FEMA) types.	
		Sustain	F2	Activate public health emergency operations		
			Sustain	T1	Prior to an event or incident, identify incident command and emergency management functions for which public health is responsible	
			Sustain	T2	Prior to an event or incident, identify a pool of staff who have the skills necessary to fulfill required incident command and emergency management roles deemed necessary for a response	
			Sustain	T3	Prior to an event or incident, identify staff to serve in the required incident command and emergency management roles for multiple operational periods to ensure continuous staffing during activation.	
			Build	T4	Prior to an event or incident, identify primary and alternate physical locations or a virtual structure that will serve as the public health emergency operations center.	
			Sustain	T5	At the time of an event or incident, notify designated incident command staff of public health response.	
			Sustain	T6	In preparation for or at the time of an event or incident, assemble designated staff at the appropriate emergency operations center	
				Sustain	P1	Standard operating procedures for the public health EOC.
				Sustain	P2	NIMS certification based on discipline, level, and jurisdictional requirements
		Sustain	F3	Develop incident response strategy		
			Sustain	T1	Produce or contribute to an Incident Commander or Unified Command approved Incident Action Plan prior to the start of the second operational period.	
			Sustain	T2	Disseminate the Incident Action Plan to public health response staff.	
			Sustain	T3	Revise and brief staff on the Incident Action Plan at least at the start of each new operational period.	
				Build	P1	Template for producing incident action plans

		Build	F4	Manage and sustain the public health response		
			Sustain	T1	Coordinate public health and medical emergency management operations for the public health response	
			Build	T2	Track and account for all public health resources during the public health response.	
			Sustain	T3	Maintain situational awareness using information gathered from medical, public health, and other health stakeholders	
				Sustain	P1	Process to ensure continued performance of pre-identified essential functions
		Sustain	F5	Demobilize and evaluate public health emergency operations.		
			Sustain	T1	Return resources to a condition of "normal state of operation" as appropriate.	
			Sustain	T2	Conduct final incident closeout of public health operations including the turnover of documentation, an incident debriefing, and a "final closeout" with the responsible agency or jurisdiction executive/officials.	
			Sustain	T3	Produce After Action Report for public health operations to identify improvement areas and promising practices.	
			Sustain	T4	Implement Improvement Plan items that have been assigned to public health.	
			Sustain	T5	Track the implementation progress of Improvement Plan items assigned to public health through a corrective action system.	
				Sustain	P1	Demobilization procedures for public health operations.
10%	$78,669	4	Emergency Public Information and Warning			
		Build	F1	Activate the emergency public information system		
			Sustain	T1	Prior to an incident, identify Public Information Officer, support staff and potential spokesperson(s) to convey information to the public.	
			Build	T2	Prior to an incident, identify a primary and alternate physical and/or virtual structure that will be used to support alerting and public information operations.	
			Build	T3	Prior to the incident, ensure identified personnel are trained in the functions they may be asked to fulfill.	
			Sustain	T4	At the time of an incident, notify Public Information Officer, support staff, spokesperson(s), and subject matter experts of the need to either be on-call or to report for duty as necessary within a time frame appropriate to the incident.	
			Sustain	T5	At the time of an incident, assemble public information staff at the physical or virtual location, debrief on incident, and assign response duties.	
			Build	T6	Assist local public health systems in implementing emergency communication abilities.	
				Sustain	P1	Standard operating procedures for the public health EOC.
				Build	P2	Message templates addressing jurisdictional vulnerabilities.
				Build	S1	NIMS training for public information staff
				Build	S2	Crisis and emergency risk communication training
		Build	F2	Determine the need for a joint public information system		
			Build	T1	As applicable to the incident, establish a Virtual Joint Information Center, if establishment of a full-fledged Joint Information Center is not optimal.	
			Sustain	T2	Identify a health department representative to participate in the jurisdiction's emergency operations center to ensure public health messaging capacity	
			Sustain	T3	Assign tasks to support staff to support message coordination and public information through three principal functions: Research, Media Operations, and Administration, as applicable to the incident.	
				Build	E1	Minimum components of a virtual joint information center.

Attachment A: Capability Summary

		Build	F3	Establish and participate in information system operations.	
			Build	T1	Develop, recommend, and execute approved public information plans and strategies on behalf of the Incident Command or Unified Command structure.
			Sustain	T2	Based on jurisdictional structure, provide a single release point of information for health and healthcare issues through a pre-identified spokesperson in coordination with the JIC.
			Sustain	T3	Facilitate rumor control for media outlets for the jurisdiction such as television, internet, radio, and newspapers.
		Build	F4	Establish avenues for public interaction and information exchange	
			Build	T1	Establish mechanisms for public and media inquiries that can be scalable to meet the needs of the incident.
			Sustain	T2	If health department websites exist, post incident-related information on health department website as a means of informing and connecting with the public.
			Build	T3	Utilize social media (e.g., Twitter and Facebook) when and if possible for public health messaging.
		Build	F5	Issue public information, alerts, warnings, and notifications.	
			Sustain	T1	Prior to the incident, comply with established jurisdictional legal guidelines to avoid communication of information that is protected for national security or law enforcement reasons or that may infringe on individual and entity rights.
			Build	T2	Disseminate information to the public using pre-established message maps in languages and formats that take into account jurisdiction demographics, at-risk populations, economic disadvantages, limited language proficiency, and cultural or geographical isolation.
			Sustain	T3	Transmit health-related messaging information to responder organizations through secure messaging platforms.
3%	**$20,334**	**5**	**PHEP Fatality Management**		
		Build	F1	Determine role for public health in fatality management.	
			Sustain	T1	Prior to an incident, characterize potential fatalities based on jurisdictional risk assessment and the impact of these potential fatalities on jurisdictional resource needs
			Build	T2	Prior to an incident, coordinate with subject matter experts to determine public health's role in an incident that may result in fatalities.
			Build	T3	Prior to an incident, coordinate with jurisdictional, private and federal Emergency Support Function #6 and Emergency Support Function #8 resources as necessary to determine their roles and requirements for the response.
		Sustain	F2	Activate public health fatality management operations.	
			Sustain	T1	Assess data from the incident to inform and guide the public health resources needed for the response.
			Sustain	T2	Identify and coordinate with jurisdictional, regional, private, and federal Emergency Support Function #8 resources with expertise in the potential cause(s) of fatalities to make recommendations regarding all phases of human remains disposition: recovery, processing, storing, and disposing.
			Sustain	T3	Coordinate with partners to initiate pre-determined processes for all phases of human remains disposition.
			No Activity	T4	Coordinate incident details among members of the public health and medical health systems by sharing information between programs and linking information databases, based on the scope of the incident.

		Build	F3	Mental/behavioral support at the healthcare organization level		
			Build	T1	Coordinate with partners for the establishment of a mechanism to collect antemortem data.	
			Build	T2	Coordinate with partners to identify and assemble the resources required to collect and communicate ante mortem data.	
			No Activity	T3	Coordinate with partners and assist, if needed, in the collection and dissemination of antemortem data to families of the deceased and law enforcement officials.	
			No Activity	T4	Coordinate with partners to support electronic recording and reporting of antemortem data through electronic systems and/or other information sharing platforms.	
				Build	P1	Procedure for the collection of antemortem data.
		Build	F4	Participate in survivor mental/behavioral health services		
			Build	T1	Coordinate with partners to assemble the required staff and resources to provide non-intrusive mental/behavioral health services to responders.	
			Build	T2	Coordinate with partners to facilitate availability of culturally appropriate assistance.	
			Build	T3	Coordinate with Emergency Support Function 8 partners to support the provision of mental/behavioral health services to family members of the deceased and incident survivors as needed	
		No Activity	F5	Participate in fatality processing and storage operations		
7%	**$51,748**	**6**	**Information Sharing**			
		Build	F1	Identify stakeholders to be incorporated into information flow.		
			Build	T1	Prior to and as necessary during an incident, identify intra-jurisdictional stakeholders across public health, public safety, private sector, law enforcement, and other disciplines to determine information-sharing needs	
			Build	T2	Prior to and as necessary during an incident, identify inter-jurisdictional public health stakeholders to determine information sharing needs.	
			Build	T3	Work with elected officials, identified stakeholders and private sector leadership to promote and ensure continual connection and use continuous quality improvement process to define and redefine information-sharing needs.	
				Build	P1	Processes to engage stakeholders
				Build	P2	Role-based public health directory.
		Build	F2	Identify and develop rules and data elements for sharing.		
			Sustain	T1	Identify current jurisdictional and federal regulatory, statutory, privacy-related and other provisions, laws, and policies that authorize and limit sharing of information relevant to emergency situational awareness.	
			Build	T2	Prior to and as necessary during an incident, identify routine or incident-specific data requirements for each stakeholder.	
			Build	T3	Identify public health events and incidents that will necessitate information exchange.	
			Sustain	T4	Utilize continuous quality improvement or have a processes and a corrective action system to identify and correct unintended legal and policy barriers to sharing of situational awareness information that are within the jurisdictional public health agency's control	
				Build	P1	Data-exchange requirements
				Sustain	P2	Health Information exchange protocols

Attachment A: Capability Summary

		Sustain	F3			Exchange information to determine a common operating picture.
			Sustain	T1		Prior to and during an incident, collaborate with and participate in jurisdictional health information exchange (e.g., fusion centers, health alert system, or equivalent).
			Sustain	T2		Maintain data repositories that are able to support data exchange with other regional and federal public health entities. Store data according to jurisdictional and/or federal standards for formatting, vocabulary, and encryption.
			Sustain	T3		Prior to and during an incident, request, send, and receive data and information using encryption that meets jurisdictional and/or federal standards.
				Build	P1	Protocol for the development of Public Health Alert messages.
0%	$0	7	Mass Care			
		No Activity	F1	Determine public health role in mass care operations.		
		No Activity	F2	Determine mass care needs of the impacted population		
		No Activity	F3	Coordinate public health, medical, and mental/behavioral health services		
		No Activity	F4	Monitor mass care population health		
16%	$124,529	8	Medical Countermeasure Dispensing			
		Build	F1	Identify and initiate medical countermeasure dispensing strategies		
			Build	T1		Determine what medical countermeasures are best suited and available for the incidents most likely to occur based on jurisdictional risk assessment.
			Build	T2		Identify and fill required response roles
				Build	P1	Written plans to identify the medical countermeasures.
		Build	F2	Receive medical countermeasures.		
			Build	T1		Assess the extent to which current jurisdictional medical countermeasure inventories can meet incident needs.
			Build	T2		Request additional medical countermeasures from private, jurisdictional, and/or federal partners using established procedures, according to incident needs.
			Build	T3		Identify and notify any intermediary distribution sites based on the needs of the incident
				Build	P1	Written plans to request additional medical countermeasures.
		Build	F3	Activate dispensing modalities		
			Build	T1		Activate dispensing strategies, dispensing sites, dispensing modalities and other approaches to achieve dispensing goals commensurate with the targeted population.
			Build	T2		Activate staff that will support the dispensing modality in numbers necessary to achieve dispensing goals commensurate with the targeted population.
			Build	T3		If indicated by the incident, implement mechanisms for providing medical countermeasures for public health responders, critical infrastructure personnel, and their families
			Build	T4		Initiate site-specific security measures for dispensing locations
			Build	T5		Inform public of dispensing operations including locations, time period of availability, and method of delivery.
				Build	P1	Medical countermeasure dispensing activities support
				Build	P2	Procedure for activation of dispensing modalities.

Attachment A: Capability Summary

		Build	F4	Dispense medical countermeasures to identified population		
			Build	T1		Maintain dispensing site inventory management system to track quantity and type of medical countermeasures present at the dispensing site.
			Build	T2		Screen and triage individuals to determine which medical countermeasure is appropriate to dispense to individuals if more than one type or subset of medical countermeasure is being provided at the site.
			Build	T3		Distribute pre-printed drug/vaccine information sheets that include instructions on how to report adverse events.
			Build	T4		Monitor dispensing site throughput and adjust staffing and supplies as needed in order to achieve dispensing goals commensurate with the targeted population.
			Build	T5		Document doses of medical countermeasures dispensed, including but not limited to: product name and lot number, date of dispensing, and location of dispensing
			Build	T6		Report aggregate inventory and dispensing information to jurisdictional authorities at least weekly during an incident, but potentially more frequently based on incident needs.
			Build	T7		Determine the disposition of unused medical countermeasures within the jurisdictional health system according to jurisdictional policies
				Build	P1	Medical countermeasure dispensing to target populations
		Build	F5	Report adverse events		
			Build	T1		Activate mechanism(s) for individuals and healthcare providers to notify health departments about adverse events.
			No Activity	T2		Report adverse event data to jurisdictional and federal entities according to jurisdictional protocols.
				Build	P1	Protocol to govern reporting of adverse events
				Build	S1	Adverse event report training
0%	$0	9	Medical Materiel Management and Distribution			
		No Activity	F1	Direct and activate medical materiel management and distribution		
		No Activity	F2	Acquire medical materiel		
		No Activity	F3	Maintain updated inventory management and reporting system		
		No Activity	F4	Establish and maintain security		
		No Activity	F5	Distribute medical materiel		
		No Activity	F6	Recover medical material and demobilize distribution operations		
0%	$0	10	Medical Surge			
		No Activity	F1	Assess the nature and scope of the incident		
		No Activity	F2	Support activation of medical surge.		
		No Activity	F3	Support jurisdictional medical surge operations		
		No Activity	F4	Support demobilization of medical surge operations		
1%	$4,157	11	Non-Pharmaceutical Interventions			
		Build	F1	Engage partners and identify factors that impact non-pharmaceutical interventions		
			Build	T1		Identify jurisdictional legal, policy, and regulatory authorities that enable or limit the ability to recommend and implement non-pharmaceutical interventions, in both routine and incident-specific situations.

Attachment A: Capability Summary

			No Activity	T2	Prior to an incident, engage healthcare organizations, government agencies, and community sectors in determining their roles and responsibilities in non-pharmaceutical interventions on an ongoing basis through multidisciplinary meetings.	
				No Activity	P1	Implementing non-pharmaceutical interventions plan.
				No Activity	P2	Communication and reporting plan
		No Activity	F2	Determine non-pharmaceutical interventions		
		No Activity	F3	Implement non-pharmaceutical interventions		
		No Activity	F4	Monitor non-pharmaceutical interventions		
0%	$0	12	Public Health Laboratory Testing			
		No Activity	F1	Manage laboratory activities		
		No Activity	F2	Perform sample management		
		No Activity	F3	Conduct testing and analysis for routine and surge capacity		
		No Activity	F4	Support public health investigations		
		No Activity	F5	Report results		
20%	$152,525	13	Public Health Surveillance and Epidemiological Investigation			
		Sustain	F1	Conduct public health surveillance and detection		
			Sustain	T1	Engage and retain stakeholders who can provide health data to support routine surveillance and to support response to an identified public health threat or incident	
			Sustain	T2	Conduct routine and incident-specific morbidity and mortality surveillance as indicated by the situation using inputs such as reportable disease surveillance, vital statistics, syndromic surveillance, hospital discharge abstracts, population-based surveys, disease registries, and active case finding.	
			Sustain	T3	Provide statistical data and reports to public health and other applicable jurisdictional leadership in order to identify potential populations at-risk for adverse health outcomes during a natural or man-made threat or incident.	
			Sustain	T4	Maintain surveillance systems that can identify health problems, threats, and environmental hazards and receive and respond to (or investigate) reports 24/7.	
				Sustain	E1	Access to health information infrastructure and surveillance systems
				Sustain	P1	Document the legal and procedural framework for information exchange
				Sustain	P2	Protocols for accessing health information
				Sustain	P3	Protocols to gather and analyze surveillance data
				Sustain	P4	Procedures to ensure 24/7 health department access
				Sustain	P5	Protocols to notify CDC of cases on the Nationally Notifiable Infectious Disease List
				Build	S1	Tier 1 Competencies and Skills for Applied Epidemiologists
		Sustain	F2	Conduct public health and epidemiological investigations		
			Sustain	T1	Conduct investigations of disease, injury or exposure in response to natural or man-made threats or incidents and ensure coordination of investigation with jurisdictional partner agencies.	

			Sustain	T2	Provide epidemiological and environmental public health consultation, technical assistance, and information to local health departments regarding disease, injury, or exposure and methods of surveillance, investigation, and response.	
			Sustain	T3	Report investigation results to jurisdictional and federal partners, as appropriate.	
				Sustain	P1	Investigation report templates
				Sustain	S1	Staffing capacity to manage the routine epidemiological investigation systems
		Sustain	F3	Recommend, monitor, and analyze mitigation actions		
			Sustain	T1	Determine public health mitigation, including clinical and epidemiological management and actions to be recommended for the mitigation of the threat or incident based upon data collected in the investigation and on applicable science-based standards outlined by Morbidity and Mortality Weekly Report, control of Communicable Diseases Manual, Red Book of Infectious Diseases or, as available, a state or CDC incident annex.	
			Sustain	T2	Provide information to public health officials to support them in decision making related to mitigation actions.	
			Sustain	T3	Monitor and analyze mitigation actions throughout the duration of the public health threat or incident.	
			Sustain	T4	Recommend additional mitigation activities, based upon mitigation monitoring and analysis, throughout the duration of the incident, as appropriate.	
				Sustain	P1	Protocols for recommending and initiating containment and mitigation actions
				Sustain	S1	Training in Homeland Security Exercise and Evaluation After Action Report process
		Sustain	F4	Improve public health surveillance and epidemiological investigation systems		
			Sustain	T1	Identify issues and outcomes during and after the incident.	
			Sustain	T2	Conduct post-incident/post-exercise agency evaluation meeting(s) including all active participants to identify internal protocols and deficiencies that require corrective actions in areas such as programs, personnel, training, equipment, and organizational structure.	
			Sustain	T3	Develop an After Action Report/Improvement Plan.	
			Sustain	T4	Communicate recommended After Action Report Improvement Plan corrective actions to public health leadership.	
				Sustain	P1	Communication of improvement plan
4%	$32,833	14	Responder Safety and Health			
		Build	F1	Identify responder safety and health risks.		
			Build	T1	Prior to an incident, identify the medical, environmental exposure, and mental/behavioral health risks that may be faced by staff responding to the public health incident in conjunction with partner agencies and based on jurisdictional risk assessment.	

Attachment A: Capability Summary

			Build	T2	Prior to an incident, identify subject matter experts and other informational resources that can be used by public health staff to make health and safety recommendations to the Incident Safety Officers or lead agency.	
			Build	T3	Prior to an incident, and as applicable during an incident, work with subject matter experts to develop information on potential acute and chronic health conditions that may develop/occur during and after an exposure.	
			Build	T4	In consultation with the Incident Safety Officer and subject matter experts, participate in the formulation of recommendations to the Incident Commander regarding responder-specific risks to be addressed in incident action plans.	
			Build	T5	Distribute safety materials to public health responders through daily briefings at the onset of, and throughout an incident, in consultation with the Incident Safety Officer and jurisdictional subject matter experts.	
				Build	P1	Safety and health risk plans
				Build	P2	Public health roles and responsibilities
		Build	F2	Identify safety and personal protective needs		
			Build	T1	Prior to an incident, and as applicable during an incident, work with subject matter experts to identify responder safety and health resource requirements.	
			Build	T2	Prior to an incident, and as applicable during an incident, and in conjunction with subject matter experts, formulate recommendations to public health responders regarding personal protective equipment that are consistent with local jurisdictional requirements.	
			Build	T3	Coordinate with partner agencies to provide medical countermeasures and/or personal protective equipment to public health responders, if indicated by the incident.	
				Build	P1	Risk-related personal protective equipment
				Build	E1	Personal Protective Equipment for healthcare workers.
		No Activity	F3	Coordinate with partners to facilitate risk-specific safety and health training		
		No Activity	F4	Monitor responder safety and health actions		
9%	$70,643	15	Volunteer Management			
		Sustain	F1	Coordinate volunteers		
			Sustain	T1	Prior to an incident, identify the types and numbers of volunteers most likely to be needed in a public health agency's response based on the jurisdictional community risk assessment.	
			Sustain	T2	Prior to an incident, coordinate with existing volunteer programs and partner organizations to support the pre-incident recruitment of volunteers that may be needed in a public health agency's response.	
			Sustain	T3	Prior to an incident, assure pre-incident screening and verification of volunteers' credentials through jurisdictional ESAR-VHP and Medical Reserve Corps.	
			Sustain	T4	Prior to an incident and as necessary at the time of an incident, support provision of initial and ongoing emergency response training for registered volunteers. Training should be supported in partnership with jurisdictional Medical Reserve Corps unit(s) and other partner groups.	
				Build	P1	Volunteer needs assessment for healthcare organizations response.
				Sustain	P2	Collect, assemble, maintain, and utilize volunteer information

Attachment A: Capability Summary

		Sustain	F2	Notify volunteers		
			Sustain	T1	At the time of an incident, identify the desired skills and quantity of volunteers needed for the incident from the preincident volunteer registration.	
			Sustain	T2	At the time of an incident, contact pre-incident registered volunteers using multiple modes of communication.	
			Sustain	T3	At the time of an incident, notify volunteers who are able and willing to respond of where and how to report.	
			Sustain	T4	At the time of an incident, coordinate with partner agencies to confirm credentials of responding volunteers.	
			Sustain	T5	At the time of an incident, notify partner agencies of any need for additional volunteers.	
		Build	F3	Organize, assemble, and dispatch volunteers		
			Build	T1	If the incident differs from or exceeds the public health agency's pre-incident-defined volunteer plans, identify additional volunteers that have the necessary credentials and skills.	
			Build	T2	Assure deployment briefing of public health volunteers, including safety and incident-specific training.	
			Sustain	T3	Assure tracking and rotation of volunteers as indicated by the incident and by relevant job function.	
			Build	T4	Manage spontaneous volunteers who may request to support the public health agency's response, either through incorporating them into the response or by triaging them to other potential volunteer resources.	
			Build	T5	Coordinate state and jurisdictional response roles for federal public health staff deployed to the jurisdiction.	
				Build	P1	Volunteer deployment protocols
				Build	P2	Process to manage spontaneous voluteers.
		Sustain	F4		Demobilize volunteers	
			Sustain	T1	Track (record or document) the demobilization of volunteers.	
			Sustain	T2	Assure coordination of out-processing of volunteers.	
			Sustain	T3	Coordinate with jurisdictional authorities and partner groups to identify community resources that can support volunteer post-deployment medical screening, stress, and well-being assessment and, when requested or indicated, referral to medical and mental/behavioral health services.	
				Sustain	P1	Volunteer release processes
				Sustain	P2	Volunteer exit screening protocols
100%	$760,946	TOTAL (Must equal 100%)				

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 1: Community Preparedness

Description: Community preparedness is the ability of communities to prepare for, withstand, and recover — in both the short and long terms — from public health incidents. By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health's role in community preparedness is to do the following:

- Support the development of public health, medical, and mental/behavioral health systems that support recovery
- Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents
- Promote awareness of and access to medical and mental/behavioral health 2 resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals
- Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community
- Identify those populations that may be at higher risk for adverse health outcomes
- Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane)

Allocated funding: $69,954

Performance Measure Data Element:
PHEP 1.1 (Function 2): Identification of Key Organizations - Median number of community sectors in which LHDs identified key organizations to participate in public health, medical, and mental/behavioral health-related emergency preparedness efforts. (See Pg 11-12)
PHEP 1.2 (Function 1): Community Engagement in Risk Identification - Median number of community sectors that LHDs engaged in using jurisdictional risk assessment (JRA) data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services. (See Pg 13-15)
PHEP 1.3 (Function 4): Community Engagement in Public Health Preparedness Activities - Proportion of key organizations that LHDs engaged in a significant public health emergency preparedness activity. (See Pg 16-17)
PHEP 1.4 (Function 2): Community Engagement in Recovery Planning - Median number of community sectors that LHDs engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services. (See Pg18-19)

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
In Budget Period (BP) 2, WCHD will sustain community preparedness capacity in Washoe County through continued relationship-building efforts and discussions, continued efforts to engage the community in health preparedness, and continued coordination of health preparedness trainings.	Enhanced collaborative relationships and improved preparedness planning and communications as result of achieving this short-term goal.	Training sign-in sheets, training evaluations; updated plans as appropriate, meeting agendas/minutes/notes.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Function #1: Determine risks to the health of the jurisdiction

Objective

By the end of BP2, WCHD will have continued relationship-building efforts with regional community partners. **($3,922)**

Task 1: Utilize jurisdictional risk assessment to identify, with emergency management and community and faith-based partners, the public health, medical, and mental/behavioral health services for which the jurisdiction needs to have access to mitigate identified disaster health risks. (See Pg 16)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	During BP1, WCHD updated the heath-specific jurisdictional risk assessment; during BP4 and BP5 WCHD will be involved with updating the Washoe County Emergency Management hazard assessment and mitigation plan. WCHD will meet with mental and behavioral health partners to determine mental and behavioral health risks associated with an incident that could occur in Washoe County.	May 30, 2014	Meeting notes / findings; updated plans during upcoming budget periods.

Task 2: Utilize jurisdictional risk assessment to identify, with emergency management and community and faith-based partners, the public health, medical, and mental/behavioral health services within the jurisdiction that currently support the mitigation of identified disaster health risks. (See Pg 16)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	• During BP1, WCHD updated the heath-specific jurisdictional risk assessment; during BP4 and BP5 WCHD will be involved with updating the Washoe County Emergency Management hazard assessment and mitigation plan. • WCHD will meet with mental and behavioral health partners to determine mental and behavioral health resources that can be utilized in response to an incident.	May 30, 2014	Meeting notes / findings; updated plans during upcoming budget periods.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1 (Priority): Identification of vulnerable populations. (See Pg 17)	Sustain	WCHD will continue the BP1 activity of supporting and co-administering the Northern Nevada Access and Functional Needs Workgroup.	Northern Nevada Access and Functional Needs Workgroup Meeting agendas and minutes.
Planning Resource Element 2 (Priority): Jurisdictional risk assessment related to public health, medical, and mental/behavioral health. (See Pg 17)	Sustain	WCHD will meet with mental and behavioral health partners.	Findings from meetings with mental health partners.
Skills and Training 1: Person(s) with expertise in GIS to assist in locating/mapping at-risk populations. (See Pg 18)	Sustain	WCHD will continue the BP1 activity of searching for data sets indicating mental/behavioral health composition in Washoe County to include in future GIS maps.	Potential GIS maps to be included in All-Hazards Plan.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Function #2: Build community partnerships to support health preparedness.

Objective
By end of BP2, WCHD will have continued efforts to build community partnerships that support health preparedness by administrating or participating in community groups, soliciting feedback about plans and making appropriate revisions, and coordinating community trainings. --- **$31,533**

Task 1: Identify community sector groups to be engaged for partnership based upon the jurisdictional risk assessment. (See Pg 18)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	During BP1, these sector groups were identified; during BP2 WCHD will continue BP1 outreach and partnership activities as appropriate.	June 30, 2014	Tracking number of people reached through outreach activities.

Task 2: Create and implement strategies for ongoing engagement with community partners who may be able to provide services to mitigate identified public health threats or incidents (concept of "strategic advisory council" or joint collaborative). (See Pg 19)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to administrate community groups that support health preparedness, such as the Inter-Hospital Coordinating Council and the Northern Nevada Access and Functional Needs Workgroup.	June 30, 2014	Meeting agendas, notes or minutes.

Task 3: Utilize community and faith-based partnerships as well as collaborations with any agencies primarily responsible for providing direct health-related services to help assure the community's ability to deliver public health, medical, and mental/behavioral health services in both short and long term settings during and after an incident. (See Pg 19)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will update the agency's Public Information and Communication (PIC) Plan to include the process of communicating with specified community partners needed for the delivery of services in both short-term and long-term settings during and after an incident.	June 30, 2014	Updated PIC Plan.

Task 4: Utilize a continuous quality improvement process to incorporate feedback from community and faith-based partners into jurisdictional emergency operations plans. (See Pg 19)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to solicit feedback from community groups, such as the Northern Nevada Access and Functional Needs Workgroup, on WCHD emergency response plans, and will incorporate findings into revised plans as appropriate; will determine potential future exercises to test any changes to the made to the plan.	June 30, 2014	Meeting notes or minutes; updated plans, as appropriate.

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Task 5: Identify community leaders that can act as trusted spokespersons to deliver public health messages. (See Pg 19)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	During BP1, WCHD identified community leaders that can act as trusted spokespersons to deliver public health messages. WCHD will coordinate a "working with the media" workshop for WCHD leadership, back-up PIOs, and community partners identified as trusted spokespersons.	June 30, 2014	Training sign-in sheet; training evaluation.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Participation in existing or new partnerships representing the listed community sectors. (See Pg 19)	Build	WCHD will participate in new partnerships such as the Community Resiliency Workgroup. WCHD will continue participating in existing partnerships, such as Inter-Hospital Coordinating Council.	Meeting agendas, minutes, or notes; Community Resiliency Plan when finalized.
Planning Resource Element 2: Protocol to encourage or promote medical personnel to register and participate with MRC or ESAR-VHP. (See Pg 19)	Sustain	WCHD's protocol documentation was completed during BP1, and protocol implementation will continue during BP2 and beyond.	Tracking of medical personnel who register/participate with MRC or ESAR-VHP, by Washoe County MRC Coordinator.

Function #3: Engage with community organizations to foster public health, medical, and mental/behavioral health social networks.

Objective

By the end of BP2, WCHD will have further engaged community organizations to foster public health, medical and mental/behavioral health social networks by enhancing regional public information and warning through enhanced jurisdictional partnerships and training. --- **$13,213**

Task 1: Ensure that community constituency groups understand how to connect to public health to participate in public health and community partner preparedness efforts. (See Pg 20)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will implement a community resiliency outreach campaign, including the distribution of a comprehensive document listing community resources developed during BP1, as well as a media component.	June 30, 2014	Resource booklet distribution tracking; media tracking of reach and frequency.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Task 2: Ensure that public health, medical, and mental/behavioral health service agencies that provide essential health services to the community are connected to jurisdictional public health preparedness plans and efforts. (See Pg 20)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	During BP1 WCHD's all-hazards plan was updated, which documents the connection of public health, medical, and mental/behavioral health services were to public health preparedness efforts.	Ongoing	N/A

Task 3: Create jurisdictional networks (e.g., local businesses, community and faith-based organizations, ethnic radio/media, and, if used by the jurisdiction, social networking sites) for public health, medical, and mental/behavioral health information dissemination before, during, and after the incident. (See Pg 20)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD staff will actively serve on the newly created Washoe County Public Information / Public Warning Task Force.	June 30, 2014	Regional PI / PW Plan when finalized.
	WCHD staff will implement BP1 efforts surrounding the use of social media.	June 30, 2014	Social media policy and strategy.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Community engagement in problem solving strategy sessions. (See Pg 20)	Sustain	WCHD will continue to collect feedback on written public health emergency preparedness and response plans from groups like the Northern Nevada Access and Functional Needs Workgroup and the Local Emergency Preparedness Council.	Documentation of findings; updated plans, as appropriate.
Planning Resource Element 2: Ensure health services are culturally and socially competent. (See Pg 20)	Sustain	WCHD will continue to solicit feedback from groups like the Northern Nevada Access and Functional Needs Workgroup to ensure health services are culturally and socially competent.	Meeting minutes or notes.

Function #4: Coordinate training or guidance to ensure community engagement in preparedness efforts.

Objective

By the end of BP2, WCHD will have further engaged the community in preparedness efforts through implementation of a community outreach campaign, coordination of trainings, and Medical Reserve Corps volunteer recruitment. --- **$21,287**

Task 1: Integrate information on resilience, specifically the need for community-derived approaches to support the provision of public health, medical, and mental/behavioral health services during and after an incident, into existing training and educational programs related to crisis and disaster preparedness and response. (See Pg 20)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Build	WCHD will implement a community resiliency outreach campaign, including the distribution of a comprehensive document listing community resources developed during BP1, as well as a media component.	June 30, 2014	Resource booklet distribution tracking; media tracking of reach and frequency.

Task 2: Promote training to community partners that may have a supporting role to public health, medical, and mental/behavioral health sectors (e.g., education, child care, juvenile justice, child welfare, and congregate childcare settings). (See Pg 20)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will coordinate a Community Resiliency workshop for WCHD staff and community partners	April 30, 2014	Training sign-in sheet; documentation of next steps needed for BP3 activities.

Task 3: Provide guidance to community partners, particularly groups representing the functional needs of at-risk populations, to assist them in educating their own constituency groups regarding plans for addressing preparedness for and recovery from the jurisdiction's identified risks and for access to health services that may apply to the incident. (See Pg 20)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will continue to provide current online trainings for WCHD staff, MRC volunteers and community partners, and will add modules to further address resiliency in regards to functional needs populations.	May 30, 2014	Online training content uploaded; training tracking and evaluation

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Public health approaches to address children's medical and mental/behavioral health needs. (See Pg 21)	Build	During outreach activities, WCHD will provide specific educational material for families with an access or functional needs child.	Educational material; outreach tracking.
Planning Resource Element 2: Building and sustaining volunteer opportunities for community residents. (See Pg 21)	Sustain	WCHD will continue recruitment of volunteers for the Washoe County Medical Reserve Corps, when providing outreach and education at community events.	Tracking of number of people reached at events; number of MRC volunteers recruited.

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 2 : Community Recovery

Definition: Community recovery is the ability to collaborate with community partners, (e.g., healthcare organizations, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels, and improved levels where possible.

This capability supports National Health Security Strategy Objective: Incorporate Post-Incident Health Recovery into Planning and Response. Post-incident recovery of the public health, medical, and mental/behavioral health services and systems within a jurisdiction is critical for health security and requires collaboration and advocacy by the public health agency for the restoration of services, providers, facilities, and infrastructure within the public health, medical, and human services sectors. Monitoring the public health, medical and mental/behavioral health infrastructure is an essential public health service.

Allocated funding: $109,656

Performance Measure Data Element:

This capability consists of the ability to perform Functions 1-3 as detailed below. The community recovery evaluation tool is designed to capture descriptive information about response and recovery activities. (See Pg 26-30)

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
In Budget Period (BP) 2, WCHD will build the capacity of the community recovery infrastructure in Washoe County by: 1) helping to facilitate the building of collaborative partnerships internally between WCHD divisions, and externally with community sectors and emergency response partners; 2) enhancing the delivery of public health, mental/behavioral health, and medical services during community recovery through the coordination of education and training for the community; and 3) determining how to solicit feedback from the community-at-large during incident recovery efforts.	Enhanced community resiliency in Washoe County following an incident as result of achieving this short-term goal.	Updated PIC Plan; training and exercise sign-in sheets; updated staff training reports; staff readiness survey results; online training content uploaded; post-incident community assessment tool; resource booklet distribution tracking; media campaign reach and frequency; tracking of AAR/IP corrective action progress; meeting agendas and minutes.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Function #1: Identify and monitor public health, medical, and mental/behavioral health system recovery needs.

Objective
By the end of BP2, WCHD will train and engage public health staff to be prepared to respond to system recovery needs following an incident, and will collaborate with jurisdictional partners to enhance communication with Washoe County residents and visitors through public information warning systems as well as soliciting feedback from them about the aftermath of an incident. -- **$42,866**

Task 1: In collaboration with jurisdictional partners, document short-term and long-term health service delivery priorities and goals. (See Pg 22)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue collaborating with jurisdictional partners to document short-term and long term health service delivery priorities and goals, as incidents occur.	Ongoing	Regional AAR/IPs as appropriate.

Task 2: Identify the services that can be provided by the public health agency and by community and faith-based partners that were identified prior to the incident as well as by new community partners that may arise during the incident response. (See Pg 22)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue collaboration efforts to identify services that can be provided by community partners that may arise during an incident.	Ongoing	Regional AAR/IPs as appropriate.

Task 3: Activate plans previously created with neighboring jurisdictions to provide identified services that the jurisdiction does not have the ability to provide during and after an incident. (See Pg 22)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue activating previously created plans with neighboring jurisdictions to provide identified services that the jurisdiction does not have the ability to provide during and after an incident, if appropriate.	Ongoing	Regional AAR/IPs as appropriate.

Task 4: In conjunction with healthcare organizations (e.g., healthcare facilities and public and private community providers) and based upon recovery operations, determine the community's health service priorities and goals that are the responsibility of public health. (See Pg 22)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	• WCHD will coordinate training and a tabletop exercise for public health staff on the newly revised WCHD COOP plan. • WCHD will transfer documentation of public health staffs' NIMS trainings to the Washoe County Learning Management System to improve access to needed employee training status during an incident recovery period. • WCHD will conduct a follow-up readiness survey of public health staff to continue to assess and improve upon the agency's ability to serve the community following an incident.	April 30, 2014 June 30, 2014 February 28, 2014	Training/exercise sign-in sheets. Updated personnel training transcripts. Staff readiness survey results; BP3 and BP4 training strategy.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Identify recovery needs (See Pg 23)	Sustain	WCHD will continue working with jurisdictional partners to identify recovery needs following an incident.	Regional AAR/IPs as appropriate.
Planning Resource Element 2: Community assessment (See Pg 23)	Sustain	During BP1, WCHD updated the health-specific community assessment; during BP4 and BP5, WCHD will participate in Washoe County Emergency Management's activities to update the regional assessment and mitigation plan.	Updated regional assessment and mitigation plan, most likely during BP4 or BP5.
Planning Resource Element 3: Operational plans (See Pg 23)	Build	WCHD will coordinate training and a tabletop exercise for public health staff on the newly revised WCHD COOP plan.	Training / exercise sign-in sheet.

Function #2: Coordinate community public health, medical, and mental/behavioral health system recovery operations.

Objective

By the end of BP2, WCHD will provide training to public health staff, MRC Volunteers and community partners to address effective, appropriate and coordinated systems recovery approach following an incident, and will implement an outreach campaign promoting community resiliency among Washoe County residents. --- **$54,498**

Task 1: Participate with the recovery lead jurisdictional agencies (e.g., emergency management and social service) to ensure that the jurisdiction can provide health services needed to recover from a physical or mental/behavioral injury, illness, or exposure sustained as a result of the incident, with particular attention to the functional needs of at-risk persons (e.g., those displaced from their usual residence). (See Pg 24)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	◦ WCHD will continue partnerships with recovery lead jurisdictional agencies before, during and after an incident. ◦ WCHD will continue to provide current online trainings for WCHD staff, jurisdictional government and community partners, and will add modules to further address training needs surrounding functional needs populations. ◦ WCHD will coordinate a Community Resiliency workshop for WCHD staff and community partners.	April 30, 2014	Online training content uploaded. Training sign-in sheet; documentation of next steps for BP3.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Task 2: In conjunction with jurisdictional government and community partners, inform the community of the availability of mental/behavioral, psychological first aid, and medical services within the community, with particular attention to how these services affect the functional needs of at-risk persons (including but not limited to children, elderly, their care givers, the disabled, or individuals with limited economic resources). (See Pg 25)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	• WCHD will implement a community resiliency outreach campaign, including the distribution of a document listing community resources developed during BP1, as well as a media component. • WCHD will coordinate a Psychological First Aid workshop for MRC Volunteers and community partners.	June 30, 2014 April 30, 2014	• Resource booklet distribution tracking; media tracking of reach and frequency. • Training sign-in sheet; evaluation.

Task 3: Notify the community via community partners of the health agency's plans for restoration of impacted public health, medical, and mental/behavioral health services. (See Pg 25)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will update the agency's Public Information and Communication Plan to include the process of communicating with specified community partners in the instance the agency needs to communicate plans for restoration of impacted services.	June 30, 2013	Updated Public Information and Communication plan.

Task 4: Solicit community input via community partners regarding health service recovery needs during and after the acute phase of the incident. (See Pg 24)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will research community assessment instruments/resources used to solicit community feedback to determine corrective actions following an incident, and will strategize next steps needed to pilot the method selected.	June 30, 2014	Community assessment template; documented strategy to pilot assessment; adopted and documented assessment collecting of community feedback in WCHD response plans during BP3.

Task 5: Partner with public health, medical, and mental/behavioral health professionals and other social networks (e.g., faith-based, volunteer organizations, support groups, and professional organizations) from within and outside the jurisdiction, as applicable to the incident, to educate their constituents regarding applicable health interventions being recommended by public health. (See Pg 25)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	• WCHD will implement a community resiliency outreach campaign, including the distribution of a document listing community resources developed during BP1, as well as a media component. • WCHD will coordinate a "working with the media" workshop to better prepare	June 30, 2014	Resource booklet distribution tracking; media tracking of reach and frequency.

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Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

	WCHD back-up PIOs, other WCHD staff, and community partners to effectively partner with the media during a public health incident.	March 30, 2014	Training sign-in sheet; training evaluation.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
No Priority Elements			

Function #3: Implement corrective actions to mitigate damages from future incidents

Objective

By the end of BP2, WCHD will further collaborative efforts with jurisdictional partners to enhance the region's ability to implement corrective actions mitigating damages from future incidents through coordinated planning, assessment and training. -- **$12,291**

Task 1: In conjunction with jurisdictional government and community partners, conduct post-incident assessment and planning as part of the after action report process that affects short and long-term recovery for those corrective actions that are within the control and purview of jurisdictional public health, including the mitigation of damages from future incidents. (See Pg 26)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue partnerships with jurisdictional government and community partners in conducting post-assessment and planning for corrective actions that are within the purview of WCHD's authority.	Ongoing	Regional AAR/IPs, as appropriate.

Task 2: Collaborate with sector leaders to facilitate collection of community feedback to determine corrective actions. (See Pg 26)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will research post-incident community assessment instruments/resources, and will strategize next steps needed to pilot the collecting of community feedback to determine corrective actions following a public health incident.	June 30, 2014	Community assessment template; documented strategy to pilot assessment; adopted and documented assessment collecting of community feedback in WCHD response plans during BP3.

Task 3: Implement corrective actions for items that are within the scope or control of public health to affect short and long-term recovery, including the mitigation of damages from future incidents. (See Pg 26)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue identifying corrective actions in written After Action Reports/Improvement Plans (AAR/IPs), will track and document progress on action items from all AAR/IPs, and will report progress to the Department Emergency Management Committee.	June 30, 2014	AAR/IP tracking; Department Emergency Management Committee minutes.

Task 4: Facilitate and advocate for collaborations among government agencies and community partners so that these agencies can fulfill their respective roles in completing the corrective actions to protect the health of the public.(See Pg 26)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	• WCHD staff will actively serve on the newly created Washoe County Community Resiliency Workgroup. • WCHD will continue administrating the Inter-Hospital Coordinating Council and the Northern Nevada Access and Functional Needs Workgroup.	June 30, 2014 June 30, 2014	• Workgroup meeting notes or minutes; Community Resiliency Plan draft, possible in BP3; updated Washoe County Hazard Risk Mitigation Plan BP4 or BP5. • Meeting agendas and minutes.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
No Priority Elements			

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 3 : Emergency Operations Coordination

Definition: Emergency operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System.

Allocated funding: $45,898

Performance Measure Data Element:
PHEP 3.1 (Function 2): Staff Assembly - Time for pre-identified staff covering activated public health agency incident management lead roles (or equivalent lead roles) to report for immediate duty. (See Pg 33-35)
– Start time: Date and time that a designated official began notifying staff to report for immediate duty to cover activated incident management lead roles
– Stop time: Date and time that the last staff person notified to cover an activated incident management lead role reported for immediate duty
PHEP 3.2 (Function 3): IAP - Production of the approved Incident Action Plan before the start of the second operational period (See Pg 36-38)
PHEP 3.3 (Function 5): AAR and IP - Time to complete a draft of an After Action Report (AAR) and Improvement Plan(IP). (See Pg 39-40)
– Start time: Date exercise or public health emergency operation completed
– Stop time: Date the draft After Action Report and Improvement Plan were submitted for clearance within the public health agency

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
Increase WCHD's ability to conduct emergency operations through continued training and exercising of incident command staff.	75% of pre-identified incident command staff participating in training/exercise.	AAR/IPs and sign in sheets

Function #1: Conduct preliminary assessment to determine need for public activation.

Objective

Sustain WCHD's ability to assess and determine the need for a public health activation. --- **$9,287**

Task 1: At the time of an incident and as applicable during an incident, work with jurisdictional officials (e.g., other agency representatives; elected or appointed leadership officials; epidemiology, laboratory, surveillance, medical, and chemical, biological, and radiological subject matter experts; and emergency operations leadership) to analyze data, assess emergency conditions and determine the activation levels based on the complexity of the event or incident. Activation levels should be consistent with jurisdictional standards and practices (e.g., jurisdictional Emergency Operations Plans and applicable annexes). (See Pg 27)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Build	Include in WCHD plans the method for identifying the appropriate notifications and stakeholders to coordinate with during an emergency and include activation levels consistent with jurisdictional standards and practices.	January 2014	Updated Department Emergency Operations Plan

Task 2: At the time of an incident and as applicable during an incident, determine whether public health has the lead role, a supporting role, or no role. (See Pg 27)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD Crisis Action Team along with Washoe County Crisis Action team with input from Washoe County Emergency Management will make decision regarding lead and supporting roles at the time of an incident.	Dependent on incident	AAR/IP

Task 3: Define incident command and emergency management structure for the public health event or incident according to one of the Federal Emergency Management Agency (FEMA) types. (See Pg 27)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Review and revise the WCHD Department Emergency Management Plan to include FEMA incident types.	January 2014	Updated Department Emergency Operations Plan

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
No Priority Elements			

Function #2: Activate public health emergency operations

Objective

Sustain WCHD's ability to activate for a public health emergency. --- **$10,215**

Task 1: Prior to an event or incident, identify incident command and emergency management functions for which public health is responsible. (See Pg 28)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review the WCHD public health staff matrix that identifies appropriate staff based on incident type.	March 2014	Matrix

Task 2: Prior to an event or incident, identify a pool of staff who have the skills necessary to fulfill required incident command and emergency management roles deemed necessary for a response. The pool should include public health subject matter experts, Incident Commander, Section Chiefs, Command Staff, and support positions (e.g., Informational Technology Specialist). (See Pg 28)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review and maintain ICS roster of WCHD staff for incident command staffing to ensure	June 2014	WCHD Department Operations

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Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

	appropriate skills based on staff matrix referred to in Function 2, Task 1.		Center Roster

Task 3: Prior to an event or incident, identify staff to serve in the required incident command and emergency management roles for multiple operational periods to ensure continuous staffing during activation. (See Pg 29)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review and maintain ICS roster of WCHD staff for incident command staffing to ensure continuous staffing for three consecutive 12 hour shifts during activation.	June 2014	WCHD ICS Roster

Task 4: Prior to an event or incident, identify primary and alternate physical locations or a virtual structure (owned by public health or have access to through a memorandum of understanding or other written agreements) that will serve as the public health emergency operations center. (See Pg 29)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Primary and alternate physical locations have been identified in the WCHD COOP and are primarily Washoe County facilities. MOUs will be developed to confirm these locations.	August 2015	COOP and MOUs

Task 5: At the time of an event or incident, notify designated incident command staff of public health response. (See Pg 29)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Notify WCHD Incident Command Staff through alert drills or for a real event.	December 2013	AAR/IP

Task 6: In preparation for or at the time of an event or incident, assemble designated staff at the appropriate emergency operations center(s) (i.e., public health emergency operations center or jurisdictional emergency operations center). (See Pg 29)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Determine WCHD's ability to assemble Incident Command staff within 1 hour of notification with alert and assembly drill.	May 2014	AAR/IP

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Standard operating procedures for the public health EOC. (See Pg 29)	Sustain	Update Department Emergency Management Plan as necessary.	Department Emergency Management Plan
Skill & Training 1: NIMS certification based on discipline, level, and jurisdictional requirements (See Pg 30)	Sustain	Continue to monitor staff ICS certification level, ensure new staff complete required ICS training and both notify staff of training opportunities and provide ICS 300 and 400 through WCHD.	Learning Management System Printout

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Function #3: Develop incident response strategy.

Objective

Continue to produce Incident Action Plans for each operational period through exercises or real events. --- $10,215

Task 1: Produce or contribute to an Incident Commander or Unified Command approved Incident Action Plan prior to the start of the second operational period. (See Pg 31)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Ensure an IAP is produced for each operational period for exercises and real events.	June 2014	AAR/IP

Task 2: Disseminate the Incident Action Plan to public health response staff. (See Pg 31)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Ensure that Incident Command staff have access to Incident Action Plans during exercises and events.	June 2014	IAP, AAR/IP

Task 3: Revise and brief staff on the Incident Action Plan at least at the start of each new operational period. (See Pg 31)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Ensure Incident Action Plans are updated at the start of each operational period and Incident Command Staff are briefed on the updated Incident Action Plan.	June 2014	IAPs and AAR/IP

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Template for producing incident action plans (See Pg31)	Build	Create IAP templates for each based on various, expected types of incidents.	IAP templates

Function #4: Manage and sustain the public health response.

Objective

Exercise conducted to confirm coordination of public health and medical emergency management during Urgent Solidarity Full Scale Exercise in May 2013. --- $8,121

Task 1: Coordinate public health and medical emergency management operations for the public health response (e.g., phone calls, meetings, and conference calls). (See Pg 32)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Coordinate public health and EMS, and hospital operations at Regional Emergency Management Operations Center during Urgent Solidarity FSE May 2013.	August 2013	AAR/IP

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Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Task 2: Track and account for all public health resources during the public health response. (See Pg 32)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Utilize WebEOC Resource Manager during an exercise or event.	June 2014	AAR/IP

Task 3: Maintain situational awareness using information gathered from medical, public health, and other health stakeholders (e.g., fusion centers). (See Pg 32)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Maintain situational awareness during Urgent Solidarity FSE May 2013.	August 2013	AAR/IP

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Process to ensure continued performance of pre-identified essential functions (See Pg 32)	Sustain	COOP table-top exercise for WCHD staff	AAR/IP

Function #5: Demobilize and evaluate public health emergency operations.

Objective

Review and revise WCHD Demobilization Plan to ensure information is updated. --- $8,059

Task 1: Return resources to a condition of "normal state of operation" as appropriate. This may include archiving records and restoring systems, supplies, and staffing to a pre-incident ready state. (See Pg 34)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review and revise Demobilization Plan to address archiving records and restoring both supplies and staff to pre-incident levels.	June 2014	Demobilization Plan

Task 2: Conduct final incident closeout of public health operations including the turnover of documentation, an incident debriefing, and a "final closeout" with the responsible agency or jurisdiction executive/officials. (See Pg 34)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review Demobilization Plan to ensure final closeout with responsible agency or jurisdiction officials.	June 2014	Demobilization Plan

Task 3: Produce After Action Report for public health operations to identify improvement areas and promising practices. (See Pg 34)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Continue completing AAR/IPs after events and exercises and track identified improvements.	June 2014	AAR/IP and IP Tracking

Task 4: Implement Improvement Plan items (e.g., project work plans and evidence of improvement actions) that have been assigned to public health. (See Pg 34)

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Continue to improve plans and actions and processes based on improvements identified in AAR/IPs.	June 2014	AAR/IP and IP Tracking

Task 5: Track the implementation progress of Improvement Plan items assigned to public health through a corrective action system. (See Pg 34)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Track improvements identified in AAR/IPs through the WCHD IP corrective process.	June 2014	IP Corrective Action Spreadsheet

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Demobilization procedures for public health operations. (See Pg 34)	Sustain	Review and revise Demobilization Plan as needed.	Demobilization Plan

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 4 : Emergency Public Information and Warning

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

Allocated funding: $78,669

Performance Measure Data Element:

PHEP 4.1 (Function 5): Public Message Dissemination - Time to issue a risk communication message for dissemination to the public.
(See Pgs 47-49)

- Start time: Date and time that a designated official requested that the first risk communication message be developed
- Stop time: Date and time that a designated official approved the first risk communication message for dissemination

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
By the end of Budget Period (BP) 2, WCHD will continue efforts to enhance the capability surrounding emergency public information and warning by: actively serving on the newly-created Public Information / Public Warning Taskforce; continuing conducting call-down drills of staff; utilizing the Public Information Officer (PIO) as the agency's spokesperson and member on regional JICs; implementing the newly developed WCHD media policy addressing public communication topics like social media; coordinating/facilitating/participating in community trainings and exercises; revising the agency's Public Information and Communication (PIC) Plan; and, working with public and private agencies and organizations at the local, area, state, regional, and federal levels.	Achieving this short-term goal will better prepare WCHD to effectively disseminate public health messages which adhere to the CDC's Crisis and Emergency Risk Communication (CERC) principles, and work with community partners to disseminate Joint Information Center (JIC) messages when appropriate.	Sign-in sheets; meeting minutes, notes or agendas, updated website as appropriate; revised PIC plan; press releases and web and social media postings.

Function #1: Activate the emergency public information system

Objective

By the end of BP2, WCHD will participate in the Public Warning/Public Information Task Force coordinated through Washoe County Regional Emergency Operations Center, conduct National Incident Management System Incident Command System 300/400 Trainings, and conduct or participate in a Crisis Emergency Risk Communication (CERC) Training. --- **$18,023**

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Attachment B: Scope of Work by Capability

Task 1: Prior to an incident, identify Public Information Officer, support staff (depending on jurisdictional vulnerabilities and subject matter expertise), and potential spokesperson(s) to convey information to the public. (See Pg 36)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	During BP1, the WCHD PIO, support staff and potential spokespersons were identified.	Ongoing	N/A

Task 2: Prior to an incident, identify a primary and alternate physical and/or virtual structure that will be used to support alerting and public information operations

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	During BP1, WCHD revised the media policy to address social media; media policy will be implemented in BP2.	June 30, 2014	Documented short-term social media strategy.

Task 3: Prior to the incident, ensure identified personnel are trained in the functions they may be asked to fulfill. (See Pg 36)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	• WCHD will coordinate and facilitate an ICS 300 class and ICS 400 class with attendance of 40 students. • WCHD will conduct or participate in at least one CERC training.	• February 28, 2014 • June 30, 2014	Training sign-in sheets.

Task 4: At the time of an incident, notify Public Information Officer, support staff, spokesperson(s), and subject matter experts, if applicable to the incident, of the need to either be on-call or to report for duty as necessary within a time frame appropriate to the incident. (See Pg 36)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue implementing current call-down activities.	Ongoing	Call-down drill activity documentation including sign-in sheets with attendee and time.

Task 5: At the time of an incident, assemble public information staff at the physical or virtual location, debrief on incident, and assign response duties. (See Pg 36)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue with PIO duties at Regional Emergency Operation Center or other sites as determined.	Ongoing	Sign-in sheets; appropriate key org identification on time cards.

Task 6: Assist local public health systems in implementing emergency communication abilities. (See Pg 36)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	A WCHD representative will attend regularly scheduled Public Information / Public Warning Task Force meetings and participate as member of Public Outreach Committee.	June 30, 2014	Meeting minutes, notes or agendas; Regional PI/PW Plan.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Standard operating procedures for the public health EOC. (See Pg 36)	Sustain	Review the Washoe County Emergency Management Plan.	N/A
Planning Resource Element 2: Message templates addressing jurisdictional vulnerabilities. (See Pg 36)	Build	WCHD staff will update the Public Information and Communications (PIC) Plan.	Revised PIC Plan.
Skill & Training 1: NIMS training for public information staff (See Pg 37)	Build	WCHD staff will coordinate and facilitate an ICS 300 class and ICS 400 class with attendance of 40 students.	Training sign-in sheet.
Skill & Training 2: Crisis and emergency risk communication training (See Pg 37)	Build	WCHD staff will conduct or participate in at least one CERC training.	Training sign-in sheet or proof of participation.

Function #2: Determine the need for a joint public information system

Objective

By the end of BP2, WCHD will coordinate area-wide Public Information Officer simulated public health emergency activity. -- **$15,205**

Task 1: As applicable to the incident, establish a Virtual Joint Information Center, if establishment of a full-fledged Joint Information Center is not optimal. (See Pg 38)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Coordinate an area-wide Public Information Officer (PIO) training using the Division of Strategic National Stockpile's Program Preparedness Branch online role-playing scenario that enables users to participate in a simulated public health emergency. The electronic system – known as the **Medical Countermeasure Response Trainer (MCRT)** – is designed to exercise the public information and warning-targeted capability and follows guidelines from the Homeland Security Exercise and Evaluation Program.	June 30, 2014	Online training/exercise sign-in sheet.

Task 2: Identify a health department representative to participate in the jurisdiction's emergency operations center to ensure public health messaging capacity is represented if a Joint Information Center (JIC) or Virtual Joint Information Center is not applicable to the incident. --- (See Pg 38)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	In BP1, WCHD identified staff representatives to participate in the jurisdiction's emergency operations center to ensure public health messaging capacity is represented in a JIC.	Ongoing	N/A

Task 3: Assign tasks to support staff (with staff redundancy to support extended operational periods) to support message coordination and public information through three principal functions: Research, Media Operations, and Administration, as applicable to the incident. (See Pg 38)

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD PIO will review CERC fundamentals with back-up PIOs.	December 30, 2013	Sign-in sheet

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Equipment and Technology 1: Minimum components of a virtual joint information center. (See Pg 39)	Build	WCHD will implement the online MCRT training and exercise.	Training and exercise sign-in sheet.

Function #3: Establish and participate in information system operations.

Objective

By end of BP2, the WCHD will develop an information system of operations concurrent with Department of Homeland Security/FEMA/Center for Domestic Preparedness/Emergency Management Institute Best Practices. --- **$14,276**

Task 1: Develop, recommend, and execute approved public information plans and strategies on behalf of the Incident Command or Unified Command structure. (See Pg 40)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD PIO will complete Department of Homeland Security/FEMA/CDP/Emergency Institute EO389 Master Public Information Officer Training.	September 9-13, 2013	Certificate of completion.

Task 2: Based on jurisdictional structure, provide a single release point of information for health and healthcare issues through a pre-identified spokesperson in coordination with the JIC. (See Pg 40)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	During BP1, a WCHD spokesperson was pre-identified to provide a single point of information for health and healthcare issues in coordination with the JIC.	Ongoing	N/A

Task 3: Facilitate rumor control for media outlets for the jurisdiction such as television, internet, radio, and newspapers. (See Pg 40)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will participate in ongoing Public Information / Public Warning taskforce sponsored by Washoe County Emergency Management.	Ongoing	Meeting minutes, notes or agendas; regional PI / PW Plan.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
No Priority Elements			

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Function #4: Establish avenues for public interaction and information exchange

Objective

By end of BP2, WCHD PIO will continue effective public information dissemination on issues current to Health District activities and participate in applicable drills, exercises, JIC trainings, and other networking activities to improve and enhance future public health messaging. --- **$16,755**

Task 1: Establish mechanisms (e.g., call center, poison control center, and non-emergency line such as 211 or 311) for public and media inquiries that can be scalable to meet the needs of the incident. (See Pg 41)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will work with statewide Public Information/Public Warning Taskforce in selection and/or development of newly-available public information warning programs and applications similar to Ping4, MyStateUSA/EAS, and IPAWS.	Ongoing	Implementation of programs.

Task 2: If health department websites exist, post incident-related information on health department website as a means of informing and connecting with the public. (See Pg 41)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to have webmaster post pertinent information through the website such as press releases, media advisories, and social media releases.	Ongoing	Updated website, as appropriate. Media tracking and monitoring through VOCUS and TV Eyes.

Task 3: Utilize social media (e.g., Twitter and Facebook) when and if possible for public health messaging. (See Pg 41)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	During BP1, WCHD revised the media policy to address social media; media policy will begin implementation in BP2.	June 30, 2014	Documented short-term social media strategy.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
No Priority Elements			

Function #5: Issue public information, alerts, warnings, and notifications.

Objective

By end of BP2, WCHD will continue to work independently or coordinate with Washoe County Emergency Management to issue public information, alerts, warnings and notifications as needed. --- **$14,411**

Attachment B: Scope of Work by Capability

Task 1: Prior to the incident, comply with established jurisdictional legal guidelines to avoid communication of information that is protected for national security or law enforcement reasons or that may infringe on individual and entity rights. (See Pg 42)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to work with Washoe County's legal counsel to ensure the communication of information complies with legal guidelines.	Ongoing	Documentation from Washoe County's legal counsel, as it is made available to WCHD.

Task 2: Disseminate information to the public using pre-established message maps in languages and formats that take into account jurisdiction demographics, at-risk populations, economic disadvantages, limited language proficiency, and cultural or geographical isolation. (See Pg 42)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will update its PIC plan, using feedback from the Northern Nevada Access and Functional Needs Workgroup, to ensure pre-established messages are culturally appropriate and effective for the diverse population.	June 30, 2014	Revised PIC plan.

Task 3: Transmit health-related messaging information to responder organizations through secure messaging platforms. (See Pg 43)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will provide press release and current web and social media postings follow agency protocol through webmaster.	Ongoing	Press releases and web and social media postings.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
No Priority Elements			

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 5 : PHEP Fatality Management

Definition: Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident

Performance Measures:
PHEP 5.2 (Function 1): Identify Role with Partners (LHDs) - Proportion of PHEP-funded LHDs that have defined fatality management roles and responsibilities of public health in relation to those of key local partners (e.g., emergency management, coroners and medical examiners, and funeral directors). (See Pgs 56-58)

Allocated funding: $20,334

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
WCHD will collaborate with WCMECO (Washoe County Medical Examiner Coroner's Office) to continue enhancing fatality management capabilities within the region with the continued development of the Northern Nevada Disaster Victim Recovery Team and community Family Assistance Centers.	Washoe County will have a cache of personnel specially trained in fatality response to be able to assist whether it's within the Family Assistance Center or the recovery of human remains.	• Family Assistance Center Annex • Training documentation of the NNDVRT

Function #1: Determine role for public health in fatality management.

Objective

By the end of Budget Period 2, WCHD will have continued to build the fatality management capabilities within the region by building upon the Budget Period 1 project to develop a Northern Nevada Disaster Victim Recovery Team. --- **$5,783**

Task 1: Prior to an incident, characterize potential fatalities based on jurisdictional risk assessment and the impact of these potential fatalities on jurisdictional resource needs. (See Pg 45)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review and update the Mass Fatality Annex to the Regional Emergency Operations Center as necessary based on real-world incident lessons learned.	June 30, 2014	Revised Mass Fatality Annex

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Task 2: Prior to an incident, coordinate with subject matter experts (e.g., those with expertise in epidemiology, laboratory, surveillance; community cultural/religious beliefs or burial practices; chemical, biological, radiological and emergency operations leads; and partners from hospital, mortuary, emergency medical services) to determine public health's role in an incident that may result in fatalities. (See Pg 45)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	By the end of Budget Period 2, WCHD will have continued to build the fatality management capabilities within the region by building upon the Budget Period 1 project to develop a Northern Nevada Disaster Victim Recovery Team.	June 30, 2014	NNDVRT team training documentation

Task 3: Prior to an incident, coordinate with jurisdictional, private and federal Emergency Support Function #6 and Emergency Support Function #8 resources as necessary to determine their roles and requirements for the response. (See Pg 45)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	By the end of Budget Period 2, WCHD will work with regional partners to develop protocols relating to the interface between Public Health, Washoe County Medical Examiner Coroner's Office and the healthcare organizations.	June 30, 2014	Standard operating procedures

Function #2: Activate public health fatality management operations.

Objective

By the end of Budget Period 2, WCHD will have continued to build the fatality management capabilities within the region by building upon the Budget Period 1 project to develop a Northern Nevada Disaster Victim Recovery Team. --- **$4,850**

Task 1: Assess data from the incident to inform and guide the public health resources needed for the response. (See Pg 48)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review and update the Mass Fatality Annex to the Regional Emergency Operations Center as necessary based on real-world incident lessons learned.	June 30, 2014	Revised Mass Fatality Annex

Task 2: Identify and coordinate with jurisdictional, regional, private, and federal Emergency Support Function #8 resources with expertise in the potential cause(s) of fatalities to make recommendations regarding all phases of human remains disposition: recovery, processing (e.g., decontamination, infection control, and other mitigation measures), storing, and disposing. (See Pg 48)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review and update the Mass Fatality Annex to the Regional Emergency Operations Center as necessary based on real-world incident lessons learned.	June 30, 2014	Revised Mass Fatality Annex

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Task 3: Coordinate with partners to initiate pre-determined (e.g., local, regional, state, federal, and private sector) processes for all phases of human remains disposition. (See Pg 48)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Review and update the Mass Fatality Annex to the Regional Emergency Operations Center as necessary based on real-world incident lessons learned.	June 30, 2014	Revised Mass Fatality Annex

Task 4: Coordinate incident details among members of the public health and medical health systems by sharing information between programs and linking information databases, based on the scope of the incident. (See Pg 48)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No activities			

Function #3: Mental/behavioral support at the healthcare organization level.

Objective

By the end of Budget Period 2, WCHD will have reviewed and updated (if necessary) the regional Family Assistance Center (FAC) plan developed in Budget Period 1, to ensure the inclusion of ante-mortem data collection. --- **$4,850**

Task 1: Coordinate with partners for the establishment of a mechanism (e.g., Family Assistance Center) to collect antemortem data. (See Pg 50)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	By mid-year of Budget Period 2, WCHD will review the regional FAC plan to determine if a review is necessary	December 31, 2013	• FAC plan review and revision • Training for regional partners

Task 2: Coordinate with partners to identify and assemble the resources required to collect and communicate ante mortem data. (See Pg 50)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	By mid-year of Budget Period 2, WCHD will review the regional FAC plan to determine if a revision is necessary	December 31, 2013	• FAC plan review and revision • Training for regional partners

Task 3: Coordinate with partners and assist, if needed, in the collection and dissemination of antemortem data to families of the deceased and law enforcement officials. (See Pg 50)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No activities			

Task 4: Coordinate with partners to support electronic recording and reporting of antemortem data through electronic systems and/or other information sharing platforms. (See Pg 50)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No activities			

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Procedure for the collection of antemortem data. (See Pg 50)	Build	By mid-year of Budget Period 2, WCHD will review the regional FAC plan to determine if a revision is necessary	Family Assistance Center plan with resource annex

Function #4: Participate in survivor mental/behavioral health services

Objective

By the end of Budget Period 2, WCHD will have begun to obtain memorandum of agreements with mental/behavioral health providers previously identified during Budget Period 1 and expand the list to include regional partners not identified. --- **$4,850**

Task 1: Coordinate with partners to assemble the required staff and resources to provide non-intrusive mental/behavioral health services to responders. (See Pg 52)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will reach out to previously identified mental/behavioral health services providers to obtain memorandum of agreements for staffing the community FAC or providing mental health support to Public Health responders.		MOA with mental health professionals

Task 2: Coordinate with partners to facilitate availability of culturally appropriate assistance (e.g., addressing language barriers and religious or cultural practices). (See Pg 52)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will develop a list of regional partners who would be able to provide culturally appropriate assistance to member of the community being served in the community FAC.		FAC annex with a list of providers

Task 3: Coordinate with Emergency Support Function 8 partners to support the provision of mental/behavioral health services to family members of the deceased and incident survivors as needed. (See Pg 52)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will reach out to previously identified mental/behavioral health services providers to obtain memorandum of agreements for staffing the community FAC or providing mental health support to Public Health responders.		MOA with mental health professionals

Function #5: Participate in fatality processing and storage operations

Objective

No activities planned at this time.

Attachment B: Scope of Work by Capability

Task 1: Make recommendations to incident management/jurisdictional lead agency on procedures for the safe recovery, receipt, identification, decontamination, transportation, storage, and disposal of human remains. Recommendations can also include an assessment of the need for temporary burial, procurement of public property for temporary burial, and security/privacy requirements of the processing facility. (See Pg 53)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No activities			

Task 2: Assist, if needed or requested, in multi-specialty forensic analysis to identify human remains and determine the cause and manner of death. (See Pg 53)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No activities			

Task 3: Coordinate with partners to support electronic death reporting. (See Pg 53)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No activities			

Task 4: Coordinate with partners to facilitate the collection and reporting of mortality information (e.g., vital records). (See Pg 53)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No activities			

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Subgrant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 6 : Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance.

Allocated funding: $51,748

Performance Measure Data Element:

PHEP 6.1 (Function 1 & 3): Share Epidemiological/Clinical Data (Awardee) - The awardee health department can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs). (See Pgs 60-61)

PHEP 6.2 (Function 1 & 3): Share Epidemiological/Clinical Data (LHDs) - Proportion of PHEP-funded local health departments that can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs). (See Pgs 62-64)

HPP-PHEP 6.1 (Function 3): Information Sharing - Percent of local partners that reported requested Essential Elements of Information (EEI) to the health and medical lead within the requested timeframe. (See Pgs 65-67)

Note: The page #'s listed for Performance Measures above correspond to CDC's "*BP1 Performance Measures Specifications and Implementation Guidance*", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014..

Short–term Goal	Planned Outcome	Output Documentation
WCHD will collaborate with regional partners to research and develop tools for regional informational sharing. This will enable continued communication during emergency response.	A Public Information / Public Warning regional plan that has an annex specifically for health communications.	Public Information / Warning Health Annex; training sign-in sheets; documentation from Washoe County's legal counsel as it is made available to WCHD; and revised Public Information and Communication Plan.

Function #1: Identify stakeholders to be incorporated into information flow.

Objective

By end of BP2, WCHD will identify stakeholders to be incorporated into information flow by building partnerships through active participation in the Public Warning/Public Information Task Force coordinated through Washoe County Regional Emergency Operations Center. --- **$24,307**

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Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Attachment B: Scope of Work by Capability

Task 1: Prior to and as necessary during an incident, identify intra-jurisdictional stakeholders across public health, public safety, private sector, law enforcement, and other disciplines to determine information-sharing needs. (See Pg 55)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	WCHD will attend regularly scheduled Public Warning / Public information Task Force meetings, and participate on the Taskforce's Public Outreach Committee to determine information-sharing needs.	June 30, 2014	Meeting agenda, notes, etc; Regional Public Information / Public Warning Plan when it's completed in the region.

Task 2: Prior to and as necessary during an incident, identify inter-jurisdictional public health stakeholders to determine information sharing needs. (See Pg 55)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Through the Public Information / Public Warning Taskforce, WCHD will assist in the development of a regional plan that addresses communications before, during and after incident, including the identification of stakeholders.	June 30, 2014	PI/PW Regional Plan.

Task 3: Prior to and as necessary during an incident, work with elected officials, identified stakeholders (both inter- and intra-jurisdictional) and private sector leadership to promote and ensure continual connection (e.g., ongoing standing meetings, webinars, and teleconferences) and use continuous quality improvement process to define and redefine information-sharing needs. (See Pg 55)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	• Through the Public Information / Public Warning Taskforce, WCHD will assist in the continuous quality improvement process to define and redefine information sharing and needs. • WCHD will further contribute to continuous quality improvement in the region by providing trainings for community partners, including ICS 300 and 400 and CERC. • The WCHD PIO will complete the EO389 Master Public Information Officer Training through the Department of Homeland Security/ FEMA/CDP/Emergency Management Institute, and will bring back knowledge gained to empower the Public Information / Public Warning Taskforce and WCHD leadership with best practices, including continuous quality improvement surrounding information sharing.	June 30, 2014	Training sign-in sheets; PI/PW Regional Plan.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Processes to engage stakeholders (See Pg 55)	Build	Through participation in the Public Information / Public Warning Taskforce, WCHD will work with community partners to identify a process to engage stakeholders.	PI/PW Regional Plan.
Planning Resource Element 2: Role-based public health directory. (See Pg 56)	Build	WCHD will add appropriate personnel to communications database.	Updated communications database.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Function #2: Identify and develop rules and data elements for sharing.

Objective

By end of BP2, WCHD will work with community partners through the Public Warning/Public Information Task Force to identify and develop rules and data elements for sharing. --- **$17,314**

Task 1: Prior to and as necessary during an incident, identify, through public health agency legal counsel (and counsel to other agencies and jurisdictions as appropriate), current jurisdictional and federal regulatory, statutory, privacy-related and other provisions, laws, and policies that authorize and limit sharing of information relevant to emergency situational awareness. Such laws and policies may include Health Insurance Portability and Accountability Act (HIPAA), Office of the National Coordinator Health IT Information Technology Policy, HHS Information Management Policy, and specific requirements of current memoranda of understanding and memoranda of agreements; these laws may address privacy, civil liberties, intellectual property, and other substantive issues. (See Pg 57)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to utilize the agency's legal counsel to obtain guidance on all legal-related matters.	Ongoing	Documentation from Legal Counsel as it is made available to WCHD.

Task 2: Prior to and as necessary during an incident, identify routine or incident-specific data requirements for each stakeholder. (See Pg 57)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Through the Public Information / Public Warning Taskforce, WCHD will work with community partners to further identify incident-specific data requirements for stakeholders.	June 30, 2014	PI/PW Regional Plan.

Task 3: Prior to and as necessary during an incident, identify public health events and incidents that, when observed, will necessitate information exchange. (See Pg 57)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Through the Public Information / Public Warning Taskforce, WCHD will work with community partners to further identify incidents which will necessitate information exchange.	June 30, 2014	PI/PW Regional Plan.

Task 4: Prior to, during, and after an incident, utilize continuous quality improvement or have a processes and a corrective action system to identify and correct unintended legal and policy barriers to sharing of situational awareness information that are within the jurisdictional public health agency's control (e.g., legal and policy barriers, opportunities to shorten the amount of time to share data). (See Pg 57)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to utilize the agency's legal counsel to obtain guidance on all legal-related matters.	Ongoing	Documentation from Legal Counsel as it is made available to WCHD.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Data-exchange requirements (See Pg 57)	Build	Through the Public Information / Public Warning Taskforce, WCHD will work with community partners to identify data exchange requirements.	PI/PW Regional Plan.
Planning Resource Element 2: Health Information exchange protocols (See Pg 57)	Sustain	WCHD will continue to utilize the agency's legal counsel to obtain guidance on all legal-related matters, including heath information exchange protocols.	Documentation from Legal Counsel as it is made available to WCHD.

Function #3: Exchange information to determine a common operating picture.

Objective
By the end of BP2, WCHD will continue to exchange information with community partners to determine a common operating picture. -- **$10,127**

Task 1: Prior to and during an incident, collaborate with and participate in jurisdictional health information exchange (e.g., fusion centers, health alert system, or equivalent). (See Pg 59)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to collaborate with and participate in jurisdictional health information exchanges such as the Public Information / Public Warning Taskforce, Nevada Department of Public Safety PIO group, and WCHD Crisis Communicators List.	Ongoing	Documentation of health information exchange, as appropriate.

Task 2: Prior to and during an incident, maintain data repositories that are able to support data exchange with other regional and federal public health entities. Store data according to jurisdictional and/or federal standards for formatting, vocabulary, and encryption. (See Pg 59)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	◦ WCHD will continue to appropriately utilize its internal instance of WebEOC, and/or Washoe County Emergency Management's instance of WebEOC, and Web Fusion, to support data exchange with other public health entities as necessary. ◦ WCHD will continue to utilize its Biostatistician's expertise to maintain certain data repositories and support data exchange.	Ongoing	Data in WebEOC.

Task 3: Prior to and during an incident, request, send, and receive data and information using encryption that meets jurisdictional and/or federal standards. (See Pg 59)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue its practice of requesting, sending and receiving data and information using encryption that meets jurisdictional and federal standards.	Ongoing	N/A

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Attachment B: Scope of Work by Capability

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Protocol for the development of Public Health Alert messages. (See Pg 59)	Build	As appropriate, WCHD will review and update the Public Information and Communication plan to ensure the protocol for the development of Public Health Alert messages is compliant with jurisdictional and federal standards.	Potentially an updated PIC Plan.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 7: Mass Care

Definition: Mass care is the ability to coordinate with partner agencies to address the public health, medical, and mental/behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that health needs continue to be met as the incident evolves.

Allocated funding: $ 00

Performance Measure Data Element:
PHEP 7.1 (Function 1): Define Roles with Partners (Awardee) - The awardee health department has defined its role in mass care operations in coordination with ESF-6 and other key partners. (See Pgs 69-71)
PHEP 7.2 (Function 1): Define Roles with Partners (LHDs) - Proportion of PHEP-funded local health departments that have defined their role in mass care operations in coordination with ESF-6 and other key partners. (See Pgs 72-74)
Evaluation Tool (Function 1-4): This instrument is intended to be completed by any state or local health department(s) within the awardee jurisdiction involved in mass care operations. However, the awardee will always be responsible for submitting these data to CDC. Health departments not involved in mass care operations are not required to complete this tool. (See Pgs 75-78)

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
No Activity Planned for BP2		

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 8 : Medical Countermeasure Dispensing

Definition: Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

Allocated funding: $124,529

Performance Measure Data Element:

Composite Measure (Function 1-5): MCMDD - Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC's Office of Public Health Preparedness and Response. (See Pgs 79-80)

Note: The page #'s listed for Performance Measures above correspond to CDC's "*BP1 Performance Measures Specifications and Implementation Guidance*", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
By the end of BP2, WCHD staff will ensure WCHD medical countermeasure plans are in accordance with CDC public health guidelines and recommendations in an effort to limit mortality in the event of a real public health emergency within Washoe County.	100% of WCHD SNS staff will receive training specific to revised POD operations in order to prepare them for a real public health emergency.	1. Updated Medical Countermeasures Distribution and Dispensing (MCMDD) Plan. 2. Updated Point of Dispensing (POD) Operations Manual 3. Sign-in sheets from staff training(s)

Function #1: Identify and initiate medical countermeasure dispensing strategies

Objective

Objective 1: By mid-year, WCHD staff will revise the WCHD Medical Countermeasures Distribution and Dispensing (MCMDD) Plan to better meet the needs of Washoe County residents in the event of a real public health emergency *as it relates to the identification and initiation of medical countermeasure dispensing strategies*.

Objective 2: By mid-year, WCHD staff will revise the WCHD Point of Dispensing (POD) Operations Manual to better meet the needs of Washoe County residents in the event of a real public health emergency *as it relates to the identification and initiation of medical countermeosure dispensing strategies*.
$23,881

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Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: Nationol Standards for State and Local Planning*", March 2011

Attachment B: Scope of Work by Capability

Task 1: Prior to an incident, and if applicable during an incident, engage subject matter experts (e.g., epidemiology, laboratory, radiological, chemical, and biological) including federal partners, to determine what medical countermeasures are best suited and available for the incidents most likely to occur based on jurisdictional risk assessment. (See Pg 71)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Hold meetings with subject matter experts to improve upon medical countermeasure plans.	June 30, 2014	Meeting sign-in sheets and minutes if applicable.

Task 2: Prior to an incident, and if applicable during an incident, engage private sector, local, state, regional, and federal partners, as appropriate to the incident, to identify and fill required response roles. (See Pg 71)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	1. Develop MOUs and/or Interlocal Agreements with private and public partners to identify and fill required response roles. 2. Coordinate training and educational opportunities for WCHD staff and volunteers and Private POD partners.	June 30, 2014	1. MOUs and/or Interlocal Agreements 2. Trainings & educational opportunities sign in sheet

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Written plans to identify the medical countermeasures. (See Pg 71)	Build	Revise MCMDD and POD Operations Manual to include standard operating procedure related to: -number and location of people affected by the incident, including AFM groups -possible agents/causes of incident -potential medical countermeasures -timeline for establishing medical countermeasure dispensing operations -personnel and staffing matrix -severity of possible incidents	Updated MCMDD and POD Operations Manual.

Function #2: Receive medical countermeasures.

Objective

Objective 1: By mid-year, WCHD staff will revise the WCHD Medical Countermeasures Distribution and Dispensing (MCMDD) Plan to better meet the needs of Washoe County residents in the event of a real public health emergency *as it relates to the receipt of medical countermeasures*.

Objective 2: By mid-year, WCHD staff will revise the WCHD Point of Dispensing Operations Manual to better meet the needs of Washoe County residents in the event of a re al public health emergency *as it relates to the receipt of medical countermeasures*. --- $23,181

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Task 1: Assess the extent to which current jurisdictional medical countermeasure inventories can meet incident needs. (See Pg 73)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Determine available medical countermeasure inventories.	December 31, 2013	List of resources and their medical countermeasure inventories.

Task 2: Request additional medical countermeasures from private, jurisdictional, and/or federal partners using established procedures, according to incident needs. (See Pg 73)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	1. Revise medical countermeasure requesting procedures. 2. Coordinate training and educational opportunities for WCHD staff and volunteers in addition to Private POD partners.	June 30, 2014	1. Revised MCMDD 2. Revised POD Ops Manual 3. Sign-in sheets for training and educational opportunities.

Task 3: Identify and notify any intermediary distribution sites based on the needs of the incident, if applicable. (See Pg 73)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Revise medical countermeasure identification and notification procedures, if applicable as it relates to intermediary distribution sites.	June 30, 2014	1. Revised MCMDD 2. Revised POD Ops Manual

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Written plans to request additional medical countermeasures. (See Pg 74)	Build	Revise MCMDD and POD Operations Manual to include: -assessment of local inventory/medical countermeasure cache -identification of local pharmaceutical and medical supply wholesalers -process for requesting additional medical countermeasures if local supplies are exhausted -storage of medical countermeasures	Updated MCMDD and POD Operations Manual.

Function #3: Activate dispensing modalities.

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Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Attachment B: Scope of Work by Capability

Objective
Objective 1: By end of BP2, WCHD staff will revise the WCHD Medical Countermeasures Distribution and Dispensing (MCMDD) Plan to better meet the needs of Washoe County residents in the event of a real public health emergency *as it relates to activation of dispensing madalities.*
Objective 2: By end of BP2, WCHD staff will revise the WCHD Point of Dispensing Operations Manual to better meet the needs of Washoe County residents in the event of a real public health emergency *as it relates to dispensing modalities*.
Objective 3: By end of BP3, all Private POD partners will have plans in place that address activation of their Private POD site. -- $30,512

Task 1: Activate dispensing strategies, dispensing sites, dispensing modalities and other approaches, as necessary, to achieve dispensing goals commensurate with the targeted population. (See Pg 75)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	1. Revise POD Ops Manual to reflect newly updated public POD locations. 2. Provide training to Private POD partners in the development of Private POD planning. 3. Assist in the development of Private POD Plans for each Private POD partner which address activation of Private POD sites. 4. Activate dispensing strategies as necessary if a real life emergency occurs.	June 30, 2014	1. Revised POD Ops Manual 2. Sign-in sheets for trainings 3. Private POD Plans

Task 2: Activate staff that will support the dispensing modality in numbers necessary to achieve dispensing goals commensurate with the targeted population. (See Pg 75)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	1. Update roster of WCHD SNS Department Operations Center staff. 2. Update Public POD on-site staff. 3. Provide training to SNS DOC and on-site POD staff with regard to POD operations. 4. Activate staff as necessary if a real life public health emergency occurs.	June 30, 204	1. SNS DOC Roster 2. On-site POD rosters 3. Sign-in sheets for trainings

Task 3: If indicated by the incident, implement mechanisms for providing medical countermeasures for public health responders, critical infrastructure personnel, and their families, if applicable. (See Pg 75)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	1. Develop MOUs and/or Interlocal Agreements with public health responders, critical infrastructure personnel and their families.	June 30, 2014	MOUs and/or Interlocal Agreements

Task 4: Initiate site-specific security measures for dispensing locations, if applicable. (See Pg 75)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	1. Meet with Washoe County Sheriff's Office to ensure all Public POD sites have security plans and include these plans in the POD Ops Manual 2. Ensure all Private POD Planning documents include security measures	June 30, 2014	Security Plans for each Public and Private dispensing site

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards far State and Local Planning***", March 2011

Task 5: Inform public of dispensing operations including locations, time period of availability, and method of delivery. (See Pg 75)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Develop canned flyers/messages and PSAs to be used for activation of POD sites	December 31, 2014	1. Flyers/Messages 2. PSAs

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Medical countermeasure dispensing activities support (See Pg 75)	Build	Develop MOUs and Interlocal Agreements with Private POD partners and Public POD facility owners	MOUs and Interlocal Agreements
Planning Resource Element 2: Procedure for activation of dispensing modalities. (See Pg 75)	Build	1. Revise Public POD activation procedures if necessary. 2. Assist Private POD partners in the development of activation plans. 3. Identify additional dispensing modalities and develop MOUs with these agencies.	1. Revised POD Ops Manual 2. Private POD Plans 3. Private POD MOUs

Function #4: Dispense medical countermeasures to identified population

Objective

- Objective 1: By end of BP2, WCHD staff will revise the WCHD Medical Countermeasures Distribution and Dispensing (MCMDD) Plan to better meet the needs of Washoe County residents in the event of a real public health emergency *os it relates to dispensing medical countermeasures*.
- Objective 2: By end of BP2, WCHD staff will revise the WCHD Point of Dispensing Operations Manual to better meet the needs of Washoe County residents in the event of a real public health emergency *as it relates to dispensing medical countermeasures*.
- Objective 3: By end of BP2, all Private POD partners will have plans in place that address activation of their Private POD site and dispensing of medical countermeasures.
- $23,541

Task 1: Maintain dispensing site inventory management system to track quantity and type of medical countermeasures present at the dispensing site. (See Pg 77)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Ensure appropriate staff are trained in WebIZ CRA and Insight	December 31, 2014	Documentation of trained WebIZ CRA and Insight staff members

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Task 2: Screen and triage individuals to determine which medical countermeasure is appropriate to dispense to individuals if more than one type or subset of medical countermeasure is being provided at the site. (See Pg 77)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Provide screening and triaging trainings for both WCHD staff and Private POD partners using SNS medical screening forms	June 30, 2014	Sign-in sheets for trainings

Task 3: Distribute pre-printed drug/vaccine information sheets that include instructions on how to report adverse events. (See Pg 77)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Distribute pre-printed drug/vaccine information sheets that include instructions on how to report adverse events before and during training opportunities to both WCHD staff and Private POD partners.	June 30, 2014	List of staff and Private POD partners who received information sheets, including date received.

Task 4: Monitor dispensing site throughput and adjust staffing and supplies as needed in order to achieve dispensing goals commensurate with the targeted population. (See Pg 77)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	N/A (unless event occurs and PODs are activated)		

Task 5: Document doses of medical countermeasures dispensed, including but not limited to: product name and lot number, date of dispensing, and location of dispensing (e.g., address and zip code). (See Pg 77)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	N/A (unless event occurs and PODs are activated)		

Task 6: Report aggregate inventory and dispensing information to jurisdictional authorities at least weekly during an incident, but potentially more frequently based on incident needs. (SeePg 77)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	N/A (unless event occurs and PODs are activated)		

Task 7: Determine the disposition of unused medical countermeasures within the jurisdictional health system according to jurisdictional policies. (See Pg 77)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Develop procedures for the disposition of unused medical countermeasures and include procedures in the MCMDD.	December 31, 2014	Procedures in MCMDD.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Medical countermeasure dispensing to target populations (See Pg 78)	Build	Revise written dispensing processes and protocols in MCMDD related to screening and triaging of patients	Revised procedures in MCMDD

Function #5: Report adverse events

Objective

Objective 1: By mid-year, WCHD staff will revise the WCHD Medical Countermeasures Distribution and Dispensing (MCMDD) Plan to better meet the needs of Washoe County residents in the event of a real public health emergency as it relates to reporting of adverse events. -- $23,414

Task 1: Activate mechanism(s) for individuals and healthcare providers to notify health departments about adverse events. (See Pg 79)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Develop a procedure for individuals and healthcare providers to notify the WCHD about adverse events.	December 31, 2013	Updated procedures in MCMDD

Task 2: Report adverse event data to jurisdictional and federal entities according to jurisdictional protocols. (See Pg 79)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	N/A (unless event occurs and PODs are activated)		

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Protocol to govern reporting of adverse events (See Pg 80)	Build	Include processes and protocols to govern reporting of adverse events that include: -messages that articulate the importance of adverse reporting -process to ensure individuals receive the information sheet about potential adverse events of the medical countermeasure dispensed -information required to document adverse events	Processes in MCMDD
Skill & Training Element 1: Adverse event report training (See Pg 80)	Build	Provision of procedures to WCHD staff and Private POD partners	E-mail documentation of provision of procedures

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Washoe County Health District CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13 Scope of Work (SOW) July 1, 2013 through June 30, 2014	
PHEP Capability #9 : Medical Material Management & Distribution	
PHEP Capability # 10 : Medical Surge	
Allocated funding:	**$ 00 -- No Planned Activity for BP2**

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 11 : Non-Pharmaceutical Interventions

Definition: Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following:

- Isolation and quarantine
- Restrictions on movement and travel advisory/warnings
- Social distancing
- External decontamination
- Hygiene
- Precautionary protective behaviors

Allocated funding: $4,157

Performance Measure Data Element:
PHEP 11.1 (Function 1): Determine Role with Partners (Awardee) - The awardee health department has collaborated with legal, scientific and community partners to determine roles and responsibilities for the development and implementation of NPI recommendations. (See Pgs 83-85)
PHEP 11.2 (Function 1): Determine Role with Partners (LHDs) - Proportion of PHEP-funded local health departments that have collaborated with legal, scientific and community partners to determine roles and responsibilities for the development and implementation of NPI recommendations. (See Pgs 86-88)
PHEP 11.3 (Function 1-3): Develop NPI Recommendations with Partners - Proportion of key partners identified to have an incident-specific role that participated in the development or implementation of NPI during an incident. (See Pgs 89-91)

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
By June 30, 2014, WCHD will have a thorough understanding of the legal and regulatory authorities available to implement isolation, quarantine, social distancing and other forms of non-pharmaceutical intervention.	Legal bench book available to guide future planning	Bench book.

Function #1: Engage partners and identify factors that impact non-pharmaceutical interventions

Objective
By June 30, 2014, WCHD will develop a draft bench book that outlines relevant legal authorities related to the implementation of non-pharmaceutical interventions.
Task 1: Prior to an incident, identify jurisdictional legal, policy, and regulatory authorities that enable or limit the ability to recommend and implement non-pharmaceutical interventions, in both routine and incident-specific situations. (See Pg 102)

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Request a legal review of statutory and regulatory authority related to isolation/quarantine, facility closure, and event cancelation from the Assistant District Attoruney assigned to the Washoe County Health Authority and/or the Deputy Attorney General assigned to the Nevada State Health Division	June 30, 2013	Report from the ADA or DAG.

Task 2: Prior to an incident, engage healthcare organizations, government agencies, and community sectors (e.g., education, social services, faith-based, business, and legal) in determining their roles and responsibilities in non-pharmaceutical interventions on an ongoing basis through multidisciplinary meetings. (See Pg 102)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Implementing non-pharmaceutical interventions plan. (See Pg 102)	No Activity	Target is BP 3	
Planning Resource Element 2: Communication and reporting plan (See Pg 102).	No Activity	Target is BP 3	

Function #2: Determine non-pharmaceutical interventions.

Objective

Target is BP 3

Task 1: At the time of the incident, assemble subject matter experts to assess the severity of exposure and/or transmission at the jurisdictional level, and determine non-pharmaceutical intervention recommendations. (See Pg104)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Intervention recommendation and/or implementation plan (See Pg 104)	No Activity	Target is BP 3	

Function #3: Implement non-pharmaceutical interventions

Objective

Target is BP 3

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Attachment B: Scope of Work by Capability

Task 1: At the time of an incident, activate non-pharmaceutical intervention locations (e.g., isolation or quarantine sites) through coordination with jurisdictional officials (e.g., law enforcement, medical, and school). (See Pg 105)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 2: At the time of an incident, assist community partners with coordinating support services (e.g., medical care and mental health) to individuals included in non-pharmaceutical intervention(s). (See Pg 105)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 3: At the time of an incident, provide recommendations for voluntary or mandatory closure of congregate locales and events to jurisdictional officials (e.g., emergency management, law enforcement, school, and tribal entities) and stakeholders (e.g., mall/store owners, faith-based congregations, and convention centers/event coordinators), if needed. (See Pg 105)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 4: At the time of an incident, provide recommendations for voluntary or mandatory restrictions on movement in conjunction with jurisdictional officials (e.g., emergency management, law enforcement, and transportation), if needed. (See Pg 105)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 5: Upon request, activate jurisdictional processes for managing and detaining passengers at ports of entry through coordination with CDC's Division of Global Migration and Quarantine, port authorities, and jurisdictional officials as applicable to the incident. (See Pg 105)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 6: At the time of an incident, assure ability to conduct external decontamination of potentially contaminated or contaminated individuals. (See Pg 105)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 7: At the time of an incident, educate and inform the public, response agencies and other partners regarding the recommended intervention(s). (See Pg 105)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

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Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Isolation and quarantine plans (See Pg 106)	No Activity	Target is BP 3	
Planning Resource Element 2: Separation of cohort plan (See Pg 106)	No Activity	Target is BP 3	

Function #4: Monitor non-pharmaceutical interventions

Objective

Target is BP 3

Task 1: Assess the degree of transmission, contamination, infection and severity of exposure. (See Pg 108)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 2: Disseminate situational awareness reports on impact of the intervention to all agencies involved in the intervention(s). (See Pg 108)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 3: Revise recommendation(s) for non-pharmaceutical interventions as indicated by the incident, including recommending intervention escalation or de-escalation. (See Pg 108)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Task 4: Document non-pharmaceutical implementation actions taken by local jurisdictions and document feedback from community partners assisting in the intervention(s) as part of the incident After Action Report. (See Pg 108)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity	Target is BP 3		

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
No Priority Elements			

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability #12 : Public Health Laboratory Testing	
Allocated funding:	**$ 00 -- No Activity Planned in BP2**

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability #13 : Public Health Surveillance & Epidemiological Investigation

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

Allocated funding: **$152,525**

Performance Measure Data Element:
PHEP 13.1 (Function 1): Disease Reporting - Proportion of reports of selected reportable diseases received by a public health agency within the awardee required time frame. (See Pgs 122-125)
– Numerator: Number of reports of selected reportable disease received by a public health agency within the awardee-required timeframe
– Denominator: Number of reports of selected reportable disease received by a public health agency
PHEP 13.2 (Function 3): Disease Control - Proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate timeframe (See Pgs 126-128)
– Numerator: Number of reports of selected reportable diseases for which public health control measure(s) were initiated within an appropriate timeframe
– Denominator: Number of reports of selected reportable diseases received by a public health agency
PHEP 13.3 (Function 2): Outbreak Investigation Reports-Percentage of infectious disease outbreak investigations that generate reports (See Pgs 130-132)
– Numerator: Number of infectious disease outbreak investigation reports generated
– Denominator: Number of infectious disease outbreaks investigated
PHEP 13.4 (Function 2): Outbreak Reports with Minimal Elements - Percentage of infectious disease outbreak investigation reports that contain all minimal elements (See Pgs 133-134)
– Numerator: Number of infectious disease outbreak investigation reports generated containing all minimal elements
– Denominator: Number of infectious disease outbreak reports generated
PHEP 13.5 (Function 2): Exposure Reports - Percentage of epidemiological investigations of acute environmental exposures that generate reports (See Pgs 135-137)
– Numerator: Number of epidemiological investigation reports of acute environmental exposures generated
– Denominator: Number of epidemiological investigations of acute environmental exposures
PHEP 13.6 (Function 2): Exposure Reports with Minimal Elements - Percentage of acute environmental exposure reports that contain all minimal elements (See Pgs 138-139)
– Numerator: Number of epidemiological investigation reports of acute environmental exposures containing all minimal elements
– Denominator: Number of epidemiological investigation reports of acute environmental exposures generated

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementotion Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Complete the build out of Target Capability 13: Public Health Surveillance and Epidemiological Investigation.	Only sustaining activities will be required.	See output documentation under functions below.

Function #1: Conduct public health surveillance and detection

Objective

By June 30, 2014, WCHD will sustain the tasks outlined below and Epidemiology staff will document attainment of Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies. -- **$41,374**

Task 1: Engage and retain stakeholders, which are defined by the jurisdiction, who can provide health data to support routine surveillance, including daily activities outside of an incident, and to support response to an identified public health threat or incident (See Pg 119)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to engage stakeholders through reminders about legally mandated reporting in the EpiNews publication.	Ongoing	EpiNews publications

Task 2: Conduct routine and incident-specific morbidity and mortality surveillance as indicated by the situation (e.g. complications of chronic disease, injury, or pregnancy) using inputs such as reportable disease surveillance, vital statistics, syndromic surveillance, hospital discharge abstracts, population-based surveys, disease registries, and active case finding. (See Pg 119)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Routine surveillance will continue to be conducted in accordance with NRS/NAC 441A	Ongoing	NBS and Staff investigation notes.
Sustain	Existing syndromic surveillance systems will be maintained including FirstWatch, and NRDM while continuing to transition from HMS to BioSense.	Ongoing	Syndromic surveillance SOP

Task 3: Provide statistical data and reports to public health and other applicable jurisdictional leadership in order to identify potential populations at-risk for adverse health outcomes during a natural or man-made threat or incident. (See Pg 119)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Statistical data will continue to be shared through internal reports on a weekly basis and with external partners through the EpiNews.	Ongoing	CD Log and EpiNews Publications

Task 4: Maintain surveillance systems that can identify health problems, threats, and environmental hazards and receive and respond to (or investigate) reports 24/7. (See Pg 119)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Identification of health problems, threats, and environmental hazards will be achieved through continued analysis of surveillance data and encouragement of outbreak reporting by professionals and members of the public.	Ongoing	EpiNews Publications.

Attachment B: Scope of Work by Capability

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Equipment & Technology 1: Access to health information infrastructure and surveillance systems (See Pg 121)	Sustain	WCHD will continue to make computers and appropriate analytical software available for epidemiology staff use.	Appropriate software installed
Planning Resource Element 1: Document the legal and procedural framework for information exchange (See Pg 119)	Sustain	Existing WCHD Communicable Disease Manual and Outbreak Response SOP capture the legal and procedural framework for information exchange, access to health information, and confidentiality.	WCHD Outbreak Response SOP and Communicable Disease Manual
Planning Resource Element 2: Protocols for accessing health information (See Pg 119)	Sustain	WCHD will continue to update and maintain existing MOUs for accessing health information such as hospital discharge data, vital statistics, cancer registry, etc.	MOUs
Planning Resource Element 3: Protocols to gather and analyze surveillance data (See Pg 120)	Sustain	WCHD will continue to utilize existing protocols for gathering and analyzing syndromic surveillance data and will update as needed for the transition from HMS to BioSense	Syndromic Surveillance Protocol
Planning Resource Element 4: Procedures to ensure 24/7 health department access (See Pg 120)	Sustain	WCHD will continue to retain the services of an answering service that will refer calls to epidemiology staff 24/7.	Call logs
Planning Resource Element 5: Protocols to notify CDC of cases on the Nationally Notifiable Infectious Disease List (See Pg 120)	Sustain	WCHD will continue to utilize the NBS to notify CDC of cases on the Nationally Notifiable Infectious Disease List.	NBS
Skills & Training 1: Tier 1 Competencies and Skills for Applied Epidemiologists (See Pg 121)	Build	WCHD Epidemiology staff will complete the self assessment for Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.	Completed self assessments
	Build	WCHD Epidemiology staff will identify and complete training to address any deficits in the Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.	Staff training records

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

	Build	WCHD Senior Epidemiology staff will complete the self assessment for Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.	Completed self assessments
	Build	WCHD Senior Epidemiologist staff will identify and complete training to address any deficits in the Tier 2 Competencies and skills for Applied Epidemiologists in Governmental Public Health Agencies.	Staff training records

Function #2: Conduct public health and epidemiological investigations

Objective

By June 30, 2014, WCHD will sustain the tasks outlined below. --- **$38,281**

Task 1: Conduct investigations of disease, injury or exposure in response to natural or man-made threats or incidents and ensure coordination of investigation with jurisdictional partner agencies. Partners include law enforcement, environmental health practitioners, public health nurses, maternal and child health, and other regulatory agencies if illegal activity is suspected. (See Pg 122)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to conduct investigations as required by law and/or public health necessity and will involve partner organizations as indicated.	Ongoing	NBS system and investigative files

Task 2: Provide epidemiological and environmental public health consultation, technical assistance, and information to local health departments regarding disease, injury, or exposure and methods of surveillance, investigation, and response (See Pg 122)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to provide epidemiological and environmental consultation to neighboring jurisdictions and partner agencies as requested.	Ongoing	Staff notes

Task 3: Report investigation results to jurisdictional and federal partners, as appropriate. (See Pg 122)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to report investigation results to jurisdictional a federal partners utilizing NBS.	Ongoing	NBS system

Attachment B: Scope of Work by Capability

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Investigation report templates (See Pg 122)	Sustain	WCHD will continue to utilize the existing Outbreak Response SOP and conduct an annual review of the document with updates as needed.	WCHD Outbreak Response SOP
Skills & Training 1: Staffing capacity to manage the routine epidemiological investigation systems (See Pg 124)	Sustain	WCHD will continue to provide training opportunities for staff to enhance their capacity to mange routine epidemiological investigation systems	Staff training records

Function #3: Recommend, monitor, and analyze mitigation actions

Objective

By June 30, 2014, WCHD will sustain the tasks outlined below. -- **$36,435**

Task 1: Determine public health mitigation, including clinical and epidemiological management and actions to be recommended for the mitigation of the threat or incident based upon data collected in the investigation and on applicable science-based standards outlined by Morbidity and Mortality Weekly Report, control of Communicable Diseases Manual, Red Book of Infectious Diseases or, as available, a state or CDC incident annex. (See Pg 124)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to determine and implement mitigation actions based on applicable science and standards outlined in reference documents.	Ongoing	NBS, Staff investigation notes, and Outbreak final reports

Task 2: Provide information to public health officials to support them in decision making related to mitigation actions. (See Pg 124)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to provide information for decision makers to support decision making related to mitigation actions	Ongoing	NBS, Staff investigation notes, and Outbreak final reports

Task 3: Monitor and analyze mitigation actions throughout the duration of the public health threat or incident. (See Pg 124)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to monitor mitigation results.	Ongoing	NBS, Staff investigation notes, and Outbreak final reports

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards far State and Local Planning***", March 2011

Task 4: Recommend additional mitigation activities, based upon mitigation monitoring and analysis, throughout the duration of the incident, as appropriate. (See Pg 125)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to recommend additional measures as needed based on monitoring of mitigation results	Ongoing	NBS, Staff investigation notes, and Outbreak final reports

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Protocols for recommending and initiating containment and mitigation actions (See Pg 125)	Sustain	Existing plans, SOPs and protocols will continue to be reviewed and updated as needed.	Response plans and SOPs
Skill & Training 1: Training in Homeland Security Exercise and Evaluation After Action Report process (See Pg 125)	Sustain	Awareness level training on HSEEP will be provided to all epidemiology staff.	Staff Training Records

Function #4: Improve public health surveillance and epidemiological investigation systems

Objective

By June 30, 2014, WCHD will sustain the tasks outlined below. -- **$36,435**

Task 1: Identify issues and outcomes during and after the incident. (See Pg 126)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to identify issues and outcomes during and after incidents.	Ongoing	Outbreak final reports and AAR/IPs

Task 2: Conduct post-incident/post-exercise agency evaluation meeting(s) including all active participants (e.g., law enforcement, volunteer agencies, clinical partners or environmental regulatory agency) to identify internal protocols and deficiencies that require corrective actions in areas such as programs, personnel, training, equipment, and organizational structure. (See Pg 126)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to conduct post-incident evaluation meetings with active participants after major outbreak investigations and/or exercises.	Ongoing	Outbreak final reports and AAR/IPs

Attachment B: Scope of Work by Capability

Task 3: Develop an After Action Report/Improvement Plan. (See Pg 126)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to develop an AAR/IP after major outbreak investigations and/or exercises	Ongoing	Outbreak final reports and AAR/IPs

Task 4: Communicate recommended After Action Report Improvement Plan corrective actions to public health leadership. (See Pg 126)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	WCHD will continue to communicate AAR/IP information to public health leadership after major outbreaks and/or exercises	Ongoing	Outbreak final reports and AAR/IPs

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Communication of improvement plan (See Pg 126)	Sustain	WCHD will continue to communicate AAR/IP information to public health leadership after major outbreaks and/or exercises	Outbreak final reports and AAR/IPs

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 14 : Responder Safety and Health

Definition: The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

Allocated funding: $32,833

Performance Measure Data Element:
PHEP 14.1 (Function 1, 3 and 4): Deployment Safety and Health Program (Awardee) - The awardee health department has a deployment safety and health program in place for public health responders [Yes/No] (See Pgs 143-145)
PHEP 14.2 (Function 1, 3 and 4): Deployment Safety and Health Program (LHDs) - Proportion of PHEP-funded local health departments that have a deployment safety and health program in place for public health responders (See Pgs 146-148)
PHEP 14.3 (Function 4): Screening/Out-Processing - Proportion of deployed public health responders screened for medical readiness prior to deployment and outprocessed post-deployment (See Pgs 149-150)
PHEP 14.4 (Function 4): Responder Health Outcomes - Percentage of public health responders who were injured, ill, exposed, or killed as a result of deployment during an incident (See Pgs 151-152)

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
By the end of BP2, WCHD staff will identify responder health and safety resources that address responder safety and health risks and needs in an effort to better protect responders in the event off a public health emergency.	All public health responders will have access to a Health and Safety Plan as it relates to public health emergencies.	A Health and Safety Plan which contains: 1. Lists/Fact sheets/Risk assessment identifying: • medical health risks • environmental exposures • mental/behavioral health risks 2. Matrices that address identified risks and: • Resources

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

		▫ Acute and chronic health conditions ▫ PPE needs ▫ Safety needs

Function #1: Identify responder safety and health risks.

Objective

By end of year, WCHD staff will create Responder Health and Safety Fact Sheets which include safety and health recommendations as they relate to identified risks. --- $16,416

Task 1: Prior to an incident, identify the medical, environmental exposure, and mental/behavioral health risks that may be faced by staff responding to the public health incident in conjunction with partner agencies and based on jurisdictional risk assessment. (See Pg 127)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Identification of medical, environmental exposure, and mental/behavioral health risks through research and community collaboration.	December 31, 2013	Risk assessment identifying medical, environmental exposure, and mental health risks that first responders may be faced with during public health emergencies.

Task 2: Prior to an incident, identify subject matter experts and other informational resources that can be used by public health staff to make health and safety recommendations to the Incident Safety Officers or lead agency. (See Pg 127)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Identification of subject matter experts.	June 30, 2014	Matrix which identifies subject matter experts by risk category.

Task 3: Prior to an incident, and as applicable during an incident, work with subject matter experts to develop information on potential acute and chronic health conditions that may develop/occur during and after an exposure. (See Pg 127)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Meetings with subject matter experts and research pertaining to potential acute and chronic health conditions.	June 30, 2014	Matrix which identifies potential acute and chronic health conditions related to identified risks.

Task 4: In consultation with the Incident Safety Officer and subject matter experts, participate in the formulation of recommendations to the Incident Commander regarding responder-specific risks to be addressed in incident action plans. (See Pg 127)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	1. Write an Incident Action Plan template for public health emergencies. 2. Create a Responder Safety and Health Plan for use by the Safety Officer, Incident Commander and responders as needed.	June 30, 2014	• Incident Action Plan template that includes responder – specific risks to be addressed during emergency responses. • Responder Safety and Health Plan that recommends possible solutions to responder specific risks during emergency responses.

Task 5: Distribute safety materials to public health responders through daily briefings at the onset of, and throughout an incident, in consultation with the Incident Safety Officer and jurisdictional subject matter experts. (See Pg 127)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	1. Write an Incident Action Plan template for public health emergencies. 2. Create a Responder Health and Safety Fact Sheets for use by the Safety Officer, Incident Commander and responders.	June 30, 2014	1. Incident Action Plan template that includes responder – specific risks to be addressed during emergency. 2. Fact Sheets that can be distributed to responders, which address Health and Safety materials.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Safety and health risk plans (See Pg 127)	Build	Document safety and health risk scenarios likely to be faced by public health responders that addresses: -limits of exposure of injury necessitating response -Job-specific worker safety guides -potential for post-event medical and mental/behavioral health follow-up assessments	Responder Safety and Health Plan

Note: The page #'s listed in this table correspond to CDC's "*Public Health Preparedness Capabilities: National Standards for State and Local Planning*", March 2011

Planning Resource Element 2: Public health roles and responsibilities (See Pg 128)	Build	Document public health roles and responsibilities related to identified risks and identify: -PPE -protective actions	Responder Safety and Health Plan

Function #2: Identify safety and personal protective needs

Objective

By end of year, WCHD staff will create Responder Health and Safety Facts Sheets which include safety and health recommendations as they relate to identified risks. --- $16,416

Task 1: Prior to an incident, and as applicable during an incident, work with subject matter experts (e.g., state environmental health, state occupational health and safety, hazard-specific subject matter experts, and emergency managers) to identify responder safety and health resource requirements (e.g., equipment needs). (See Pg 129)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Identify safety and PPE needs as they related to identified risks.	December 31, 2013	Matrix of safety and PPE needs as they relate to identified risks.

Task 2: Prior to an incident, and as applicable during an incident, and in conjunction with subject matter experts, formulate recommendations to public health responders regarding personal protective equipment that are consistent with local jurisdictional requirements. (See Pg 129)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Create Fact Sheets that list recommendations to public health responders regarding PPE.		Fact Sheets

Task 3: Coordinate with partner agencies to provide medical countermeasures and/or personal protective equipment to public health responders, if indicated by the incident. (See Pg 129)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	Update Medical Countermeasures Distribution and Dispensing Plan to include PPEs to public health responders.	June 30, 2014	1. Revised procedures in MCMDD 2. Responder Safety and Health Plan

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Risk-related personal protective equipment (See Pg 130)	Build	Develop recommendations for risk-related PPE for public health responders.	Responder Safety and Health Plan
Equipment Resource Element 1: Personal Protective Equipment for healthcare workers. (See Pg 130)	Build	1. Identify PPE that is consistent with identified risks. 2. Create a resource inventory of PPE.	PPE Resource Inventory

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Function #3: Coordinate with partners to facilitate risk-specific safety and health training

Objective
No Activity planned for BP2

Task 1: Prior to an incident, and as applicable during an incident, work with subject matter experts to determine/recommend risk-specific training (both training for protective actions as well as training for response to exposure or injury). (See Pg 131)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity			

Resource Element: Plans (P), Equipment, Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Skills and Training 1: Risk-specific safety training on N-95 (See Pg 131)			
Skills and Training 2: Risk-specific training documentation (See Pg 131)			

Function #4: Monitor responder safety and health actions

Objective
N/A for BP2

Task 1: Conduct or participate in exposure, mental/behavioral health, and medical surveillance of public health incident responders before, during, and after an incident. (See Pg 131)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity			

Task 2: Coordinate with healthcare partners to facilitate access to and promote the availability of medical and mental/behavioral health services for responders, either on-site or off-site as applicable to the incident. (See Pg 131)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity			

Task 3: Provide guidance to partner organizations to help conduct monitoring of any responder staff for medical/mental/behavioral incident-related health outcomes. (See Pg 131)

Attachment B: Scope of Work by Capability

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity			

Task 4: Utilize surveillance data and other applicable inputs from partner agencies to provide recommendations or considerations for any changes related to the use of personal protective equipment (e.g., to alter, suspend, or terminate any activity or personal protective equipment usage judged to improve the outcome or be an imminent danger or immediately dangerous to life and health). (See Pg 131)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity			

Task 5: Support the Public Information Officer and partner agencies to implement risk-communication strategies that communicate risks to responders after the completion of the acute phase of an incident. Include risks known pre-incident and those discovered during and after the acute phase. (See Pg 131)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
No Activity			

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Health surveillance (See Pg 132)	No Activity		
Equipment Resource Element 1: Responder Database (See Pg 132)	No Activity		

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Washoe County Health District
CDC Public Health Emergency Preparedness (BP2) Sub-grant #CDC08-13
Scope of Work (SOW) July 1, 2013 through June 30, 2014

PHEP Capability # 15 : Volunteer Management

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

Allocated funding: $70,643

Performance Measure Data Element:

PHEP 15.1 (Function 1-2): Managing Volunteers (Awardee) - The awardee health department has plans, processes and procedures in place to manage volunteers supporting a public health or medical incident [Yes/No] (See Pgs 155-156)

PHEP 15.2 (Function 1-2): Managing Volunteers (LHDs) - Proportion of PHEP-funded LHDs that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident (See Pgs 157-158)

HPP-PHEP 15.1 (Function 3-4): Volunteer Management - Proportion of volunteers deployed to support a public health/medical incident within an appropriate timeframe (See Pgs 159-160)

Note: The page #'s listed for Performance Measures above correspond to CDC's "***BP1 Performance Measures Specifications and Implementation Guidance***", Version 1.1

Outcome Objective: 100% of capability will be achieved by 6/30/2014.

Short–term Goal	Planned Outcome	Output Documentation
Ensure that Renown, St. Mary's, Northern Nevada and Incline Village Health Center and other healthcare organizations have or have access to plans, processes, and procedures to contact the MRC Program Coordinator to utilize MRC volunteers; including rapid verification of credentials and affiliation with deployed entities. To assure that WCHD's MRC program will be able to meet requests for volunteers in a timely manner. Additionally, ongoing training opportunities will be scheduled and made available for MRC Volunteers to improve skill by the end of BP2s.	MOU's or agreements will be developed to ensure that in the occurrence of the need to utilize MRC-volunteers; Renown, St. Mary's, Northern Nevada and Incline Village Health Centers will be the target. Additionally, the American Red Cross will also be included in the process.	Written MOU's or agreements that outlines the process with each of the healthcare facilities identified.

Function #1: Coordinate volunteers

Objective

Prior to an incident or event the MRC Coordinator will develop written plans along with WC hospitals to determine which situations would warrant the use of MRC volunteers. Once the "need responses" for volunteers are determined training initiatives will be developed to address these situations by the end of BP2 ---- **$18,681**

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Attachment B: Scope of Work by Capability

Task 1: Prior to an incident, identify the types and numbers of volunteers most likely to be needed in a public health agency's response based on the jurisdictional community risk assessment. (See Pg 133)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	MRC coordinator will use information from a revised "healthcare requesting procedure" form that local healthcare organizations will complete to develop written plans to establish what situations would warrant the use of MRC-volunteers. MRC volunteer information in E- Coordinator, which is the WCHD's electronic volunteer registration system, will be used to update and identify volunteers to respond to the new written response plans.	Ongoing during budget period	The newly developed written response plans.

Task 2: Prior to an incident, coordinate with existing volunteer programs (e.g., ESAR-VHP, Medical Reserve Corps) and partner organizations to support the pre-incident recruitment of volunteers that may be needed in a public health agency's response. (See Pg 133)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	MRC Coordinator will recruit new volunteers through the media and participate in events that will promote MRC mission. E-Coordinator will also be updated with new and existing volunteer's information during budget period 2.	Ongoing during budget period	Number of MRC volunteers information that is updated and sustained.

Task 3: Prior to an incident, assure pre-incident screening and verification of volunteers' credentials through jurisdictional ESAR-VHP and Medical Reserve Corps. (See Pg 133)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	Prior to an incident MRC Coordinator will have previously verified volunteers credentials by checking with state licensing agencies and then storing information in E-Coordinator which contains ESARP-VHP and MRC data and can be easily accessed electronically.	Ongoing during budget period	Records of Volunteers from ESRAP-VHP.

Task 4: Prior to an incident and as necessary at the time of an incident, support provision of initial and ongoing emergency response training for registered volunteers. Training should be supported in partnership with jurisdictional Medical Reserve Corps unit(s) and other partner groups. (See Pg 133)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	MRC Coordinator will provide volunteers information on the written process of how to report to a situation upon activation which can include the need in some instances for "just-in-time" training. A partnership will also be established with CERT, NNOVAD, the Red Cross and REMSA, local healthcare organizations and other MRC Units in Nevada. The partners will have periodic regular scheduled meetings.	Ongoing during budget period	A copy of revised MRC Standard Operating Procedures.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Volunteer needs assessment for healthcare organizations response. (See Pg 133)	Build	MRC Coordinator will collaborate with local health care organizations and determine volunteers' needs based upon risk assessment needs data information that will be gathered.	Written risk needs data information.
Planning Resource Element 2: Collect, assemble, maintain, and utilize volunteer information. (See Pg 133)	Sustain	E-Coordinator will be updated with volunteers' information.	Volunteer information entered in E-Coordinator.

Function #2: Notify volunteers

Objective

MRC Coordinator will review and revise the current MRC volunteer request process to ensure that prospective volunteers are notified and mobilized in the appropriate health professional role for WCHD's local health care organizations by the end of BP2. ---- **$15,000**

Task 1: At the time of an incident, identify the desired skills and quantity of volunteers needed for the incident from the preincident volunteer registration. (See Pg 135)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	MRC coordinator will review local healthcare organizations "requesting procedure" form at the time of an incident for volunteers. The role and quantity of volunteers available will be assessed which will be aided with the use of E-Coordinator (computerized volunteer system).	Ongoing during budget period	The written and revised SOP process that will ensure proper volunteer response.

Task 2: At the time of an incident, contact pre-incident registered volunteers using multiple modes of communication. (See Pg 135)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	The modes to contact MRC-volunteers will consist of a written telephone call down procedure that will be revised in the MRC-SOP.	Ongoing during budget period	Revised written MRC-SOP.

Task 3: At the time of an incident, notify volunteers who are able and willing to respond of where and how to report. (See Pg 135)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	The role and quantity of volunteers needed will be written and included in the revised MRC- SOP. The E-Coordinator (computerized volunteer system) will be used to help notify volunteers.	Ongoing during budget period	The revised SOP

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

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Task 4: At the time of an incident, coordinate with partner agencies to confirm credentials of responding volunteers. (See Pg 135)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain		MRC coordinator will check with State licensing Departments and/or also request copies of certifications licenses from new and current volunteers prior to incidents. A written process will be written with select local healthcare organizations to confirm credentials.	Ongoing during budget period	The revised SOP and written agreements with partner organizations.

Task5: At the time of an incident, notify partner agencies of any need for additional volunteers. (See Pg 135)

Planned Activity Type	Funding Amount	Planned Activity Description	Date of Completion	Output Documentation
Sustain		MRC coordinator will review and revise where needed the current healthcare organization's written request procedure at the time of an incident for volunteers. The role and quantity of volunteers required will also be assessed with the use of E-Coordinator, the WCHD's computerized volunteer system.	Ongoing during budget period	The written request process that will ensure proper volunteer response.

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
No Priority Elements			

Function #3: Organize, assemble, and dispatch volunteers

Objective

MRC Coordinator will develop a written protocol for allocating MRC volunteers that are needed simultaneously across several healthcare organizations. This process will include the placement of volunteers through the appropriate deployment channels and match the assignment of volunteers to the needs of the requesting WC healthcare organizations that will be based on volunteer availability by the end of BP2.

$19,962

Task 1: If the incident differs from or exceeds the public health agency's pre-incident-defined volunteer plans, identify additional volunteers that have the necessary credentials and skills. (See Pg 136)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	MRC Coordinator will develop a written plan that will identify additional volunteers e.g., : Interstate jurisdictional systems; ESAR-VHP; Intrastate jurisdictional system; and other Healthcare Coalition volunteers. ASPR's Medical Surge Capacity Handbook will be referenced to build this capacity.	Ongoing during budget period	The written plan that will identify additional volunteers.

Task 2: Assure deployment briefing of public health volunteers, including safety and incident-specific training. (See Pg 136)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Build	Volunteers will be deployed consistent with the current MRC – SOP guidelines. Training will be provided that will include personal safety concerns and in addition to just in time training for specific incidents.	Ongoing during budget period	The revised MRC-SOP guidelines.

Task 3: Assure tracking and rotation of volunteers as indicated by the incident and by relevant job function. (See Pg 137)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	The current MRC SOP will be reviewed and revised to assure that the current tracking and rotation of volunteers is still useful.	Ongoing during budget period	The written SOP

Task 4: Manage spontaneous volunteers who may request to support the public health agency's response, either through incorporating them into the response or by triaging them to other potential volunteer resources. (See Pg 137)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	MRC Coordinator will develop written protocols for the tracking and handling of spontaneous volunteers, This may require developing a simulated exercise to test the effectiveness of the process along instituting a just in time training exercise.	Ongoing during budget period	The development of written protocols for the handling of spontaneous volunteers.

Task 5: Coordinate state and jurisdictional response roles for federal public health staff deployed to the jurisdiction. (See Pg 137)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Build	MRC Coordinator will collaborate with the state MRC coordinator in developing written protocols in coordination response roles for federal public health staff deployed to our local jurisdiction.	Ongoing during budget period	The written protocols in coordinating response roles for federal public health staff

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Volunteer deployment protocols. (See Pg 137)	Build	The MRC volunteer deployment protocol is written in the MRC- SOP. The E-Coordinator (computerized volunteer system) is used to help notify volunteers. Current practice will be reviewed and revised to ensure its usefulness in practice.	The MRC volunteer deployment protocol is written in the MRC- SOP.
Planning Resource Element 2: Process to manage spontaneous volunteers. (See Pg 137)	Build	MRC Coordinator will develop written protocols for the tracking and handling of spontaneous volunteers, This may require developing a simulated exercise to test the effectiveness of the process along instituting a just in time exercise.	The development of written protocols for the handling of spontaneous volunteers.

Function #4: Demobilize volunteers

Objective

MRC Coordinator will Coordinate the demobilization of MRC volunteers based on evolving incident requirements or incident status. This includes coordination with the appropriate partner agencies to ensure provision of medical and mental/behavioral health support needed for the volunteers' physical and mental well-being by the end of BP2. --- **$17,000**

Task 1: Track (record or document) the demobilization of volunteers. (See Pg 138)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	The MRC volunteer demobilization protocol is written in the MRC- SOP. The E-Coordinator (computerized volunteer system) will be used to document and record demobilized volunteers. The current written process will be reviewed and revised to ensure its usefulness	Ongoing during budget period	The written MRC volunteer deployment protocol in the MRC- SOP.

Task 2: Assure coordination of out-processing of volunteers. (See Pg 138)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	The out-processing or completion of a shift by the MRC volunteers is currently written in the MRC-SOP. The current process will be revised to ensure that coordination and collaboration with local health care organizations is included in the process by utilizing the "healthcare requesting procedure" form data.	Ongoing during budget period	The revised written MRC – SOP.

Task 3: Coordinate with jurisdictional authorities and partner groups to identify community resources that can support volunteer post-deployment medical screening, stress, and well-being assessment and, when requested or indicated, referral to medical and mental/behavioral health services. (See Pg 138)

Planned Activity Type	Planned Activity Description	Date of Completion	Output Documentation
Sustain	MRC Coordinator will revise the current written SOP to make sure in the coordination and participate with local healthcare organizations authorities that MRC volunteers are able to identify community resources that will support the volunteer post deployment screening process and medical screening, stress, and well-being assessments and when requested or indicated, have a process to refer volunteers to medical and mental/behavioral health services.	Ongoing during budget period	The revised written deployment process in the SOP.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

Attachment B: Scope of Work by Capability

Resource Element: Plans (P), Equipment (E), Skills (S)	Planned Activity Type	Planned Activity Description	Output Documentation
Planning Resource Element 1: Volunteer Release Processes. (See Pg 139)	Sustain	The out-processing or completion of a shift by the MRC volunteers is currently written in the MRC-SOP. The current process will be revised to ensure that coordination and collaboration with local health care organizations is included in the process by convening meetings with select groups.	The revised written MRC volunteer completion of shift or out processing protocol in the MRC- SOP.
Planning Resource Element 2: Volunteer exit screening protocols. (See Pg 139)	Sustain	MRC Coordinator will revise the current written SOP to make sure in the coordination and participate with local healthcare organizations authorities that MRC volunteers are able to identify community resources that will support the volunteer post deployment screening process and medical screening, stress, and well-being assessments and when requested or indicated, have a process to refer volunteers to medical and mental/behavioral health services.	The revised written deployment process in the SOP.

Note: The page #'s listed in this table correspond to CDC's "***Public Health Preparedness Capabilities: National Standards for State and Local Planning***", March 2011

WASHOE COUNTY HEALTH DISTRICT

ADMINISTRATIVE HEALTH SERVICES

Public Health
Prevent. Promote. Protect.

STAFF REPORT
BOARD MEETING DATE: 9/26/13

DATE: September 19, 2013

TO: District Board of Health

FROM: Eileen Stickney, Administrative Health Services Officer
Washoe County Health District
(775) 328-2417, estickney@washoecounty.us

SUBJECT: Proposed Approval of Agreement Between the Washoe County Health District and Public Health Foundation in the amount of $63,900 to conduct part of a Fundamental Review of the Health District; and if approved, authorize the Chairman to execute the agreement.

RECOMMENDATION

Staff recommends that the Washoe County District Board of Health approve the proposed Agreement Between the Washoe County Health District and Public Health Foundation; and authorize the Chairman to execute the agreement.

SUMMARY

The approval of this agreement supports the Washoe County Health District Administrative Health Services (AHS) Division's mission to ensure administrative compliance for fiscal and operational policies as established by the District Board of Health and Board of County Commissioners.

DBOH Strategic Goal #3:
Secure and deploy resources for sustainable impact.

AHS Strategic Goal #1:
Ensure fiscal stability and good stewardship or resources.

BACKGROUND

Attached please find the contract with the Public Health Foundation to engage its services (including Dr. Beitsch) through professional services contracts to conduct a fundamental review of the Washoe County Health District.

PREVIOUS ACTION

At the May 23, 2013 Washoe County District Board of Health meeting, the Board authorized the Interim District Health Officer to expend up to $80,000 for review and analysis of the Health District.

At the July 25, 2013 Washoe County District Board of Health meeting, the Board directed the Interim District Health Officer to continue seeking possible consultants for the review and bring a recommendation to the Board for approval.

At the August 22, 2013 Washoe County District Board of Health meeting, the Board directed the Interim District Health Officer to proceed with a Fundamental Review that engages the professional services of Mr. Stefanak and those of the Public Health Foundation (including Dr. Beitsch) through professional services contracts.

FISCAL IMPACT

There will be a fiscal impact to the Health Fund in the amount of $63,900 accounted for in 170200-710100.

POSSIBLE MOTION

Move to approve staff recommendation to approve the proposed Agreement Between the Washoe County Health District and Public Health Foundation; and authorize the Chairman to execute the agreement.

Eileen Stackury
Administrative Health Services Officer

Attachment

AGREEMENT

This Agreement is made and entered into between the WASHOE COUNTY HEALTH DISTRICT, hereinafter referred to as "District," and Public Health Foundation, hereinafter referred to as "Consultant".

Whereas, The District has agreed to have a fundamental review at the recommendation of the Board of County Commissioners of Washoe County to further substantiate the general fund dollars received; and

Whereas, Consultant is highly qualified to provide a thorough review of public health practices and make appropriate recommendations,

Now, therefore, in consideration of the mutual promises contained herein, the parties agree as follows:

Consultant agrees to:

1. Review and assess District structure, legal, operations, oversight, and management of performance utilizing a framework composed of the Public Health Accreditation Board (PHAB) domains, standards, and measures and the "Minimum Package of Public Health Services" developed by the State of Ohio as the benchmarks for purposes of comparison. The District review will include a review of the governance structure of the District. The assessment will focus on exploring efficiency, effectiveness, and opportunities for District continuous improvement based on data provided by District and our experience in the field. The review will include an assessment of programs and activities that are mandated by statute of by the Interlocal agreement, whether these programs exceed mandated requirements, and whether program services are duplicated or can be delivered by other organizations in the community. The assessment will also include recommendations as appropriate regarding outsourcing of District programs or services versus delivery using personnel employed at District.
2. Conduct the fundamental assessment in three phases, with on-site presence during each phase. The PHF assessment team will be led by Dr. Leslie Beitsch and include Dr. John W. Moran and Carol Moehrle; staff members in the PHF Performance Management and Quality Improvement division will be utilized as appropriate
3. In Phase 1 the PHF assessment team will visit District, the District Board of Health, senior managers in the District, and key stakeholders, briefing them on the assessment process and collect initial data to support the structural, legal, operational, oversight, and performance assessment. This visit is planned for October 17th and 18th, 2013
4. Phase 2 begins with District conducting a self-assessment utilizing the PHAB accreditation self-assessment tools. It is recommended that this self-assessment not require collection of documentary evidence, but still be done with sufficient specificity to identify key programs in conformance with standards/measures. Following completion of the self-assessment, and analysis of data by PHF, the PHF assessment team will conduct its second on-site visit to validate the self-assessment findings through further collection of data. This visit is planned for November 12-15, 2013.

5. During Phase 3 all data are analyzed and a report focused on findings and actionable recommendations will be prepared. The report will address structure, legal, operations, oversight, and managing of performance through the lens of efficiency, effectiveness, and opportunities for organizational continuous improvement. Phase 3 culminates with an on-site presentation of PHF assessment team findings and recommendations to the Board of Health and Washoe Senior managers. A draft report will be provided to District no later than January 31, 2014 (assuming the fundamental assessment commences no later than October 1, 2013 under an approved contract). This draft report will integrate the work of the PHF team and financial services reviews. The final report will be provided to District no later than February 20, 2013 with a presentation to the District Board of Health on February 27, 2013. The assessment team will provide additional information as may be requested by the Board during the presentation.
6. Although the assessment is presented as three distinct phases for purposes of deliverables and invoices, the assessment process will be ongoing and iterative. It is dependent upon District for data and information to be provided throughout the assessment.
7. Consultant shall comply with all federal, state and local laws required to carry out the services to be performed under this agreement.
8. Consultant hereby assigns to the District all rights to all products, reports, documents, photographs, videos, data and drawings produced by Consultant as a result of its services to the District during the terms of this Agreement.

The District agrees to:

1. Pay Public Health Foundation $63,900 for the above agreed to scope of work. Contract total to be paid in installments of $15,975 (25%) as follows: First installment to be paid upon execution of this agreement. Second installment to be paid upon completion of Phase 1 above. Third installment to be paid upon completion of Phase 2. Final installment to be paid upon completion of Phase 3 and presentation to District Board of Health.
2. Provide work and meeting space during site visits.
3. Reserve the right to withhold payment if it is determined that the services described herein have not been provided.
4. Provide all necessary data and information required by consultant throughout the assessment.

HIPAA: The parties acknowledge that they are subject to the provisions of the Health Insurance Portability and Accountability Act and the regulations promulgated there under (hereinafter "HIPAA"), pertaining to the maintenance, handling, retention, confidentiality and availability of records and data containing protected health information, as that term is defined by 45 C.F.R. § 164.501. It is agreed that in addition to maintaining such records and data in accordance with HIPAA and any more restrictive provision of state law, including but not limited to Chapters 441A of the Nevada Revised Statutes and the Nevada Administrative Code, the parties will require that any employee, contractor or agent who may have access to the records and data provide comparable protections to those provided by the parties. Consultant agrees to abide by the terms of the Business Associate Agreement attached hereto as Exhibit A and incorporated by reference.

Indemnification and Hold Harmless: Consultant shall save, hold harmless, and indemnify the District, its officers, agents and employees, from and against all claims, causes of action, liabilities, expenses and costs, including reasonable attorneys' fees, for injury or death of any person or damage to property arising out of, or connected with, work performed under this Agreement which is the result of any acts or omissions, whether negligent or otherwise, of Consultant, its officers, agents, subcontractors or employees.

Term: The term of this Agreement is from October 1, 2013 through March 14, 2014.

Termination: This Agreement and any amendments may be terminated by either party at any time, without cause or penalty upon thirty (30) days written notice to the other party. Only services satisfactorily performed up to the date of receipt of notice shall be compensated by the District and such compensation shall be pursuant to the terms of this Agreement.

Severability: The provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of the Agreement shall be in effect and binding upon the parties.

Waiver of Provision: Any waiver of any terms or conditions hereof must be in writing and signed by the parties hereto. A waiver of any of the terms or conditions hereof shall not be construed as a waiver of any other terms or conditions hereof.

Amendments: This Agreement may be amended at any time by mutual agreement of the parties without additional consideration, provided that before any amendment shall be operative or valid it shall be reduced to writing and signed by the parties.

Entire Agreement: This Agreement contains the entire agreement between the parties and shall be binding upon the parties and no other agreements, oral or written, have been entered into with respect to the subject of this Agreement.

Notices: Official notices required under this Agreement shall be sent to the parties by certified or registered mail, return receipt requested, postage prepaid in the United States Postal Service to the addresses set forth below, or to such other addresses as the parties may designate in writing from time to time by notice given in accordance with the provisions of this section.

Notices to Consultant shall be addressed to:

Margie Beaudry
Public Health Foundation
1300 L Street, NW Suite 800
Washington, DC 20005

Notices to the District shall be addressed to:

Kevin Dick
Washoe County Health District
PO Box 11130
Reno, NV 89520

Governing Law: This agreement shall be governed by the laws of the State of Nevada. Any action brought pursuant to this action shall be brought in Washoe County, Nevada.

Witness whereof, the parties hereto or a representative of either have set their hands and subscribed their signatures as of the date and year indicated.

WASHOE COUNTY DISTIRCT BOARD OF HEALTH

By: _____ Date: _____
Matt Smith, Chairman

PUBLIC HEALTH FOUNDATION

By: _____ Date: _____
Sue Madden, COO/CFO

Exhibit A

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
BUSINESS ASSOCIATE AGREEMENT
BETWEEN
WASHOE COUNTY HEALTH DISTRICT
Hereinafter referred to as "Covered Entity"

and

Public Health Foundation
Hereinafter referred to as "Business Associate"

This agreement is entered into between Covered Entity and Business Associate, effective upon signature.

Business Associate acknowledges and agrees that all protected health information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic medium by Covered Entity or its operating units to Business Associate on Covered Entity's behalf shall be subject to this agreement.

OBLIGATIONS AND ACTIVITIES OF the BUSINESS ASSOCIATE

1. Business Associate agrees to not use or disclose Protected Health Information other than as permitted by this Agreement or as Required by Law.
2. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided by this Agreement.
3. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
4. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
5. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
6. Business Associate agrees to provide access, at the request of the Covered Entity, and in the time and manner as set forth in the contract's Inspection and Audit provisions, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164.524.
7. Business Associate agrees to make any amendments to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an Individual, and in the time and manner as mutually agreed between the parties.
8. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, available to the Covered Entity, or the Secretary, in a time and manner as set forth in the contract's Inspections and Audit

provisions or designated by the Secretary, for the purpose of the Secretary determining Covered Entity's compliance with the Privacy Rule.

9. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual in accordance with 45 CFR 164.528.
10. Business Associate agrees to provide to Covered Entity or an Individual, in time and manner as set forth in the contract's Inspection and Audit provisions, information collected in accordance with the previous section of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

PERMITTED USE AND DISCLOSURES BY BUSINESS ASSOCIATE

General Use and Disclosure Provisions *(1. and 2. are alternative approaches)*

1. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.
2. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate.
3. Except as otherwise limited by this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of Business Associate, provided that disclosures are:
    a. Required by Law, or
    b. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and
    c. The person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
4. Except as otherwise limited by this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services for Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).
5. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1).

OBLIGATIONS OF COVERED ENTITY

1. Covered Entity shall notify Business Associate of any limitations in its Notice of Privacy Practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect (Business Associate's) use or disclosure of Protected Health Information.
2. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
3. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that (Covered Entity) has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

PERMISSABLE REQUESTS BY COVERED ENTITY

Except in the event of lawful data aggregation or management and administrative activities, Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

TERM AND TERMINATION

1. TERM:
   The Term of the Agreement shall extend beyond the termination of the contract and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created and received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination.
2. EFFECT OF TERMINATION
   a. Except as provided in paragraph (b.) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from (Covered Entity), or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
   b. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to (Covered Entity) notification of the conditions that make return or destruction infeasible.

      Upon a mutual determination that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

MISCELLANEOUS

1. AMENDMENT: The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Public Law No 104-191.
2. SURVIVAL: The respective rights and obligations of Business Associate under EFFECT OF TERMINATION of this Agreement shall survive the termination of this Agreement.
3. INTERPRETATION: Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

COVERED ENTITY	BUSINESS ASSOCIATE
Washoe County Health District 1001 E. Ninth Street Reno, NV 89512	Public Health Foundation 1300 L Street, NW, Suite 800 Washington DC 20005
_____ (Authorized Signature)	_____ (Authorized Signature)
Matt Smith (Print Name)	_____ (Print Name)
Chairman, WCDBOH (Print Title)	_____ (Print Title)
_____ Date	_____ Date

REMSA

Regional Emergency Medical Services Authority

REMSA

OPERATIONS REPORTS

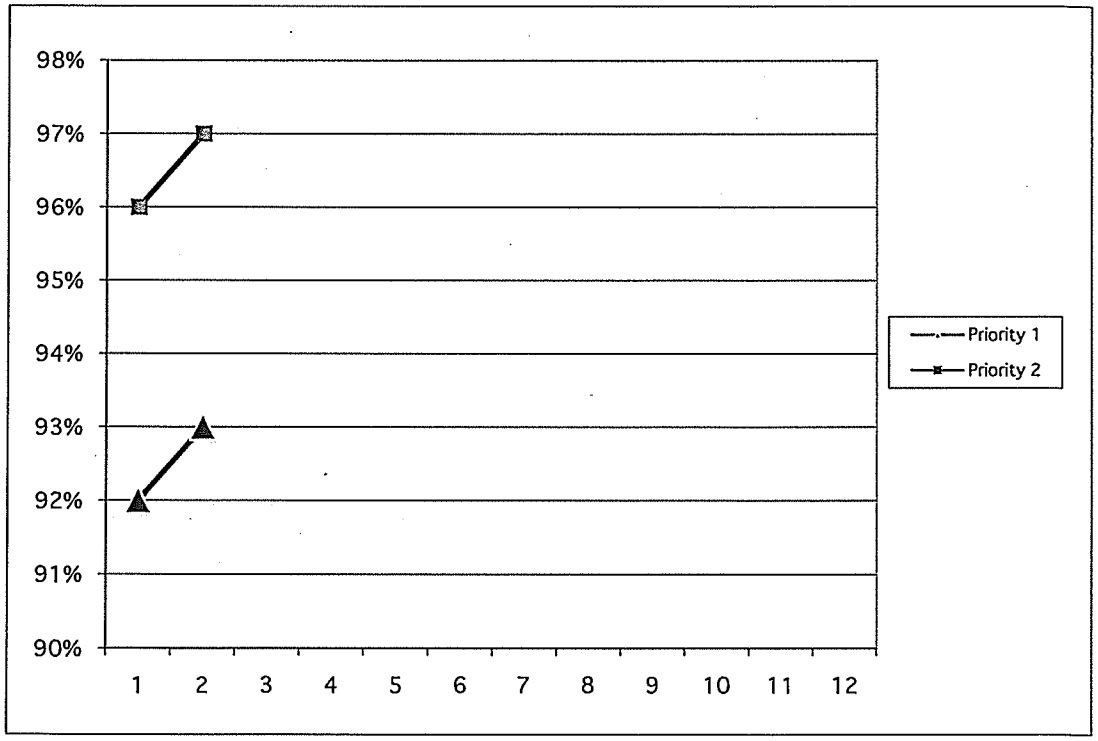
FOR

AUGUST 2013

450 Edison Way • Reno, NV 89502-4117
775.858.5700 • fax 775.858.5726

Fiscal 2014

Month	Avg. Response Time	Avg. Travel Time	Priority 1	Priority 2
Jul. 2013	5 mins. 56 secs.	5 mins. 3 secs.	92%	96%
Aug.	6 mins. 0 secs.	5 mins. 3 secs.	93%	97%
Sept.				
Oct.				
Nov.				
Dec.				
Jan. 2014				
Feb.				
Mar.				
Apr.				
May				
June 2014				



Care Flight

Month	#Patients	Gross Sales	Avg. Bill	YTD Avg.
Jul-13	15	$116,951	$7,797	$7,797
Aug.	20	$183,197	$9,160	$8,576
Sept.			$0	$8,576
Oct.			$0	$8,576
Nov.			$0	$8,576
Dec.			$0	$8,576
Jan. 2014			$0	$8,576
Feb.			$0	$8,576
Mar.			$0	$8,576
Apr.			$0	$8,576
May			$0	$8,576
June			$0	$8,576
Totals	35	$300,148	$8,576	$8,576

Adjusted Allowed Average Bill - $7,641.00

REMSA Ground

Month	#Patients	Gross Sales	Avg. Bill	YTD Avg.
Jul-13	3528	$3,760,993	$1,066	$1,066
Aug.	3361	$3,580,384	$1,065	$1,066
Sept.			$0	$1,066
Oct.			$0	$1,066
Nov.			$0	$1,066
Dec.			$0	$1,066
Jan. 2014			$0	$1,066
Feb.			$0	$1,066
Mar.			$0	$1,066
Apr.			$0	$1,066
May			$0	$1,066
June			$0	$1,066
Totals	6889	$7,341,377	$1,066	$1,066

Allowed ground avg bill - $1,067.00

REMSA
Monthly Debt Payments
as of 9/17/2013

Acct No	Current Monthly Payment (P&I)
7197508-5001	$ 14,977.27
7197608-5002	10,241.51
7197608-9042	16,480.17
7197608-9047	10,279.43
7197608-9048	6,572.61
7197608-9049	14,993.51
7197608-9050	4,787.55
7197608-9051	22,530.20
7197608-9052	738.75
7197608-9053	2,196.54
7197608-9054	2,435.75
7197608-9055	8,353.72
7197608-9056	2,338.59
7197608-9057	17,511.94
7197608-9058	25,972.42
7197608-9059	2,373.09
10099003	11,871.59
10099004	11,871.59
10099005	12,488.60
Total	$ 199,014.83

REMSA

Regional Emergency Medical Services Authority

CARE FLIGHT

OPERATIONS REPORT

FOR

AUGUST 2013

450 Edison Way • Reno, NV 89502-4117
775.858.5700 • fax 775.858.5726

CARE FLIGHT OPERATIONS REPORT
AUGUST 2013
WASHOE COUNTY

- **In Town Transfer:**
  0 Ground ITTs were completed

- **Outreach, Education, & Marketing:**
  - **0 Community Education & Public Events**

- Statistics

Washoe County Flights

	# patients
Total Flights:	20
Total Patients	20
Expired on Scene	1
Refused Transport (AMA)	0
Scene Flights	18
Hospital Transports	2
Cardiac	6
Trauma	9
Medical	5
Pulmonary	0
High Risk OB	0
Neuro	0
Pediatrics	0
Newborn	0
Full Arrest	0
Surgical	0
Total	**20**

REMSA

GROUND OPERATIONS REPORT

FOR

AUGUST 2013

450 Edison Way • Reno, NV 89502-4117
775.858.5700 • fax 775.858.5726

REMSA®

GROUND AMBULANCE OPERATIONS REPORT

August 2013

1. OVERALL STATISTICS:

Total Number Of System Responses	5920
Total Number Of Responses In Which No Transport Resulted	2543
Total Number Of System Transports	3377

2. CALL CLASSIFICATION REPORT:

Cardiopulmonary Arrests		1%
Medical		45%
OB		1%
Psychiatric/Behavioral		5%
Transfers		16%
Trauma		25%
Trauma – MVA	7%	
Trauma – Non MVA	18%	
Unknown/Other		7%

Total Number of System Responses 100%

3. MEDICAL DIRECTOR'S REPORT:

The Clinical Director reviewed:

100% Full Arrest Ground Charts
100% Pediatric ALS and BLS Ground Charts
100% All Ground Intubations

Review of the following patient care records (PCR) for accurate and complete documentation and appropriate use of protocol:

- 100% of cardiopulmonary arrests
- 100% of pediatric patients both ALS and BLS transport and non-transport patients
- 100% of advanced airways (outside cardiac arrests)
    - ETCO2 use in cardiac arrests and advanced airway
- 100% of Phase 6 Paramedic and EMT PCRs
- 100% Pain/Sedation Management
- Total of 3311 PCRs

All follow-up deemed necessary resulting from Communication CQI was completed by Chris Barton, EMD, Communications Education and CQI Coordinator

4. EDUCATION AND TRAINING REPORT:

A. Public Education

Advanced Cardiac Life Support

Date	Course Location	Students
8/4/2013	EMS CES 911 Training Site	6
8/7/2013	REMSA	11
8/13/2013	EMS CES 911 Training Site	1
8/15/2013	REMSA	10
8/18/2013	EMS CES 911 Training Site	1
8/23/2013	REMSA	4
8/25/2013	EMS CES 911 Training Site	2
8/27/2013	REMSA	5

Advanced Cardiac Life Support Recert

Date	Course Location	Students
5/10/2013	Tahoe Pacific Hospitals	4
7/12/2013	Tahoe Pacific Hospitals	2
8/4/2013	EMS CES 911 Training Site	1
8/5/2013	Barb Murphy-Vonarx	1
8/12/2013	REMSA	10
8/13/2013	EMS CES 911 Training Site	2
8/17/2013	John Mohler & Co	8
8/20/2013	EMS CES 911 Training Site	1
8/21/2013	REMSA	9
8/26/2013	EMS CES 911 Training Site	2

8/27/2013	Saint Mary's Regional Medical Center	6
8/27/2013	REMSA	1
8/28/2013	EMS CES 911 Training Site	1
8/28/2013	Eastern Plumas Healthcare	1
8/29/2013	REMSA	10

Advanced Cardiac Life Support Skills

Date	Course Location	Students
8/2/2013	REMSA	1
8/7/2013	Riggs Ambulance	1
8/7/2013	REMSA	1
8/27/2013	Riggs Ambulance	2
8/28/2013	REMSA	1

Advanced Cardiac Life Support Prep Course

Date	Course Location	Students
8/2/2013	REMSA	4

Advanced Cardiac Life Support Instructor

Date	Course Location	Students
4/4/2013	Saint Mary's Regional Medical Center	4

Basic Life Support Instructor

Date	Course Location	Students
8/15/2013	Barrick Gold Exploration - REMSA	6
8/23/2013	REMSA	13

Bloodborne Pathogen

Date	Course Location	Students

8/22/2013	ABC Fire	7
8/28/2013	Life Touch Studios - REMSA	12

Health Care Provider CPR

Date	Course Location	Students
8/1/2013	REMSA	9
8/1/2013	Josh Duffy	1
8/3/2013	National Guard	2
8/3/2013	Riggs Ambulance	12
8/3/2013	Kenny Cohen	2
8/6/2013	Tahoe Pacific Hospitals	1
8/6/2013	REMSA	10
8/6/2013	EMS CES 911 Training Site	3
8/6/2013	Milan Institute	10
8/8/2013	Hometown Health - REMSA	6
8/8/2013	Eastern Plumas Healthcare	2
8/8/2013	Nye County EMS	8
8/9/2013	Humboldt General Hospital	1
8/9/2013	Barrick Cortez Gold Mine	1
8/10/2013	EMS CES 911 Training Site	8
8/10/2013	REMSA	8
8/10/2013	Tyler Teese	2
8/12/2013	EMS CES 911 Training Site	1
8/14/2013	EMS CES 911 Training Site	5
8/14/2013	Family Mountain Medicine - REMSA	4
8/14/2013	REMSA	10
8/14/2013	Spine Nevada - REMSA	2

8/16/2013	West Hills Hospital	9
8/17/2013	Great Basin College	13
8/19/2013	CPR 1st Aid Training Site	1
8/20/2013	REMSA	9
8/21/2013	TMCC - REMSA	6
8/21/2013	TMCC - REMSA	5
8/22/2013	REMSA	9
8/23/2013	Lander County Community Health	6
8/24/2013	EMS CES 911 Training Site	6
8/25/2013	CPR 1st Aid Training Site	4
8/27/2013	REMSA	9
8/28/2013	EMS CES 911 Training Site	1
8/28/2013	Sierra Nevada Job Corps	6
8/28/2013	Trent Waechter	1
8/29/2013	CPR 1st Aid Training Site	1
8/29/2013	REMSA	8

Health Care Provider Employee

Date	Course Location	Students
8/1/2013	REMSA	1
8/7/2013	REMSA	1
8/12/2013	REMSA	2
8/13/2013	REMSA	1
8/13/2013	REMSA	1
8/13/2013	REMSA	1
8/13/2013	REMSA	1
8/20/2013	REMSA	4

8/23/2013	REMSA	2
8/26/2013	REMSA	1
8/27/2013	REMSA	2
8/29/2013	REMSA	2
8/30/2013	REMSA	1

Health Care Provider Recert

Date	Course Location	Students
5/22/2013	Carson BLM	19
8/3/2013	National Guard	2
8/5/2013	REMSA	10
8/5/2013	Storey County Fire Department	14
8/6/2013	Infection Control - REMSA	9
8/6/2013	Lawrence Smith	1
8/6/2013	EMS CES 911 Training Site	9
8/7/2013	Digestive Health - REMSA	19
8/7/2013	Dr. Frank Caffaratti - REMSA	13
8/8/2013	REMSA	9
8/9/2013	Career College of Northern Nevada	1
8/13/2013	REMSA	1
8/13/2013	EMS CES 911 Training Site	2
8/14/2013	Spine Nevada - REMSA	3
8/15/2013	REMSA	10
8/17/2013	REMSA	7
8/18/2013	Nampa Fire Department	1
8/19/2013	REMSA	9
8/20/2013	EMS CES 911 Training Site	2

8/20/2013	Tahoe Forest Hospital	10
8/20/2013	Lassen CPR Plus	1
8/21/2013	REMSA	14
8/22/2013	REMSA	10
8/23/2013	REMSA	9
8/24/2013	Majen	1
8/25/2013	EMS CES 911 Training Site	3
8/26/2013	REMSA	10
8/26/2013	Lassen CPR Plus	1
8/27/2013	Eastern Plumas Healthcare	2
8/27/2013	REMSA	14
8/28/2013	REMSA	8
8/29/2013	EMS CES 911 Training Site	1
8/29/2013	Regent Care Center Reno	9
8/31/2013	EMS CES 911 Training Site	1

Health Care Provider Skills

Date	Course Location	Students
6/12/2013	Tahoe Pacific Hospitals	1
6/19/2013	Tahoe Pacific Hospitals	1
7/29/2013	Majen	1
7/30/2013	Tahoe Forest Hospital	2
8/1/2013	REMSA	2
8/1/2013	REMSA	2
8/6/2013	Tahoe Pacific Hospitals	2
8/6/2013	Leslie Gillman-Ward	1
8/6/2013	REMSA	2

8/7/2013	Tahoe Forest Hospital	1
8/8/2013	REMSA	1
8/8/2013	REMSA	1
8/9/2013	EMS CES 911 Training Site	1
8/9/2013	Tahoe Forest Hospital	1
8/12/2013	REMSA	4
8/12/2013	Tahoe Forest Hospital	1
8/13/2013	Tahoe Forest Hospital	1
8/14/2013	Majen	1
8/14/2013	REMSA	1
8/16/2013	Williow Springs	13
8/19/2013	Tahoe Forest Hospital	1
8/20/2013	Tahoe Forest Hospital	2
8/20/2013	Tahoe Forest Hospital	1
8/21/2013	Jennifer James	1
8/22/2013	Majen	1
8/23/2013	Great Basin College	1
8/23/2013	Tahoe Forest Hospital	1
8/26/2013	Riggs Ambulance	1
8/26/2013	REMSA	1
8/26/2013	REMSA	2
8/28/2013	Riggs Ambulance	1
8/28/2013	Majen	2
8/28/2013	REMSA	1
8/28/2013	REMSA	4
8/29/2013	REMSA	1

8/30/2013	REMSA	1
8/30/2013	Majen	3

Heart Saver CPR/AED

Date	Course Location	Students
8/5/2013	Washoe County School District	5
8/5/2013	Dustin Hopfe	8
8/6/2013	Dustin Hopfe	4
8/6/2013	Matt Hoff	1
8/7/2013	REMSA	10
8/7/2013	Majen	14
8/8/2013	Majen	4
8/9/2013	Project Uplift	5
8/9/2013	Nye County EMS	6
8/13/2013	EMS CES 911 Training Site	3
8/14/2013	Patagonia	6
8/15/2013	Patagonia	6
8/15/2013	Patagonia	5
8/15/2013	Patagonia	6
8/16/2013	Sierra Nevada Job Corps	10
8/19/2013	Washoe County School District	5
8/20/2013	Elko County School District	1
8/21/2013	Erica Krysztof	4
8/21/2013	Washoe County School District	4
8/22/2013	Dustin Hopfe	1
8/23/2013	Elko County School District	11
8/24/2013	REMSA	8
8/24/2013	Washoe County School District	5

8/26/2013	Erica Krysztof	8
8/27/2013	Erica Krysztof	3
8/27/2013	Nampa Fire Department	1
8/27/2013	Washoe County School District	6
8/28/2013	Nixon Pyramid Lake Clinic - REMSA	5
8/28/2013	Airport Fire Department	1
8/28/2013	Erica Krysztof	5
8/30/2013	EMS CES 911 Training Site	1

Heart Saver CPR/First Aid

Date	Course Location	Students
8/1/2013	Sierra Nevada Job Corps	8
8/1/2013	Majen	3
8/2/2013	Community Living Options	2
8/2/2013	Sierra Nevada Job Corps	12
8/3/2013	REMSA	3
8/5/2013	Sierra Nevada Job Corps	2
8/5/2013	Eagle Valley Childrens Home	5
8/6/2013	Small Mines Development	16
8/6/2013	Majen	10
8/7/2013	Amazon	1
8/7/2013	Community Living Options	3
8/7/2013	Elko County School District	5
8/8/2013	Majen	7
8/8/2013	Eagle Valley Childrens Home	4
8/9/2013	Sierra Nevada Job Corps	10
8/10/2013	Majen	5

8/10/2013	REMSA	7
8/12/2013	Majen	5
8/13/2013	Majen	7
8/13/2013	Elko County School District	12
8/13/2013	University Nevada Reno Cooperative Extension - REMSA	9
8/14/2013	OrthoPro - REMSA	6
8/16/2013	Riggs Ambulance	25
8/17/2013	REMSA	4
8/17/2013	Riggs Ambulance	7
8/19/2013	Elko County School District	4
8/19/2013	Majen	7
8/19/2013	Nampa Fire Department	9
8/20/2013	Majen	10
8/21/2013	Amazon	9
8/21/2013	EMS CES 911 Training Site	2
8/21/2013	Susan Phillips	3
8/22/2013	ABC Fire	7
8/23/2013	Barrick Goldstrike	13
8/26/2013	Barrick DR	7
8/26/2013	EMS CES 911 Training Site	4
8/27/2013	Small Mines Development	17
8/28/2013	Nixon Pyramid Lake Clinic - REMSA	3
8/28/2013	Life Touch Studios - REMSA	11
8/28/2013	Majen	14
8/28/2013	Amazon	1
8/28/2013	Airport Fire Department	3

8/28/2013	Airport Fire Department	4
8/31/2013	Amazon	1

Heart Saver First Aid

Date	Course Location	Students
8/1/2013	Sierra Nevada Job Corps	4
8/1/2013	Milan Institute	6
8/7/2013	Milan Institute	10
8/7/2013	Washoe County School District	3
8/8/2013	REMSA	2
8/13/2013	University Nevada Reno Cooperative Extension - REMSA	1
8/15/2013	Community Living Options	1
8/15/2013	Sierra Nevada Job Corps	12
8/16/2013	Sierra Nevada Job Corps	12
8/19/2013	Nye County EMS	10
8/20/2013	Nye County EMS	10
8/21/2013	Nye County EMS	9
8/27/2013	EMS CES 911 Training Site	2
8/28/2013	Nixon Pyramid Lake Clinic - REMSA	9
8/28/2013	Airport Fire Department	2

Heart Saver CPR/First Aid - Spanish

Date	Course Location	Students
8/9/2013	Barrick DR	6
8/28/2013	Barrick DR	12

Heart Saver Pediatric CPR/First Aid

Date	Course Location	Students

8/1/2013	EMS CES 911 Training Site	4
8/3/2013	REMSA	10

Pediatric Advanced Life Support

Date	Course Location	Students
8/8/2013	REMSA	4
8/11/2013	EMS CES 911 Training Site	6
8/13/2013	REMSA	12
8/19/2013	REMSA	2

Pediatric Advanced Life Support Recert

Date	Course Location	Students
8/6/2013	Barb Murphy-Vonarx	1
8/7/2013	Eastern Plumas Healthcare	1
8/14/2013	EMS CES 911 Training Site	1
8/21/2013	EMS CES 911 Training Site	1
8/23/2013	REMSA	9
8/25/2013	Zack Marcus	2
8/26/2013	REMSA	3

CE Courses

Date	Course Description / Location	Students
8/15/13	REMSA- Management of Stroke	39

Ongoing Courses

Date	Course Description / Location	Students
2/1/13	REMSA Education- Paramedic	15
8/14/12	REMSA Education - Paramedic	13

6/25/13	REMSA Education - EMT	28
	Total Students This Report	1336

5. COMMUNITY RELATIONS:

Community Outreach:

Point of Impact

Date	Description	Attending
8/8/13	AAA Car Seat Inspections, Reno office, 6795 South Virginia Street, Suite D. Point of Impact partnered with AAA to hold this event.	1 staff, 1 volunteer
8/24/13	Child Safety Seat Checkpoint, hosted by UNR Early Head Start, 401 West 2nd Street, Reno; 18 cars and 20 seats inspected.	4 staff, 10 volunteers

Northern Nevada Fitting Station Project

Date	Description	Attending
8/14/13	Quarterly Fitting Station partners meeting, REMSA.	3 volunteers
8/22/13	Fitting Station marketing partners teleconference.	3 volunteers

Safe Kids Washoe County

Date	Description	Attending
8/1/13	Washoe County Child Death Review Board bi-monthly meeting, Washoe County Social Services.	2 staff
8/3/13	Liquid Gold Fun Run. Provided Cribs for Kids information for table, Reno.	
8/3/13	Scheel's Back to School Fair, Safe Kids and Point of Impact information table, Sparks.	1 staff, 2 volunteers; 50 attendees
8/3/13	Nurturing Nest open house, Cribs for Kids information table, Reno.	1 staff; 100 attendees
8/4/13	Scheel's Back to School Fair, Safe Kids and Point of Impact information table, Sparks.	1 volunteer, 50 attendees
8/6/13	Walk This Way annual conference call.	2 staff

8/6/13	Coral Academy of Science Student Safety Patrol training	1 staff, 2 volunteers, 17 students
8/6/13	Join Together Northern Nevada Coalition monthly meeting, Reno. Planning for Fall Prescription Drug Round Ups.	1 staff
8/8/13	Cribs for Kids Train the Trainer at Humboldt General Hospital, Winnemucca.	1 staff, 8 attendees
8/9/13	El Sol Back to School Immunization and Wellness Fair, Cribs for Kids information table, Sparks.	1 staff, 1000 attendees
8/13/13	Bi-monthly Safe Kids Washoe County Board of Directors meeting, REMSA.	7 volunteers, 1 staff
8/13/13	Mini Golf Tournament subcommittee meeting, Sparks.	6 volunteers
8/13/13	Monthly Safe Kids Coalition Meeting, Sparks.	17 volunteers, 1 staff
8/13/13	Photovoice subcommittee meeting.	4 volunteers
8/14/13	Child Death Review Public Awareness Subcommittee grant submission meeting, Carson City.	2 staff
8/15/13	SIDS? Not SIDS? Presentation Renown Nursing staff, Reno.	1 staff, 8 attendees
8/19/13	Immunize Nevada Board of Directors strategic planning meeting, Reno.	1 staff
8/19/13	Northern Nevada Maternal Child Health Coalition meeting, Reno.	1 staff
8/21/13	Immunize Nevada monthly meeting and open house, Reno.	2 staff
8/21/13	Saint Mary's Wellness Wednesday interview with Channel 4 KRNV on Not Even For A Minute.	1 staff
8/22/13	SIDS? Not SIDS? Presentation Renown Nursing staff, Reno.	1 staff, 9 attendees
8/24/13	Inter Tribal Council of Nevada WIC Program Community Health Fair, Point of Impact, Safe Kids, and Cribs for Kids information table, Sparks.	1 staff, 1 volunteer
8/27/13	Annual Safe Kids Worldwide Buckle Up webinar.	2 staff
8/28/13	Child Death Review Executive Committee meeting; attended by teleconference. $14,900 grant approved for Cribs for Kids/Safe Sleep public awareness campaign.	2 staff

Meetings

Date	Description	Attending
8/15/13	Employee Resource Team	1 staff

GROUND AMBULANCE AND CARE FLIGHT

INQUIRIES

FOR

AUGUST 2013

INQUIRIES

August 2013

There were no inquiries in the month of August.

GROUND AMBULANCE

CUSTOMER SERVICE

FOR

AUGUST 2013

450 Edison Way • Reno, NV 89502-4117
775.858.5700 • fax 775.858.5726

GROUND AMBULANCE CUSTOMER COMMENTS AUGUST 2013

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
1	You did well.	You need to take your time.	All of you are doing such wonderful work, and a wonderful service. Thank you for your help.
2	Did great job in my care.	Keep up good work.	Fine job.
3	Fed mt cats before taking me to the hospital. Much appreciated.		
4	Everything, very friendly, prompt, professional and caring.		Caring and very compassion. All techs been wonderful.
5	From my point of view EVERYTHING...even after I snapped at the female.(sorry....pain so intense I never paid attention to her name) she calmed me quickly and effectively.		Thank you for your services provided and the wonderful people who make it happen.
6	The complete run.	Keep doing what you are doing.	Great.
7	You lifted a great pressure off my husband and helped him in his CVA.		Great job.
8	Everything that was needed.	Keep up the good work.	
9	What I am upset with, they could not get the neck collar on me right so they didn't use collar but taped me to board with tape.	I think you should have more than one neck collar that works or that they know how it works, I don't know which it was I was also not covered right no warm or "just" blankets. They let me lie there in ambulance cold and in shock for a good 1/2 hr with door open. Please reply.	
10	We certainly appreciated your service. You saved his life.		
11	Kept me calm, very professional technician.	Service was great.	
12	Professional care.		
13	Very nice and helpful in a stressful time. Helped me find my keys and lock up my house at a time when I was not thinking straight. Good experience. Thank you.		
14	The staff was able to calm me down and take my mind off my surroundings and surcomstances.		
15	Everything was wonderful.		
16	Quick and responsive.	Nothing.	
17	Everything. Thank you.		
18	I want to thank all of you from my heart.		
19	Quick and courteous.		
20	Very well.		
21	The dispatcher stayed on the phone with my husband. The ambulance arrived quickly to transport me to St.Mary's	Can't think of anything. Crew was very attentive.	The personnel were caring and tried to be gentle with my injury.
22	You were kind, caring, friendly and efficient.		
23	Very professional.		I thought everything went well.
24	Patient was treated with kindness and respect. Remsa staff moved quickly to help us with our emergency.		
25	Everything. Including keeping me calm.	Can't think of anything you could do better. I'd say the drivers etc are perfect in my book.	No questions. How can you improve on perfect?
26	Everyone was nice, excellent in their job and waiting on me as a patient. So give everyone 6doz of roses. Thank you all.		
27	You took good care of me.		
28	Patient care and meds.		Service was great, professional and there when I needed it.
29	The responders were concerned, caring and efficient.	The very 1st billing was labeled overdue and they could not explain why.	
30	Bedside manner, very helpful.	Nothing.	Great.
31	I am sorry but I can't remember anything.		I do thank you for the service even though I can't recall it.
32	Gave my wife comfort and reassurances.	Nothing.	
33	Personnel very competent and polite.	Dispatching.	Was very gratifying.
34	Were there immediately. Very efficient, took my husband to the hospital.		
35	Professional as usual.	Took 20 min for ambulance to arrive.	
36	Nice and polite to my mom.		
37	Everything was good.	Nothing.	
38		I did not authorize transfer therefore I feel I should not have to pay. I have no insurance.	
39	Everything.	The group were very helpful.	They were all great.
40	Fast service and friendly staff.		Excellent.

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
41		I called the day before I needed patient transfered from home to St. Mary's was told no problem just call that morning and let them know what time. When I called I was then told I couldn't get help without the proper paper work from Dr. Had I known this I could have taken care of it. So instead after many years of paying for Silver Saver, I had to get a friends husband to come to my home and help me get my mother into my car. Not sure I will be renewing this.	
42		Since patient was having a seizure, we should have been instructed to place him on his side.	
43	Response time and care.		
44	Everything.		Remsa always gives great and professional service.
45	Staff was extremely helpful and very efficient. Gave information as needed.	Service was great. Staff was very polite.	Very satisfied with service provided.
46	You were able to relieve my discomfort quickly.		The two paramedics were very friendly and made sure my dogs were also taken care of before we left my house.
47	Prompt response, dispatcher stayed on line with me until ambulance arrival.	Train personnel in ambulance better in IV placement. Crew had a lot of trouble and it really hurt, left bruises. I have very prominent veins and usually no one has trouble.	
48	Everything.	Very bumpy ride, other than that everything was good.	
49	Transport from Renown south to Renown main.	Service was excellent.	
50	Your response was fast. They were so fast in getting more oxygen to the patient and getting him to the hospital.		
51	Treated the patient kind and understanding.	Do not change.	
52	You all were very kind. Thank you for playing a part in saving my sons life and allowing him to celebrate his 3rd birthday.		
53	Everything.		
54	Took good care of me.		Just keep up the good service.
55	Very nice and helpful.	Did everything great.	
56	Everyone was as always very courteous, did everything right, no problems.	Continue as always.	
57	Everything.	Just keep doing what you are doing. You are perfect.	
58	Made me feel safe and well taken care of.		
59	Telling my family what was going on because I was disoriented.		
60			Yes. Driver and tech were very friendly. The ambulance A/C conditioner was broken so it was very hot in ambulance for us and the tech.
61	Transportation to VA hospital.		
62	Taking care of my husband.	Keep on.	
63	Your EMT's are amazing. They kept a scared, frantic mom calm. One of them gave my son sunglasses to wear which was very kind and made me smile. Can't thank them enough.		
64	Everything.		Excellent service, very much needed.
65	They were all helpful .	Nothing.	
66	Everything.	Can't think of a thing.	
67	I was transported to my destination in a supportive and caring manner.		
68	Talked to me on the way to the hospital.		
69		Keep up the good work.	The crew was very thoughtful and professional. They explained everything in laymen's terms, were very attentive and polite.
70	Very professional.	Nothing.	
71	Everyone was very helpful and very kind. They were great. Treated me very well.	Nothing.	
72	Coming quickly to my house.		
73	Very prompt and efficient service. Professional		Very considerate and caring.
74	Everything.	You are amazing.	
75	Came immediately.	Everything good.	Care was helpful and very concerned.
76	The very courtesy of the people was greatly appreciated.		
77	All things.	Nothing.	Thank you for taking care of me and my dispatcher- may god bless you.
78	Quick.		
79	Everything.	Just continue the good service.	Perfect.
80	Everything, no complaints.		Stay this professional always. Might need your help again.
81	They took me where I wanted to go.		It went better this time then it did last time on June 19 2012.

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
82	Prompt, knowledgeable, professional and helpful.		Thank you.
83	You got me to the hospital.	Everything was excellent.	
84	The woman who was part of the team was great made me feel comfortable.		Make sure that you have personnel on Remsa that can show compassion.
85	Both paramedics were very kind and professional.		
86	They did an excellent job.		
87	Communicate with family and friends.	Not sure I was scrambled.	Wonderful care and communication.
88	Everything.	Did a very good job.	
89	The EMT's were wonderful. I'm glad they were there.		
90	Everything.	Keep it up.	You all are just great and wonderful.
91	As far as I'm concerned, Everything.		
92	Everything.		
93	I had a broken hip and it was very nice to have caring people around me.		
94	Kept her calm and made her feel very safe.	Just keep doing what your doing now it's working.	Thank you.
95	You helped me out in a tight position.		
96	Yes on that behalf of the patient.		
97	Very helpful.	I am satisfied. Thank you.	They asked questions about my condition. No complaints. Very patient, very kind.
98	Your people have always been very kind and considerate.	Nothing I can think of.	Service in general is very good in my opinion.
99	They were patient and understanding. Did a great job.		
100	Over all everything.	Nothing.	Service was excellent.
101	When I was in your care you did everything you could do to help me, that good.	As always keep doing what you can do to help us as you are doing.	
102	Remsa located me on a mountain bike trail and administered medication amd assisted me during an very stressful time of need.		Thank you very much from the Galena Mountain Bike Trail. Your staff was profeesional, caring and on top of their game.The female crew member was so sweet. She took the leadership role immediately and was so gracious when I asked her to call me by my full name. She made a very painful injury managable. Thanks again for everything.
103	Communicate everything I needed from home to St Mary's.	Nothing.	
104	Everything was done in a very professional manner.	Maintain doing as you are.	
105	Everything.		
106	Helpful on the phone and were quick, professional and very caring.		
107	All very kind.	Can't think of anything.	
108	On medical transportation.	Same as above.	
109	Arrived quickly, moved me from bench to the gurney when I got motion sickness. Set up shunt for IV quickly and painlessly, no bruising.	Nothing. I received excellent care.	
110	Response time was good. Attention to patient excellent. Also family considered.		
111	Very kind, very helpful. Gentle and personable.		You were all awesome. Thank you.
112	You did everything well.	I don't know what it would be.	Your people treated me like I was their favorite granddad.
113	Very caring service. Efficient and helpful.		
114	Put me at ease and told me not to feel guilty when I called them. you are great.		75 years old wore button never used it until one morning I fell backwards into my empty bath tub. I stayed there for hours until supper meals on wheels told me to push the button. I felt ashamed but they made me feel it was alright to call them.Now I have called you several times since. You guys are great.
115	The ambulance people were on top of things, real good. They were wonderful.	Okay but mixed up and got passed around. Medical records and billing or insurance questions. Getting out records where need. Slow on getting information to me.	As the patients wife I think the care was great. You were great, Medical care for my husband was fantastic. and I see know room for improvement, just keep doing the way your services are.
116	Everyone involved was courteous and efficient. Did their job well.		
117	Just great job.		
118	All services.		
119	Everything.		
120	Kept me calm.		Why was I taken to Renown when Northern Nevada Med Center was across the street?
121	Everything.	Can't think of anything.	Very nice.
122	Everything.		
123	I have very poor hearing and the personnel were very patient and made sure I understood them.		

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
124	Everything.	I really do not know.	Everything was done very professionally and accurate.
125	Everything. The paramedics are excellent.	All you do is great.	Like I said, the paramedics are wonderful.
126	Very professional, thoughtful and caring.	Well skilled in their profession.	
127	Everything.	I was taken care of very well.	Thank you for your care.
128	You were very patient and caring while dealing with dealing with a very cranky and uncooperative patient.	You're doing great.	
129	Lift me out of lounge chair.	Nothing.	
130	The crew was very good and very thoughtful.		
131	Response time.	After requesting to be taken to Renown, I felt I was subtly coerced by Remsa personnel to be taken to Saint Mary's because I did not meet the "appropriate criteria" for Renown and because it was suggested that Renown, as a larger hospital, would be busier and the wait would likely be longer than at Saint's.	
132	Did a great job transporting my mother back home from the hospital.		
133	Everything. your people tried to keep me calm.	Send same two fellows.	
134	On time and good professional help.		
135	Saved my life.	Nothing more.	Thank you, Thank you, Thank you. I am doing just great. Thank you again for saving my life.
136	You came when we needed you most.	Nothing we can think of.	We are from out of town and knew no one.
137	Assured that bandages to needed areas were applied promptly and skillfully.		
138	Everything well.		
139	You saved my life. I needed 3 units of blood after they took me to hospital.	Nothing. They kept me calm.	
140	The members of the ambulance were very professional and they knew their job very well.		
141	They were very helpful for me.		
142	The men were very helpful.		Thank you very much for your help.
143	Just very pleasant. Explained everything being done and answered all questions.		
144	I really did not want to go to the hospital for financial reasons. they said I should go, but it wasn't what I wanted to do.They were all very nice and empathetic. Thank you.		
145	All.		
146	Everything.	Couldn't be better.	
147	Everything.		
148	Very calm, very professional and here quickly.		
149	Calmed patient down and reassured her she would be OK. Thank you.		Very fast response, excellent communication.
150	Willing to help in anyway when he was brought home, very nice.		Nice and friendly. wife said they were always smiling.
151	Very kind and reassuring. Let friend know where to come and get me.	Nothing.	
152	Arrived at time.	Nothing everything was great.	
153	Everything.	Nothing.	
154	Everything was wonderful. Thanks to all.	Continue as always.	We appreciate all considerations from all.
155	Everything was wonderful. Thanks to all.	Continue as always.	We appreciate all considerations from all.
156	I have no complaints		I had good care.
157	Very patient with my mother.		
158	Gentleness of handling, nice.	Don't lose my clothing suitcase!	Was dressed out of the laundry room at rehab, no clothing.
159	Made me feel safe.	Keep on keeping on.	
160	Very kind and helpful. Helped to calm us down.	Can not think of anything.	We felt safe.
161	I was very satisfied with the service, especially the driver, the questions he asked.	Nothing.	
162	Considerate and efficient staff. Handled the transport to the hospital very well.		Good job. Well done.
163	Arrived quickly, even remembered to ask which hospital (Renown South Meadows) as about to leave to go to Renown down town.	All very good.	Thank you for being there.
164	Safe transport and care,		
165	Make sure the patient was taken care of and comfortable.		
166	Everything. Thank you.		
167	Everything was exceptional.		
168	Keeping me calm.		

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
169	The crew in the ambulance was professional, calming and went out of his way to keep me informed. Excellent care giver.		
170	All. Thank you.		
171	Responded quickly and efficiently. There courteous and helpful under very difficult and emergent circumstances. I am very grateful for their service.	Could not have been better.	I am moving out of state on 8/8/13 to be close to family, but will remain forever thankful for their care and kindness.
172	Good all around service.		
173	You were here within minutes. They were kind and professional.		Super service.
174	Arrived in timely manner, were very helpful and personable.	Doing well.	Was very thankful your service was available.
175	Got me to the hospital okay.	Had to put the intravenous in twice in the hospital it swelled up and had to be moved. Need more training on intravenous procedures.	
176	All things.	Keep it up.	No comment, all is well.
177	Everything.	Nothing.	Wonderful care and quick service.
178	Everything.		
179	They were good at putting me asleep pre-surgery.	Nothing.	
180	Everything was great.		Excellent staff.
181	Everything went very well. Crew was very helpful and caring.	Continue the good work.	Thank you.
182	Compassionate.		
183	Everything.	The same.	
184	Patient, polite, caring.	Everything was great.	Everything OK.
185	personnel were professional efficient and were especially helpful in easing our concerns about patient's condition and our uncertainty about being in a very stressful situation in an unfamiliar city.	Your service is excellent and outstanding in my view.	You provide excellent service and we are most appreciative of the genuine care, concern and friendliness of the personnel who attended the needs of my husband on 7/16/13.
186	Fast response, professional, considerate.	Just be available.	Family very pleased with quick response.
187	They were awesome. The two made my fears subside tremendously.		
188	Response time good.		
189	All the best you could.	Be there, as always.	
190	All of the above.		
191	Th service and very helpful.	None just perfect.	
192	Reached me in a timely manner. Careful in painful move to gurney.Friendly and positive attitude.		
193	Everything. Very professional, don't change anything.	No need to. Great job.	Good to have you in our neighborhood. Thanks again.
194	Everything. The crew was kind, gentle, sensitive, got the job done very well.	Can't think of a thing.	
195	Competent and pleasant.		
196	Everything as always.	Thank you so much for all the help over the past year.	
197	Get me to the procedure in time.		Everyone is so great.
198	Fast response, helpful on everything. Thank you.	Next time be careful with that thing they slid under you and snaps together, it pinched me twice.	
199	Your staff is always fabulous!		
200	I am sure you did a great job. I wasn't there but my wife has no recollection of anything as she was having a seizure. She is doing well now and I'm sure your staff were instrumental in getting her the care she needed ASAP. Thanks.		
201	The crew members were very very polite and helpful. We were treated great.	I don't think I could have been treated any better.	We did not talk to anyone about billing for ambulance.
202	Explain what was going on.	Response time was slow.	Good service. Could have gotten here faster.
203	Sick now.	Got here asap.	Will change to another company.
204	Took care of me and telling me what was going on.	To also bill my secondary insurance. They billed medicare only.	Your service is great.
205	Everything.	Noting.	It's very very good.
206	Everything.	Nothing.	Good.
207	Everyone was very polite.		
208	We are so very satisfied with Remsa. We would refer them to everybody.	Can't think of anything. Your folks are great.	
209	The technical help was excellent and assessment thoughtful and kind.		

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
210	Everything well, IV start failed, carried me downstairs without incident.		
211	They did a great job! Thank you everyone.		
212	Everything, dispatch was calm, fire dept nice and efficient. EMT very nice and efficient.		Thank you to all of the responders.
213	Very professional and polite. Nice guys. They did everything possible to make sure I was comfortable.	Nothing. Everything was done to the utmost ability to see my needs.	These guys were great, attending to my needs.
214	Calming influence on my granddaughter. They explained everything they were doing.		It was fast and professional.
215	Came promptly and took care of my aunt.		Everything was great.
216	Every wear, professional at the highest level.		
217	Very patient. Very discrete, this incident happened at my office.	Nothing. It was excellent service.	Thank the 2 EMT's for me. Great job.
218	When I got there the staff was right on things.	Nothing.	I felt that the care was very good.
219	Remsa cool.		
220	Communicate very well.	Keep being the people you are.	The two ambulance drivers were very caring.
221	Dispatcher asked lots of questions, told me what to do, kept me apprised of where ambulance was, gave food instructions and advice. Kept me calm. Stayed on the phone until help arrived.	Nothing I can think of, for a bad situation it all went very well.	Care was excellent, techs calming and attentive, even asked if I needed help putting furniture back. 10 out of 10 service.
222	Although helpful, I as an RN feel there was a lot of diagnosing with your EMT's that maybe pressured my husband into the trip by ambulance. I had said "No" in my personal diagonsis! Not your issue but you might tell your EMT'S they are not MD's!		
223	Gentleman that drove ambulance and in charge was more than helpful.		The paramedic pointed out that med could be problem, saved my life.
224	Very friendly, helpful and efficient.	Everyone was kind and efficient and knew their job.	Excellent care and service.
225	As far as I know, everything. this was a first		Friendly, professional.
226	Everything. Excellent.		Awesome personnel.
227	Everything you did was right and you were very professional, while still compassionate/caring.		I feel the care given was Excellent. The whole team was awesome. Thank you so very much.
228	Handle me, treated me most kindly, made sure I was better.	Keep up the way you all are doing.	
229	Everybody was great.		
230	The patient wasn't conscious during ambulance trip.		I think from earlier experiences with Remsa, you are efficient, caring, helpful, knowledgeable and prompt.
231	Very professional service, respectful, kind.		
232	Explained where we were going and about how long it would take.		
233	The "A-team" was fantastic. They made my serious back pain sensitive to them as well.		The driver was cautious and drove appropiataly. Great time.
234	Everything. They were very understanding and patient when I had trouble moving.	Not a thing.	I was taken care of like I was important.
235	Everything.	Keep doing what your doing.	All is well.
236	Very quick response, less than two minutes. Put me at ease.		
237	Everything.	You can't improve on excellence.	
238	You explained why you were there and calmed the patient down and talked him into going to the hospital.	You did everything very well.	I called for my husband and you were wonderful with him. Thank you so much.
239	Prompt courteous, reassuring response. Very professional.	Keep it up.	
240	Very prompt, professional. Helpful in communicating family. Very courteous.		
241	Response team was kind and compassionate to patient.		Exceptional service.
242	Everything, Thanks!		Please do not release any PHI information.
243	Well done over all.		
244	The entire procedure was great.	Improve the interactions from robotic to a personal one. They performed their jobs reverantly, but the patient personal interaction can improve.	
245	On time, very professional, extra care for comfort of patient.	Nothing significant.	Great service.
246	Transported me well.	Let me talk once in a while.	Very professional.
247	Everything.		
248	Excellent.		
249	Assisting me.	Unknown.	Medics were helpful, friendly and polite.
250	Everything.	No.	Everyone where great.
251	Fast services to hospital.		
252	Took good care of me. Just as well I didn't take the train the same day.	Talk to me, not my sister. I wanted to know what was going. Did after I insisted.	
253	Rapid response time, listen to med issues and profession. Kindness shown.	Nothing your paramedics were great.	

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
254	I used me health alert and response from everyone was quick.		
255	The medical staff flight crew were very reassuring about the ambulatory phase. I was very sick and nervous. Your staff helped me feel everything was going to be okay and I felt I was "in good hands"		Great job.
256	The crew was very knowledgeable and courteous assessing the situation and preparing me for transport.	This crew was very professional, I don't think they could have served me better.	Excellent and professional, dedicated to the well being of the patient.
257	Got me to VA hospital.		
258	Everything.		
259	Your staff treated us like a member of their family. We thank you.	Nothing.	
260	Bed side mannor.	Service was wonderful.	Thank you for great services.
261	Courteous, made me fell comfortable.	Nothing.	
262	The crew were awesome. Told me what was going on and were great.		The EMT staff at the ballpark were awesome too. Very calm and told me my options,Everyone did a fabulous job. I am grateful.
263	Very kind and caring.		Excellent service.
264	Responded in timely matter. Talked calmly and clearly to me, repeated things when I asked them to.	Make sure person putting in IV has more experience at it. Person who tried to put IV in felt like it hit the bone in my right hand. I screamed loud, he was a trainee. Never did get IV in and my right top of hand is still bruised and sore and it has been 2 wks and 3 days.	
265	Professional, polite, reassuring, Comfortable, very good.	Nothing.	Experts. Nothing could of made me fell more comfortable. I'm a critical.
266	Very informative about traveling to hospital.	Nothing.	
267	Got me to the emergency at Renown.		Thank you for your services.
268	Got here fast.	Keep up the good work.	
269	Friendly, courteous, explained short drive to ER.		
270	Very professional and polite. Nice folks and did whatever it took to make me comfortable.	Nothing. It was perfect.	The guys were very polite and nice.
271	You kept orienting me.		You are very good at what you do.
272	Everything.	Nothing. The paramedics were great! Very efficient and professional.	Keep up the good work.
273	Fast response, polite, professional.		
274	Everything.		
275	Provide assistance, recently called with in couple of weeks.		
276	You picked me up with a broken rt. foot in a cast. Took me to VA.		
277	Extremely well.		
278	Your drivers were incredibly kind, polite and professional.	Nothing. Your two men were fabulous indeed.	Great customer service and care. Thank you for having such great employees.
279	Care and showed concern for patient and desire to make patient comfortable.	Keep up the good work.	The EMT showed excellent knowledge and care and concern to get the patient comfortable enough to get on the gurney and then for the ride and bumps.
280			Very good.
281	Everything.	All well done.	
282	Everything.		
283	Caring for patient.	Nothing noted.	Fast, efficient and professional.
284	excellent on all items.	Don't know.	I was treated with tender loving care.
285	Very nice.		
286	Treated me with kindness and courtesy while administering to my needs in a professional manner.		
287	Very prompt, polite, professional and smart. Knew their business.	More comfortable ride.	
288	Very good.	OK	
289	Everything.	Nothing because you are all ready perfect.	You guys are the best helpers.
290	Gentle handling, compassionate positive attitude.	Nothing. Thank you.	
291	The minute Remsa personnel waked in my door I felt relief and comfort.	Nothing.	
292	Very efficient and professional. Went "above and beyond" when dealing with my cats.		The paramedics made a stressful situation VERY unstressful.
293	Everything	Everything was fine. Very pleased.	Crew was here very quickly.
294	Everything.	All was done very professionally.	
295	Patient is also a pilot and gives you pilot and on board staff an A+. Excellent landing.		Haven't seen a bill yet.
296	Your crew was kind, attentive and understanding.	Couldn't ask for more.	
297	house and got my husband to the VA. He is and has been treated at the VA and if they didn't get him there it would have been a real mess for me. Please thank them for me. Taking their time to talk him into going to the VA.		They went above their duty to get him to go there. Thank you again.
298	The EMT's calm, efficient and caring attitudes was so appreciated in a stressful situation.		

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
299	I did not call 911. Doctor said I blacked out and think my heart stopped.		I did not call 911 after my fall.
300	I called Remsa because my husband was dying, the young men were so respectful, sincere and concerned. they were excellent.		
301	Everyone was kind and considerate.	Nothing. Response time is fast.	Good service.
302	Everything.	Stay the same.	
303	Everything worked out for the better. Thank you.	Stay the same.	
304	We've had Remsa at least three or four times for patient. Everyone great always.	Nothing I can think of always great service always.	I have some very sad news. Patient passed away.
305	Everything.		Not present this date, but on other occasions your people have been very polite, helpful, understanding and efficient. No complaints.
306	Very professional and courteous staff with both RFD and Remsa.		
307	All OK and good.		
308	All OK and good.		
309	Very good.		
310	Saved the patient.		
311	Perfectly	I can't think of anything.	Staff well trained and always pleasant and helpful.
312	Everything you guys are the best.	Nothing you guys a perfect just the way you are.	You guys a best peaple I ever ment.
313	Everything.	Not a thing.	What a great staff. They are wonderful.
314	Just about everything.	Can't think of anything.	Thank you very much for everything. You did all you could do for the patient and we all appreciate it.
315	Everyone on your staff was wonderful.	I don't see how you can improve you are excellent.	
316	Everything.	Just keep up the good services.	
317	Calm me down. Cleaned cuts on my face.	Remsa responded fast. Very good.	They help me and were very nice.
318	Everything.	Nothing.	Your personnel are perfect.
319	Good skills and was rehelpful to my family.	Nothing.	
320	The whole experience was good. Staff was courteous, professional and knowledgeable.		
321	Response.	Remove greed from billing.	
322	Yes. I was very scared and I believe they helped me in all ways.		They were kind and business like.
323	All of your people was very nice to all of us.	Thank you.	
324	Everything.		
325	Very informative, explained what was wrong and how to fix it.	Everything was good.	
326	Driver was personable and pleasant.	Communication. Had to move my son in first ambulance and plane, but not given reason or explaination.	
327	Made yourselves available.	Made yourselves available again.	I was very happy to have REMSA at our event.
328	The entire thing. M e and my dog were both scared. They calmed us down and talked to us.	Everything was fine.	The crew was wonderful.
329	Quick response, communicated infroamtion well.		
330			I was incoherent after the fall and the break, so I can't comment much about the experience.
331	Pleasant to talk with.		
332	This was the second time we had the same crew, they did a good job both times. Communication was good.		Good care both times.
333	Listened to patient. Compassionate.		
334	Patient care 1-through-10 10	Nothing.	
335	Followed pt instruction well.	Get to know policy and procedure better. If you only ask what you do need, how do you expect to improve service? You put my life at risk with inaccurate services.	Transport meds with patient to prevent errors in medication documentation as occurred.
336	All OK and good.		
337	All OK and good.		
338	Your paramedics were very friendly, comforting, and professional. I had suffered a heart attack. We were visiting from Pittsburgh.	I'm sure you will keep your excellent service for future visitors.	Your paramedics made the decision to take me to St. Mary's hospital. It turns out I did have a heart attack and I am grateful to them.
339	Kept my mind off the injury, communicated with me directly.	The staff of Remsa that were there were very thoughtful and professional.	A;; the staff service in general was well cordinated and medication was suiffently completed.
340			Sorry I was out of it the whole time. Must have been good as I got to the hospital okay.
341	Very professional.	Just keep up what you are doing.	I am a retired b/c from a fire district which provided amb. Your team was awesome.
342	The crew was great, letting me know what they were doing and going to do.	They were angels in everything they did.	They kept my wife informed on everything. The ride was smooth and cautious as well.
343	Calmed me down, cleaned cuts on my face. Remsa responded fast, very good.		They help me and were very nice.
344	The driver called my insurance company to find out what hospitals were in network. H e dealt patiently with a dim witted customer service person.		
345	Paramedics kind competent took time with my 91yr old mom Thank you.		
346	Put shunt in arm very effecently, better than the previous time.		

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
347	Everything.	Nothing. couldn't be better.	Your care was excellent.
348	Everything.	Nothing.	As a retired health professional(ER/OR/RN) I was truly impressed and knew I was in good hands. Crew was exceptional.
349	Fast, respectful, explained everything.	Nothing.	I found my self relaxed and confident in the care recieved. Thank you.
350	Complete med aid. Perfect help and treatment.		Couldn't have been better service and treatment.
351	Everything.		
352	All above.	Same.	Excellent.
353	Took me to hospital.		
354	Everything.	Nothing.	
355	Moved patient well.		Excellent.
356	Everything to me went well.	Nothing, everything went well.	Everything went well. Thank you very much.
357	Arrived quickly. Very polite.		
358	My husband said that dispatch was very calming and helpful.	Just keep on doing what you are doing, works very well.	It was a scary experience but from dispatch to medics were all positive and kind, respectful and knowledgeable. Thank you.
359	Yes! Everything.		
360	Very good.		
361	Everything. The crew was not only professional, they were very kind and concerned an=bout getting me the help I needed. Sincerety. Thank you god for sending them here.		
362	Everything.	Keep me well.	
363	Everything.	Your doing just fine.	I felt I was in good hands during a bad health problem.
364	Everything.	All was great.	All was perfect and made me happy. Thank you.
365	Everything.	Nothing.	
366	Everything.		
367	Remsa were here on several occasions during patient's last days. Everyone of them were amazing. They were professional, compassionate and kind.		Thank you for all the help you gave us. I t was a difficult time.
368	Great as always.		
369	You were very punctual ans attentive. Explained the need and the window of time to get to the hospital.	All was well done.	
370	Everything.		
371	Fast to arrive, friendly, professional.	Not much.	Good guys, tried very hard.
372	Aseset problem well, gave pain meds and transported so family could follow.		
373	Everything was great.		
374	Everything was good.		Very good.
375	Everything.		
376	Arrived very fast.		I was not picked up from the above address we moved.
377	Everyone was thorough and acted professionally. They put me at ease.	Nothing.	I am very pleased with the service.
378	Very very good, helped me in every way.		
379	Everything was great.		
380	Everything you provided was wonderful. Not only was my experience wonderful, but they treated my wife the same. They were comforting in every way to both of us. Thank you for being so wonderful at such a terrible time in out life.		
381	Everything.		
382	Great service.	Great care Remsa and Sparks Fire.	
383	Everything, everyone was professional.		
384	Everything was fine.		
385	This was the 2nd call and I appreciate them not using the siren on the 2nd call. The 1st it was appropriate.		Very good. At 90 I appreciate this service very much. Thank you.
386	Very caring and helped me stay calm.	Nothing I can think of.	The only issue I had was the 911 person transferred me while I was attending my son and I didn't know that. She was asking for the address and I told her I already gave you the address, it was kind of frustrating.
387	Courteous, understanding of situation. Told me who had purse. Friendly.	Nothing in my case.	Tried not to scare me or over whelm me with all # of people.
388	Remsa was here in a reasonable amount of time as we live in Cold Springs. Was excellent in bringing the patient around as she is a diabetic. Excellent, God bless your crews.		Your service is excellent.
389	The agents were informative and very considerate.		
390	The speed of response, the care of the EMT's, access to oxygen, expertise with IV needles.	Keep on doing what you are doing.	They were wonderful.
391	Very courteous and patient.		Glad to be a member of Silver Saver.
392	Save my life, grateful, got me to the hospital on time heart problems.	Excellent, grateful, thank you.	Excellent.

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
393	Yes		Could not get up, had to call 911 who called the medics to come in, why?
394	Provided good treatment.	Continue your caring service.	It was well done and I commend you all. Thank you.
395	Very professional and explained every procedure prior to completing said.	For me nothing, my care has always been the best.	By the dispatcher Fire and Remsa were requested not to use sirens when turning into street and they have always been great as we have a lot of services and aged people. Thank you for your help.
396	Quick response. Very polite and courteous.	Everything was excellent.	
397	Prompt, careful, calm.	All good.	
398			Every time Remsa has served our family they have been great
399	Very prompt and polite.	Not much.	
400	Quickness of arrival, care in ambulance.		
401	You put me at ease (was scared).	I did not see anything for me. My needs were served.	Thank you for your service.
402	Kept me relaxed.	Nothing that I can think of.	
403	Everything. Each and every professional that day explained everything to me.		
404	All the steps necessary for my safety and comfort.	Continue your services.	Well provided service.
405	Everything, wonderful.	Nothing.	Awesome. Thank you.
406	Clean up bloody mess.		
407	Fine.		
408	Everything.	Nothing.	Went out of their way to make sure proper care was given. Even talked to patient's cardiologist.
409	Mother fell off port a potty, hurt her back, pain was severe, gave her pain med IV.	We felt you were very professional and took great care to comfort my mother.	
410	Quick response, crew was professional and caring.	We were happy with your service.	
411	Everything was good.	Nothing.	
412	Everything.		
413	Driver is friendly. Made mom feel safe and comfortable.		
414	The experienced EMT was able to locate and establish IV site. I'm a rather hard stick.	Continue with exceptional, professional and effective service.	
415	Good help.		
416	Good service/ good food.		
417	Treated me very well, Couldn't ask for any better service.	Nothing.	Treated my wife with much kindness, Thank you
418	Very professional.		
419	Very fast service all your people were super nice and polite putting me at ease.	Can't think of one thing to improve.	
420	Took my blood sugar 130 and BP.		
421	Everything was just great.		Great.
422	The crew inspired trust.		Practiced professionals.
423	Everything.		Excellent.
424	Good communication to keep me awake post accident.	Taking of medical information and cards.	
425	Everything.	Nothing.	
426	Talk to patient in ambulance.	Nothing.	
427	Extremely well.	Nothing.	You just do the best.
428	You were great.		
429	Absolutely great. Could not have been more helpful, caring and efficient.	Be patient- payment forthcoming, soon as i can get to my desk and mail.	
430	Very helpful and polite.		
431	Drivers explained how process would work and were very helpful and polite through whole journey.		
432	Th team were polite and helpful with my been transfered. I fractured my febular. The driver were very smooth and careful to watch for bumps. I was in pain. This crew were excellent.		
433	Everyone was nice and told me what was going on.	Not a thing. They were the best of the best.	They were great. Thanks for a job well done.
434	Everything.		
435	Very well. Response team was very professional with their handling the situation.		
436	Quick response.	Doing an excellent job.	Great service for seniors.
437	Polite and very helpful.	Can't think of anything.	Service was excellent.
438	Patient felt safe.		
439	Everything was done well, I was treated with great care and kept alive to reach the emergency room.	I can't even imagine doing ANYTHING better. Every part of their care and compassion for me was prefect.	Same as above, I simply could not be more satisfied with the medic people or anything else. Thank them for me please.
440	Everything.		Wonnerful staff, very professional.
441	You helped my husband and got him to the hospital on time, Thank you. You all did great.		All great.
442	Everything. Crew was calm, efficient, courteous and calming.	Nothing.	The crew knew their job and performed it beautifully.
443	The person that was with me in the back was very nice, she talk to me and let me know what was going on I like that.	Everything was good.	Very good.
444	Everything.	The same.	You people are great.

	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments
445	Everything.		Your services are very competent.
446	Nicely ask me questions.	Nothing.	You guys are great.
447	Got me to the hospital way fast and were very attentive.	Nothing really.	
448	Pick and delivery with ease, All went perfect, Thank you.	I wouldn't change a thing.	You are all the best in my eyes. Thank you for helping me when I needed you so much.
449	Told them what was going on while setting up their equipment, they knew right away what was happening to me.		Called ahead for a cardiologist to meet us. Very informative, all the way to the hospital one of them even checked on me before he left. Very good care.

REMSA

Regional Emergency Medical Services Authority

CARE FLIGHT

CUSTOMER SERVICE

FOR

AUGUST 2013

450 Edison Way • Reno, NV 89502-4117
775.858.5700 • fax 775.858.5726

CARE FLIGHT CUSTOMER COMMENTS AUGUST 2013

	What Did We Do Well	What Can We Do To Serve You Better	Description / Comments
1	Made me feel safe and comfortable.		The pilot and nurse were both very nice and made me feel safe.
2	All good.		
3	Everyone was very helpful and explained all they were doing at the time. Very courteous and caring.		
4			On the day of the accident 7-18-13 I told paramedics "DO NOT LIFE FLIGHT ME". "I do not have ins, drive me". One of the paramedics repeated my refusal to use life flight. Immediately after that I was given a shot that totally knocked me out. I did not wake until I was about 1 hour or so out of surgery.
5			I did not have contact with you, but I'm grateful for your speed in getting Hannah to Renown. Hannah passed away 3:30am 7/4/13
6	The crew was very pleasant and helpful with taking my husband on board. They were cheerful and made him feel safe.	Nothing, just keep your crew smiling and cheerful.	
7	Getting patient from Truckee to Reno imediately.	The service was what we needed.	Well done.
8	Good - but scary for the first time.	Nothing.	
9	Everything		Awesome!!!
10	The flight nurses were amazing. They handled my young son as if her were their own.		
11	Transporting me safely and carefully to Renown hospital from my accident site.		The staff was well trained and efficient in their service.
12			
13	Transported myself with care and professionalism with a lighthearted attitude.	Put mirror in helicopter so patient can enjoy the experience and view.	Had to call for patient invoice to submit for voca ID.
14	Nurse was very kind and attentive. Tried to make me comfortable and reassure me.		They were very efficient in transferring me from ER to Care Flight, very kind!
15	Arrived at the hospital very quickly, they took very good care of me during the flight		The Care Flight staff is great! Keep up the good work.
16	Selected best available location within reach of accident.		Absolutely first class care and legitimate concern for the patient.
17	You did everything well. Care was great.	Nothing	
18	Everything		
19	Kept me informed		
20	Gave me a sedative b/c I was very uncomfortable during flight, polite!		
21	Everything! Rapid response truly caring and assuring. Wonderful!	Stay as great as you are!	I live in CA. First experience w/heart problem. First ride in helicopter, AWESOME!
22	Made me feel at ease		
23	I'm his wife I couldn't be there when he arrived at Carson but I understand everything went well.	Keep up the good work. No complaints except he did say he was cold. Thanks again.	Enclosed is a 50 dollar check. We can't thank you all enough.
24	I was very frightened and the Care Flight nurses kept me calm. They were very attentive to my needs and kept me comfortable.	Nothing. I was very pleased with the service.	Not only did the nurses help me medically, they were also sensitive to my emotional needs. We were in a horrible vehicle accident and I was a bit shook up.
25	Everything was done in a very excellent manner and there was much response and 2 teams of people.		
26	Very professional and competent. Very good at making its people involved feel at ease. My wife appreciated the information.		Very good service!
27	The upbeat attitude and personal care received by me from flight crew was phenomenal.	I can't think of anything.	Excellent care.
28	Was prompt and took good care of me.	Nothing. You already do a good job.	The service is excellent.
29	Swift transfer from Churchill to Renown.		
30			
31	Everything, thank you very much to all the staff that treated me and my wife. Thank you for looking after her as well as myself.	I couldn't think of anything that could have been done better. You are wonderful people.	
32	By receiving this letter is the only way I knew she was transported by air.	I was not notified until 4 hours later. Not your fault. You were there for her.	I'm assuming you did a good job. Thank you for providing such a needed service. how can I continue to help?
33	Everything-the crew was top notch.	Nothing-You guys were awesome.	
34	Due to my injuries, I have no memory of the flight. I was transported safely. Thank you for providing this service.		
35	All of the above plus kindness.	It couldn't improve for me.	it was completed with efficiency and care.

REMSA

PUBLIC RELATIONS REPORT

FOR

AUGUST 2013

PUBLIC RELATIONS

August 2013

ACTIVITY	RESULTS
Finalized community benefit report and sent to print.	Community benefit report will appear in the Reno Gazette Journal on Sept. 25 and the NNBW on Sept. 30
Began the work on a Safe Sleep radio spot and online media buy to promote Cribs for Kids and importance of safe sleep for infants.	Program will launch in October.
Wrote press release regarding the EMS Memorial Bike Ride.	Press release will go out in September
Wrote press release regarding Child Passenger Safety Week.	Press release will go out in September

Daily Sparks Tribune
Your Community Newspaper Since 1910

Staying safe and eating right

by Andrea Tyrell

Aug 22, 2013

According to the Centers of Disease Control, most kids in the United States do not eat the daily recommendation of 2 and half to 6 cups of fruits and vegetables. With the rising cost of food, many parents cannot afford fresh groceries to feed their families. Many government services help to solve that problem, including Women, Infants and Children (WIC).

The Inter-Tribal Council of Nevada WIC will host a Family Fun Festival Saturday, from 10 a.m. to 2 p.m. at its office parking lot, located at 680 Greenbrae Drive. This event is free to the public.

"Many don't know where we're located as we're a little hidden," said Dawn Halona-Brown, vendor coordinator at Inter-Tribal Council. "There are a lot of people who are qualified for WIC and don't know it.

The Family Fun Festival will have food demonstrations taught by WIC nutritionists, helping parents make vegetables more delectable to their picky eaters.

"We're going to teach parents how to make nutritious meals out of the food they receive in the WIC packages," said Halona-Brown. "Depending on the time of the year, the packages are filled with different produce and sometimes, parents don't know how to properly cook something."

"We provide families with quality fresh fruit and vegetables," said Tara Olson, a nutritionist with the Inter-Tribal Council. "We actually have pretty lenient guidelines so a lot of people can qualify. We're available to help those not working to the middle class."

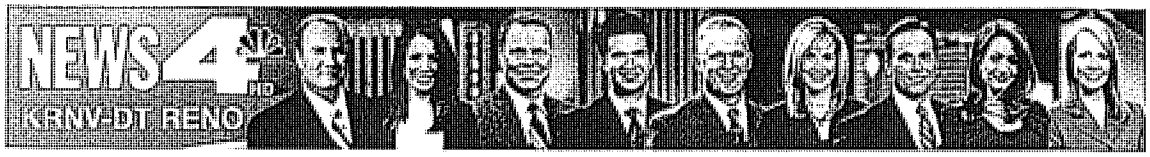
WIC Women Infants & Children

The Sparks Fire and Police departments will be at the event, providing child fingerprinting services, as well as REMSA's Northern Nevada Fitting Station, which will be teaching parents make sure their child car seats are accurately belted and secure. Case del Vida and the Crisis Call Center will also be on site with information about the services they offer.

WIC is a federally funded program that provides foods and teaches nutrition and healthy eating habits to children from infant to age five and mothers, pregnant through post postpartum.

"We just wanted to gather together as a team to promote WIC and let everyone know that we're here to help," said Halona-Brown.

For more information about this event and the WIC program, visit itcnwicprogram.org or call 398-4960.



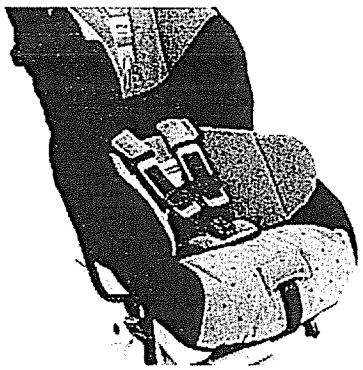
REMSA, UNR to Hold Child Safety Seat Inspection

Published: 8/15/13 12:47 pm
Updated: 8/15 12:51 pm

RENO, Nev. (KRNV & MyNews4.com) -- REMSA, in partnership with UNR Early Head Start, will hold a child safety seat inspection checkpoint.

Each seat will be checked by Nationally Certified Child Passenger Safety Technicians to ensure that it is properly installed in the vehicle, is the appropriate seat for the child riding in it and that the seat has not been recalled. Parents will also receive education on the proper installation and use of car seats. The inspection is limited to 30 cars and early arrival is recommended.

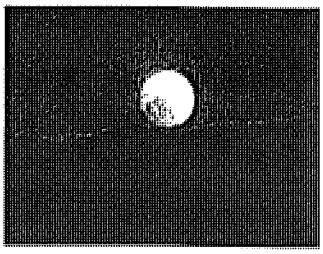
WHEN: Saturday, August 24, 9:00 a.m.
WHERE: UNR Early Head Start, Nelson Building, 401 West Second Street, Reno



RGJ.com

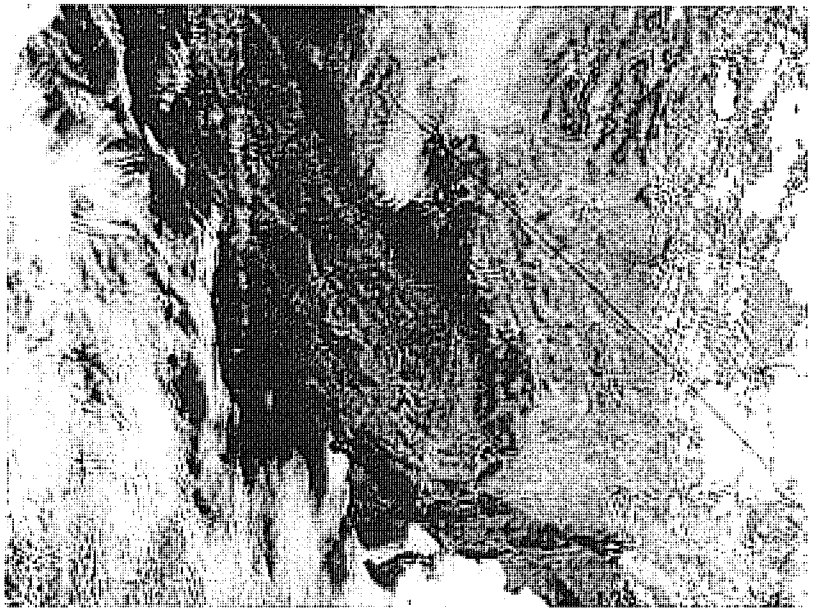
California wildfires continue smoke to Nevada; local air quality unhealthy for some people

Aug. 24, 2013



Written by
MARTIN GRIFFITH
Associated Press

Steve Malaglowicz of Reno sent this photo of the sunrise behind his house on Friday, Aug. 23, 2013.



NASA Goddard Space Flight Center satellite picture of the smoke at the California-Nevada border on Saturday. / NASA Goddard Space Flight Center MODIS picture

Air quality index for particle pollution
Good: 0-50
Moderate: 51-100: Unusually sensitive people should consider reducing prolonged heavy exertion.
Unhealthy for sensitive groups: 101-150: People with heart or lung disease, older adults and children should avoid prolonged or heavy exertion.
Unhealthy: 151 to 200: People with heart or lung disease, older adults and children should avoid prolonged or heavy exertion. Everyone else should reduce prolonged or heavy exertion.

Very unhealthy: 201 to 300: People with heart or lung disease, older adults and children should avoid all physical activity outdoors. Everyone else should avoid prolonged or heavy exertion.
Source: Washoe County Health District

9:44 p.m. update:
At 9 p.m., the local air quality was considered "unhealthy for sensitive groups," with a rating of 145. Seniors, children and those with heart or lung issues should avoid lengthy or heavy activity.

6:37 p.m. update:
Dense smoke from major California wildfires continued to pour into the Reno-Lake Tahoe area Saturday, causing event cancellations and local health officials to expand pollution warnings into Tuesday.

Poor visibility also has prevented the Reno-based Care Flight air ambulance service from responding to some emergency calls in the last couple of days, said Temple Fletcher, its program director.

"There have been flights we can and can't take depending on visibility," she said. "But I'm not aware of any adverse outcome because of it. ... Patients are being transported by ground instead."

Care Flight helicopters can only operate when there's visibility of 3 miles. But the smoke has reduced visibility to 1 mile in some areas along the eastern Sierra, including Reno and Carson City.

The air quality index around Reno remained in the "unhealthy" range as it hit the 153 mark late Saturday afternoon, down from 169 earlier in the day and 200 on Friday, according to the Washoe County Health District. That level means that everyone should cut lengthy or heavy activity, and seniors, children and those with heart or lung issues should avoid it.

The smoke is coming from fires such as the Rim Fire along the northwest edge of Yosemite National Park, which has charred nearly 200 square miles and is just 5 percent contained. The American Fire in the Tahoe National Forest west of Reno has burned 34 square miles and is 67 percent contained.

Health officials expect the smoke to affect the Reno area at least through Tuesday, with unhealthy conditions that could harm the most vulnerable, such as the elderly and young children.

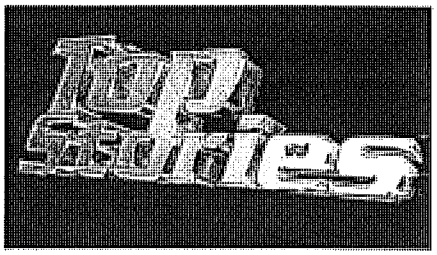
Thick smoke prompted school officials across the region to cancel all outdoor activities Friday, including football practices.

"This is pretty bad — the worst I've ever seen it in Reno," Sean Abbey told the Reno Gazette-Journal, adding the smoke was making him cough and his eyes water. "There are people that are going to get sick over this."

Officials at Renown Regional Medical Center in Reno and Northern Nevada Medical Center in Sparks reported an increase in patients with respiratory problems at their emergency rooms Friday.

Weekend events scrubbed included a fundraising outdoor concert for cancer patients in Carson City, an outdoor family concert and a star-gazing party in the Minden area, and a Nevada-USF women's soccer game in Reno. The smoke also prompted the cancellation of an air show Saturday at Lake Tahoe.

Authorities respond to potential HAZMAT situation



Updated: Monday, August 26 2013, 05:31 PM CDT RENO –

On Monday, August 26th, 2013 at about 10:22 a.m., the Reno Police Department, Reno Fire Department HAZMAT, and **REMSA** responded to a call from a business in the 700 block of Forest St. in Reno regarding a letter containing a suspicious powdery substance with a note indicating the substance could cause harm. The business was evacuated while the Reno Fire Department HAZMAT team performed initial field testing on the substance. Testing indicated it was a common household substance and not a threat to the health and safety of those who came into contact, nor was it a threat to the public. Additional samples were collected by the Washoe County Department of Public Health for more extensive laboratory testing to confirm the field tests. A criminal investigation has been initiated by the Reno Police Department.

Read More at: http://www.foxreno.com/news/features/top-stories/stories/authorities-respond-potential-hazmat-situation-466.shtml

Washoe County Health District

Public Health

TO: District Board of Health Members

FROM: Randall Todd, DrPH
Director, Epidemiology and Public Health Preparedness

DATE: September 18, 2013

SUBJECT: Emergency Medical Services Working Group Update

The EMS Working Group met on September 6, 2013. Issues discussed at the meeting included:

- Data – Data definitions have been received from Sparks Fire. Truckee Meadows Fire submitted their data definitions just a few days prior to the September 6 meeting. Reno Fire definitions are still pending. REMSA data a call receive times for Priorities 2 and 3 were still pending as of the meeting date but have subsequently been received. There are some outstanding issues with 911 dispatch data that appear to be possibly incomplete. All parties agreed to work on getting the information to the Health District for analysis. Once the definitions are complete it is planned to assess 2 additional months of data so that analysis can be based on a full quarter.

- Emergency Medical Dispatch – Discussion continued on this topic and included some debate on whether or not utilization of field-experienced dispatchers as utilized by REMSA is a requirement and, if not, if it represents a best practice. This remains an area of disagreement.

Randall L. Todd, DrPH
Director, Epidemiology and Public Health Preparedness

WASHOE COUNTY HEALTH DISTRICT

Public Health
Prevent. Promote. Protect.

TO: District Board of Health Members

FROM: Kevin Dick
Interim District Health Officer

DATE: September 26, 2013

SUBJECT: REMSA Franchise Agreement Negotiations Extension Request

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SUMMARY:
The elected bodies of the City of Sparks, the City of Reno, and the Washoe County Board of County Commissioners and appointed body of the District Board of Health directed their respective Managers to create an Emergency Medical Services Working Group (EMS-WG) for the purposes of reviewing and implementing the recommendations of the Emergency Medical Services System Analysis Final Report dated August 2012 by the TriData Division of the System Planning Corporation (TriData Report).

The TriData Report included 38 recommendations for the improvement in the Emergency Medical Services (EMS) delivery system for the Washoe County region including the updating of the current Franchise Agreement with the regional ambulance provider, the Regional Emergency Medical Services Authority (REMSA).

At the concurrent meeting held on June 10, 2013, the elected and appointed officials of the four jurisdictions directed their respective managers to negotiate a "renewed" Franchise Agreement with REMSA within 120 days. The 120 days is scheduled to expire on October 2, 2013. The motion before the Washoe County District Board of Health (DBOH), per the meeting minutes, read as follows:

> **"Chair Smith moved, seconded by Council Member Ratti, to direct the EMS Working Group to open negotiations with REMSA on an updated agreement within 120 days.**
>
> **MOTION CARRIED**
> **Washoe County Board of Health**
>
> ***The motion was also approved by the Board of County Commissioners, Reno City Council, and Sparks City Council."***

The 120 days is scheduled to expire on October 2, 2013.

The EMS-WG has reached consensus on a large number of the TriData Report recommendations. Several recommendations are moving forward through the actions in organized meetings between the local jurisdictions Managers and REMSA.

A subcommittee assigned by the EMS-WG Managers has determined a working outline of agreement issues to serve as a scope of work for developing a comprehensive updating of the current agreement between the City of Reno, the City of Sparks, Washoe County, and the Washoe County District Board of Health and REMSA.

BACKGROUND:

The Washoe County Board of County Commissioners commissioned the TriData Division of the Systems Planning Corporation (TriData) to review and provide recommendations on the efficiency and effectiveness of the regional Emergency Medical Services (EMS). The study culminated with TriData submitting to Washoe County, the City of Reno, the City of Sparks, and the Washoe County District Board of Health the Emergency Medical Services Systems Analysis – Final Report dated August 2012 (TriData Report).

The Executive Summary of the TriData Report states:

> "*Overall, Washoe County EMS providers at all levels provide timely, high quality response in a professional manner. It is easy to notice the dedication of each participant within the system. The combination of fire first response, with either commercial or fire-based EMS transportation is an appropriate method to provide service. We note throughout the report that most challenges stem from the lack of EMS oversight, with the system operating on a fragmented basis. The lack of system transparency, distrust between system participants, and failure to take advantage of technologies that could solidify system cohesiveness are at the root of most administrative, operational, and financial issues.*"
>
> Source: TriData Final Report-August 2012, page 1.

The TriData Report addresses the REMSA Franchise Agreement as follows:

> "***Evaluation of REMSA Franchise Agreement***
>
> *We are very concerned about the status of the REMSA Franchise Agreement. Since 1990, most of the negotiated changes have clearly favored REMSA, limiting the DBOH oversight authority. The EMS system is supposed to resemble a PUM with an independent oversight organization (REMSA), and an independent contractor (RASI). In practice, it is difficult to tell the difference between organizations, with REMSA functioning as a private EMS contractor.*
>
> *The agreement allows for either a contract rebid or a market share analysis to determine whether the current contractor is retained. Regardless, no more than seven years should go by without a competitive provider selection process. Several metrics identified by the agreement does not provide enough information to fully evaluate the performance of the contractor. Also, the required $200,000 performance bond is inadequate to protect the citizens from system failure. The minimum performance bond or irrevocable line of credit should be $1,000,000.*

Using arbitration to decide EMS transport fees is an unnecessary surrender of DBOH authority. The oversight agency should have complete discretion of granting a fee increase. If alternative dispute resolution is needed, it should be limited to mediation.

Sections 30 and 31 are of concern. Issues concerning successor financial liability cannot be directly answered because there are many possible succession models. EMS services are encouraged to seek their local legal counsel for guidance. There is a major issue concerning the administrative acknowledgement of DBOH-REMSA modification agreements. We offer suggestions to handle these agreement gaps.

The DBOH-franchisee agreement is in need of a complete overhaul. There must be appropriate checks and balances that assure a fair process that ensures oversight while providing an environment for good patient care in a business friendly environment."

Source: TriData Final Report-August 2012, pages 4-5.

The TriData report goes on to state, "Washoe County now has the time, place, and opportunity to make significant changes to the EMS system that will facilitate future growth and success. The current providers are dedicated to providing excellent patient care in a professional manner. Strengthening the EMS system can occur by empowering an oversight agency with the authority to oversee all aspects of EMS. Redesign of the EMS franchise agreement is necessary to shift the balance of power to the oversight agency."

The TriData Report included 38 recommendations for the improvement of Emergency Medical Services (EMS) delivery system for the Washoe County region including the updating of the current Franchise Agreement with the regional ambulance provider, the Regional Emergency Medical Services Authority (REMSA). The status of the 38 recommendations was provided in detail at the Concurrent Meeting on June 10, 2013.

At the concurrent meeting held on June 10, 2013, the elected and appointed officials of the four jurisdictions directed the EMS Working Group to open negotiations with REMSA on an updated agreement within 120 days (see the motion above). The 120 days is scheduled to expire on October 2, 2013.

The EMS-WG has reached consensus on a large number of the TriData Report recommendations. Several recommendations are moving forward in organized meetings between the local jurisdictions Managers and REMSA.

The 15 outstanding recommendations in need of negotiation of the TriData Report recommendations at the June 10, 2013 Concurrent Meeting remains as follows:

TABLE 1 – Outstanding TriData Report Recommendations

Recommendation Number and Report Page No.	TriData Report Recommendation
FRANCHISE AGREEMENT	
TriData #17 (Page 122)	Section 1 of the Franchise Agreement should be redesigned to prohibit any REMSA board appointee or their employer organization from being associated with RASI or any successor franchisees. All consumer board members should be directly appointed by the DBOH.
TriData #18 (Page 123)	If REMSA continues to use market analysis, it should include intra-model and extra-model comparisons. No more than seven years should elapse without conducting a full competitive bid.
TriData #19 (Page 124)	Require REMSA or the contracted agency to post a surety bond, or secure an irrevocable line of credit for at least $1,000,000. The franchise agreement should also include a clause that upon declaration of default by the District Health Officer or DBOH, either REMSA or ay service contractor cannot bring legal action to delay the DBOH's access to the funds.
TriData #20 (Page 124)	The eight minute response time requirement should be required for all calls classified by the PSAP as Charlie, Delta, or Echo (Priority 1 or 2).
TriData #23 (Page 126)	Determine ambulance response time fines based on both the act of lateness and degree of lateness. Assess a $100 penalty for being late and an additional $15.28 (as per CPI changes) per minute to a maximum of $250.
TriData #24 (Page 126)	Funds collected for EMS contract performance standard violations should be used to offset EMS oversight costs incurred by the Washoe County DBOH.
TriData #26 (Page 127)	Require REMSA to submit their annual report to the DBOH within 90 days of the fiscal year end.
TriData #28 (Page 129)	Restructure REMSA to assure greater separation of the public utility oversight group (REMSA) and the contractor (RASI).
TriData #31 (Page 133)	The new Washoe County EMS agency should enter into an agreement with REMSA for the provision of county-wide EMS Education and Training; Granting of function privileges would remain under control of the local agency and its medical director. Local agencies could opt out of or augment REMSA provided education and training. Regulatory oversight of the education and training processes would be the responsibility of the Washoe County EMS Manager and EMS Medical Director. REMSA could provide these services cost-free in exchange for EMS first responder services being provided by Cities and Fire District.
TriData #36 (Page 137)	Municipal first responders should be reimbursed by REMSA for providing first responder services.

Recommendation Number and Report Page No.	TriData Report Recommendation
DISPATCH	
TriData #13 (Page 117)	Combine 911/dispatch centers into one central county-wide resource so that all data is collected in one central location with singular methodology. Alternatively, develop a virtual consolidation between dispatch centers using a universal CAD or type of CAD for the County.
TriData #16 (Page 118)	Place all EMS Communications on the 800 MHz radio system.
MEDICAL OVERSIGHT	
TriData #29 (Page 130)	The County Commissioners should authorize the District Board of Health (or other lead agency) to create a countywide EMS oversight authority. The District Health Officer (or designated department head) would be responsible for day-to-day oversight. The DHO would need a staff to accomplish this oversight.
TriData #30 (Page 131)	The chosen lead agency should appoint an EMS Staff that includes: an EMS Manager, EMS Medical Director, EMS Information Specialist, EMS Quality Manager, and EMS Education and Training Manager.
OTHER	
TriData #37 (Page 137)	The Reno Fire Department, IAFF, and the volunteer service should work out any issues assure that the closest, qualified unit will be sent to a medical emergency.

ANALYSIS:

Summary of the EMS-WG's current progress on the implementation of the 38 recommendations from the TriData Report was presented to the Concurrent Meeting via the Executive Summary dated June 30, 2013. The outstanding 15 recommendation in need of further negotiation prior to implementation are shown above in Table 1.

While the issues outstanding prior to the June 10th Concurrent Meeting has been actively discussed by the EMS-WG on a frequent basis with all parties present, the specific negotiation points being developed by the Managers are still a work-in-progress due the complexity of the current REMSA Franchise Agreement; the current regional EMS environment; patient needs; and the numerous topics needing full discussion to renew and modernize the agreement and implement the recommendations in the TriData Report.

To meet the policy requirement from the action taken by the DBOH in the June 10, 2013 motion on this topic (see above), a subcommittee assigned by the EMS-WG Managers has determined a working outline on the franchise agreement's details to serve as a scope of work for developing a comprehensive renewal of the current agreement between the Washoe County District Board of Health and REMSA, which is acceptable to the City of Reno, the City of Sparks, and Washoe County.

The scope of work being completed to renew the current agreement between the local jurisdictions and REMSA, taking into consideration the outstanding issues in Table 1 above and the other TriData recommendations, includes but is not limited to the following:

- Definitions
- Obligations of the parties to the agreement
- Scope of Services
- Fees, Rates, and Procedures
- Programs and Services
- Surety, Indemnity, Liability,
- Transfer, Assignment, and Subcontracting
- Default and change in law

The Managers are finalizing their respective thoughts on the scope of work and would submit meeting the October 2, 2013 deadline provided by the elected and appointed officials is not feasible due to the complexity of the numerous outstanding issues to bring closure to a renewed agreement. An extension of time is requested to move from an outdated and somewhat generalized franchise agreement to one that is modernized and specific in its requirements and defined responsibilities. This is necessary in order to provide greater transparency and the ability to manage overall EMS system performance in conjunction with the other EMS provider agencies and provide the meaningful oversight proposed by the TriData report.

Staff is recommending an extension of 120 days from October 3, 2013 through January 31, 2014 to bring the proper elements to the table for negotiation with REMSA.

ALTERNATIVES:

1. The DBOH may choose to accept the recommendations of staff on the renewing of an Emergency Medical Services agreement with REMSA by extending the negotiation period for 120 days to January 31, 2014.

2. The DBOH may choose not to accept the recommendations of staff on the renewing of an Emergency Medical Services agreement with REMSA by extending the negotiation period for 120 days to January 31, 2014, and provide other direction to the Interim District Health Officer.

POSSIBLE MOTION:
Move to authorize the Interim District Health Officer to extend the negotiation period for 120 days for the purpose of renewing an agreement with REMSA for Emergency Medical Services.

Kevin Dick
Interim District Health Officer

Washoe County Health District

September 13, 2013

To: Members District Board of Health

From: Eileen Stickney

Subject: Health Fund Revenue and Expenditure Report for August 2013

Recommendation

Staff recommends that the District Board of Health accept the attached report of revenues and expenditures for the Health Fund for August 2013 of fiscal year 14.

Background

The attached reports are for the accounting period 2/14 and the percentages should approximate 16% of the year. The total revenues and expenditures for the current year (FY14) compared to last year (FY13) are as follows:

August 2013	FY14 – REV	FY13 – REV	FY14 – EXP	FY13 – EXP
GFTransfer Overhead			$483,005.66 17%	
AHS	$82,933.66 7%	$87,903.22 8%	399,236.63 15%	$400,396.60 15%
AQM	$246,899.00 11%	$216,943.25 10%	331,952.40 13%	$339,014.72 12%
CCHS	$111,223.14 5%	$37,852.54 2%	$650,177.78 14%	$751,658.59 15%
EHS	$262,025.61 13%	$226,004.55 13%	$916,195.16 16%	$1,033,763.33 18%
EPHP	$90,389.40 5%	$172,786.05 9%	$312,120.61 15%	$401,273.31 17%
Adjustments				
TOTAL	**$793,470.81 8%**	**$741,489.61 8%**	**$3,092,688.24 15%**	**$2,926,106.55 14%**

The Environmental Oversight Account for August 2013 is $108,314.13.

I would be happy to answer any questions of the Board during the meeting or you may contact me directly at 328-2417. Thank you.

Eileen Stickney

Administrative Health Services Officer

Enclosure

Washoe County Health District
REVENUE
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
422503 Environmental Permits	63,177.00-	9,798.00-	53,379.00-	16	51,500.00-	8,418.00-	43,082.00-	16
422504 Pool Permits	74,690.00-	3,624.00-	71,066.00-	5	68,000.00-	3,576.00-	64,424.00-	5
422505 RV Permits	13,306.00-	1,938.00-	11,368.00-	15	10,500.00-	1,442.00-	9,058.00-	14
422507 Food Service Permits	492,181.00-	76,168.00-	416,013.00-	15	369,000.00-	61,595.00-	307,405.00-	17
422508 Wat Well Const Perm	23,567.00-	8,302.00-	15,265.00-	35	20,000.00-	7,596.00-	12,404.00-	38
422509 Water Company Permits	3,200.00-	594.00-	2,606.00-	19	2,500.00-	261.00-	2,239.00-	10
422510 Air Pollution Permits	584,012.00-	98,271.00-	485,741.00-	17	448,037.00-	73,151.25-	374,885.75-	16
422511 ISDS Permits	66,522.00-	18,893.00-	47,629.00-	28	49,000.00-	7,810.00-	41,190.00-	16
422513 Special Event Permits	99,623.00-	32,360.00-	67,263.00-	32	79,000.00-	22,526.00-	56,474.00-	29
422514 Initial Applic Fee	35,226.00-	5,096.00-	30,130.00-	14	27,000.00-	4,678.00-	22,322.00-	17
* Licenses and Permits	1,455,504.00-	255,044.00-	1,200,460.00-	18	1,124,537.00-	191,053.25-	933,483.75-	17
431100 Federal Grants	5,174,744.05-	166,399.75-	5,008,344.30-	3	5,860,619.51-	172,462.75-	5,688,156.76-	3
431105 Federal Grants - Indirect	243,178.41-	5,514.47-	237,663.94-	2	125,376.00-	2,033.52-	123,342.48-	2
432100 State Grants	72,652.00-		72,652.00-		281,857.00-		281,857.00-	
432310 Tire Fee NRS 444A.090	468,548.00-	63,664.65-	404,883.35-	14	418,766.00-	66,093.55-	352,672.45-	16
432311 Pol Ctrl 455B.830	300,000.00-	78,739.00-	221,261.00-	26	300,000.00-	79,864.00-	220,136.00-	27
* Intergovernmental	6,259,122.46-	314,317.87-	5,944,804.59-	5	6,986,618.51-	320,453.82-	6,666,164.69-	5
460162 Services to Other Agencies								
460500 Other Immunizations	89,000.00-	11,054.07-	77,945.93-	12	89,000.00-	15,804.00-	73,196.00-	18
460501 Medicaid Clinical Services	8,200.00-	334.25-	7,865.75-	4	36,200.00-	44.46	36,244.46-	0-
460503 Childhood Immunizations	20,000.00-	3,388.50-	16,611.50-	17	30,000.00-	4,610.00-	25,390.00-	15
460508 Tuberculosis	4,100.00-	678.32-	3,421.68-	17	4,100.00-	994.57-	3,105.43-	24
460509 Water Quality								
460510 IT Overlay	35,344.00-	7,555.00-	27,789.00-	21	113,400.00-	20,990.00-	92,410.00-	19
460511 Birth and Death Certificates	450,000.00-	79,859.00-	370,141.00-	18	400,000.00-	86,193.00-	313,807.00-	22
460512 Duplication Service Fees		8.96-	8.96			3.00-	3.00	
460513 Other Healt Service Charges					2,700.00-	1,374.00-	1,326.00-	51
460514 Food Service Certification	19,984.00-	3,101.00-	16,883.00-	16	13,900.00-	2,551.00-	11,349.00-	18
460515 Medicare Reimbursement								
460516 Pgm Inc-3rd Prty Rec	1,750.00-	183.30-	1,566.70-	10	2,250.00-		2,250.00-	
460517 Influenza Immunization	7,000.00-	36.50-	6,963.50-	1	7,000.00-	49.00-	6,951.00-	1
460518 STD Fees	21,000.00-	3,434.18-	17,565.82-	16	23,000.00-	3,453.60-	19,546.40-	15
460519 Outpatient Services								
460520 Eng Serv Health	50,707.00-	7,507.00-	43,200.00-	15	44,000.00-	2,579.00-	41,421.00-	6
460521 Plan Review - Pools & Spas	3,816.00-	1,052.00-	2,764.00-	28	2,500.00-	530.00-	1,970.00-	21
460523 Plan Review - Food Services	18,765.00-	4,673.00-	14,092.00-	25	17,000.00-	3,519.00-	13,481.00-	21
460524 Family Planning	27,000.00-	6,040.87-	20,959.13-	22	44,000.00-	5,314.78-	38,685.22-	12
460525 Plan Review - Vector	36,021.00-	9,560.00-	26,461.00-	27	30,000.00-	5,192.00-	24,808.00-	17
460526 Plan Review-Air Quality	65,272.00-	4,433.00-	60,839.00-	7	40,000.00-	6,254.00-	33,746.00-	16
460527 NOE-AQM	113,934.00-	14,440.00-	99,494.00-	13	100,000.00-	17,095.00-	82,905.00-	17
460528 NESHAP-AQM	135,389.00-	19,816.00-	115,573.00-	15	84,000.00-	14,808.00-	69,192.00-	18
460529 Assessments-AQM	57,888.00-	9,424.00-	48,464.00-	16	41,000.00-	8,557.00-	32,443.00-	21
460530 Inspector Registr-AQ	14,655.00-	2,113.00-	12,542.00-	14	2,600.00-	2,838.00-	238.00	109
460531 Dust Plan-Air Quality	187,690.00-	19,663.00-	168,027.00-	10	95,000.00-	14,376.00-	80,624.00-	15
460532 Plan Rvw Hotel/Motel						322.00-	322.00	
460533 Quick Start								
460534 Child Care Inspection	10,560.00-	1,968.00-	8,592.00-	19	8,500.00-	1,914.00-	6,586.00-	23
460535 Pub Accomod Inspectn	22,540.00-	3,507.00-	19,033.00-	16	17,300.00-	2,949.00-	14,351.00-	17
460570 Education Revenue	2,900.00-	480.00-	2,420.00-	17	5,700.00-	149.00-	5,551.00-	3

Washoe County Health District
REVENUE
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
* Charges for Services	1,403,515.00-	214,309.95-	1,189,205.05-	15	1,253,150.00-	222,374.49-	1,030,775.51-	18
484050 Donations Federal Pgm Income	37,550.00-	7,298.99-	30,251.01-	19	41,934.00-	7,580.16-	34,353.84-	18
484195 Non-Govt'l Grants	55,988.00-		55,988.00-		114,750.00-		114,750.00-	
484197 Non-Gov. Grants-Indirect								
485100 Reimbursements								
485110 Workers Comp Reimb								
485121 Jury Reimbursements								
485300 Other Misc Govt Rev	69,558.75-	2,500.00-	67,058.75-	4		27.89-	27.89	
* Miscellaneous	163,096.75-	9,798.99-	153,297.76-	6	156,684.00-	7,608.05-	149,075.95-	5
** Revenue	9,281,238.21-	793,470.81-	8,487,767.40-	9	9,520,989.51-	741,489.61-	8,779,499.90-	8

Washoe County Health District
EXPENSE
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
701110 Base Salaries	9,184,929.10	1,406,955.16	7,777,973.94	15	9,442,227.37	1,477,474.74	7,964,752.63	16
701120 Part Time	565,939.67	67,666.19	498,273.48	12	529,904.89	88,317.04	441,587.85	17
701130 Pooled Positions	430,542.66	71,928.88	358,613.78	17	522,298.86	77,874.84	444,424.02	15
701140 Holiday Work	2,818.65	925.92	1,892.73	33	1,450.00	51.44	1,398.56	4
701150 xcContractual Wages								
701200 Incentive Longevity	165,403.00	524.59	164,878.41	0	158,292.00	494.22	157,797.78	0
701300 Overtime	66,703.00	8,904.62	57,798.38	13	50,325.11	8,438.08	41,887.03	17
701403 Shift Differential								
701406 Standby Pay		100.00-	100.00					
701408 Call Back	1,000.00		1,000.00		1,000.00	99.98	900.02	10
701412 Salary Adjustment	230,084.60-		230,084.60-		52,986.54		52,986.54	
701413 Vac Payoff/Sick Pay-Term		15,517.87	15,517.87-			25,885.01	25,885.01-	
701415 Physical Fitness Pay								
701417 Comp Time		3,012.29	3,012.29-			16,569.07	16,569.07-	
701419 Comp Time - Transfer		1,848.58	1,848.58-					
701500 Merit Awards								
* Salaries and Wages	10,187,251.48	1,577,184.10	8,610,067.38	15	10,758,484.77	1,695,204.42	9,063,280.35	16
705110 Group Insurance	1,418,327.59	225,927.51	1,192,400.08	16	1,449,189.10	226,687.55	1,222,501.55	16
705210 Retirement	2,513,907.30	369,895.06	2,144,012.24	15	2,410,125.05	370,413.74	2,039,711.31	15
705215 Retirement Calculation								
705230 Medicare April 1986	136,185.22	21,219.55	114,965.67	16	139,962.64	22,598.66	117,363.98	16
705320 Workmens Comp	66,138.03	11,023.02	55,115.01	17	64,187.41	10,655.44	53,531.97	17
705330 Unemply Comp	15,179.22	3,794.85	11,384.37	25	15,533.45	15,533.45		100
705360 Benefit Adjustment					10,656.00		10,656.00	
705510 Severance Pay								
* Employee Benefits	4,149,737.36	631,859.99	3,517,877.37	15	4,089,653.65	645,888.84	3,443,764.81	16
710100 Professional Services	849,074.83	7,085.00	841,989.83	1	1,091,804.38	77,407.04	1,014,397.34	7
710105 Medical Services	9,173.00	1,004.00	8,169.00	11	9,264.00	136.00	9,128.00	1
710108 MD Consultants	46,950.00	3,200.00	43,750.00	7	46,900.00	5,412.50	41,487.50	12
710110 Contracted/Temp Services	53,500.03	7,118.92	46,381.11	13	71,051.00	3,185.17	67,865.83	4
710119 Subrecipient Payments								
710200 Service Contract	103,593.00	19,013.59	84,579.41	18	105,243.00	26,079.86	79,163.14	25
710205 Repairs and Maintenance	11,470.00	266.80	11,203.20	2	20,549.91	2,106.03	18,443.88	10
710210 Software Maintenance	15,636.00	12,000.00	3,636.00	77	16,200.00	3,000.00	13,200.00	19
710300 Operating Supplies	123,961.00	11,369.81	112,591.19	9	132,737.55	7,441.03	125,296.52	6
710302 Small Tools & Allow	10,685.00	229.96	10,455.04	2	3,685.00		3,685.00	
710308 Animal Supplies	1,600.00	582.75	1,017.25	36	2,000.00	132.78	1,867.22	7
710312 Special Dept Expense								
710319 Chemical Supplies	232,300.00	168,635.13	63,664.87	73	231,950.00	231,816.20	133.80	100
710325 Signs and Markers								
710334 Copy Machine Expense	27,247.00	3,407.39	23,839.61	13	28,274.89	3,489.50	24,785.39	12
710350 Office Supplies	39,673.50	2,554.15	37,119.35	6	44,171.01	5,060.05	39,110.96	11
710355 Books and Subscriptions	7,594.00	1,339.93	6,254.07	18	8,413.00	582.07	7,830.93	7
710360 Postage	21,830.00	2,686.39	19,143.61	12	21,954.00	3,078.61	18,875.39	14
710361 Express and Courier	685.00	47.88	637.12	7	610.75	205.52	405.23	34
710391 Fuel & Lube	100.00		100.00		100.00		100.00	
710400 Payments to Other Agencies								
710412 Do Not Use								
710500 Other Expense	23,931.96	1,582.35	22,349.61	7	45,973.51	950.44	45,023.07	2
710502 Printing	30,270.00	2,188.56	28,081.44	7	31,499.00	1,246.87	30,252.13	4

Washoe County Health District
EXPENSE
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
710503 Licenses & Permits	7,887.00	445.00	7,442.00	6	8,870.00	2,022.39	6,847.61	23
710504 Registration								
710505 Rental Equipment	1,900.00		1,900.00		5,178.00	411.00	4,767.00	8
710506 Dept Insurance Deductible		33.86	33.86-			150.00	150.00-	
710507 Network and Data Lines	5,530.00	1,753.54	3,776.46	32	6,486.00	963.59	5,522.41	15
710508 Telephone Land Lines	42,359.00	6,202.62	36,156.38	15	46,535.00	5,930.65	40,604.35	13
710509 Seminars and Meetings	31,265.00	4,457.50	26,807.50	14	32,320.00	6,620.50	25,699.50	20
710512 Auto Expense	18,702.20	2,307.64	16,394.56	12	19,784.00	2,214.01	17,569.99	11
710514 Regulatory Assessments	11,920.00	2,980.00	8,940.00	25	11,920.00	2,980.00	8,940.00	25
710519 Cellular Phone	15,660.00	2,385.96	13,274.04	15	18,447.00	1,241.44	17,205.56	7
710524 Utility relocation		200.00	200.00-					
710529 Dues	10,756.01	1,530.00	9,226.01	14	11,926.00	4,157.00	7,769.00	35
710535 Credit Card Fees	11,925.00	2,510.37	9,414.63	21	11,455.00	1,983.62	9,471.38	17
710546 Advertising	41,770.00	1,264.00	40,506.00	3	44,728.86		44,728.86	
710550 Small Differences								
710551 Cash Discounts Lost								
710577 Uniforms & Special Clothing	25,500.00	200.41	25,299.59	1	3,000.00	279.97	2,720.03	9
710585 Undesignated Budget	62,228.75		62,228.75		71,077.00		71,077.00	
710600 LT Lease-Office Space	109,115.00	19,063.70	90,051.30	17	113,439.00	18,706.88	94,732.12	16
710620 LT Lease-Equipment								
710703 Biologicals	246,790.79	11,252.39	235,538.40	5	249,583.98	35,526.54	214,057.44	14
710714 Referral Services					9,040.00		9,040.00	
710721 Outpatient	93,092.55	292.08	92,800.47	0	110,399.15	7,849.94	102,549.21	7
710872 Food Purchases	10,175.50	7.00	10,168.50	0	11,675.00	639.21	11,035.79	5
711010 Utilities	180.00		180.00		2,700.00		2,700.00	
711100 ESD Asset Management	47,436.00	8,174.00	39,262.00	17	17,040.00	2,688.00	14,352.00	16
711113 Equip Srv Replace	27,084.14	4,601.20	22,482.94	17	25,938.64	4,338.76	21,599.88	17
711114 Equip Srv O & M	46,868.56	7,688.88	39,179.68	16	42,163.13	8,997.54	33,165.59	21
711115 Equip Srv Motor Pool	16,741.00		16,741.00		18,346.00		18,346.00	
711117 ESD Fuel Charge	55,492.05	9,731.94	45,760.11	18	51,253.35	12,038.89	39,214.46	23
711119 Prop & Liab Billings	74,502.09	12,417.06	62,085.03	17	80,283.41	13,380.56	66,902.85	17
711210 Travel	231,811.03	19,012.29	212,798.74	8	251,954.25	13,341.63	238,612.62	5
711300 Cash Over Short								
711399 ProCard in Process								
711400 Overhead - General Fund	2,898,034.00	483,005.66	2,415,028.34	17	2,553,372.00		2,553,372.00	
711504 Equipment nonCapital	112,098.36	8,306.20	103,792.16	7	155,955.08	49,809.50	106,145.58	32
* Services and Supplies	5,866,098.35	854,135.91	5,011,962.44	15	5,897,250.85	567,601.29	5,329,649.56	10
781004 Equipment Capital	231,954.82	29,508.24	202,446.58	13	397,107.01	17,412.00	379,695.01	4
781007 Vehicles Capital	100,000.00		100,000.00					
* Capital Outlay	331,954.82	29,508.24	302,446.58	9	397,107.01	17,412.00	379,695.01	4
** Expenses	20,535,042.01	3,092,688.24	17,442,353.77	15	21,142,496.28	2,926,106.55	18,216,389.73	14
485196 Insur Reimb-F/A Loss								
* Other Fin. Sources								
621001 Transfer From General	8,603,891.00-		8,603,891.00-		8,623,891.00-		8,623,891.00-	
* Transfers In	8,603,891.00-		8,603,891.00-		8,623,891.00-		8,623,891.00-	
811001 Transfer to General								
818000 Transfer to Intrafund								
* Transfers Out								
** Other Financing Src/Use	8,603,891.00-		8,603,891.00-		8,623,891.00-		8,623,891.00-	
*** Total	2,649,912.80	2,299,217.43	350,695.37	87	2,997,615.77	2,184,616.94	812,998.83	73

Washoe County Health District
Administrative Health Services
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
431100 Federal Grants	1,109,048.06-	82,933.66-	1,026,114.40-	7	1,109,658.25-	87,903.22-	1,021,755.03-	8
431105 Federal Grants - Indirect	1,921.50-		1,921.50-					
* Intergovernmental	1,110,969.56-	82,933.66-	1,028,035.90-	7	1,109,658.25-	87,903.22-	1,021,755.03-	8
460511 Birth and Death Certificates								
460512 Duplication Service Fees								
* Charges for Services								
484195 Non-Govt'l Grants	55,988.00-		55,988.00-		114,750.00-		114,750.00-	
484197 Non-Gov. Grants-Indirect								
485100 Reimbursements								
485300 Other Misc Govt Rev	67,353.75-		67,353.75-					
* Miscellaneous	123,341.75-		123,341.75-		114,750.00-		114,750.00-	
** Revenue	1,234,311.31-	82,933.66-	1,151,377.65-	7	1,224,408.25-	87,903.22-	1,136,505.03-	7
701110 Base Salaries	1,610,653.89	252,656.98	1,357,996.91	16	1,620,335.85	254,751.61	1,365,584.24	16
701120 Part Time								
701130 Pooled Positions	5,000.00	2,528.93	2,471.07	51	5,000.00	2,645.99	2,354.01	53
701140 Holiday Work								
701200 Incentive Longevity	33,265.00		33,265.00		30,755.00	57.70	30,697.30	0
701300 Overtime	1,200.00	989.81	210.19	82	1,200.00	378.21	821.79	32
701412 Salary Adjustment	3,642.80		3,642.80		10,554.54		10,554.54	
701413 Vac Payoff/Sick Pay-Term						3,173.40	3,173.40-	
701417 Comp Time		2,805.87	2,805.87-			18.92	18.92-	
701419 Comp Time - Transfer		1,848.58	1,848.58-					
701500 Merit Awards								
* Salaries and Wages	1,653,761.69	260,830.17	1,392,931.52	16	1,667,845.39	261,025.83	1,406,819.56	16
705110 Group Insurance	258,484.26	41,232.55	217,251.71	16	254,302.59	39,921.12	214,381.47	16
705210 Retirement	421,998.67	61,863.96	360,134.71	15	384,397.43	60,533.91	323,863.52	16
705215 Retirement Calculation								
705230 Medicare April 1986	22,856.87	3,499.81	19,357.06	15	22,639.74	3,613.85	19,025.89	16
705320 Workmens Comp	11,691.26	1,948.56	9,742.70	17	11,339.00	1,889.84	9,449.16	17
705330 Unemply Comp	2,683.24	670.81	2,012.43	25	2,755.00	2,755.00		100
705510 Severance Pay								
* Employee Benefits	717,714.30	109,215.69	608,498.61	15	675,433.76	108,713.72	566,720.04	16
710100 Professional Services	36,744.00	2,500.00	34,244.00	7	45,500.00	6,000.00	39,500.00	13
710105 Medical Services	150.00	67.00	83.00	45	350.00	26.00	324.00	7
710108 MD Consultants								
710200 Service Contract	500.00	0.49	499.51	0	1,500.00		1,500.00	
710205 Repairs and Maintenance	200.00		200.00		400.00	80.00	320.00	20
710300 Operating Supplies	9,397.00	3,426.28	5,970.72	36	9,100.00	373.63	8,726.37	4
710312 Special Dept Expense								
710334 Copy Machine Expense	3,500.00	1,191.78	2,308.22	34	4,500.00	1,194.45	3,305.55	27
710350 Office Supplies	10,963.50	616.15	10,347.35	6	9,993.00	795.52	9,197.48	8
710355 Books and Subscriptions	1,000.00	76.00	924.00	8	1,000.00	24.94	975.06	2
710360 Postage	1,680.00	97.30	1,582.70	6	1,625.00	165.93	1,459.07	10
710361 Express and Courier	100.00		100.00		100.00		100.00	
710500 Other Expense	1,600.00	67.20	1,532.80	4	1,600.00	140.00	1,460.00	9
710502 Printing	4,480.00		4,480.00		4,780.00	19.75	4,760.25	0
710503 Licenses & Permits	1,992.00	120.00	1,872.00	6	2,340.00	240.00	2,100.00	10
710507 Network and Data Lines	630.00	118.76	511.24	19	630.00		630.00	

Washoe County Health District
Administrative Health Services
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
710508 Telephone Land Lines	9,580.00	1,441.22	8,138.78	15	10,080.00	1,167.64	8,912.36	12
710509 Seminars and Meetings	2,800.00	712.50	2,087.50	25	5,300.00	1,476.50	3,823.50	28
710512 Auto Expense	2,336.00	245.97	2,090.03	11	3,336.00	325.05	3,010.95	10
710519 Cellular Phone	1,520.00	85.74	1,434.26	6	1,470.00	157.66	1,312.34	11
710529 Dues	4,030.02		4,030.02		2,850.00	2,485.00	365.00	87
710546 Advertising	150.00		150.00		150.00		150.00	
710585 Undesignated Budget								
710600 LT Lease-Office Space	67,464.00	12,323.70	55,140.30	18	71,788.00	11,966.88	59,821.12	17
710872 Food Purchases	2,725.50		2,725.50		2,725.00		2,725.00	
711010 Utilities					1,000.00		1,000.00	
711100 ESD Asset Management						48.00	48.00-	
711114 Equip Srv O & M						133.15	133.15-	
711115 Equip Srv Motor Pool								
711117 ESD Fuel Charge						186.08	186.08-	
711119 Prop & Liab Billings	13,169.78	2,194.96	10,974.82	17	14,239.00	2,373.18	11,865.82	17
711210 Travel	36,428.55	3,905.72	32,522.83	11	41,165.00	1,088.64	40,076.36	3
711504 Equipment nonCapital	3,456.01		3,456.01		4,275.00	189.05	4,085.95	4
* Services and Supplies	216,596.36	29,190.77	187,405.59	13	241,796.00	30,657.05	211,138.95	13
** Expenses	2,588,072.35	399,236.63	2,188,835.72	15	2,585,075.15	400,396.60	2,184,678.55	15
818000 Transfer to Intrafund								
** Other Financing Src/Use								
*** Total	1,353,761.04	316,302.97	1,037,458.07	23	1,360,666.90	312,493.38	1,048,173.52	23

Washoe County Health District
Air Quality Management
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
422510 Air Pollution Permits	584,012.00-	98,271.00-	485,741.00-	17	448,037.00-	73,151.25-	374,885.75-	16
* Licenses and Permits	584,012.00-	98,271.00-	485,741.00-	17	448,037.00-	73,151.25-	374,885.75-	16
431100 Federal Grants	708,173.00-		708,173.00-		912,531.00-		912,531.00-	
431105 Federal Grants - Indirect	29,372.00-		29,372.00-		30,224.00-		30,224.00-	
432100 State Grants					182,000.00-		182,000.00-	
432311 Pol Ctrl 455B.830	300,000.00-	78,739.00-	221,261.00-	26	300,000.00-	79,864.00-	220,136.00-	27
* Intergovernmental	1,037,545.00-	78,739.00-	958,806.00-	8	1,424,755.00-	79,864.00-	1,344,891.00-	6
460513 Other Healt Service Charges								
460526 Plan Review-Air Quality	65,272.00-	4,433.00-	60,839.00-	7	40,000.00-	6,254.00-	33,746.00-	16
460527 NOE-AQM	113,934.00-	14,440.00-	99,494.00-	13	100,000.00-	17,095.00-	82,905.00-	17
460528 NESHAP-AQM	135,389.00-	19,816.00-	115,573.00-	15	84,000.00-	14,808.00-	69,192.00-	18
460529 Assessments-AQM	57,888.00-	9,424.00-	48,464.00-	16	41,000.00-	8,557.00-	32,443.00-	21
460530 Inspector Registr-AQ	14,655.00-	2,113.00-	12,542.00-	14	2,600.00-	2,838.00-	238.00	109
460531 Dust Plan-Air Quality	187,690.00-	19,663.00-	168,027.00-	10	95,000.00-	14,376.00-	80,624.00-	15
* Charges for Services	574,828.00-	69,889.00-	504,939.00-	12	362,600.00-	63,928.00-	298,672.00-	18
485300 Other Misc Govt Rev								
* Miscellaneous								
** Revenue	2,196,385.00-	246,899.00-	1,949,486.00-	11	2,235,392.00-	216,943.25-	2,018,448.75-	10
701110 Base Salaries	1,275,216.35	193,044.81	1,082,171.54	15	1,345,462.49	207,782.99	1,137,679.50	15
701130 Pooled Positions	17,646.29	1,040.75	16,605.54	6	93,151.68	2,780.95	90,370.73	3
701140 Holiday Work	418.65		418.65		250.00	51.44	198.56	21
701150 xcContractual Wages								
701200 Incentive Longevity	20,530.00	198.45	20,331.55	1	19,210.00		19,210.00	
701300 Overtime	3,400.00	355.99	3,044.01	10	10,045.11	1,622.37	8,422.74	16
701408 Call Back								
701412 Salary Adjustment								
701413 Vac Payoff/Sick Pay-Term		14,058.02	14,058.02-					
701417 Comp Time		89.29	89.29-					
701500 Merit Awards								
* Salaries and Wages	1,317,211.29	208,787.31	1,108,423.98	16	1,468,119.28	212,237.75	1,255,881.53	14
705110 Group Insurance	176,696.79	28,669.11	148,027.68	16	172,127.11	23,870.70	148,256.41	14
705210 Retirement	332,632.51	48,358.19	284,274.32	15	324,109.95	49,302.35	274,807.60	15
705230 Medicare April 1986	18,136.32	2,891.05	15,245.27	16	19,385.69	2,989.96	16,395.73	15
705320 Workmens Comp	8,275.26	1,379.22	6,896.04	17	7,585.40	1,264.24	6,321.16	17
705330 Unemply Comp	1,899.24	474.82	1,424.42	25	1,843.00	1,843.00		100
* Employee Benefits	537,640.12	81,772.39	455,867.73	15	525,051.15	79,270.25	445,780.90	15
710100 Professional Services	396,190.26	1,075.00	395,115.26	0	385,103.78	906.00	384,197.78	0
710105 Medical Services	1,525.00		1,525.00		1,416.00		1,416.00	
710200 Service Contract	1,600.00		1,600.00		500.00		500.00	
710205 Repairs and Maintenance	1,000.00		1,000.00		10,741.91	2,026.03	8,715.88	19
710210 Software Maintenance	3,386.00		3,386.00		4,200.00		4,200.00	
710300 Operating Supplies	1,000.00	42.30	957.70	4	11,079.55	1,532.18	9,547.37	14
710334 Copy Machine Expense	4,400.00	480.89	3,919.11	11	4,400.00	480.88	3,919.12	11
710350 Office Supplies	3,500.00	69.43	3,430.57	2	4,000.00	860.43	3,139.57	22
710355 Books and Subscriptions	100.00	288.03	188.03-	288	224.00	289.23	65.23-	129
710360 Postage	3,000.00	620.30	2,379.70	21	2,900.00	571.66	2,328.34	20
710361 Express and Courier	75.00		75.00		80.75	191.50	110.75-	237
710500 Other Expense	100.00	1,175.00	1,075.00-	1,175	100.00		100.00	
710502 Printing	800.00	101.63	698.37	13	800.00	359.07	440.93	45

Washoe County Health District
Air Quality Management
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
710503 Licenses & Permits					135.00	232.39	97.39-	172
710505 Rental Equipment	1,800.00		1,800.00		1,800.00		1,800.00	
710506 Dept Insurance Deductible		33.86	33.86-					
710507 Network and Data Lines		960.00	960.00-			835.00	835.00-	
710508 Telephone Land Lines	5,500.00	643.80	4,856.20	12	6,500.00	695.03	5,804.97	11
710509 Seminars and Meetings					3,005.00	770.00	2,235.00	26
710512 Auto Expense	500.00	67.24	432.76	13	1,000.00	3.89	996.11	0
710519 Cellular Phone	4,700.00	613.02	4,086.98	13	4,700.00	328.89	4,371.11	7
710529 Dues	3,250.00	300.00	2,950.00	9	4,435.00	740.00	3,695.00	17
710535 Credit Card Fees	2,300.00	636.01	1,663.99	28	1,600.00	373.20	1,226.80	23
710546 Advertising	1,650.00	904.00	746.00	55	1,000.00		1,000.00	
710550 Small Differences								
710577 Uniforms & Special Clothing	100.00	200.41	100.41-	200	1,100.00	279.97	820.03	25
710585 Undesignated Budget	25,879.62		25,879.62					
710600 LT Lease-Office Space								
710721 Outpatient								
711100 ESD Asset Management	6,432.00	1,340.00	5,092.00	21	2,592.00	432.00	2,160.00	17
711113 Equip Srv Replace	9,523.78	1,587.56	7,936.22	17	8,499.58	1,586.78	6,912.80	19
711114 Equip Srv O & M	11,981.33	1,764.05	10,217.28	15	10,384.74	1,941.25	8,443.49	19
711115 Equip Srv Motor Pool								
711117 ESD Fuel Charge	12,156.58	1,752.14	10,404.44	14	10,687.05	2,149.39	8,537.66	20
711119 Prop & Liab Billings	9,321.78	1,553.64	7,768.14	17	9,525.40	1,587.56	7,937.84	17
711210 Travel	34,419.48	1,438.65	32,980.83	4	36,088.25	7,372.83	28,715.42	20
711300 Cash Over Short								
711399 ProCard in Process								
711504 Equipment nonCapital	11,800.35		11,800.35		37,117.08	3,549.56	33,567.52	10
* Services and Supplies	557,991.18	17,646.96	540,344.22	3	565,715.09	30,094.72	535,620.37	5
781004 Equipment Capital	151,576.82	23,745.74	127,831.08	16	342,770.01	17,412.00	325,358.01	5
* Capital Outlay	151,576.82	23,745.74	127,831.08	16	342,770.01	17,412.00	325,358.01	5
** Expenses	2,564,419.41	331,952.40	2,232,467.01	13	2,901,655.53	339,014.72	2,562,640.81	12
818000 Transfer to Intrafund								
** Other Financing Src/Use								
*** Total	368,034.41	85,053.40	282,981.01	23	666,263.53	122,071.47	544,192.06	18

Washoe County Health District
Community and Clinical Health Services
Pds 1-2, FY14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
431100 Federal Grants	1,875,162.86-	73,531.59-	1,801,631.27-	4	2,131,855.53-		2,131,855.53-	
431105 Federal Grants - Indirect	92,460.00-	4,918.57-	87,541.43-	5	15,300.00-		15,300.00-	
432100 State Grants	22,652.00-		22,652.00-		24,857.00-		24,857.00-	
* Intergovernmental	1,990,274.86-	78,450.16-	1,911,824.70-	4	2,172,012.53-		2,172,012.53-	
460162 Services to Other Agencies								
460500 Other Immunizations	89,000.00-	11,054.07-	77,945.93-	12	89,000.00-	15,804.00-	73,196.00-	18
460501 Medicaid Clinical Services	8,200.00-	334.25-	7,865.75-	4	36,200.00-	44.46	36,244.46-	0-
460503 Childhood Immunizations	20,000.00-	3,388.50-	16,611.50-	17	30,000.00-	4,610.00-	25,390.00-	15
460508 Tuberculosis	4,100.00-	678.32-	3,421.68-	17	4,100.00-	994.57-	3,105.43-	24
460515 Medicare Reimbursement								
460516 Pgm Inc-3rd Prty Rec	1,750.00-	183.30-	1,566.70-	10	2,250.00-		2,250.00-	
460517 Influenza Immunization	7,000.00-	36.50-	6,963.50-	1	7,000.00-	49.00-	6,951.00-	1
460518 STD Fees	21,000.00-	3,434.18-	17,565.82-	16	23,000.00-	3,453.60-	19,546.40-	15
460519 Outpatient Services								
460524 Family Planning	27,000.00-	6,040.87-	20,959.13-	22	44,000.00-	5,314.78-	38,685.22-	12
460570 Education Revenue	2,400.00-	324.00-	2,076.00-	14	4,500.00-	63.00-	4,437.00-	1
* Charges for Services	180,450.00-	25,473.99-	154,976.01-	14	240,050.00-	30,244.49-	209,805.51-	13
484050 Donations Federal Pgm Income	37,550.00-	7,298.99-	30,251.01-	19	41,934.00-	7,580.16-	34,353.84-	18
484195 Non-Govt'l Grants								
485110 Workers Comp Reimb								
485300 Other Misc Govt Rev	2,205.00-		2,205.00-			27.89-	27.89	
* Miscellaneous	39,755.00-	7,298.99-	32,456.01-	18	41,934.00-	7,608.05-	34,325.95-	18
** Revenue	2,210,479.86-	111,223.14-	2,099,256.72-	5	2,453,996.53-	37,852.54-	2,416,143.99-	2
701110 Base Salaries	2,046,242.25	319,117.29	1,727,124.96	16	2,237,201.94	354,020.94	1,883,181.00	16
701120 Part Time	541,787.10	64,212.79	477,574.31	12	505,752.32	83,604.92	422,147.40	17
701130 Pooled Positions	204,802.33	41,247.48	163,554.85	20	175,944.41	37,670.77	138,273.64	21
701140 Holiday Work								
701150 xcContractual Wages								
701200 Incentive Longevity	47,486.00		47,486.00		48,012.00	148.06	47,863.94	0
701300 Overtime	1,280.00	44.02	1,235.98	3	1,280.00	260.50	1,019.50	20
701403 Shift Differential								
701406 Standby Pay		100.00-	100.00					
701412 Salary Adjustment	34,459.06-		34,459.06-		75.00-		75.00-	
701413 Vac Payoff/Sick Pay-Term						6,513.33	6,513.33-	
701415 Physical Fitness Pay								
701417 Comp Time						7,024.55	7,024.55-	
701419 Comp Time - Transfer								
701500 Merit Awards								
* Salaries and Wages	2,807,138.62	424,521.58	2,382,617.04	15	2,968,115.67	489,243.07	2,478,872.60	16
705110 Group Insurance	414,555.78	63,259.32	351,296.46	15	433,968.28	69,803.65	364,164.63	16
705210 Retirement	651,180.47	96,999.76	554,180.71	15	658,011.56	103,779.42	554,232.14	16
705230 Medicare April 1986	34,770.23	5,498.16	29,272.07	16	36,909.75	6,412.71	30,497.04	17
705320 Workmens Comp	18,911.83	3,151.96	15,759.87	17	18,435.65	3,072.60	15,363.05	17
705330 Unemply Comp	4,340.42	1,085.13	3,255.29	25	4,479.25	4,479.25		100
* Employee Benefits	1,123,758.73	169,994.33	953,764.40	15	1,151,804.49	187,547.63	964,256.86	16
710100 Professional Services	66,232.00	1,342.00	64,890.00	2	75,150.71	3,417.60	71,733.11	5
710105 Medical Services	850.00	42.00	808.00	5	850.00		850.00	
710108 MD Consultants	46,950.00	3,200.00	43,750.00	7	46,900.00	5,412.50	41,487.50	12
710110 Contracted/Temp Services	1,000.00	2,063.50	1,063.50-	206	1,000.00		1,000.00	
710119 Subrecipient Payments								
710200 Service Contract	3,798.00	2,371.84	1,426.16	62	6,048.00	2,356.01	3,691.99	39

Washoe County Health District
Community and Clinical Health Services
Pds 1-2, FY14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
710205 Repairs and Maintenance	3,770.00	266.80	3,503.20	7	3,800.00		3,800.00	
710210 Software Maintenance								
710300 Operating Supplies	72,402.00	1,199.06	71,202.94	2	76,719.00	3,001.81	73,717.19	4
710334 Copy Machine Expense	14,497.00	1,566.59	12,930.41	11	13,847.00	1,519.43	12,327.57	11
710350 Office Supplies	12,360.00	745.84	11,614.16	6	13,520.01	1,489.84	12,030.17	11
710355 Books and Subscriptions	2,250.00	55.00	2,195.00	2	2,060.00		2,060.00	
710360 Postage	3,600.00	399.29	3,200.71	11	4,490.00	508.95	3,981.05	11
710361 Express and Courier	285.00	47.88	237.12	17	245.00	14.02	230.98	6
710412 Do Not Use								
710500 Other Expense	14,595.96	241.15	14,354.81	2	30,602.51	652.64	29,949.87	2
710502 Printing	10,000.00	1,347.36	8,652.64	13	9,675.00	575.03	9,099.97	6
710503 Licenses & Permits	3,055.00	325.00	2,730.00	11	3,555.00	1,550.00	2,005.00	44
710504 Registration								
710505 Rental Equipment								
710506 Dept Insurance Deductible						150.00	150.00-	
710507 Network and Data Lines	2,080.00	273.72	1,806.28	13	2,560.00	83.02	2,476.98	3
710508 Telephone Land Lines	13,229.00	1,986.49	11,242.51	15	13,975.00	1,921.67	12,053.33	14
710509 Seminars and Meetings	5,650.00	1,306.00	4,344.00	23	4,750.00	1,585.00	3,165.00	33
710512 Auto Expense	13,566.20	1,848.39	11,717.81	14	13,318.00	1,437.58	11,880.42	11
710519 Cellular Phone	360.00	245.50	114.50	68	540.00	18.28	521.72	3
710524 Utility relocation		200.00	200.00-					
710529 Dues	800.00	1,050.00	250.00-	131	1,350.00	550.00	800.00	41
710535 Credit Card Fees	3,215.00	384.59	2,830.41	12	3,245.00	383.87	2,861.13	12
710546 Advertising	26,845.00	360.00	26,485.00	1	34,903.86		34,903.86	
710551 Cash Discounts Lost								
710577 Uniforms & Special Clothing	200.00		200.00		200.00		200.00	
710585 Undesignated Budget					15,300.00		15,300.00	
710703 Biologicals	243,370.00	11,057.19	232,312.81	5	246,163.19	35,526.54	210,636.65	14
710714 Referral Services					9,040.00		9,040.00	
710721 Outpatient	90,957.55	280.00	90,677.55	0	108,264.15	7,269.46	100,994.69	7
710872 Food Purchases	6,450.00	7.00	6,443.00	0	6,550.00	639.21	5,910.79	10
711010 Utilities					1,700.00		1,700.00	
711100 ESD Asset Management	1,608.00	134.00	1,474.00	8	288.00		288.00	
711114 Equip Srv O & M	546.37	115.69	430.68	21	550.44		550.44	
711115 Equip Srv Motor Pool								
711117 ESD Fuel Charge	711.35	194.37	516.98	27	711.35		711.35	
711119 Prop & Liab Billings	21,303.49	3,550.60	17,752.89	17	23,150.65	3,858.42	19,292.23	17
711210 Travel	33,713.00	5,930.02	27,782.98	18	28,184.00	758.01	27,425.99	3
711399 ProCard in Process								
711504 Equipment nonCapital	5,850.00	5,762.50	87.50	99	6,530.00	189.00	6,341.00	3
* Services and Supplies	726,099.92	49,899.37	676,200.55	7	809,735.87	74,867.89	734,867.98	9
781004 Equipment Capital	30,378.00	5,762.50	24,615.50	19	17,000.00		17,000.00	
* Capital Outlay	30,378.00	5,762.50	24,615.50	19	17,000.00		17,000.00	
** Expenses	4,687,375.27	650,177.78	4,037,197.49	14	4,946,656.03	751,658.59	4,194,997.44	15
811001 Transfer to General								
818000 Transfer to Intrafund								
** Other Financing Src/Use								
*** Total	2,476,895.41	538,954.64	1,937,940.77	22	2,492,659.50	713,806.05	1,778,853.45	29

Washoe County Health District
Environmental Health Services
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
422503 Environmental Permits	63,177.00-	9,798.00-	53,379.00-	16	51,500.00-	8,418.00-	43,082.00-	16
422504 Pool Permits	74,690.00-	3,624.00-	71,066.00-	5	68,000.00-	3,576.00-	64,424.00-	5
422505 RV Permits	13,306.00-	1,938.00-	11,368.00-	15	10,500.00-	1,442.00-	9,058.00-	14
422507 Food Service Permits	492,181.00-	76,168.00-	416,013.00-	15	369,000.00-	61,595.00-	307,405.00-	17
422508 Wat Well Const Perm	23,567.00-	8,302.00-	15,265.00-	35	20,000.00-	7,596.00-	12,404.00-	38
422509 Water Company Permits	3,200.00-	594.00-	2,606.00-	19	2,500.00-	261.00-	2,239.00-	10
422511 ISDS Permits	66,522.00-	18,893.00-	47,629.00-	28	49,000.00-	7,810.00-	41,190.00-	16
422513 Special Event Permits	99,623.00-	32,360.00-	67,263.00-	32	79,000.00-	22,526.00-	56,474.00-	29
422514 Initial Applic Fee	35,226.00-	5,096.00-	30,130.00-	14	27,000.00-	4,678.00-	22,322.00-	17
* Licenses and Permits	871,492.00-	156,773.00-	714,719.00-	18	676,500.00-	117,902.00-	558,598.00-	17
431100 Federal Grants	362,198.04-		362,198.04-		340,000.00-		340,000.00-	
431105 Federal Grants - Indirect	27,470.00-		27,470.00-					
432100 State Grants	50,000.00-		50,000.00-		75,000.00-		75,000.00-	
432310 Tire Fee NRS 444A.090	468,548.00-	63,664.65-	404,883.35-	14	418,766.00-	66,093.55-	352,672.45-	16
* Intergovernmental	908,216.04-	63,664.65-	844,551.39-	7	833,766.00-	66,093.55-	767,672.45-	8
460509 Water Quality								
460510 IT Overlay	35,344.00-	7,555.00-	27,789.00-	21	113,400.00-	20,990.00-	92,410.00-	19
460512 Duplication Service Fees		8.96-	8.96			3.00-	3.00	
460513 Other Healt Service Charges					2,700.00-	1,374.00-	1,326.00-	51
460514 Food Service Certification	19,984.00-	3,101.00-	16,883.00-	16	13,900.00-	2,551.00-	11,349.00-	18
460520 Eng Serv Health	50,707.00-	7,507.00-	43,200.00-	15	44,000.00-	2,579.00-	41,421.00-	6
460521 Plan Review - Pools & Spas	3,816.00-	1,052.00-	2,764.00-	28	2,500.00-	530.00-	1,970.00-	21
460523 Plan Review - Food Services	18,765.00-	4,673.00-	14,092.00-	25	17,000.00-	3,519.00-	13,481.00-	21
460525 Plan Review - Vector	36,021.00-	9,560.00-	26,461.00-	27	30,000.00-	5,192.00-	24,808.00-	17
460532 Plan Rvw Hotel/Motel						322.00-	322.00	
460533 Quick Start								
460534 Child Care Inspection	10,560.00-	1,968.00-	8,592.00-	19	8,500.00-	1,914.00-	6,586.00-	23
460535 Pub Accomod Inspectn	22,540.00-	3,507.00-	19,033.00-	16	17,300.00-	2,949.00-	14,351.00-	17
460570 Education Revenue	500.00-	156.00-	344.00-	31	1,200.00-	86.00-	1,114.00-	7
* Charges for Services	198,237.00-	39,087.96-	159,149.04-	20	250,500.00-	42,009.00-	208,491.00-	17
485100 Reimbursements								
485121 Jury Reimbursements								
485300 Other Misc Govt Rev		2,500.00-	2,500.00					
* Miscellaneous		2,500.00-	2,500.00					
** Revenue	1,977,945.04-	262,025.61-	1,715,919.43-	13	1,760,766.00-	226,004.55-	1,534,761.45-	13
701110 Base Salaries	2,975,071.19	444,446.34	2,530,624.85	15	3,018,372.82	473,960.55	2,544,412.27	16
701130 Pooled Positions	200,194.04	25,946.56	174,247.48	13	236,872.77	28,594.17	208,278.60	12
701140 Holiday Work	2,400.00	925.92	1,474.08	39	1,200.00		1,200.00	
701150 xcContractual Wages								
701200 Incentive Longevity	50,500.00		50,500.00		50,800.00	288.46	50,511.54	1
701300 Overtime	59,123.00	6,421.54	52,701.46	11	36,600.00	6,061.09	30,538.91	17
701406 Standby Pay								
701408 Call Back	1,000.00		1,000.00		1,000.00	99.98	900.02	10
701412 Salary Adjustment	199,268.34-		199,268.34-					
701413 Vac Payoff/Sick Pay-Term						16,198.28	16,198.28-	
701415 Physical Fitness Pay								
701417 Comp Time						9,525.60	9,525.60-	
701500 Merit Awards								
* Salaries and Wages	3,089,019.89	477,740.36	2,611,279.53	15	3,344,845.59	534,728.13	2,810,117.46	16

Washoe County Health District
Environmental Health Services
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
705110 Group Insurance	411,488.13	67,123.72	344,364.41	16	434,110.13	67,923.20	366,186.93	16
705210 Retirement	776,699.80	112,607.86	664,091.94	14	728,879.94	112,412.53	616,467.41	15
705230 Medicare April 1986	41,720.32	6,435.23	35,285.09	15	41,940.99	6,894.55	35,046.44	16
705320 Workmens Comp	19,168.03	3,194.68	15,973.35	17	18,838.38	3,139.74	15,698.64	17
705330 Unemply Comp	4,399.22	1,099.81	3,299.41	25	4,577.10	4,577.10		100
* Employee Benefits	1,253,475.50	190,461.30	1,063,014.20	15	1,228,346.54	194,947.12	1,033,399.42	16
710100 Professional Services	217,318.30	1,475.00	215,843.30	1	325,401.67	1,880.00	323,521.67	1
710105 Medical Services	6,548.00	895.00	5,653.00	14	6,548.00	110.00	6,438.00	2
710110 Contracted/Temp Services	35,000.03	3,116.19	31,883.84	9	65,000.00	1,569.81	63,430.19	2
710200 Service Contract	95,300.00	13,702.51	81,597.49	14	95,300.00	21,158.93	74,141.07	22
710205 Repairs and Maintenance	5,500.00		5,500.00		4,600.00		4,600.00	
710210 Software Maintenance	250.00		250.00					
710300 Operating Supplies	25,650.00	7,985.60	17,664.40	31	20,100.00	2,533.41	17,566.59	13
710302 Small Tools & Allow	10,685.00	229.96	10,455.04	2	3,685.00		3,685.00	
710308 Animal Supplies	1,600.00	582.75	1,017.25	36	2,000.00	132.78	1,867.22	7
710319 Chemical Supplies	232,300.00	168,635.13	63,664.87	73	231,950.00	231,816.20	133.80	100
710325 Signs and Markers								
710334 Copy Machine Expense	1,900.00	30.87	1,869.13	2	2,250.00	33.03	2,216.97	1
710350 Office Supplies	6,250.00	291.76	5,958.24	5	9,100.00	148.23	8,951.77	2
710355 Books and Subscriptions	2,100.00	225.00	1,875.00	11	2,400.00	119.00	2,281.00	5
710360 Postage	10,600.00	1,312.93	9,287.07	12	9,775.00	1,348.84	8,426.16	14
710361 Express and Courier	175.00		175.00		175.00		175.00	
710391 Fuel & Lube	100.00		100.00		100.00		100.00	
710500 Other Expense	200.00	49.00	151.00	25	8,300.00	157.80	8,142.20	2
710502 Printing	12,600.00	332.77	12,267.23	3	11,525.00	175.20	11,349.80	2
710503 Licenses & Permits	2,690.00		2,690.00		2,690.00		2,690.00	
710505 Rental Equipment								
710506 Dept Insurance Deductible								
710507 Network and Data Lines	2,220.00	232.44	1,987.56	10	2,500.00		2,500.00	
710508 Telephone Land Lines	8,960.00	1,401.71	7,558.29	16	9,710.00	1,423.72	8,286.28	15
710509 Seminars and Meetings	16,515.00	1,914.00	14,601.00	12	13,415.00	2,564.00	10,851.00	19
710512 Auto Expense	50.00		50.00		100.00		100.00	
710514 Regulatory Assessments	11,920.00	2,980.00	8,940.00	25	11,920.00	2,980.00	8,940.00	25
710519 Cellular Phone	6,600.00	844.97	5,755.03	13	6,600.00	496.40	6,103.60	8
710529 Dues	1,565.99	180.00	1,385.99	11	1,661.00	382.00	1,279.00	23
710535 Credit Card Fees	4,410.00	1,101.61	3,308.39	25	4,610.00	879.57	3,730.43	19
710546 Advertising	10,500.00		10,500.00		6,050.00		6,050.00	
710577 Uniforms & Special Clothing	25,200.00		25,200.00		1,700.00		1,700.00	
710585 Undesignated Budget	36,349.13		36,349.13					
710600 LT Lease-Office Space	41,651.00	6,740.00	34,911.00	16	41,651.00	6,740.00	34,911.00	16
710721 Outpatient								
711100 ESD Asset Management	32,964.00	5,092.00	27,872.00	15	11,856.00	1,824.00	10,032.00	15
711113 Equip Srv Replace	17,182.42	2,950.64	14,231.78	17	17,061.11	2,688.98	14,372.13	16
711114 Equip Srv O & M	32,731.24	5,647.84	27,083.40	17	30,573.49	6,204.58	24,368.91	20
711115 Equip Srv Motor Pool	16,741.00		16,741.00		16,741.00		16,741.00	
711117 ESD Fuel Charge	42,624.12	7,785.43	34,838.69	18	39,776.37	9,703.42	30,072.95	24
711119 Prop & Liab Billings	21,592.09	3,598.68	17,993.41	17	23,656.38	3,942.74	19,713.64	17
711210 Travel	76,000.00	7,264.67	68,735.33	10	81,150.00	3,075.44	78,074.56	4
711399 ProCard in Process								

Washoe County Health District
Environmental Health Services
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
711504 Equipment nonCapital	89,242.00	1,395.04	87,846.96	2	62,544.00		62,544.00	
* Services and Supplies	1,161,784.32	247,993.50	913,790.82	21	1,184,175.02	304,088.08	880,086.94	26
781004 Equipment Capital	50,000.00		50,000.00		25,000.00		25,000.00	
781007 Vehicles Capital	100,000.00		100,000.00					
* Capital Outlay	150,000.00		150,000.00		25,000.00		25,000.00	
** Expenses	5,654,279.71	916,195.16	4,738,084.55	16	5,782,367.15	1,033,763.33	4,748,603.82	18
485196 Insur Reimb-F/A Loss								
* Other Fin. Sources								
621001 Transfer From General								
* Transfers In								
818000 Transfer to Intrafund								
* Transfers Out								
** Other Financing Src/Use								
*** Total	3,676,334.67	654,169.55	3,022,165.12	18	4,021,601.15	807,758.78	3,213,842.37	20

Washoe County Health District
Epidemiology Public Health Preparedness
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
431100 Federal Grants	1,120,162.09-	9,934.50-	1,110,227.59-	1	1,366,574.73-	84,559.53-	1,282,015.20-	6
431105 Federal Grants - Indirect	91,954.91-	595.90-	91,359.01-	1	79,852.00-	2,033.52-	77,818.48-	3
* Intergovernmental	1,212,117.00-	10,530.40-	1,201,586.60-	1	1,446,426.73-	86,593.05-	1,359,833.68-	6
460511 Birth and Death Certificates	450,000.00-	79,859.00-	370,141.00-	18	400,000.00-	86,193.00-	313,807.00-	22
* Charges for Services	450,000.00-	79,859.00-	370,141.00-	18	400,000.00-	86,193.00-	313,807.00-	22
** Revenue	1,662,117.00-	90,389.40-	1,571,727.60-	5	1,846,426.73-	172,786.05-	1,673,640.68-	9
701110 Base Salaries	1,277,745.42	197,689.74	1,080,055.68	15	1,220,854.27	186,958.65	1,033,895.62	15
701120 Part Time	24,152.57	3,453.40	20,699.17	14	24,152.57	4,712.12	19,440.45	20
701130 Pooled Positions	2,900.00	1,165.16	1,734.84	40	11,330.00	6,182.96	5,147.04	55
701140 Holiday Work								
701150 xcContractual Wages								
701200 Incentive Longevity	13,622.00	326.14	13,295.86	2	9,515.00		9,515.00	
701300 Overtime	1,700.00	1,093.26	606.74	64	1,200.00	115.91	1,084.09	10
701412 Salary Adjustment					42,507.00		42,507.00	
701413 Vac Payoff/Sick Pay-Term		1,459.85	1,459.85-					
701417 Comp Time		117.13	117.13-					
701500 Merit Awards								
* Salaries and Wages	1,320,119.99	205,304.68	1,114,815.31	16	1,309,558.84	197,969.64	1,111,589.20	15
705110 Group Insurance	157,102.63	25,642.81	131,459.82	16	154,680.99	25,168.88	129,512.11	16
705210 Retirement	331,395.85	50,065.29	281,330.56	15	314,726.17	44,385.53	270,340.64	14
705230 Medicare April 1986	18,701.48	2,895.30	15,806.18	15	19,086.47	2,687.59	16,398.88	14
705320 Workmens Comp	8,091.65	1,348.60	6,743.05	17	7,988.98	1,289.02	6,699.96	16
705330 Unemply Comp	1,857.10	464.28	1,392.82	25	1,879.10	1,879.10		100
705360 Benefit Adjustment					10,656.00		10,656.00	
* Employee Benefits	517,148.71	80,416.28	436,732.43	16	509,017.71	75,410.12	433,607.59	15
710100 Professional Services	132,590.27	693.00	131,897.27	1	260,648.22	65,203.44	195,444.78	25
710105 Medical Services	100.00		100.00		100.00		100.00	
710108 MD Consultants								
710110 Contracted/Temp Services	17,500.00	1,939.23	15,560.77	11	5,051.00	1,615.36	3,435.64	32
710200 Service Contract	2,395.00	2,938.75	543.75-	123	1,895.00	2,564.92	669.92-	135
710205 Repairs and Maintenance	1,000.00		1,000.00		1,008.00		1,008.00	
710210 Software Maintenance	12,000.00	12,000.00		100	12,000.00	3,000.00	9,000.00	25
710300 Operating Supplies	15,512.00	1,283.43-	16,795.43	8-	15,739.00		15,739.00	
710334 Copy Machine Expense	2,950.00	137.26	2,812.74	5	3,277.89	261.71	3,016.18	8
710350 Office Supplies	6,600.00	830.97	5,769.03	13	7,558.00	1,766.03	5,791.97	23
710355 Books and Subscriptions	2,144.00	695.90	1,448.10	32	2,729.00	148.90	2,580.10	5
710360 Postage	2,950.00	256.57	2,693.43	9	3,164.00	483.23	2,680.77	15
710361 Express and Courier	50.00		50.00		10.00		10.00	
710500 Other Expense	7,436.00	50.00	7,386.00	1	5,371.00		5,371.00	
710502 Printing	2,390.00	406.80	1,983.20	17	4,719.00	117.82	4,601.18	2
710503 Licenses & Permits	150.00		150.00		150.00		150.00	
710505 Rental Equipment	100.00		100.00		3,378.00	411.00	2,967.00	12
710506 Dept Insurance Deductible								
710507 Network and Data Lines	600.00	168.62	431.38	28	796.00	45.57	750.43	6
710508 Telephone Land Lines	5,090.00	729.40	4,360.60	14	6,270.00	722.59	5,547.41	12
710509 Seminars and Meetings	6,300.00	525.00	5,775.00	8	5,850.00	225.00	5,625.00	4
710512 Auto Expense	2,250.00	146.04	2,103.96	6	2,030.00	447.49	1,582.51	22
710519 Cellular Phone	2,480.00	596.73	1,883.27	24	5,137.00	240.21	4,896.79	5
710529 Dues	1,110.00		1,110.00		1,630.00		1,630.00	

Washoe County Health District
Epidemiology Public Health Preparedness
Pds 1-2, FY 14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
710535 Credit Card Fees	2,000.00	388.16	1,611.84	19	2,000.00	346.98	1,653.02	17
710546 Advertising	2,625.00		2,625.00		2,625.00		2,625.00	
710585 Undesignated Budget					55,777.00		55,777.00	
710620 LT Lease-Equipment								
710703 Biologicals	3,420.79	195.20	3,225.59	6	3,420.79		3,420.79	
710721 Outpatient	2,135.00	12.08	2,122.92	1	2,135.00	580.48	1,554.52	27
710872 Food Purchases	1,000.00		1,000.00		2,400.00		2,400.00	
711010 Utilities	180.00		180.00					
711100 ESD Asset Management	6,432.00	1,608.00	4,824.00	25	2,304.00	384.00	1,920.00	17
711113 Equip Srv Replace	377.94	63.00	314.94	17	377.95	63.00	314.95	17
711114 Equip Srv O & M	1,609.62	161.30	1,448.32	10	654.46	718.56	64.10-	110
711115 Equip Srv Motor Pool					1,605.00		1,605.00	
711117 ESD Fuel Charge					78.58		78.58	
711119 Prop & Liab Billings	9,114.95	1,519.18	7,595.77	17	9,711.98	1,618.66	8,093.32	17
711210 Travel	51,250.00	473.23	50,776.77	1	65,367.00	1,046.71	64,320.29	2
711504 Equipment nonCapital	1,750.00	1,148.66	601.34	66	45,489.00	45,881.89	392.89-	101
* Services and Supplies	305,592.57	26,399.65	279,192.92	9	542,456.87	127,893.55	414,563.32	24
781004 Equipment Capital					12,337.00		12,337.00	
* Capital Outlay					12,337.00		12,337.00	
** Expenses	2,142,861.27	312,120.61	1,830,740.66	15	2,373,370.42	401,273.31	1,972,097.11	17
818000 Transfer to Intrafund								
** Other Financing Src/Use								
*** Total	480,744.27	221,731.21	259,013.06	46	526,943.69	228,487.26	298,456.43	43

Washoe County Health Distirct
Undesignated
Pds 1-2, FY14

Accounts	2014 Plan	2014 Actuals	Balance	Act%	2013 Plan	2013 Actual	Balance	Act%
710400 Payments to Other Agencies								
711400 Overhead - General Fund	2,898,034.00	483,005.66	2,415,028.34	17	2,553,372.00		2,553,372.00	
** Expenses	2,898,034.00	483,005.66	2,415,028.34	17	2,553,372.00		2,553,372.00	
621001 Transfer From General	8,603,891.00-		8,603,891.00-		8,623,891.00-		8,623,891.00-	
* Transfers In	8,603,891.00-		8,603,891.00-		8,623,891.00-		8,623,891.00-	
818000 Transfer to Intrafund								
* Transfers Out								
** Other Financing Src/Use	8,603,891.00-		8,603,891.00-		8,623,891.00-		8,623,891.00-	
*** Total	5,705,857.00-	483,005.66	6,188,862.66-	8-	6,070,519.00-		6,070,519.00-	

Washoe County Health District

ENVIRONMENTAL HEALTH SERVICES DIVISION

STAFF REPORT

BOARD MEETING DATE: 09/26/2013

DATE: September 17, 2013

TO: District Board of Health Members

FROM: James English, REHS, CP-FS, Environmental Health Specialist Supervisor
Waste Management and Land Development Program
775-328-2428; jenglish@washoecounty.us

SUBJECT: Update on citation and enforcement regarding prevention of bear activity within populated areas.

BACKGROUND

The Washoe County District Board of Health approved changes to the *Regulations of the Washoe County District Board of Health Governing Solid Waste Management* at their September 2010 meeting. The regulations included definitions for animal resistant containers and an enforcement mechanism for requiring the procurement of containers when violations to the updated regulations occur. In January of 2011, the Washoe County Health District (WCHD) developed a fact sheet regarding how to file complaints when wildlife disturbs or rummages through garbage containers within the health district.

Specific regulations related to animal resistant containers and enforcement related to wildlife, including bears rummaging through garbage containers, and the complaint fact sheet on the subject are available online at http://www.washoecounty.us/health/ehs/regulations.html.

CURRENT ACTIONS RELATED TO WILDLIFE/SOLID WASTE ISSUES

From October 2010 to December 2012, the WCHD has received two complaints related to bear/solid waste issues from separate addresses. WCHD staff responded and investigated both complaints. One location had an animal resistant container and one did not. Staff educated the second property owner on proper storage of solid waste and our new regulations regarding animal resistant containers.

From January 2013 to present the WCHD has received three complaints related to bear/solid waste issues. Of the three complaints, two were valid. Both property owners of the valid complaints voluntarily obtained animal resistant containers.

WCHD staff has been working in conjunction with Nevada Division of Wildlife, Incline Village Improvement District, Waste Management, Inc. and individuals to continue education efforts to minimize wild animals having access to solid waste within the health district.

Incline Village eying bearproof trash bins; customers would pay possible $250 cost

Written by **Jeff DeLong – Reno Gazette-Journal**
August 17, 2013

Incline Village residents could soon be required to store their garbage in bear-resistant containers in a change that might set the stage for similar actions in other bear-prone areas of Washoe County and elsewhere along the Carson Range.

The proposal by officials with the Incline Village General Improvement District comes during a summer of mounting problems posed by garbage-raiding black bears and a rising outcry from residents who insist too many bears are being killed as a result.

Washoe County commissioners canceled a scheduled Tuesday discussion on bears and possible future changes in trash management policy to await the result of a proposal to be considered by Incline officials in September.

The idea is to minimize human-bear conflicts caused by bears attracted to carelessly handled trash, said Joe Pomroy, public works director for the upscale north Lake Tahoe community.

"If this is the way to reduce those conflicts, that's what we would want," Pomroy said.

On Sept. 25, representatives of Waste Management Inc., are scheduled to appear before the Incline district's Board of Trustees with a proposal that would provide all of the community's 4,200 single-family homes with bear-resistant trash containers.

Use of the portable plastic trash carts, reinforced with metal at the top to prevent access by bears and other animals, would be required by the district, which includes Incline Village and Crystal Bay. The cost to Waste Management would be passed to its residential customers in the area with increased fees, Pomroy said.

What that cost will be is yet to be determined and enacting the new system would entail a process taking "multiple months," he said. The need to prevent easy access to trash by bears is clear, said Jim Hammerel, a newly seated trustee who campaigned on the need to address worsening urban bear issues at Incline.

"I think the vast majority of our residents see this as something that's way overdue," Hammerel said. "People talk about bear problems. It's not a bear problem, it's a human problem. The bears are here because people are irresponsible with their trash."

BY THE NUMBERS
Total human-bear conflicts in 2012: 237
Washoe County/Incline Village: 22 percent
Other parts of Washoe County: 55 percent
Douglas County: 16 percent
Carson City: 7 percent
Source: Nevada Department of Wildlife

Using Your Dollars Wisely: Analyzing Your Costs for Public Health Accreditation

NALBOH
National Association of Local Boards of Health

BACKGROUND

One of the biggest challenges public health agencies face while pursuing accreditation is the cost associated with the process. Public health governing bodies can help the public health agency they oversee by developing and/or approving the agency's budget with the needs of the accreditation process in mind. To simplify this task, NALBOH has developed this cost analysis tool to assist governing boards with identifying the type of resources and the average funds needed to support the pre-accreditation application process. Based on this information the governing body can make an informed decision on whether or not their agency has or can acquire sufficient resources to successfully fulfill the accreditation prerequisites and application fee.

Costs to consider prior to applying for national accreditation:

- ☐ Community Health Assessment (CHA)
- ☐ Community Health Improvement Plan (CHIP)
- ☐ Agency Strategic Plan
- ☐ Applicant Fee
- ☐ Accreditation Coordinator

HOW TO USE THIS TOOL

This tool is intended to be a "study guide" for public health governing boards and their respective health officers/health directors. Each of the five costs listed above is broken down into the overarching categories for a budget, and each budget item includes more specific details of what other health departments have used their monies on to support the accreditation prerequisites. Additionally, each of the sections includes worksheets with tables and questions to allow the individuals completing the tool to include their jurisdiction's data and information.

To inform the creation of this tool, NALBOH surveyed health departments across the country (n=22) that had completed at least one of the three prerequisites for national public health accreditation in the past 3-5 years. NALBOH conducted this national survey via phone interview or online questionnaire in February and March of 2013. While this tool is based upon quantitative and qualitative data from the survey, it may not be inclusive of all costs associated with each of the five topics above. The information and worksheets in this tool are to be used as a baseline and should be changed based upon a jurisdiction's size, legal requirements to complete any one of the accreditation prerequisites, and ability/interest in seeking national public health accreditation. NALBOH is not liable for ensuring that a health department can provide sufficient funding for each of the five costs due to their completion of this tool. A final estimated and/or budget cost for the prerequisites is at the discretion of the public health jurisdiction.

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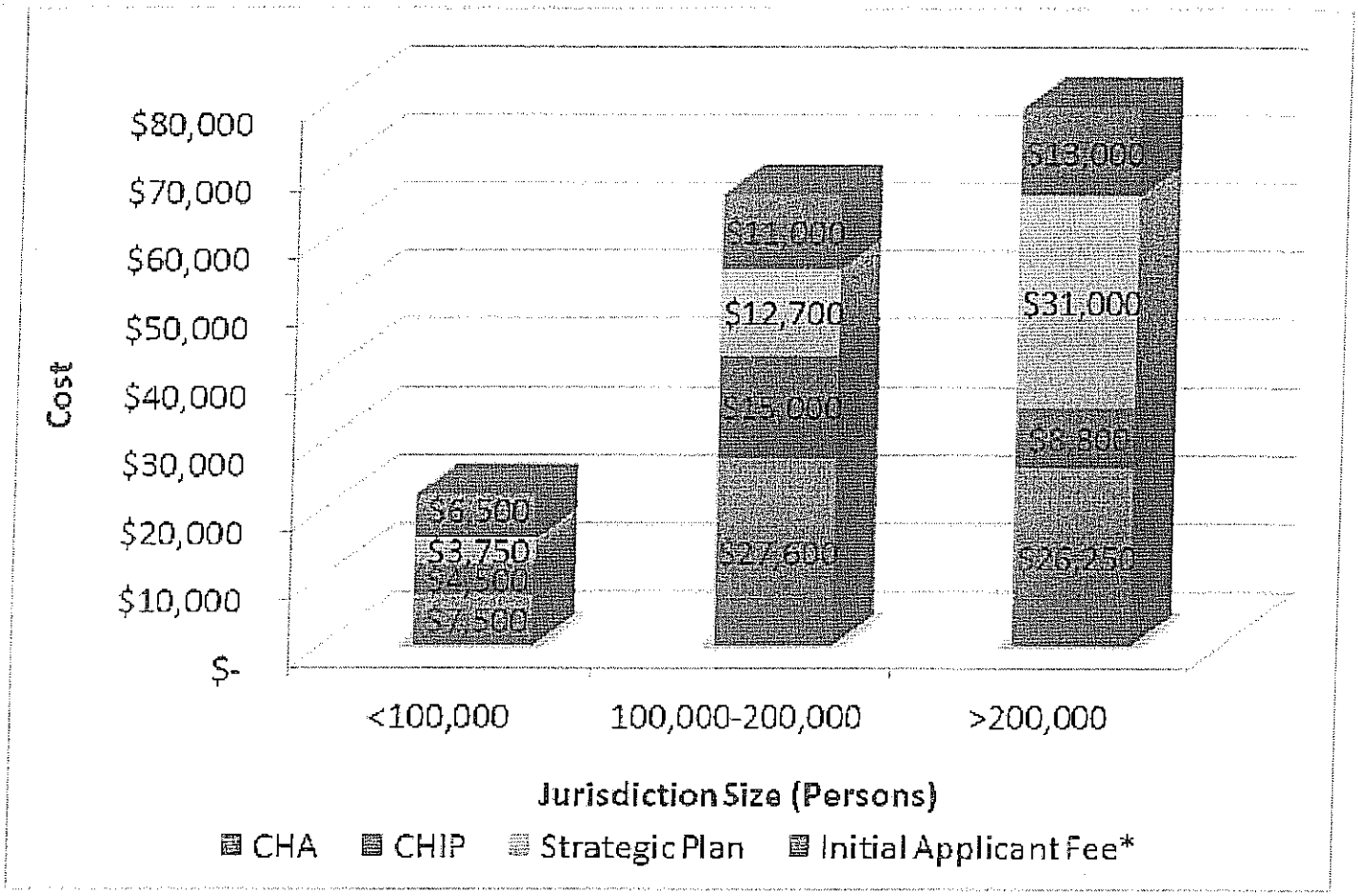
OVERALL COSTS

Based upon NALBOH's national survey of health departments that have completed a community health assessment (CHA), community health improvement plan (CHIP), and/or agency strategic plan in the past 3-5 years, the overall costs of the accreditation pre-application process often relates to the size of the jurisdiction. Below are the identified average costs for a health agency (by jurisdiction size) to complete the accreditation prerequisites and application fee:



Each health agency surveyed conducted the prerequisites in a method that was appropriate for their jurisdiction. Some health agencies may complete the process on their own while others may partner with other community organizations, health systems, or public health departments in their jurisdiction or region. On the following pages, each prerequisite is broken down with descriptions, discussion questions, and tips. The intent of the following tool is to allow your governing board to insert its own financial data and options to make an estimated cost of the pre-application process that is respective of the jurisdiction size and cost of living.

* The initial applicant fee in the chart above is not the exact amount for all health departments. To determine the applicant fee specific for your health department's jurisdiction population size, please visit www.phaboard.org/accreditation-overview/what-does-it-cost.

COMMUNITY HEALTH ASSESSMENT

"Community health assessment involves a process of collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health. It is one of the core functions of public health, which is why it's in the accreditation standards. It involves the systematic collection and analysis of data in order to provide the health department and the community it serves with a sound basis for decision-making. It should be conducted in partnership with other organizations in the community and include collecting data on health status, health needs, community assets, resources, and other community or state determinants of health status" (PHAB, 2013).

A community health assessment (CHA) identifies community health problems. A CHA is exactly what it sounds like: an assessment of the community's health. Some states require public health agencies to conduct CHAs on a routine basis, while others do not. Furthermore, some public health agencies choose to complete this process on their own while others collaborate with health systems, other public health departments, and community organizations.

Costs to Consider:

☐ **Staff**

On average, NALBOH's survey found that staffing accounted for 78% of the health agencies' CHA budgets. These staff members were often responsible for coordination, participation in meetings, collection of data, analysis of findings, and collaboration with partners. The most common titles or positions of staff members assigned to a CHA included:

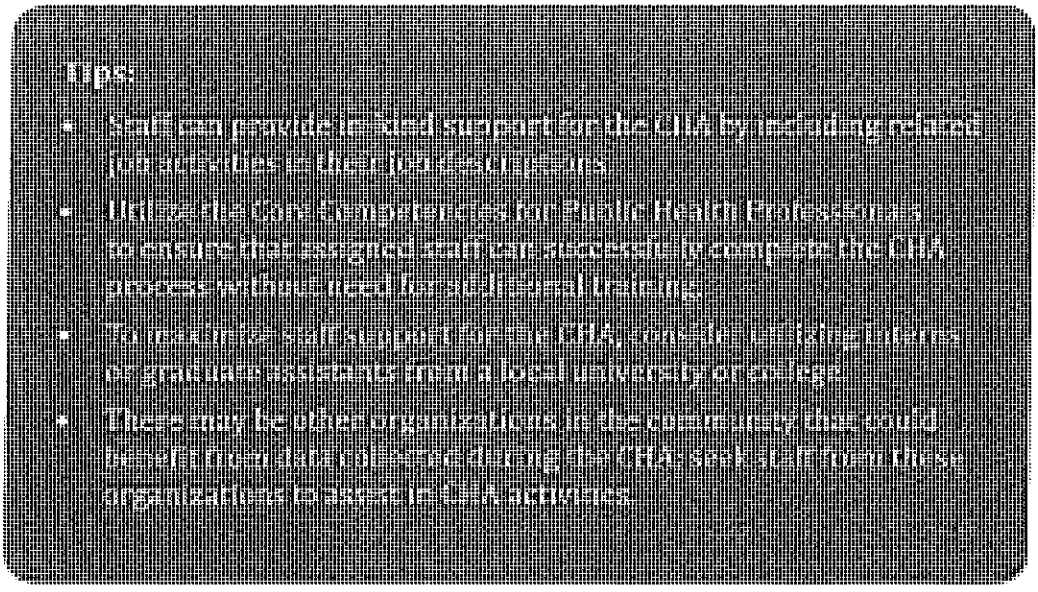
- Health Officer/Health Director
- Epidemiologist
- Health Educator
- Accreditation Coordinator
- Registered Nurse
- Administrative Assistant
- Data Analyst
- Policy Director
- Health Promotion Supervisor

Questions:

Which staff members are being proposed to work on the CHA?

Staff Title	% Time	Current Salary/Pay	Estimated Project Cost
Ex: Health Director	*5%*	*$65,000*	*$3,250*
		Estimated Cost:	**$**

Question	Yes	No
Have the CHA competencies of staff been evaluated?		
Are we maximizing the competencies of our current staff to complete the CHA?		
Are new staff being proposed for the project to fill expertise gaps?		
Will we need to provide additional funding to train assigned staff on CHA?		
Can staff at other community organizations be used to fill competency needs? • What are our competency needs? • Which organizations may have someone at staff will related expertise? ***Expertise needed*** / ***Organization*** / ***Who will contact*** *Data Analyst* / *Local hospital* / *John: Knows hospital president*		
Should we require that CHA activities be included in specific job descriptions?		
Would it be beneficial for our agency to have 1 FTE specifically for CHA activities?		
Do we have a process in place to ensure that necessary staff will be available to complete a CHA as often as needed/required?		



☐ Materials, Supplies, and Other Costs

Depending upon the method used to complete the CHA (e.g., door-to-door survey, mailed survey, collection of previously published data, etc.), the costs associated with materials, supplies, and other costs may vary. Health departments in NALBOH's survey reported that materials, supplies, and other costs accounted for an average of 14% of the overall CHA cost. A majority of the sites surveyed reported that this budget line item was primarily for meeting expenses including facility rentals, food/beverage costs, meeting supplies (e.g., flip charts, markers, poster paper, etc.), and handouts. Other items included paper surveys, postage and envelopes, technology, office supplies, and incentives.

Primary Costs to Consider Based Upon How CHA Will Be Conducted		
Online	***Printed***	***Previously Published Data***
Incentive	Printed surveys (contracted or printed at agency)	Internet access
Internet access	Postage	Computer(s)
Computer(s)	Envelopes	Promotion of results (e.g., print, electronic, virtual, forum, etc.)
Database to store responses	Return postage-paid envelope	
"Stock" online survey program	Incentive	
Marketing materials pre-survey	Marketing materials pre-survey	
Promotion of results (e.g., print, electronic, virtual, forum, etc.)	Reminder postcards	
	Promotion of results (i.e., print, electronic, virtual, forum, etc.)	

☐ Travel

Regardless of the method used to complete the CHA, travel costs may be necessary. These travel costs are often linked to mileage reimbursement and per diem as staff attend various meetings or conduct the CHA within the jurisdiction. Additionally, travel costs may be higher in larger jurisdictions that represent multiple counties, regions, or districts. Of the health departments that reported any travel costs associated with the CHA, this budget item accounted for an average of 8% of the total cost.

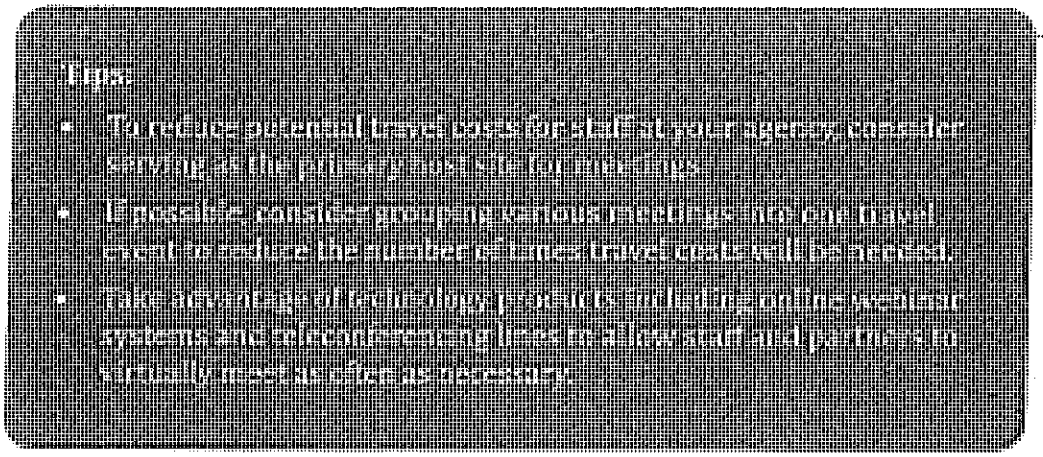
Questions:

How many meetings are estimated to be held for the CHA process? _____

How many staff will be attending? _____

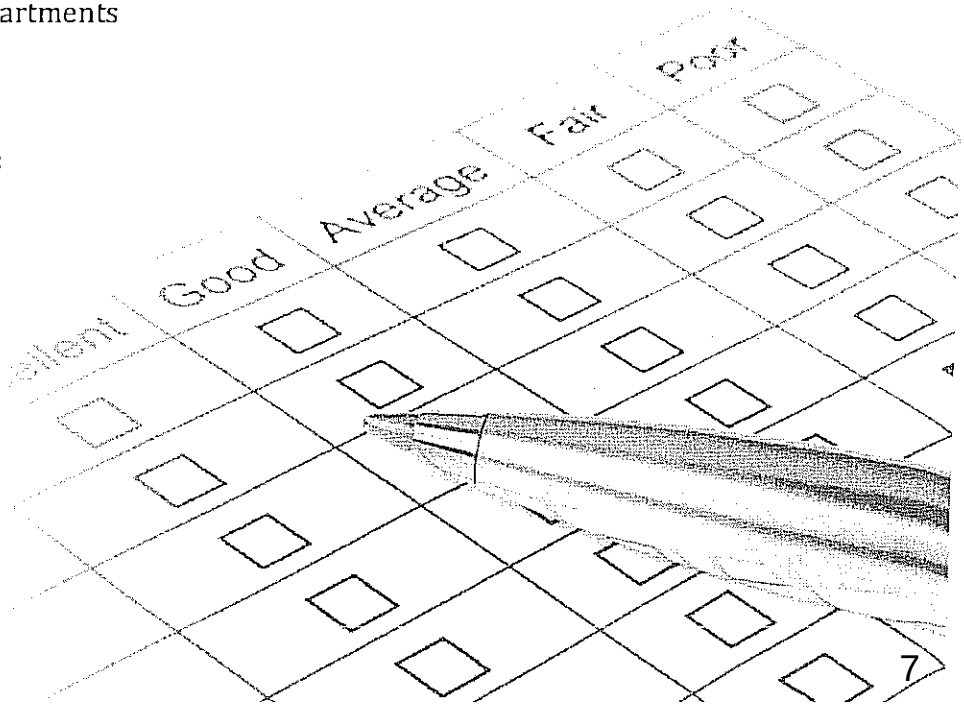
Where are the meetings located? _____

What is our agency's average cost for travel (i.e., mileage and per diem)? _____



OVERALL COMMUNITY HEALTH ASSESSMENT TIPS:

- CHAs can be expensive depending upon the method used and the jurisdiction size. It is usually beneficial for the health department to partner with other organizations or companies in the community to maximize benefits while sharing costs.
- Grants, sponsorships, and in-kind donations are great way to supplement the cost of conducting a CHA. Consider writing proposals to solicit additional funding or in-kind donations from community organizations; local/state for-profit companies; local, state, or national foundations; national public health organizations; or the federal government.
- Partnering is key to the success of a thorough and representative CHA. The following are examples of groups with whom the governing entity and health department may want to partner on designing, conducting, analyzing, or disseminating results:
  - Business organizations
  - Community groups
  - Colleges/universities
  - Hospitals/clinics
  - Neighboring health departments
  - Local schools
  - Religious organizations
  - Health coalitions
  - Voluntary organizations
  - Youth groups



COMMUNITY HEALTH IMPROVEMENT PLAN

According to the Public Health Accreditation Board (PHAB), a "community health improvement plan is a long-term systematic effort to address issues identified by the assessment and community health improvement process. It is broader than the health department agency and its development, and should include participation of a broad set of community partners. A solid community health improvement plan can be used by partners to prioritize activities and set priorities."

The community health improvement plan (CHIP) should include the following steps: 1) Prioritizing Issues, 2) Choosing Strategies, 3) Developing a CHIP and Implementation Plan, and 4) Disseminating the CHIP. This Plan should be completed using data from the community health assessment (CHA), and it should be updated at least once every 5 years. Additionally, this process should include the health department as well as all other stakeholder organizations that can implement activities to improve the health and well-being of their audience.

Costs to Consider:

☐ Staff

On average, NALBOH's survey found that staffing accounted for 88% of the health agencies' CHIP budgets. These staff members were often responsible for coordination, participation in meetings, development of activities, and collaboration with partners. The most common titles or positions of staff members assigned to a CHIP included:

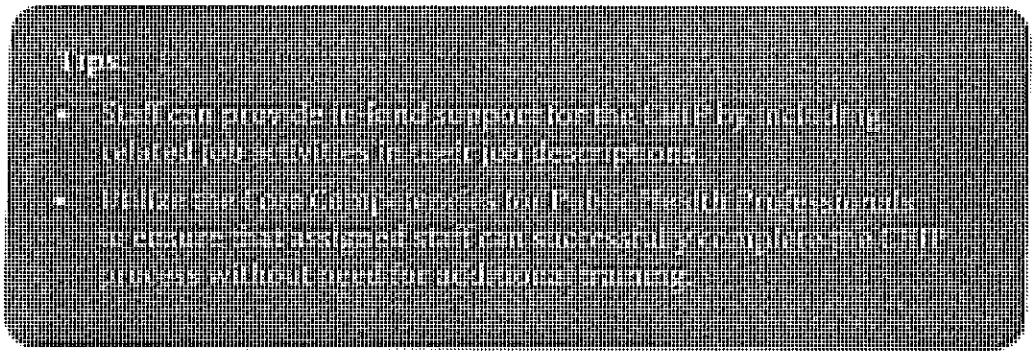
- Accreditation Coordinator
- Health Officer/Health Director
- Epidemiologist
- Health Education Supervisor/Specialist
- Registered Nurse/Public Health Nurse
- Administrative Assistant
- Senior Program Manager
- Program Coordinator

Question:

Which staff members are being proposed to work on the CHIP?

Staff Title	% Time	Current Salary/Pay	Estimated Project Cost
Ex: Health Director	*10%*	*$65,000*	*$6,500*
		Estimated Cost:	$

Question	Yes	No
Have the CHIP competencies of staff been evaluated?		
Are we maximizing the competencies of our current staff to complete the CHIP?		
Are new staff being proposed for the project to fill expertise gaps?		
Will we need to provide additional funding to train assigned staff on CHIP?		
Can staff at other community organizations be used to fill competency needs? ◦ What are our competency needs? ◦ Which organizations may have someone at staff will related expertise? ***Expertise needed*** ***Organization*** ***Who will contact*** *Meeting facilitation* *Community youth liaison* *Sue: Knows liaison leader*		
Should we require that CHIP activities be included in specific job descriptions?		
Would it be beneficial for our agency to have 1 FTE specifically for CHIP activities?		
Do we have a process in place to ensure that necessary staff will be available to complete a CHIP as often as needed/required?		
Are our governing board members paid to attend meetings?		



☐ Materials, Supplies, and Other Costs

Health departments in NALBOH's survey reported that materials, supplies, and other costs accounted a majority of the remaining budget. Sites surveyed reported that this budget line item was primarily for meeting expenses as most of the CHIP process is conducted during community-wide meetings with partners and other stakeholders. Meeting costs to consider include:

- Facility rentals
- Food/beverage costs
- Meeting supplies (e.g., flip charts, markers, poster paper, etc.)
- Handouts

Additional costs for the CHIP process may include a small number of CHIP-related publications, printing, and office supplies.

☐ Travel

Travel costs may or may not be a part of the CHIP budget depending primarily on the jurisdiction size. These travel costs are often linked to mileage reimbursement and per diem as staff attend various meetings within the jurisdiction. The following are questions the governing body may want to ask before preparing the budget:

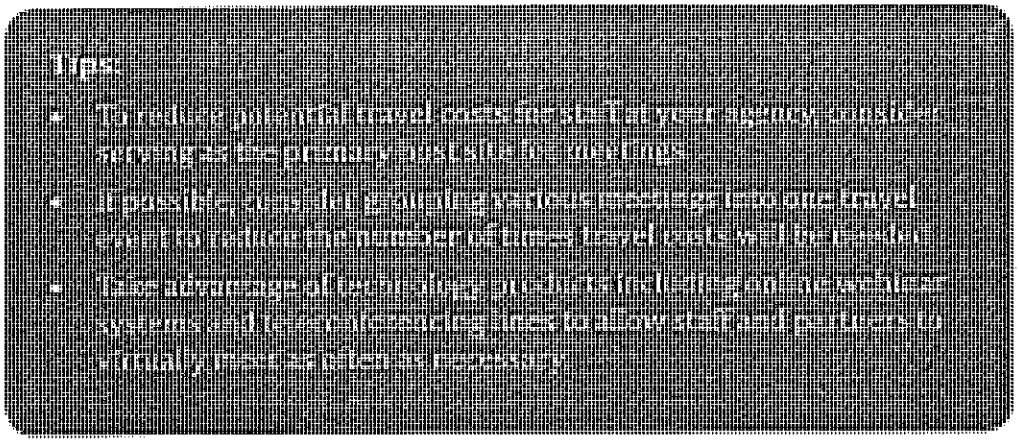
Questions:

How many meetings are estimated to be held for the CHIP process? _____

How many staff will be attending? _____

Where are the meetings located? _____

What is our agency's average cost for travel (i.e., mileage and per diem)? _____



OVERALL COMMUNITY HEALTH IMPROVEMENT TIPS:

- Partnering is key to the success of a thorough and representative CHIP. The following are examples of groups with whom the governing entity and health department may want to partner to prioritize issues, choose strategies, develop plan activities, and disseminate the CHIP:
  - Business organizations
  - Community groups
  - Colleges/universities
  - Hospitals/clinics
  - Neighboring health departments
  - Local schools
  - Religious organizations
  - Health coalitions
  - Voluntary organizations
  - Youth groups
- By the time your jurisdiction is ready to complete a CHIP, there may be volunteer fatigue. Previous conductors of the CHIP process recommend saving a majority of the partners' work for the CHIP activity planning process rather than to actually conduct the CHA.
- It is also vital to get the community involved in the CHIP process. It may be beneficial for the health department to budget for community forums or a staff liaison to support community-driven activities.

DEPARTMENT STRATEGIC PLAN

"The department strategic plan is internal to the health department, although may have been developed with input from partners. It shapes and guides what the health department does and why it does it; it sets forth the department's vision, mission, guiding principles and values, and strategic priorities; and describes measurable and time-framed goals and objectives. The strategic plan should include steps to implement portions of the community health improvement plan as well as other strategic issues for the department" (PHAB, 2013).

This final prerequisite, a department strategic plan, needs to be completed prior to submitting a Statement of Intent for the national public health accreditation program. A strong strategic plan focuses on defining the health department's mission, vision, values and strategic priorities. It also successfully incorporates activities that were developed in the community health improvement plan (CHIP) as well as other issues for the department. This process should involve, at some point, the health department staff and the governing body.

Costs to Consider:

☐ **Staff**

Based upon results from NALBOH's survey, the strategic planning process primarily involved senior level staff members and the governing body. These staff members were often responsible for coordination, participation in meetings, and adoption of the plan. The most common titles or positions of staff members assigned to a department strategic plan included:

- Health Officer/Health Director
- Division Director
- Senior Management Director
- Accreditation Coordinator

Questions:

Which staff members are being proposed to work on the strategic plan?

Staff Title	% Time	Current Salary/Pay	Estimated Project Cost
Ex: Health Director	*10%*	*$65,000*	*$6,500*
		Estimated Cost:	**$**

	Yes	No
Will we need to provide additional funding to train assigned staff on the strategic plan?		
Would it be beneficial for our agency to hire a consultant to facilitate the strategic planning process?		
Do we have a process in place to ensure that necessary staff will be available to complete a strategic plan as often as needed/required?		

☐ **Materials, Supplies, and Other Costs**

Health departments in NALBOH's survey reported that materials, supplies, and other costs accounted a majority of the remaining budget. Sites surveyed reported that this budget line item was primarily for meeting expenses as most of the srategic planning process is conducted during health department and public health governing body meetings. Meeting costs to consider include:

- Food/beverage costs
- Meeting supplies (e.g., flip charts, markers, poster paper, etc.)
- Handouts

☐ **Consultant(s)**

Of the surveyed health departments that had completed a strategic plan, 70% hired a consultant to assist with the process. Additionally, the costs associated with a consultant accounted for an average of 38% of the overall budget for this specific prerequisite. A consultant may be helpful during the development of a department strategic plan as they may serve as a facilitator during discussions and/or the person(s) responsible for synthesizing thoughts and ideas into a proposed plan that can then be adopted by the governing body and health agency. The cost of a consultant will depend upon the geographic location of the agency as well as the scope of work required.

OVERALL STRATEGIC PLANNING TIPS:

- Regardless of a health department's intent to seek national public health accreditation, it is in the best interest of the health department and its governing body to routinely create an agency strategic plan.
- The strategic planning process may take up to one year to complete, and a majority of the time will be spent discussing ideas at meetings.
- The department strategic plan should incorporate activities from the CHIP as well as other activities that are specific to the agency's programs and services.

APPLICATION FEE

Each health department is required to submit an application fee based upon the size of the jurisdictional population served by the health department. This fee is used for the evaluation of the health department in the accreditation process as well as to support the following services (PHAB, 2013):

- An assigned accreditation specialist to guide your department through the application process
- In-person training for your health department's accreditation coordinator
- Subscription to PHAB's online accreditation information system (e-PHAB), making it easier and more cost-efficient for your health department to participate in accreditation
- Site visit, including a comprehensive review of your health department's operations against the national accreditation standards by a team of peer review experts
- Annual quality improvement guidance and support for 5 years
- Identified opportunities for improvements to help your health department better serve its population
- Exclusive contribution to a growing network of accredited local health departments and best practices to enhance the evidence-base for public health

The most current fee schedule is available on the Public Health Accreditation Board's (PHAB) website at www.phaboard.org/accreditation-overview/what-does-it-cost/. The rate that is published is applicable for a 5-year period that begins with the date of submission of the full application. To assist health departments with strained budgets, three options are available to submit a payment of fees:

- Health departments can receive a discount by paying in one lump sum
- Health departments can pay in multiple year increments (3-year or 5-year) where 40% of the total fee is paid in the first year and the remaining 60% of the total fee is paid over the remaining years
- Health departments can pay with end of the year grant funds (with approval of grant project officer)

Size of Jurisdiction Population	Total Application Fee	Payment Option Chosen	First Payment Total
Example: 95,094	*$20,670*	*5-year*	*$8,270*

ACCREDITATION COORDINATOR

Health departments pursing national accreditation through the Public Health Accreditation Board (PHAB) are required to appoint one person as the Accreditation Coordinator. This person serves as the lead on all accreditation-related efforts including quality and performance improvement. Additionally, the Accreditation Coordinator cannot be the health department director.

PHAB lists the following as responsibilities of the Accreditation Coordinator:

- Conduct assessments of the health department's readiness to seek accreditation
- Complete the PHAB Online Orientation, Statement of Intent (SOI), and Application
- Coordinate the development and implementation of the health department's internal plan to engage staff in the accreditation process
- Engage partner organizations and community partners in the accreditation process
- Develop and facilitate the health department's accreditation team
- Manage the selection process for documentation for the PHAB measures
- Maintain a documents management process
- Manage the site visit and the review of the site visit report
- Manage the development and submission of required reports and fees to PHAB

How much time (% FTE) can we dedicate to this role? _____

Is there someone on staff that could already fulfill this position?

Staff Member Name *Position*

Do we want to hire a new staff member to fulfill this position? _____

What pay would be appropriate for a person to fulfill the above roles? $_____

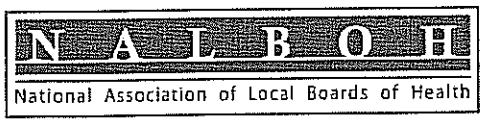
How will we provide funding for this person? _____

Grant? (Examples: national organization, local hospital)

Levy?

Current Operating Expenses?

Other?



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Channeling Change: Making Collective Impact Work

An in-depth look at how organizations of all types, acting in diverse settings, are implementing a collective impact approach to solve large-scale social problems.

BY FAY HANLEYBROWN, JOHN KANIA, & MARK KRAMER

What does a global effort to reduce malnutrition have in common with a program to reduce teenage substance abuse in a small rural Massachusetts county? Both have achieved significant progress toward their goals: the Global Alliance for Improved Nutrition (GAIN) has helped reduce nutritional deficiencies among 530 million poor people across the globe, while the Communities That Care Coalition of Franklin County and the North Quabbin (Communities That Care) has made equally impressive progress toward its much more local goals, reducing teenage binge drinking by 31 percent. Surprisingly, neither organization owes its impact to a new previously untested intervention, nor to scaling up a high-performing nonprofit organization. Despite their dramatic differences in focus and scope, both succeeded by using a collective impact approach.

In the winter 2011 issue of *Stanford Social Innovation Review* we introduced the concept of "collective impact" by describing several examples of highly structured collaborative efforts that had achieved substantial impact on a large scale social problem, such as The Strive Partnership[1] educational initiative in Cincinnati, the environmental cleanup of the Elizabeth River in Virginia, and the Shape Up Somerville campaign against childhood obesity in Somerville, Mass. All of these initiatives share the five key conditions that distinguish collective impact from other types of collaboration: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and the presence of a backbone organization. (See "The Five Conditions of Collective Impact" below.)

We hypothesized that these five conditions offered a more powerful and realistic paradigm for social progress than the prevailing model of isolated impact in which countless nonprofit, business, and government organizations each work to address social problems independently. The complex nature of most social problems belies the idea that any single program or organization, however well managed and funded, can singlehandedly create lasting large-scale change. (See "Isolated Impact vs. Collective Impact" on page 2.)

Response to that article was overwhelming. Hundreds of organizations and indi-

The Five Conditions of Collective Impact

Common Agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed-upon actions.
Shared Measurement	Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
Mutually Reinforcing Activities	Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
Continuous Communication	Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
Backbone Support	Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

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JOHN KANIA *is a managing director at FSG, where he oversees the firm's consulting practice. Before joining FSG, he was a consultant at Mercer Management and Consulting and Corporate Decisions Inc.*

MARK KRAMER *is the co-founder and a managing director of FSG. He is also the co-founder and the initial board chair of the Center for Effective Philanthropy, and a senior fellow at Harvard University's John F. Kennedy School of Government.*

Isolated Impact vs. Collective Impact

Isolated Impact	Collective Impact
Funders select individual grantees that offer the most promising solutions.	Funders and implementers understand that social problems, and their solutions, arise from the interaction of many organizations within a larger system.
Nonprofits work separately and compete to produce the greatest independent impact.	Progress depends on working toward the same goal and measuring the same things.
Evaluation attempts to isolate a particular organization's impact.	Large scale impact depends on increasing cross-sector alignment and learning among many organizations.
Large scale change is assumed to depend on scaling a single organization.	Corporate and government sectors are essential partners.
Corporate and government sectors are often disconnected from the efforts of foundations and nonprofits.	Organizations actively coordinate their action and share lessons learned.

viduals from every continent in the world, even including the White House, have reached out to describe their efforts to use collective impact and to ask for more guidance on how to implement these principles.

Even more surprising than the level of interest is the number of collective impact efforts we have seen that report substantial progress in addressing their chosen issues. In addition to GAIN and Communities That Care, Opportunity Chicago placed 6,000 public housing residents in new jobs, surpassing its goal by 20 percent; Memphis Fast Forward reduced violent crime and created more than 14,000 new jobs in Memphis, Tenn.; the Calgary Homeless Foundation housed more than 3,300 men, women, and children and contributed to stopping what had been the fastest growing rate of homelessness in Canada; and Vibrant Communities significantly reduced poverty levels in several Canadian cities.

The initiatives we cited in our initial article have also gained tremendous traction: Shape Up Somerville's approach has now been adapted in 14 communities through subsequent research projects and influenced a national cross-sector collaborative. The Strive Partnership recently released its fourth annual report card, showing that 81 percent of its 34 measures of student achievement are trending in the right direction versus 74 percent last year and 68 percent two years ago.[2] Its planned expansion to five cities when the article came out has since been vastly expanded as more than 80 communities (including as far away as the Ruhr Valley in Germany) have expressed interest in building on The Strive Partnership's success.

Part of this momentum is no doubt due to the economic recession and the shortage of government funding that has forced the social sector to find new ways to do more with less—pressures that show no signs of abating. The appeal of collective impact may also be due to a broad disillusionment in the ability of governments around the world to solve society's problems, causing people to look more closely at alternative models of change.

More and more people, however, have come to believe that collective impact is not just a fancy name for collaboration, but represents a fundamentally different, more disciplined, and higher performing approach to achieving large-scale social impact. Even the attempt to use these ideas seems to stimulate renewed energy and optimism. FSG has been asked to help launch more than one dozen collective impact initiatives, and other organizations focused on social sector capacity building such as the Bridgespan Group, Monitor Institute, and the Tamarack Institute in Canada, have also developed tools to implement collective impact initiatives in diverse settings.

As examples of collective impact have continued to surface, it has become apparent that this approach can be applied against a wide range of issues at local, national, and even global levels. In fact, we believe that there is no other way society will achieve large-scale progress against the urgent and complex problems of our time, unless a collective impact approach becomes the accepted way of doing business.

At the same time, our continued research has provided a clearer sense of what it takes for collective impact to succeed. The purpose of this article, therefore, is to expand the understanding of collective impact and provide greater guidance for those who seek to initiate and lead collective impact initiatives around the world. In particular, we will focus on answering the questions we hear most often: How do we begin? How do we create alignment? And, How do we sustain the initiative?

AWAKENING THE POWER OF COLLECTIVE IMPACT

Of all the collective impact examples we have studied, few are as different in scale as GAIN and Communities That Care, yet both of these efforts embody the principles of collective impact, and both have demonstrated substantial and consistent progress toward their goals.

GAIN, created in 2002 at a special session of the United Nations General Assembly, is focused on the goal of reducing malnutrition by improving the health and nutrition of nearly 1 billion at risk people in the developing world. The development of GAIN was predicated on two assumptions: first, that there were proven interventions that could be employed at scale to improve nutrition of the poor in developing countries, and second, that the private sector had a much greater role to play in improving the nutrition even for the very poor. GAIN is now coordinated by a Swiss Foundation with offices in eight cities around the world and more planned to open soon. In less than a decade, GAIN has created and coordinated the activity of 36 large-scale collaborations that include governments, NGOs, multilateral organizations, universities, and more than 600 companies in more than 30 countries. GAIN's work has enabled more than 530 million people worldwide to obtain nutritionally enhanced food and significantly reduced the prevalence of micronutrient deficiencies in a number of countries. In China, South Africa, and Kenya, for example, micronutrient deficiencies dropped between 11 and 30 percent among those who consumed GAIN's fortified products. During that time, GAIN has also raised $322 million in new financial commitments and leveraged many times more from its private sector and government partners.

At the other end of the spectrum, the Franklin County / North Quabbin Region

of Western Massachusetts has a population of only 88,000 people dispersed across 30 different municipalities and 844 square miles. When two local social service agencies—the Community Coalition for Teens and the Community Action of the Franklin, Hampshire, and North Quabbin Regions—first called a meeting to discuss teenage drinking and drug use, they were astonished that 60 people showed up. From that first meeting, coincidentally also in 2002, grew Communities That Care, that now includes more than 200 representatives from human service agencies, district attorney's offices, schools, police departments, youth serving agencies, faith-based organizations, local elected officials, local businesses, media, parents, and youth. Overseen by a central coordinating council, the initiative operates through three working groups that meet monthly to address parent education, youth recognition, and community laws and norms. In addition, a school health task force links these work groups to the 10 public school districts in the region. Over an eight-year time frame, the work of Communities That Care has resulted not only in reducing binge drinking, but also in reducing teen cigarette smoking by 32 percent and teen marijuana use by 18 percent. The coalition has also raised more than $5 million of new public money in support of their efforts.

Different as they may be, these two initiatives demonstrate the versatility of a collective impact approach and offer broad insights into how to begin, manage, and structure collective impact initiatives.

THE PRECONDITIONS FOR COLLECTIVE IMPACT

Three conditions must be in place before launching a collective impact initiative: an *influential champion*, *adequate financial resources*, and a sense of *urgency for change*. Together, these preconditions create the opportunity and motivation necessary to bring people who have never before worked together into a collective impact initiative and hold them in place until the initiative's own momentum takes over.

The most critical factor by far is an *influential champion* (or small group of champions) who commands the respect necessary to bring CEO-level cross-sector leaders together and keep their active engagement over time. We have consistently seen the importance of dynamic leadership in catalyzing and sustaining collective impact efforts. It requires a very special type of leader, however, one who is passionately focused on solving a problem but willing to let the participants figure out the answers for themselves, rather than promoting his or her particular point of view.[3] In the case of GAIN, four individuals with deep experience in the development field—Bill Foege, the former director of the US Centers for Disease Control who is largely credited with eradicating small pox, Kul Gautam, a senior official at UNICEF, Duff Gillespie, head of the Office of Population and Nutrition at US Agency for International Development (USAID), and Sally Stansfield, one of the original directors at The Bill & Melinda Gates Foundation—came together to look at large scale opportunities to address malnutrition in populations at risk in the developing world. Together they galvanized the 2002 UN General Assembly special session that led to the creation of GAIN and to the subsequent engagement of hundreds of government, corporate, and nonprofit participants.

Second, there must be adequate *financial resources* to last for at least two to three years, generally in the form of at least one anchor funder who is engaged from the beginning and can support and mobilize other resources to pay for the needed infrastructure and planning processes. The Gates Foundation, the Canadian International Development Agency, and the USAID played this role in the case of GAIN. For Communities That Care, a federal grant provided the necessary multi-year support.

The final factor is the *urgency for change* around an issue. Has a crisis created a breaking point to convince people that an entirely new approach is needed? Is there the potential for substantial funding that might entice people to work together, as was the case in Franklin County? Is there a fundamentally new approach, such as using the production, distribution, and demand creation capacities of the private sector to reach millions of people efficiently and sustainably, as was the case for GAIN? Conducting research and publicizing a report that captures media attention and highlights the severity of the problem is another way to create the necessary sense of urgency to persuade people to come together.

BRINGING COLLECTIVE IMPACT TO LIFE

Once the preconditions are in place, our research suggests that there are three distinct phases of getting a collective impact effort up and running.

Phase I, *Initiate Action*, requires an understanding of the landscape of key players and the existing work underway, baseline data on the social problem to develop the case for change, and an initial governance structure that includes strong and credible champions.

Phase II, *Organize for Impact*, requires that stakeholders work together to establish common goals and shared measures, create a supporting backbone infrastructure, and begin the process of aligning the many organizations involved against the shared goals and measures.

Phase III, *Sustain Action and Impact*, requires that stakeholders pursue prioritized areas for action in a coordinated way, systematically collect data, and put in place sustainable processes that enable active learning and course correcting as they track progress toward their common goals. (See "Phases of Collective Impact" on page 4.)

It is important to recognize that the initiative must build on any existing collaborative efforts already underway to address the issue. Collective impact efforts are most effective when they build from what already exists; honoring current efforts and engaging established organizations, rather than creating an entirely new

> The appeal of collective impact may be due to a broad disillusionment in the ability of governments to solve society's problems, causing people to look at alternative models of change.

solution from scratch.

Being realistic about the time it will take to get through these initial organizing stages is equally important. It takes time to create an effective infrastructure that allows stakeholders to work together and that truly can ameliorate a broken system. The first two phases alone can take between six months and two years. The scope of the problem to be addressed, the degree of existing collaboration, and the breadth of community engagement all influence the time required. Conducting a readiness assessment based on the preconditions listed above can help to anticipate the likely time required.

Once the initiative is established, Phase III can last a decade or more. Collective impact is a marathon, not a sprint. There is no shortcut in the long-term process of social change. Fortunately, progress happens along the way. In fact, early wins that demonstrate the value of working together are essential to hold the collaborative together. In a collective impact education initiative FSG is supporting in Seattle, for example, collaboration in the first year of the initiative led to a dramatic increase in students signing up for College Bound scholarships; not the ultimate goal, but an encouraging sign. Merely agreeing on a common agenda and shared measurement system during Phase II often feels like an important early win to participants.

SETTING THE COMMON AGENDA

Developing a well-defined but practical common agenda might seem like a straightforward task. Yet we find that regardless of the issue and geography, practitioners struggle to agree on an agenda with sufficient clarity to support a shared measurement system and shape mutually reinforcing activities. Setting a common agenda actually requires two steps: creating the boundaries of the system or issue to be addressed, and developing a strategic action framework to guide the activities of the initiative.

Creating Boundaries. Establishing the boundaries of the issue is a judgment call based on each situation. For example, in another collective impact initiative that focused on teen substance abuse, a cross sector set of stakeholders in Staten Island, N.Y. drew their boundaries to include key factors such as parental and youth social norms as well as prevention and treatment activities. They could as easily have included many other related "root causes" of substance abuse such as youth unemployment or domestic violence. While these issues undoubtedly contribute to substance abuse, the group felt less able to impact these areas, and therefore left these issues outside the boundaries of their efforts. On the other hand, working with retailers to limit the availability of alcohol to minors, although outside the social sector, was determined to be an issue inside the boundary of what the group felt they could take on.

Or consider the boundaries drawn by Opportunity Chicago, a collective impact effort that included foundations, government agencies, nonprofits, and employers working to connect low-skilled public housing residents to employment in connection with the city's sweeping plan to transform public housing. The initiative's leaders realized that new housing would not help if the residents could not meet the work requirement established to qualify for residency. As a result, they included workforce development within the housing initiative's boundaries and established Opportunity Chicago, the collective impact initiative that ultimately placed 6,000 residents in jobs.

Boundaries can and do change over time. After nearly a decade of addressing teen substance abuse prevention, Communities That Care is launching a second initiative to address youth nutrition and physical activity, applying the existing structure and stakeholders to a closely related but new topic area within their mission of improving youth health in their region.

Determining geographic boundaries requires the same type of judgment in balancing the local context and stakeholder aspirations. While Shape Up Somerville chose a city-wide focus to tackle childhood obesity, Livewell Colorado addressed the same issue for the entire state by bringing together a more widely dispersed group of representatives from businesses, government, nonprofits, healthcare, schools, and the transportation sector.

Although it is important to create clarity on what is and what is not part of the collective efforts, most boundaries are loosely defined and flexible. Subsequent analysis and activity may draw in other issues, players, and geographies that were initially excluded. Communities That Care, for example, began by serving only Franklin County, and expanded their geographic boundaries in their seventh year to include North Quabbin.

Developing the Strategic Action Framework. Once the initial system boundaries have been established, the task of creating a common agenda must shift to developing a strategic framework for action. This should not be an elaborate plan or a rigid theory of change. The Strive Partnership's "roadmap" for example, fits on a single page and was originally developed in just a few weeks. The strategic framework must balance the necessity of simplicity with the need to create a comprehensive understanding of the issue that encompasses the activities of all stakeholders, and the flexibility to allow for the organic learning

Phases of Collective Impact

Components for Success	PHASE I Building Action	PHASE II Organize for Impact	PHASE III Sustain Action and Impact
Governance and Infrastructure	Identify champions and form cross-sector group	Create infrastructure (backbone and processes)	Facilitate and refine
Strategic Planning	Map the landscape and use data to make case	Create common agenda (goals and strategy)	Support implementation (alignment to goals and strategies)
Community Involvement	Facilitate community outreach	Engage community and build public will	Continue engagement and conduct advocacy
Evaluation and Improvement	Analyze baseline data to identify key issues and gaps	Establish shared metrics (indicators, measurement, and approach)	Collect, track, and report progress (process to learn and improve)

process of collective impact to unfold. This framework for action can serve a critical role in building a shared agenda. As Chad Wick, one of the early champions of The Strive Partnership explains, "Our map got everyone to suspend their own view of the world and got us on a common page from which to work. It allowed others to suspend their preconceived views and be open minded about what was and what could be."

Successful frameworks include a number of key components: a description of the problem informed by solid research; a clear goal for the desired change; a portfolio of key strategies to drive large scale change; a set of principles that guide the group's behavior; and an approach to evaluation that lays out how the collective impact initiative will obtain and judge the feedback on its efforts.

Since 2002, the Tamarack Institute has been guiding Canada's approach to fighting poverty through the Vibrant Communities initiative in a dozen Canadian cities. The Tamarack Institute refers to their strategic action frameworks as "frameworks-for-change," and cogently describes their value as follows: "A strong framework for change, based on strong research and input from local players, shapes the strategic thinking of the group, helps them make tough choices about where to spend their time and energy, and guides their efforts at monitoring and evaluating their work. Ask anyone involved in the effort about where they are going and their road map for getting there, and they will tell you."[4]

We believe their description applies equally well to any strategic action framework that guides a common agenda. Our experience also suggests that it may not always make sense to start off by implementing every single strategy identified in the common agenda. It is also important to pursue a portfolio of strategies that offer a combination of easy but substantive short-term wins to sustain early momentum for the initiative, as well as more ambitious, long-term systemic strategies that may not show impact for several years.

Importantly, strategic action frameworks are not static. Tamarack goes on to note: "They are working hypotheses of how the group believes it can [achieve its goals], hypotheses that are constantly tested through a process of trial and error and updated to reflect new learnings, endless changes in the local context, and the arrival of new actors with new insights and priorities."

> Hundreds of organizations and individuals from every continent in the world, even including the White House, have reached out to describe their efforts to use collective impact.

FSG research bears out this need for continuous adaptation. The Strive Partnership has evolved their roadmap three times in the last five years. GAIN has built in a robust feedback loop from its programming, and over the past eight years has incorporated best practices and lessons learned as a fundamental component of its fourth annual strategic action framework. And Communities That Care has revised its community action plan three times in the last eight years.

Implementing a collective impact approach with this type of fluid agenda requires new types of collaborative structures, such as shared measurement systems and backbone organizations.

SHARED MEASUREMENT SYSTEMS

Practitioners consistently report that one of the most challenging aspects to achieving collective impact is shared measurement—the use of a common set of measures to monitor performance, track progress toward goals, and learn what is or is not working. The traditional paradigm of evaluation, which focuses on isolating the impact of a single organization or grant, is not easily transposed to measure the impact of multiple organizations working together in real time to solve a common problem. Competing priorities among stakeholders and fears about being judged as underperforming make it very hard to agree on common measures. Organizations have few resources with which to measure their own performance, let alone develop and maintain a shared measurement system among multiple organizations.

Yet shared measurement is essential, and collaborative efforts will remain superficial without it. Having a small but comprehensive set of indicators establishes a common language that supports the action framework, measures progress along the common agenda, enables greater alignment among the goals of different organizations, encourages more collaborative problem-solving, and becomes the platform for an ongoing learning community that gradually increases the effectiveness of all participants.[5] Mutually reinforcing activities become very clear once the work of many different organizations can be mapped out against the same set of indicators and outcomes.

Consider the collective impact effort to reduce homelessness in Calgary, Canada, supported by the Calgary Homeless Foundation (CHF). When stakeholders first came together to define common measures of homelessness, they were shocked to discover that the many agencies, providers, and funders in Calgary were using thousands of separate measures relating to homelessness. They also found that providers had very different definitions of key terms, such as the "chronic" versus "transitional" homeless, and that their services were not always aligned to the needs of the individuals served. Merely developing a limited set of eight common measures with clear definitions led to improved services and increased coordination. Even privacy issues, a major legal obstacle to sharing data, were resolved in ways that permitted sharing while actually increasing confidentiality. As Alina Turner, vice president of strategy at CHF put it, "Putting shared measures in place is a way to start the deeper systems change in a way that people can get their heads around . . . starting from a common framework to get alignment across a whole system of care."

Developing an effective shared measurement system requires broad engagement by many organizations in the field together with clear expectations about confidentiality and transparency. The Calgary homelessness initiative worked with both

a cross-sector advisory committee and a service provider committee to develop common measures from evidence-based research. The measures were then refined through iterative meetings with dozens of stakeholders before being finalized.

Shared measurement systems also require strong leadership, substantial funding, and ongoing staffing support from the backbone organization to provide training, facilitation, and to review the accuracy of data. In CHF's case, the foundation funded and staffed the development of the homelessness management information system (HMIS) and the process of developing shared measures.

Developments in web-based technology permit huge numbers of stakeholders to use shared measurement inexpensively in ways that would have been impossible even a few years ago. CHF has adopted a sophisticated HMIS system with different levels of secure data access for providers, government agencies, and funders. The Strive Partnership, in collaboration with Cincinnati Public Schools, Procter & Gamble, and Microsoft, has made major advances in shared measurement by introducing the "Learning Partner Dashboard," a web-based system that allows schools and nonprofit providers to access data including the performance of individual students and the specific services they receive. Memphis Fast Forward's Operation, Safe Community, built a tool for tracking and publicizing county-wide crime data and facilitated the memorandum of understanding that resulted in data sharing and participation by all five local municipal police departments and the Sheriff's office.

Having shared measures is just the first step. Participants must gather regularly to share results, learn from each other, and refine their individual and collective work based on their learning. Many initiatives use standardized continuous improvement processes, such as General Electric's Six Sigma process or the Model for Improvement. In the case of GAIN, the initiative has both a performance framework and rigorous monitoring and evaluation criteria which feed into an organization-wide learning agenda. Their Partnership Council, comprised of world experts in the fields of nutrition, agriculture, economics, and business, advises the board of directors on the learning agenda, reviews the data to ensure its integrity, and recommends programmatic and management improvements.

> There is no other way society will achieve large-scale progress against urgent and complex problems, unless a collective impact approach becomes the accepted way of doing business.

Regardless of the continuous improvement approach chosen, the backbone organization plays a critical role in supporting the process of learning and improving throughout the life of the collaborative.

KEEPING COLLECTIVE IMPACT ALIVE

Two key structural elements enable collective impact initiatives to withstand the overwhelming challenges of bringing so many different organizations into alignment and holding them together for so long: the *backbone organization* and *cascading levels of linked collaboration.*

Backbone Organization. In our initial article we wrote that "creating and managing collective impact requires a separate organization and staff with a very specific set of skills to serve as the backbone for the entire initiative." We also cautioned, "Coordinating large groups in a collective impact initiative takes time and resources, and too often, the expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails."

Our subsequent research has confirmed that backbone organizations serve six essential functions: providing overall strategic direction, facilitating dialogue between partners, managing data collection and analysis, handling communications, coordinating community outreach, and mobilizing funding.

Although the core backbone functions are consistent across all of the collective impact initiatives we have studied, they can be accomplished through a variety of different organizational structures. (See "Backbone Organizations" on page 7.) Funders, new or existing nonprofits, intermediaries like community foundations, United Ways, and government agencies, can all fill the backbone role. Backbone functions can also be shared across multiple organizations. The Magnolia Place Community Initiative in Los Angeles, for example, strives to optimize family functioning, health and well-being, school readiness, and economic stability for a population of 100,000. The Initiative has a small, dedicated staff that drives the work. Multiple partner organizations from the 70 organizations in the network fulfill different backbone functions, such as collecting and analyzing data, and maintaining a coherent strategic vision through communications.

Each structure has pros and cons, and the best structure will be situation-specific, depending on the issue and geography, the ability to secure funding, the highly important perceived neutrality of the organization, and the ability to mobilize stakeholders. Backbone organizations also face two distinct challenges in their leadership and funding. No collective impact effort can survive unless the backbone organization is led by an executive possessing strong adaptive leadership skills; the ability to mobilize people without imposing a predetermined agenda or taking credit for success. Backbone organizations must maintain a delicate balance between the strong leadership needed to keep all parties together and the invisible "behind the scenes" role that lets the other stakeholders own the initiative's success.

Backbone organizations must also be sufficiently well resourced. Despite the growing interest in collective impact, few funders are yet stepping up to support backbones associated with the issues they care about. Adopting a collective impact approach requires a fundamental shift in the mindset of many funders who are used to receiving credit for supporting specific short-term interventions. Collective impact offers no silver bullets. It works through many gradual improvements over time as stakeholders learn for themselves how to become more aligned and effec-

tive. Funders must be willing to support an open-ended process over many years, satisfied in knowing that they are contributing to large scale and sustainable social impact, without being able to take credit for any specific result that is directly attributable to their funding.

Worse, backbone organizations are sometimes seen as the kind of overhead that funders so assiduously avoid. Yet effective backbone organizations provide extraordinary leverage. A backbone's funding is typically less than 1 percent of the total budgets of the organizations it coordinates, and it can dramatically increase the effectiveness of the other 99 percent of expenditures. Backbone organizations can also attract new funds. As mentioned above, both GAIN and Communities That Care have raised substantial new funding for their work.

Even the best backbone organization, however, cannot single-handedly manage the work of the hundreds of stakeholders engaged in a collective impact initiative. Instead, different levels of linked collaboration are required.

Cascading Levels of Linked Collaboration. We have observed markedly similar patterns in the way successful collective impact efforts are structured across many different issues and geographies. Each begins with the establishment of an oversight group, often called a steering committee or executive committee, which consists of cross-sector CEO level individuals from key organizations engaged with the issue. Under the best circumstances, the oversight group also includes representatives of the individuals touched by the issue. This steering committee works to create the common agenda that defines the boundaries of the effort and sets a strategic action framework. Thereafter, the committee meets regularly to oversee the progress of the entire initiative.

Once the strategic action framework is agreed upon, different working groups are formed around each of its primary leverage points or strategies. GAIN, for example, is overseen by a board of directors, with a 100-person secretariat that operates through four program initiatives: large-scale fortification, multi-nutrient supplements, nutritious foods during pregnancy and early childhood, and enhancing the nutritional content of agriculture products. These programs are supported by 15 working groups on both technical and programmatic topics like salt iodization, infant and child nutrition, and advocacy, as well as functional working groups on evaluation and research, communications, and donor relations. Livewell Colorado operates with 22 cross-sector coalitions that reinforce the state's common agenda within individual communities. Communities That Care has three working groups focused on parent education, youth recognition, and community norms, and a school health task force. More complicated initiatives may have subgroups that take on specific objectives within the prioritized strategies.

Although each working group meets separately, they communicate and coordinate with each other in cascading levels of linked collaboration. Effective coordination by the backbone can create aligned and coordinated action among hundreds of organizations that simultaneously tackle many different dimensions of a complex issue. The

Backbone Organizations

Type of Backbone	Description	Example	Pros	Cons
Funder-Based	One funder initiates CI strategy as planner, financier, and convener	Calgary Homeless Foundation	◆ Ability to secure start-up funding and recurring resources ◆ Ability to bring others to the table and leverage other funders	◆ Lack of broad buy-in if CI effort seen as driven by one funder ◆ Lack of perceived neutrality
New Nonprofit	New entity is created, often by private funding, to serve as backbone	Community Center for Education Results	◆ Perceived neutrality as facilitator and convener ◆ Potential lack of baggage ◆ Clarity of focus	◆ Lack of sustainable funding stream and potential questions about funding priorities ◆ Potential competition with local nonprofits
Existing Nonprofit	Established nonprofit takes the lead in coordinating CI strategy	Opportunity Chicago	◆ Credibility, clear ownership, and strong understanding of issue ◆ Existing infrastructure in place if properly resourced	◆ Potential "baggage" and lack of perceived neutrality ◆ Lack of attention if poorly funded
Government	Government entity, either at local or state level, drives CI effort	Shape Up Somerville	◆ Public sector "seal of approval" ◆ Existing infrastructure in place if properly resourced	◆ Bureaucracy may slow progress ◆ Public funding may not be dependable
Shared Across Multiple Organizations	Numerous organizations take ownership of CI wins	Magnolia Place	◆ Lower resource requirements if shared across multiple organizations ◆ Broad buy-in, expertise	◆ Lack of clear accountability with multiple voices at the table ◆ Coordination challenges, leading to potential inefficiencies
Steering Committee Driven	Senior-level committee with ultimate decision-making power	Memphis Fast Forward	◆ Broad buy-in from senior leaders across public, private, and nonprofit sectors	◆ Lack of clear accountability with multiple voices

real work of the collective impact initiative takes place in these targeted groups through a continuous process of "planning and doing," grounded in constant evidence-based feedback about what is or is not working.

The working groups typically develop their own plans for action organized around "moving the needle" on specific shared measures. Once plans are developed, the working groups are then responsible for coming together on a regular basis to share data and stories about progress being made, and for communicating their activities more broadly with other organizations and individuals affected by the issue so that the circle of alignment can grow. This confers an additional benefit of collective impact: as the common agenda's center of gravity becomes more apparent to all those working on the issue, even people and organizations who have not been directly engaged as a formal part of the initiative start doing things in ways more aligned to the effort. Brenda Ranum, a leader within The Northeast Iowa Food & Fitness Initiative that has brought five rural counties together to improve access to healthy, locally grown foods and to create opportunities for physical activity, refers to this benefit in alignment as getting "order for free." In our own consulting work supporting collective impact initiatives for issues as varied as juvenile justice reform, sustainable fishing, education reform, youth development, and agricultural development, we have also observed the benefits of this "order for free" phenomenon.

The backbone organization provides periodic and systematic assessments of progress attained by the various work groups, and then synthesizes the results and presents them back to the oversight committee that carries the sustaining flame of the common agenda.

The number of working groups and the cascading layers of collaboration may also change over time. As working group strategies are modified based on an examination of what is working, some groups may end and new ones begin to pursue newly identified strategies defined by the common agenda. What is critically important is that all strategies pursued clearly link back to the common agenda and shared measures, as well as link to each other.

Memphis Fast Forward illustrates how one community can address multiple complex issues through this multi-level cascading structure. The work of Memphis Fast Forward is overseen by a 20-person cross-sector steering committee with the goal of making Memphis one of the most successful economic centers in the southern United States. They developed a common agenda focused on four key levers: public safety, education, jobs, and government efficiency. Each lever constitutes its own sub-initiative and is overseen by its own cross-sector steering committee and supported by a dedicated backbone organization. Each sub-initiative then cascades into linked working groups focused around the strategic levers unique to each of the four selected areas. Public Safety, for example, has developed its own strategic action framework that has 15 strategies, each with lead partners and cross-sector representation. The combined efforts of these linked work groups has led to a decrease in violent and property crimes of 26 percent and 32 percent respectively over the last five years.

One of the lead individuals associated with Memphis Fast Forward characterizes both the challenges and the value of this approach: "By using a decentralized but linked approach, each effort has its own governance and unique structure but all efforts come together to share learnings. It took us a while to realize the value in formally bringing the backbone organization leaders together for sharing and problem solving. Initially, the different initiatives were only loosely communicating, but then we realized that we had a great opportunity to all learn from each other and should do so more intentionally and proactively." Now leaders from the four initiatives meet monthly.

THE ESSENTIAL INTANGIBLES OF COLLECTIVE IMPACT

Our guidance here on implementing collective impact has said little about the "softer" dimensions of any successful change effort, such as relationship and trust building among diverse stakeholders, leadership identification and development, and creating a culture of learning. These dimensions are essential to successfully achieving collective impact. We, as well as others, have written extensively about the profound impact that getting the soft stuff right has on social change efforts. And indeed, all of the successful collective impact practitioners we've observed can cite numerous instances when skillful implementation of these intangible dimensions was essential to their collective efforts.

One such intangible ingredient is, of all things, food. Ask Marjorie Mayfield Jackson, founder of the Elizabeth River Project, what the secret of her success was in building a common agenda among diverse and antagonistic stakeholders, including aggressive environmental activists and hard-nosed businessmen. She'll answer, "Clam bakes and beer." So too, The Tamarack Institute has a dedicated "Recipes Section" on its website that recognizes "how food has been that special leaven in bringing people together." In attempting collective impact, never underestimate the power and need to return to essential activities that can help clear away the burdens of past wounds and provide connections between people who thought they could never possibly work together.

As much as we have tried to describe clear steps to implement collective impact, it remains a messy and fragile process. Many attempts will no doubt fail, although the many examples we have studied demonstrate that it can also succeed. Yet even the attempt itself brings one important intangible benefit that is in short supply nowadays: hope. Despite the difficulty of getting collective impact efforts off the ground, those involved report a new sense of optimism that dawns early on in the process. Developing the common agenda alone has produced remarkable changes in people's belief that the future can be different and better even before many changes have been made. For many who are searching for a reason to hope in these difficult times, this alone may be purpose enough to embrace collective impact. ❖

1 Originally named Strive when the earlier article appeared.

2 http://www.strivetogether.org/wp-content/uploads/2011/11/2011-Strive-Partnership-Report.pdf.

3 We described the qualities of such a leader as Adaptive Leadership, in Ronald Heifetz, John Kania, and Mark Kramer, "Leading Boldly," *Stanford Social Innovation Review*, winter 2004.

4 *Cities Reducing Poverty: How Vibrant Communities Are Creating Comprehensive Solutions to the Most Complex Problems of Our Times*, The Tamarack Institute, 2011: 137.

5 Mark Kramer, Marcie Parkhurst, and Lalitha Vaidyanathan, *Breakthroughs in Shared Measurement and Social Impact*, FSG, 2009.

Collective Impact Maturity Model for Community Health Improvement

Bill Barberg, President, Insightformation, Inc. March 2013

For decades, communities have struggled with implementing plans to achieve health improvement goals. Research published in the Stanford Social Innovation Review has identified five conditions of achieving "Collective Impact." This assessment identifies different levels of accomplishment for each of those conditions. Identifying where your community is in each of these vital areas is an ideal way to being the process of moving to a higher level of practices and results. Rate your organization/community on a scale of 1.0 to 4.0 on the following scale for each of the five conditions:

Starting Point	Making Some Progress	Better Approaches	Best of Promising Practices

COMMON AGENDA: Developing and Managing a Shared Strategy for Change

1. **Starting Point:**
   - Organizations are each following their own agendas without shared priorities goals or strategies.
   - Efforts are fragmented, duplicated, and there is inconsistent use of language and concepts.
2. **Making Some Progress**
   - Working together on a Community Health Needs Assessment leads to agreement on priority health issues.
   - Community organizations come together to set goals, but there is still poor alignment and collaboration on the strategies to achieve the goals.
   - Individual organizations independently develop plans or logic models to justify their actions and get funding.
3. **Better Approaches:**
   - Organizations work together to identify the underlying causes and key strategies for addressing priority issues
   - Organizations seek to find and share proven and promising practices to improve efficiency and effectiveness.
   - Strategy Maps are collaboratively developed for each of the priority issues
4. **Best of Promising Practices:**
   - A "zoomable" Strategy Map framework helps align the efforts of many community partners around the jointly-developed strategy maps.
   - All Objectives have clear "From-To Gaps" and may identify barriers and/or Key Success Factors (KSFs).
   - Strategy Maps development is integrated with Quality Improvement practices and techniques.
   - Funders and cross-sector teams actively collaborate on strategy refinement and implementation.
   - The strategy is managed by a cross-section of community leaders using state-of-the-art techniques and tools.

SHARED MEASUREMENT: Deploying a Shared System of Strategic Measurement

1. **Starting Point:**
   - Measurement chaos. There is a lot of duplicated work developing measures and collecting data, and most organizations use different, inconsistent measure definitions.
   - The measurement that is being done produces limited value. Most measures are health status measures or highly-aggregated community statistics that do little to help manage strategy implementation.
2. **Making Some Progress**
   - High-level Outcome measures are tracked, and there is agreement to work toward specific goals (SMART Goals).
   - Individual programs are measured with operational measures like inputs, outputs, efficiency and effectiveness.

- Program measures are used primarily for evaluation at the end of a program.
- Data is increasingly used for decisions, and discussions look at how to move the measures.

3. **Better Approaches:**
   - Balanced Scorecard concepts and practices (such as clarifying objectives, measures, targets and initiatives) are used for organizations to measure their strategy (both drivers and outcomes).
   - There is improved standardization in how measures are defined and used among different groups, along with increased data sharing.
   - There are common reports that include measures for a variety of organizations as well as agreed-upon community indicators.
   - Measures are used as a catalyst to improve performance at each stage of strategy development and execution.
4. **Best of Promising Practices:**
   - The Community Balanced Scorecard" (CBSC) approach is used to measure multiple aspects of the strategy.
   - Strategy management software makes strategy measurement easy and efficient. Presentation-ready formats minimize the time spent re-entering and re-packaging information for different audiences.
   - Leading and Lagging indicators are used to continually improve alignment, resource allocation and strategy execution. Multiple funders monitor initiatives, strategic drivers, and project progress with a shared system.
   - Data is efficiently shared, minimizing redundant data collection, and community organizations work to improve the quality of the data for the measures they are sharing.
   - Operational systems allow information on individuals to be appropriately shared among organizations and efficiently aggregated for community-level measures.

MUTUALLY-REINFORCING ACTIVITIES: Working as a Team to Do More with Less

1. **Starting Point:**
   - Projects are launched (and managed) by different organizations and are not part of a coordinated community strategy.
   - Most organizations are not even aware of what other organizations are planning to do in similar areas.
   - Many organizations work on similar things and duplicate work in many ways.
   - Organizations striving to do similar things compete for resources rather than seeking ways to share their efforts to do more with less.
2. **Making Some Progress**
   - Projects are tied to priority health issues, but with little emphasis on teamwork to improve effectiveness.
   - Funders may encourage collaboration (in theory), but still use competitive ways of granting resources.
   - Some progress is made in linking funding to project implementation to increases accountability.
   - There are discussions of how to reinforce each other's activities to achieve better Collective Impact.
3. **Better Approaches:**
   - Multiple organizations align their efforts around shared Strategy Maps to so their unique strengths can be best used to accomplish specific objectives that together advance an overall strategy..
   - Collaborative work on strategic objectives expands awareness of who is working on what, and increases sharing of ideas, practices, data, and tools that reduces the "re-inventing the wheel" on projects that are launched.
   - Gaps are identified, and organizations that may fill those gaps are invited to collaborate to improve overall community effectiveness.
   - An organized framework of community work enhances efforts to seek and win large grants.

4. Best of Promising Practices:

- Organizing Initiatives/Projects and programs around a "Zoomable" strategy map framework allows information on a large number of projects to be efficiently monitored and reported on.
- The shift from organization-centric planning to community strategy-centric planning brings groups together to determine how they can best combine their efforts to stretch scarce resources.
- Funders shift from rewarding projects based on individual success to rewarding collaboration and sharing.
- Projects are consistently woven together to create lasting, sustainable outcomes, optimizing community assets.
- Multiple organizations work with individuals based on coordinated care plans and shared information.

CONTINUOUS COMMUNICATION: Staying Informed, Learning, and Efficiently Collaborating

1. Starting Point:

- Very little communication among the many organizations working to improve health.
- Promising practices, materials, insights, data and expertise are rarely shared to help other organizations be more successful in achieving health improvement goals (due to both inward-focused mindsets and lack of good tools).
- People wanting information on community health issues need to seek it out from a variety of different sources.

2. Making Some Progress

- Community-wide meetings occur, but on-going information exchange is still rare and not in very useful formats.
- Cross-organization task teams are established, but they are not very effective, nor are they equipped with efficient tools to support efficient and effective collaboration.
- A variety of Websites have information that is shared, but it tends to be either overwhelming or fragmented so the use and value is limited.
- Attempts are made to use on-line tools, but those efforts are not based on best practices.

3. Better Approaches:

- Regular meetings and reports keep a wide range of stakeholders informed—and keep work from slipping.
- Action Teams work to learn from each other and from peers around the country to improve performance.
- There is reasonably good communication among the members—but it is time-intensive for staff and relies on E-mail, documents, PowerPoint, Excel and phone calls.
- Information is communicated to a variety of audiences in various ways—Website, reports, etc.

4. Best of Promising Practices:

- On-line tools with interactive, presentation-ready formats greatly reduce the time required to keep everyone informed.
- 24x7 access to centralized information optimized for different audiences keeps strategy execution top-of-mind and at people's fingertips.
- A well-designed set of wikis support rapid access to the information people need to act effectively—measures, project status, intentions and plans are available for those who care about them.
- Many partners and individuals efficiently update centralized information to accelerate progress.
- People across the community can access the most current information (maintained in one place) on a variety of Websites.
- Care providers (clinical and social) have up-to-date information on patients, even across multiple organizations

BACKBONE SUPPORT: Helping to Coordinate, Align, and Managed Successful Collective Impact

1. Starting Point:
    - No formal backbone organization exists.
    - Efforts to collaborate are difficult because there is no structure or leadership to help communicate, coordinate and align efforts.
    - There is little appreciation for the value of backbone support.

2. Making Some Progress
    - A "backbone organization" exists to serve as a mutual convener and help facilitate collaboration.
    - The backbone organization uses a people-based approach and basic technologies (documents, PowerPoint, Excel and E-mail) approach to support communication and collaboration.
    - Progress is slow because so much depends on a backbone organization that has insufficient staff and resources.

3. Better Approaches:
    - The backbone organization is reasonably well funded and has dedicated staff.
    - The community partners work together with the backbone organization to attempt to achieve all the conditions of Collective Impact.
    - The backbone support helps with community progress, but the constrained capacity of the backbone organization limits the scope of issues and organizations that can be involved.
    - The backbone staff may struggle with information overload, but they work hard to accomplish coordination and communication (using the limited tools that they have available).

4. Best of Promising Practices:
    - A backbone organization has staff along with the appropriate "digital backbone" infrastructure to allow the dedicated staff to be much more efficient and successful.
    - The on-line information management tools do much of the heavy lifting for communication, monitoring, and alignment.
    - The backbone organization is much more sustainable, because it can support more issues with fewer staff because it has the appropriate tools—which cost less than staff and scale more easily.
    - Community Partners are able to take on more of the workload (reducing the burden on the backbone organization) because they can leverage the 'digital backbone" technologies.
    - A blend of person-based, strategic and operational tools allows flexible and efficient collaboration at many different levels: strategic, operational, and relational.
    - Organizations across the community see great value in how the backbone organization and on-line infrastructure saves them time and money—so they are willing to keep funding the backbone function.

For more information on improving on this Collective Impact Maturity Model, please contact Bill Barberg.

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The Necessary Evolution of Practices to Support Collective Impact

Bill Barberg, President, Insightformation, Inc. July 6, 2013

The concept of "Collective Impact" (CI) as articulated in recent articles in the Stanford Social Innovation Review has been rapidly gaining momentum among organizations and programs that attempt to address the complex issues facing our society. The five conditions that lead to Collective Impact are clear and compelling, but achieving Collective Impact has been rare and costly. One of the primary reasons that communities and programs that aspire to achieve Collective Impact find it so difficult is that the typical practices that are used to achieve each of the five conditions are practices that were developed in an era of isolated impact. Each of the practices listed in the left column of the table below is common drives organizations to become more isolated, not collaborative.

Many of these practices are still being taught as best practices and are embedded in grant guidelines and programs that shape the environments where communities are attempting to address their grand challenges. Until these counter-productive practices are changed, attempts to achieve Collective Impact will be fighting an almost unwinnable battle, and countless billions of dollars will be spent in fragmented, redundant, and largely ineffective efforts to impact change. Fortunately, each of these outdated practices has a proven alternative that can greatly enhance the type of collaboration and teamwork that will strengthen Collective Impact and dramatically improve the efficiency and effectiveness of coalitions attempting to achieve positive community change.

Typical Practices (Driving Isolated Impact, Not CI)	Emerging Best Practices (Strengthening CI)
Common Agenda	
Logic Models	Collaboratively-Developed Strategy Maps
SMART Objectives	Objectives, Measures, Targets, Activities (BSC model)
Shared Measurement	
Shared Outcome Measures	Shared Measurement System
Measures based on Logic Models	Measures based on Community BSC Practices
Mutually-Reinforcing Activities	
Organization-centered planning processes make alignment difficult to establish & manage	Community-centered planning process systematically cascades objectives to align and optimize efforts
Vague definition of roles and commitments to mutually-reinforcing activities.	Well-defined "Community Compact Agreements" clarify and solidify the roles of each organization
Lack of cross-organization visibility hinders the trust and accountability needed for community teamwork	Shared strategy management system builds transparency, accountability and confidence
Continuous Communication	
Frequent meetings of partners	Optimized, on-line collaboration platform
Large static documents	Dynamic, "zoomable" on-line information system
Hand-crafted presentations for each new audience	On-line, self-service, presentation-ready platform with close-to-real-time information (in one place)
Backbone Support	
Staff-based approach to coordinating activities	"Digital Backbone" dramatically streamlines the coordination and information management work
Backbone organization staff does most of the coordination and communication work	Most coordination and communication work is efficiently distributed among partners
Scaling to address more issues requires more staff	Scaling to address more issues gains greater leverage (and value) from the existing digital backbone
Funding focuses on money to keep staff employed	Funds used primarily for achieving results

Learn more our White Paper Series in the Collective Impact Group on www.communitycommons.org or contact bill.barberg@insightformation.com

"Overcoming the Often Unseen Obstacles to Collective Impact"

Part 2 in the Achieving Collective Impact Series (February, 2013)

By Gil Kaufman, President, Insightformation, Inc. www.insightformation.com

TOPIC #2: UPGRADING FROM LOGIC MODELS TO STRATEGY MAPS

This paper is the second in a series focusing on improving the success of achieving Collective Impact. Well-intended use of currently accepted practices can unintentionally undermine efforts to achieve the five conditions of Collective Impact. This paper exposes the disadvantages of using Logic Models at the community level, a practice that is counterproductive in situations where there is the desire to improve results by shifting from an Isolated Impact to a Collective Impact.

The Unintended Consequences of Using Logic Models

Bringing a diverse coalition together to establish a "Common Agenda" is an essential first step in achieving Collective Impact. Unfortunately, the common tool of the Logic Model, which is frequently thought of as a best practice, typically hinders the development and execution of a common strategy to support alignment and effective teamwork.

The Logic Model was a significant improvement in program evaluation twenty years ago when the common approach to program evaluation looked almost exclusively at budgets and activities. It was the clear step forward to require grantees to "connect the dots" between their activities, the outputs, and the outcomes they were attempting to impact. However, the Logic Model tool is based on the *isolated impact* mindset that focuses on judging the effectiveness of *individual* organizations and programs. When many organizations within a community each develop their own Logic Models, the result is entrenched fragmentation. Each organization may use different logic and different techniques to develop their Logic Model. It is common for a funder to request that grant applicants submit a Logic Model with their application. This inevitably creates isolated and inconsistent Logic Models. Creating separate Logic Models does not help align their efforts. As each organization implements its own Logic Model, it becomes increasingly difficult to develop a common agenda. Collectively these organizations lack a shared strategy to address challenges that they cannot individually solve on their own. The result is systemic fragmentation and an intractable "execution gap" with regard to accomplishing the priority community outcomes.

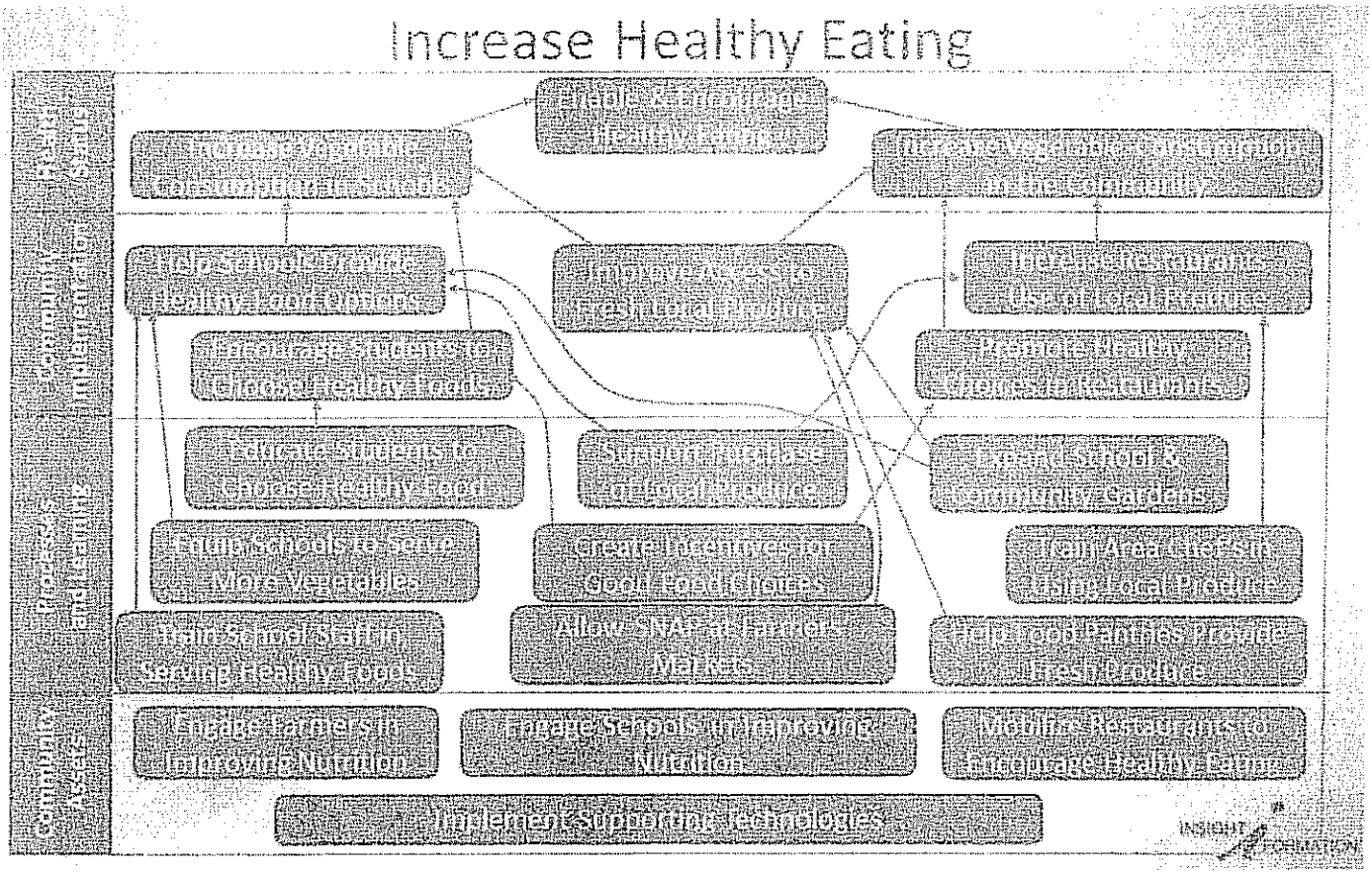
When communities attempt to develop a community-centric Logic Model to address a large issue, they find themselves using a tool that is a poor fit for the task. Logic Models were designed for individual program evaluation, not for forging community collaboration around a shared strategy. It is like trying to fit a square peg in a round hole. There have been attempts to *enhance* Logic Models to work at a community level, but since the fundamental design is not well-suited for community collaboration, those efforts have been of very limited success.

Collaboratively-Developed Strategy Maps: A Much Better Alternative

A superior tool for creating and managing a Common Agenda (and a shared strategy) among many community organizations is a collaboratively-developed Strategy Map. Strategy Maps have emerged as the single most important tool of the Balanced Scorecard methodology—a well-established framework for strategy execution that has been researched, validated and enhanced for over 20 years. The specific details and techniques for collaboratively developing Community Strategy Maps are significantly different from developing business or organizational Strategy Maps, though the underlying concepts remain intact.

The concept of a Community Strategy Map has been validated as a "best practice" in books like the "Public Health Quality Improvement Handbook" (jointly published by the Public Health Foundation and the American Society for Quality) and "More with Less: Maximizing Value in the Public Sector." Community Strategy Maps have been featured in many training sessions by ACHI, NACCHO, ASTHO, NNPHI and have been central to projects funded by the CDC, HRSA, RWJF, and others.

The following is an example of a community strategy map for increasing healthy eating. It focuses on increasing vegetable consumption in schools and in the community.

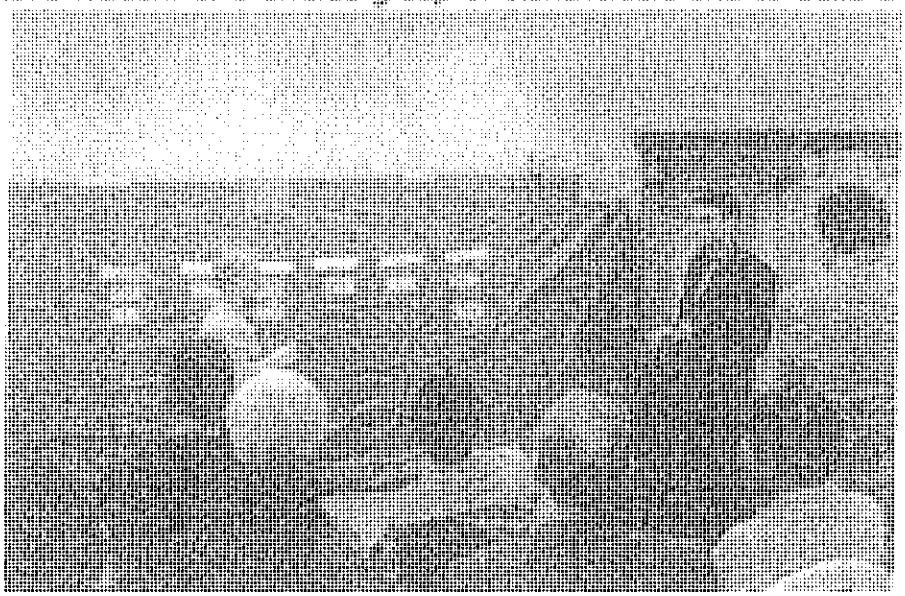


While Strategy Maps may have some superficial resemblance to Logic Models, they are fundamentally different in several key ways. In a Logic Model, each of the "layers" contains a different type of element, such as inputs, outputs, short-term outcomes, long-term outcomes. This nature of these elements makes it almost impossible to scale beyond an individual program. Looking at the inputs or outputs of dozens or hundreds of programs is not practical, and attempts to aggregate inputs or outputs to a community level have proved to be both painful and of little value.

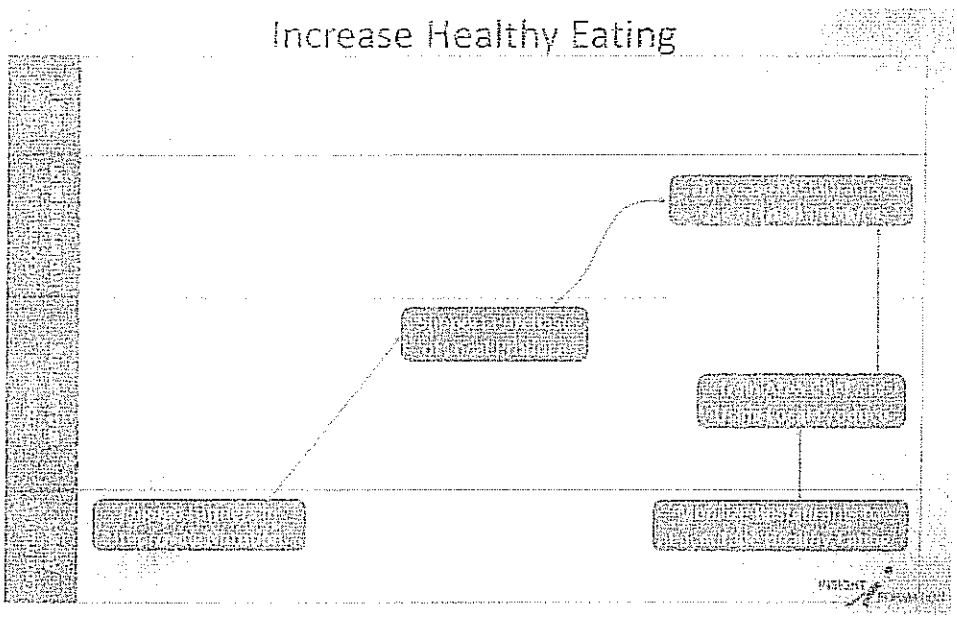
In contrast, with a Strategy Map, each layer looks at different "perspectives" of the strategy, but in each of the perspectives, the building block is the same: *a strategic objective*. Those objectives may deal with outcomes (such as reducing heart disease or reducing the number of adults who smoke), or they may deal with various causal drivers (such as increasing the number of smoke-free areas or expanding advocacy for smoke free environments), or they may deal with mobilizing and engaging community partners or funders. The objectives can be very high level (for a state or community) or more detailed (for individual issues, organizations, neighborhoods or programs). But, the building block is always the same—an objective that clearly defines a desired change. This is very important because it allows the strategy map to be "zoomable" in a way that is conceptually similar to how Google Maps® allows a user to zoom in or zoom out to see whatever level of detail that he or she cares about without being overwhelmed by other details. (*More on zoomability will be covered later in this paper.)*

A Process to Break Down Silos and Establish Shared Ownership

The process for creating Community Strategy Maps is also very different from that of creating organizational or program Logic Models. While the details of the recommended process is beyond the scope of this paper, each step of the recommended process for creating Strategy Maps is designed to bring together the collective wisdom of a diverse group of stakeholders and to build a shared buy-in for the com-munity strategy. This process creates a "Copernican Shift" from organization-centered thinking to community-centered thinking and results in a strategic framework that greatly enhances the ability of many different organizations to align and cooperate to achieve Collective Impact. A collaboratively developed Strategy Map framework is also ideal for delegating work on various sub-sets of the strategy to different multi-organizational teams. Once



developed, it is a best practice to assign an owner or advocate to each objective. In addition, each objective may be assigned to an "advisory team" that will work with a cluster of objectives that are linked in a logical way, such as the objectives below that relate to restaurants serving more locally-grown produce.



When organizational or program objectives are defined, they can be clearly aligned with the larger strategy—whether that is the strategy for something specific like Complete Streets or a higher-level strategy to reduce obesity, or an even higher-level strategy to reduce chronic disease.

The following hyperlink is a 12-minute video on creating collaborative strategy maps that clarifies the many advantages of Strategy Maps versus Logic Models. The recording uses an sample strategy map for Complete Streets)
http://vimeo.com/insightformation/review/55638847/710ed6220e

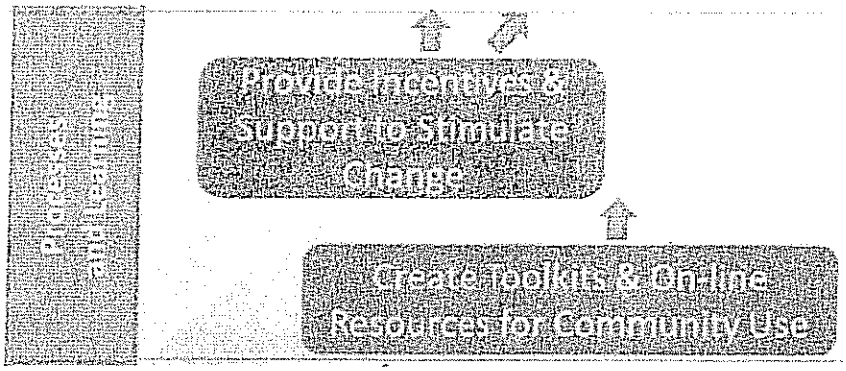
The Importance of "Zoomability" for Strategy Management

One of the keys to strategy management in a complex community setting is the ability to "zoom in" or "zoom out" to different levels of detail. This is achieved by having related strategic objectives at different levels of detail that have different assignments of responsibility, different measures, and different activities. In the Balanced Scorecard model, this is referred to as "cascading," and it is one of important concepts that has contributed to the long-term success of the Balanced Scorecard methodology. When objectives are cascaded, they should provide greater specificity how to carry out the strategy, but they are still not the specific projects or activities that will be done to implement the strategy. (Those may be called initiatives, projects or activities, not objectives.) A thoughtfully-cascaded strategy allows for much-improved prioritization and alignment of the projects that are ultimately selected and implemented.

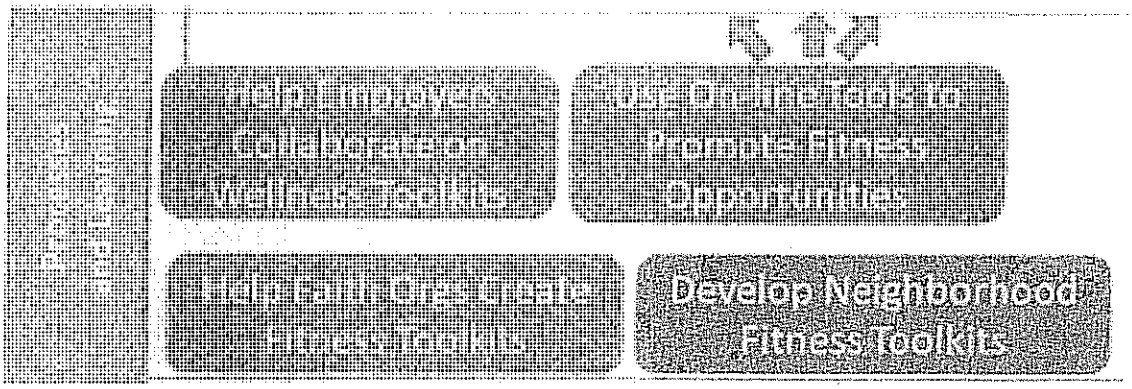
The objectives in a zoomable strategy map are linked together based on either cause & effect logic or zooming into more detail on an objective (such as a sub-set of geography or the sub-sets of an issue—like different types of substance abuse).

There is no single "correct" way to cascade a strategy, but with a strategy management platform, there should be great flexibility for how objectives can relate to one another. In some cases, it may be appropriate to look at more detailed objectives that clarify the choices of how something can be achieved. A high-level objective to "Increase Active Recreation for Youth" may be cascaded to three to five more specific objectives that establish priorities for how the community will create opportunities that had not previously existed. One objective may be to "Increase Informal Recreation Leagues" and another may be to "Promote Biking for Recreation and Transport." These more detailed objectives help a community understand how to make better use of its assets to accomplish those objectives. That could lead to another level of cascading which may include objectives for specific organizations or types of organizations. For example, the school district could have an objective to "Increase After School use of Facilities" and the Parks & Rec department could have an objective to "Engage Civic Groups & Non-profit Organizations in Bike Trail Improvements."

The following example is a Strategy Map from the St. Clair County, Illinois "Get Up & Go!" campaign for improving community health. At the higher level, the strategy includes two objectives for how this campaign will lead to improved fitness.



While these are valuable and provide a general direction for making progress, the more actionable objectives are on the next level strategy maps for "Active Living" and "Healthy Eating." In the Active Living Strategy Map, there are more specific objectives that provide an important level of detail for how the community will "Create Toolkits & On-line Resources for Community Use."



In this example, there are now three more detailed objectives for creating specific kinds of toolkits and one more specific objective for using on-line tools. Each of these objectives can have a different "Lead Advocate" or owner, different measures, and different initiatives (projects or activities). This

ability to agree as a community on the high-level direction and then "zoom in" on the more specific objectives is key to creating the alignment that supports Collective impact. Individual organizations may then define their own objectives that align with the more specific objectives shown on the zoomed in strategy map. A community with a well-developed strategy management system may have one Strategy Map for each priority issue (such as "Minimizing Tobacco Use" or "Maternal and Child Health"). In some cases, there may be a more detailed strategy map for a subset of that higher-level map. Beyond that, the zooming-in may be to more specific objectives that are not necessarily viewed in the typical Strategy Map format, but they are still objectives with all the same attributes that appropriate for objectives. It is the consistent structure of objectives, and the way that they relate to each other, that enables the zoomability that is so important in Community Strategy Maps. This flexible "zoomability" is difficult to achieve in the Logic Model approach, where each link in the cause-and-effect logic has a different definition such as inputs, outputs, short-term outcomes and long-term outcomes.

Logic Models and Shared Measurement

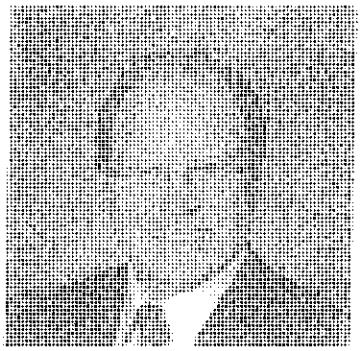
Even if a group pursuing Collective Impact can agree on "Shared Measures" for the main outcomes (like "% of kids reading at grade level in 3rd grade" or "High School graduation rate"), the widespread use of Logic Models will hinder the ability to develop a Shared Measurement System. One of the emerging Collective Impact best practices is to move beyond having just agreed-upon *outcome* measures and have a shared platform that can provide consistency and transparency to monitor a wide range of related measures. When using the Logic Model approach, the recommended approach for measurement is to develop metrics based on the various elements in the Logic Model. If each community partner develops its own Logic Model, this approach to measurement creates a very fragmented set of measures and will likely lead to a great deal of redundancy in data gathering, inconsistent data definitions and other results that will hinder efforts to achieve the benefits of a shared measurement system.

In contrast, when the measurement system is based on the process and structure for Community Strategy Maps that include cascaded objectives, there is a collaborative effort to build consensus on much more than just a few outcome measures. Measures for all the community-focused objectives get created using a process that minimizes redundancy and inconsistently defined measures. When individual programs or organizations create their own measures, they can be confident that they align with higher-level objectives in a rational way. This process also creates a relatively small number of shared strategic measures that exist between the performance measures of organizations or programs and the slowly-changing outcome measures. It is these intermediate measures, which are very difficult to create in a community where measures are based on fragmented Logic Models, that are some of the most valuable measures for monitoring and improving strategy execution.

Conclusion

Logic Models were a useful tool in an era when the focus was on evaluating the isolated impact of individual programs. They may still be useful in some cases for the evaluation of individual programs that are not part of a larger strategy. However, as the concept of Collective Impact gains more and more acceptance and validation as a key to making greater progress on the major challenges in our communities and in our society, it is time to upgrade to a set of tools that support rather than hinder the type of collaboration required to achieve a Collective Impact.

About the Author



Bill Barberg, president of Insightformation, Inc., is a globally-recognized expert on collaborative strategy execution and strategic measurement systems. He has recently presented on best practices for achieving Collective Impact at two national conferences (2012 Association for Strategic Planning, 2012 National Network of Public Health Institutes) and has consulted with a wide variety of organizations and coalitions on collaborative efforts to improve health, environmental, and other community issues. Scorecard and performance expert, James Creelman, author of the recent book, "More with Less: Maximizing Value in the Public Sector" described Mr. Barberg as a "global thought leader" on the topic and stated that "his knowledge of the do's and don'ts of building scorecards is as good as anyone in the world, and some of his innovations (especially around creating space for partner collaborations) are simply unrivalled." LinkedIn 3/30/12

About Insightformation, Inc.

Insightformation, Inc. specializes in strategy management for organizations and communities. Insightformation's strategy management platform, InsightVision is being used by states, counties, communities, hospitals and other organizations for performance management, Collective Impact, and improved strategy execution. Learn more at www.insightformation.com

For More Information,

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Collective Impact Maturity Model for Community Health Improvement

Bill Barberg, President, Insightformation, Inc. March 2013

For decades, communities have struggled with implementing plans to achieve health improvement goals. Research published in the Stanford Social Innovation Review has identified five conditions of achieving "Collective Impact." This assessment identifies different levels of accomplishment for each of those conditions. Identifying where your community is in each of these vital areas is an ideal way to being the process of moving to a higher level of practices and results. Rate your organization/community on a scale of 1.0 to 4.0 on the following scale for each of the five conditions:

Starting Point	Making Some Progress	Better Approaches	Best of Promising Practices

COMMON AGENDA: Developing and Managing a Shared Strategy for Change

1. **Starting Point:**
   - Organizations are each following their own agendas without shared priorities goals or strategies.
   - Efforts are fragmented, duplicated, and there is inconsistent use of language and concepts.
2. **Making Some Progress**
   - Working together on a Community Health Needs Assessment leads to agreement on priority health issues.
   - Community organizations come together to set goals, but there is still poor alignment and collaboration on the strategies to achieve the goals.
   - Individual organizations independently develop plans or logic models to justify their actions and get funding.
3. **Better Approaches:**
   - Organizations work together to identify the underlying causes and key strategies for addressing priority issues
   - Organizations seek to find and share proven and promising practices to improve efficiency and effectiveness.
   - Strategy Maps are collaboratively developed for each of the priority issues
4. **Best of Promising Practices:**
   - A "zoomable" Strategy Map framework helps align the efforts of many community partners around the jointly-developed strategy maps.
   - All Objectives have clear "From-To Gaps" and may identify barriers and/or Key Success Factors (KSFs).
   - Strategy Maps development is integrated with Quality Improvement practices and techniques.
   - Funders and cross-sector teams actively collaborate on strategy refinement and implementation.
   - The strategy is managed by a cross-section of community leaders using state-of-the-art techniques and tools.

SHARED MEASUREMENT: Deploying a Shared System of Strategic Measurement

1. **Starting Point:**
   - Measurement chaos. There is a lot of duplicated work developing measures and collecting data, and most organizations use different, inconsistent measure definitions.
   - The measurement that is being done produces limited value. Most measures are health status measures or highly-aggregated community statistics that do little to help manage strategy implementation.
2. **Making Some Progress**
   - High-level Outcome measures are tracked, and there is agreement to work toward specific goals (SMART Goals).
   - Individual programs are measured with operational measures like inputs, outputs, efficiency and effectiveness.

- Program measures are used primarily for evaluation at the end of a program.
- Data is increasingly used for decisions, and discussions look at how to move the measures.

3. Better Approaches:
   - Balanced Scorecard concepts and practices (such as clarifying objectives, measures, targets and initiatives) are used for organizations to measure their strategy (both drivers and outcomes).
   - There is improved standardization in how measures are defined and used among different groups, along with increased data sharing.
   - There are common reports that include measures for a variety of organizations as well as agreed-upon community indicators.
   - Measures are used as a catalyst to improve performance at each stage of strategy development and execution.
4. Best of Promising Practices:
   - The Community Balanced Scorecard" (CBSC) approach is used to measure multiple aspects of the strategy.
   - Strategy management software makes strategy measurement easy and efficient. Presentation-ready formats minimize the time spent re-entering and re-packaging information for different audiences.
   - Leading and Lagging indicators are used to continually improve alignment, resource allocation and strategy execution. Multiple funders monitor initiatives, strategic drivers, and project progress with a shared system.
   - Data is efficiently shared, minimizing redundant data collection, and community organizations work to improve the quality of the data for the measures they are sharing.
   - Operational systems allow information on individuals to be appropriately shared among organizations and efficiently aggregated for community-level measures.

MUTUALLY-REINFORCING ACTIVITIES: Working as a Team to Do More with Less

1. Starting Point:
   - Projects are launched (and managed) by different organizations and are not part of a coordinated community strategy.
   - Most organizations are not even aware of what other organizations are planning to do in similar areas.
   - Many organizations work on similar things and duplicate work in many ways.
   - Organizations striving to do similar things compete for resources rather than seeking ways to share their efforts to do more with less.
2. Making Some Progress
   - Projects are tied to priority health issues, but with little emphasis on teamwork to improve effectiveness.
   - Funders may encourage collaboration (in theory), but still use competitive ways of granting resources.
   - Some progress is made in linking funding to project implementation to increases accountability.
   - There are discussions of how to reinforce each other's activities to achieve better Collective Impact.
3. Better Approaches:
   - Multiple organizations align their efforts around shared Strategy Maps to so their unique strengths can be best used to accomplish specific objectives that together advance an overall strategy..
   - Collaborative work on strategic objectives expands awareness of who is working on what, and increases sharing of ideas, practices, data, and tools that reduces the "re-inventing the wheel" on projects that are launched.
   - Gaps are identified, and organizations that may fill those gaps are invited to collaborate to improve overall community effectiveness.
   - An organized framework of community work enhances efforts to seek and win large grants.

4. Best of Promising Practices:

- Organizing Initiatives/Projects and programs around a "Zoomable" strategy map framework allows information on a large number of projects to be efficiently monitored and reported on.
- The shift from organization-centric planning to community strategy-centric planning brings groups together to determine how they can best combine their efforts to stretch scarce resources.
- Funders shift from rewarding projects based on individual success to rewarding collaboration and sharing.
- Projects are consistently woven together to create lasting, sustainable outcomes, optimizing community assets.
- Multiple organizations work with individuals based on coordinated care plans and shared information.

CONTINUOUS COMMUNICATION: Staying Informed, Learning, and Efficiently Collaborating

1. Starting Point:

- Very little communication among the many organizations working to improve health.
- Promising practices, materials, insights, data and expertise are rarely shared to help other organizations be more successful in achieving health improvement goals (due to both inward-focused mindsets and lack of good tools).
- People wanting information on community health issues need to seek it out from a variety of different sources.

2. Making Some Progress

- Community-wide meetings occur, but on-going information exchange is still rare and not in very useful formats.
- Cross-organization task teams are established, but they are not very effective, nor are they equipped with efficient tools to support efficient and effective collaboration.
- A variety of Websites have information that is shared, but it tends to be either overwhelming or fragmented so the use and value is limited.
- Attempts are made to use on-line tools, but those efforts are not based on best practices.

3. Better Approaches:

- Regular meetings and reports keep a wide range of stakeholders informed—and keep work from slipping.
- Action Teams work to learn from each other and from peers around the country to improve performance.
- There is reasonably good communication among the members—but it is time-intensive for staff and relies on E-mail, documents, PowerPoint, Excel and phone calls.
- Information is communicated to a variety of audiences in various ways—Website, reports, etc.

4. Best of Promising Practices:

- On-line tools with interactive, presentation-ready formats greatly reduce the time required to keep everyone informed.
- 24x7 access to centralized information optimized for different audiences keeps strategy execution top-of-mind and at people's fingertips.
- A well-designed set of wikis support rapid access to the information people need to act effectively—measures, project status, intentions and plans are available for those who care about them.
- Many partners and individuals efficiently update centralized information to accelerate progress.
- People across the community can access the most current information (maintained in one place) on a variety of Websites.
- Care providers (clinical and social) have up-to-date information on patients, even across multiple organizations

BACKBONE SUPPORT: Helping to Coordinate, Align, and Managed Successful Collective Impact

1. Starting Point:
   - No formal backbone organization exists.
   - Efforts to collaborate are difficult because there is no structure or leadership to help communicate, coordinate and align efforts.
   - There is little appreciation for the value of backbone support.

2. Making Some Progress
   - A "backbone organization" exists to serve as a mutual convener and help facilitate collaboration.
   - The backbone organization uses a people-based approach and basic technologies (documents, PowerPoint, Excel and E-mail) approach to support communication and collaboration.
   - Progress is slow because so much depends on a backbone organization that has insufficient staff and resources.

3. Better Approaches:
   - The backbone organization is reasonably well funded and has dedicated staff.
   - The community partners work together with the backbone organization to attempt to achieve all the conditions of Collective Impact.
   - The backbone support helps with community progress, but the constrained capacity of the backbone organization limits the scope of issues and organizations that can be involved.
   - The backbone staff may struggle with information overload, but they work hard to accomplish coordination and communication (using the limited tools that they have available).

4. Best of Promising Practices:
   - A backbone organization has staff along with the appropriate "digital backbone" infrastructure to allow the dedicated staff to be much more efficient and successful.
   - The on-line information management tools do much of the heavy lifting for communication, monitoring, and alignment.
   - The backbone organization is much more sustainable, because it can support more issues with fewer staff because it has the appropriate tools—which cost less than staff and scale more easily.
   - Community Partners are able to take on more of the workload (reducing the burden on the backbone organization) because they can leverage the 'digital backbone" technologies.
   - A blend of person-based, strategic and operational tools allows flexible and efficient collaboration at many different levels: strategic, operational, and relational.
   - Organizations across the community see great value in how the backbone organization and on-line infrastructure saves them time and money—so they are willing to keep funding the backbone function.

For more information on improving on this Collective Impact Maturity Model, please contact Bill Barberg.

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Collective Impact: Second Insight

The Five Conditions of Collective Impact

Common Agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
Shared Measurement	Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
Mutually Reinforcing Activities	Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
Continuous Communication	Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
Backbone Support	Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

Source: Channeling Change: Making Collective Impact Work
By Fay Hanleybrown, John Kania, & Mark Kramer

Collective Impact Group

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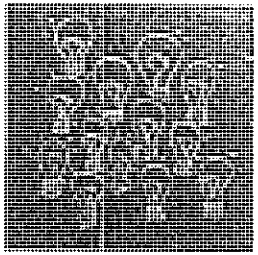

Collective Impact

Public Group active 3 hours, 41 minutes ago

The concept of Collective Impact gained visibility in a Winter 2011 article in the Stanford Social Innovation Review, and it clearly has resonated with a lot of people. Additional articles have since provided more details on the differences between practices that emphasize "Collective Impact" rather than the "Isolated Impact" of individual programs or organizations. Even the authors admit that we are still very early in a journey that should transform many aspects of the non-profit/social sector.

This group will focus on accelerating that learning and spreading the adoption of the practices that lead to Collective Impact. As much sense as it makes to work together, it is certainly not the norm. One purpose of this group will be to explore the main obstacles to Collective Impact and how to overcome them.

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Establishing a Backbone Organization

Backbone Organizations

Types of Backbones	Description	Examples	Pros	Cons
Funder-Based	One funder initiates CI strategy as planner, financier, and convener	Calgary Homeless Foundation	◆ Ability to secure start-up funding and recurring resources ◆ Ability to bring others to the table and leverage other funders	◆ Lack of broad buy-in if CI effort seen as driven by one funder ◆ Lack of perceived neutrality
New Nonprofit	New entity is created, often by private funding, to serve as backbone	Community Center for Education Results	◆ Perceived neutrality as facilitator and convener ◆ Potential lack of baggage ◆ Clarity of focus	◆ Lack of sustainable funding stream and potential questions about funding priorities ◆ Potential competition with local nonprofits
Existing Nonprofit	Established nonprofit takes the lead in coordinating CI strategy	Opportunity Chicago	◆ Credibility, clear ownership, and strong understanding of issue ◆ Existing infrastructure in place if properly resourced	◆ Potential "baggage" and lack of perceived neutrality ◆ Lack of attention if poorly funded
Government	Government entity, either at local or state level, drives CI effort	Shape Up Somerville	◆ Public sector "seal of approval" ◆ Existing infrastructure in place if properly resourced	◆ Bureaucracy may slow progress ◆ Public funding may not be dependable
Shared Across Multiple Organizations	Numerous organizations take ownership of CI wins	Magnolia Place	◆ Lower resource requirements if shared across multiple organizations ◆ Broad buy-in, expertise	◆ Lack of clear accountability with multiple voices at the table ◆ Coordination challenges, leading to potential inefficiencies
Steering Committee Driven	Senior-level committee with ultimate decision-making power	Memphis Fast Forward	◆ Broad buy-in from senior leaders across public, private, and nonprofit sectors	◆ Lack of clear accountability with multiple voices

Source: Channeling Change: Making Collective Impact Work By Fay Hanleybrown, John Kania, & Mark Kramer

Questions Answered in Each Perspective

Outcomes

What **Outcomes** are we striving to achieve?

- Short statements that describe the change
- These will have measures and targets added later

Community Implementation

What Objectives (e.g. types of **Changes, Programs, or Policies)** will our Communities Implement to accomplish the above outcomes?

- Short statements that describe the change
- If we do these things, we will be successful in achieving the outcomes

Processes and Learning

What do we need to change in **how we do things as a community**(e.g. plan, manage, align, learn, collaborate, or generally get things done) in order to successfully implement the above Objectives?

Community Assets

How will we mobilize, leverage and develop our **community assets** in order to accomplish all the Objectives listed above?

Rate Your Organization

Rate your organization on a scale of 1.0 to 4.0 on the following scale for each of the five conditions:

Starting Point		Making Some Progress		Better Approaches		Best of Promising Practices
1.0	1.5	2.0	2.5	3.0	3.5	4.0

COMMON AGENDA: DEVELOPING AND MANAGING A SHARED STRATEGY FOR CHANGE	
Comments:	**Score:**

SHARED MEASUREMENT: DEPLOYING A SHARED SYSTEM OF STRATEGIC MEASUREMENT	
Comments:	**Score:**

MUTUALLY REINFORCING ACTIVITIES: WORKING AS A TEAM TO DO MORE WITH LESS	
Comments:	**Score:**

CONTINUOUS COMMUNICATION: STAYING INFORMED, LEARNING, AND EFFICIENTLY COLLABORATING	
Comments:	**Score:**

BACKBONE SUPPORT: HELPING TO COORDINATE, ALIGN, AND MANAGED SUCCESSFUL COLLECTIVE IMPACT	
Comments:	**Score:**

Rate Your Organization

Rate your organization on a scale of 1.0 to 4.0 on the following scale for each of the five conditions:

Starting Point	Making Some Progress	Better Approaches	Best of Promising Practices
1.0	1.5 2.0 2.5 3.0 3.5		4.0

COMMON AGENDA: DEVELOPING AND MANAGING A SHARED STRATEGY FOR CHANGE

Comments:

Score:

SHARED MEASUREMENT: DEPLOYING A SHARED SYSTEM OF STRATEGIC MEASUREMENT

Comments:

Score:

MUTUALLY-REINFORCING ACTIVITIES: WORKING AS A TEAM TO DO MORE WITH LESS

Comments:

Score:

CONTINUOUS COMMUNICATION: STAYING INFORMED, LEARNING, AND EFFICIENTLY COLLABORATING

Comments:

Score:

BACKBONE SUPPORT: HELPING TO COORDINATE, ALIGN, AND MANAGED SUCCESSFUL COLLECTIVE IMPACT

Comments:

Score:

Workforce Development Plan Worksheet

Step 3 Enablers and Challenges	PHAB Measures/ Activities	Step 1 Current State	Step 2 Purpose, What to Do, How to Do	Step 4 Pause	Step 5 Work Plan	Step 6 Sustaining Gains and Improvements
	Establish relationships with academia (8.1.1 S and 10.1.2 T/S) and others (8.1.1 T/L & 10.2.2 A)					
	Assess HD workforce competencies & gaps (8.2.1 A)					
	Address competency gaps (8.2.1 A)					
	Leadership and management development activities (8.2.2 A)					
	SHD assistance to Tribal & Local HDs (8.2.3 S)					
	Use IT to support HD mission & workforce (11.1.6 A). May support other training-related documentation needs.					
	Integrate Core Competencies into job descriptions (11.1.5 A)					
	Recruitment & retention issues/ needs (11.1.5 A)					
	Other					

Scoring Enablers and Challenges:
1 – weak enabler, 5 – moderate enabler, 10 – major enabler
-1 – minimal challenge, -5 – moderate challenge, -10 – major challenge

Workforce Development Resources from the Public Health Foundation

Council on Linkages Between Academia and Public Health Practice

- Core Competencies for Public Health Professionals (Core Competencies)
  - Tools to assist practitioners use the Core Competencies
  - Examples of Core Competencies use
- Academic Health Department Learning Community
  - Sharing ways to develop, maintain, and enhance relationships between public health practice and academic organizations
  - Most meetings require no travel
  - Free to join – 130 members to date
- Improving and measuring the impact of training
  - Guide being developed to help trainers and sponsors of training improve and measure the impact of training
  - Strategies address ways to assess training needs, motivate learners and trainers, effectively design and deliver training, and evaluate the impact of training
  - Draft document posted online

http://www.phf.org/programs/council/

TRAIN – the nation's premier learning management system for public health

- Over 720,000 registered learners
- Over 29,000 training programs
- Over 4,000 providers of training
- A FREE resource for public health professionals

https://www.train.org/

Learning Resource Center – where public health, healthcare, and allied health professionals find high quality training materials at an affordable price

- Comprehensive selection of public health quality improvement publications
- Many consumer-oriented health education publications
- Search for publications by CDC's Winnable Battles and many other public health topics

http://bookstore.phf.org/

WASHOE COUNTY HEALTH DISTRICT
EPIDEMIOLOGY AND PUBLIC HEALTH PREPAREDNESS DIVISION

Public Health

September 18, 2013

MEMORANDUM

To: Members, Washoe County District Board of Health

From: Randall L. Todd, DrPH
Epidemiology and Public Health Preparedness (EPHP) Director

Subject: Report to the District Board of Health, September 2013

Communicable Disease -
Pertussis
As noted last month there is an ongoing statewide increase in pertussis cases. Another cluster of four probable cases has been identified along with a significant number of contacts in school and daycare. Staff are experimenting with the use of a robo-calling service through Survey Monkey as a more efficient means of following up with contacts and determining the status of medical visits and prophylaxis.

Suspect Mumps
A cluster of 3 suspected mumps cases have been reported among a group of young adults who had been previously vaccinated. Staff are working with our infectious disease consultant to order appropriate lab tests to either confirm the diagnosis of mumps or to identify an alternative etiology consistent with their symptoms.

Public Health Preparedness –
State Site Visit
PHP staff participated in a site visit with Nevada Division of Public and Behavioral Health PHP program staff in a review of both the CDC and ASPR year-end progress report. Much progress was made in the past fiscal/grant year on program requirements. State PHP program seemed pleased with the results and only had clarifying questions about some grant activities.

Collaboration
PHP staff participated in a collaborative effort between PHP, MRC, Sparks Fire and the Sparks Home Depot to provide preparedness outreach to customers during their Saturday Kids Workshop event.

PHP staff is collaborating with Washoe County Emergency Management to bring Kelly Burke as a speaker for the Public Information / Public Warning Taskforce Conference on November 21. This presentation will focus on the significance of communication in effectively managing a crisis and in influencing perceptions. Mr. Burke will also be providing a smaller personalized training to identified WCHD staff who work with the media frequently. Mr. Burke has previously trained staff both at the State

level and here in Washoe County. He is highly respected in his field and is often utilized to train senior staff at the CDC and federal cabinet level personnel.

PHP staff presented to Reno Access Advisory Committee on the progress of the Northern Nevada Access and Functional Needs Workgroup over the past year and on current projects, such as updating the WCHD Public Information and Communication (PIC) plan.

PHP staff has received MOUs from both Sparks Fire Department and Saint Mary's Regional Medical Center to become Private POD Partners. These agreements are awaiting signature by the District Health Officer. These two new partners, along with the other four Private POD Partners (Nevada Energy, Circus Circus, REMSA, and Renown) will pull more than 50,000 individuals away from Health District Public POD operations in the event of a public health emergency. Both Reno Fire and Truckee Meadows Fire are in the process of reviewing MOUs as well.

PHP, CCHS and State EMS staff are collaborating to train approximately 300 Reno, Sparks and Truckee Meadows firefighters/EMTs in the administration of vaccines in the event of a public health emergency. Trainings will take place in late September and early October.

PHP staff participated in the Regional Training and Exercise Planning Workshop (TEPW) and brought the information to the State Health TEPW. TEPW workshops are an important mechanism to ensure that various agencies with requirements to conduct exercises coordinate their efforts for greater efficiency.

Medical Reserve Corps (MRC)

MRC Volunteers continue to be utilized by the immunization program and in vital statistics to help patrons needing assistance in filling out the required forms, and needing directions to other Health District programs and services.

MRC volunteers were instrumental in helping with registering over 100 children in a Child ID Program held during two separate community wide venues.

MRC Volunteer assistance was also present for a blood drawing activity at the Stead area Job Corps Program.

The MRC Program Coordinator was a participant and the MC for the training conference "Health Care: A Diversity & Inclusion Mandate" sponsored by the Northern Nevada Human Resources Association.

Leadership Development

PHP Staff member Christina Conti will graduate from the Chamber Leadership Reno Sparks program this month. This is a 9-month program where Christina represented the Health District at monthly workshops. During the Leadership project, the class designed and rebuilt an accessible playground for the preschool children of Marvin Picollo School.

Randall L Todd

Randall L. Todd, DrPH, Epidemiology and Public Health Preparedness Director

WASHOE COUNTY HEALTH DISTRICT

Public Health
Prevent. Promote. Protect.

DATE: September 26, 2013

TO: District Board of Health Members

FROM: Steve Kutz, RN, MPH, Division Director
Community and Clinical Health Services
(775) 328-3759 skutz@washoecounty.us

SUBJECT: Community and Clinical Health Services (CCHS) Division Report, September 2013 District Board of Health Meeting

1. Divisional Update
2. Program Reports

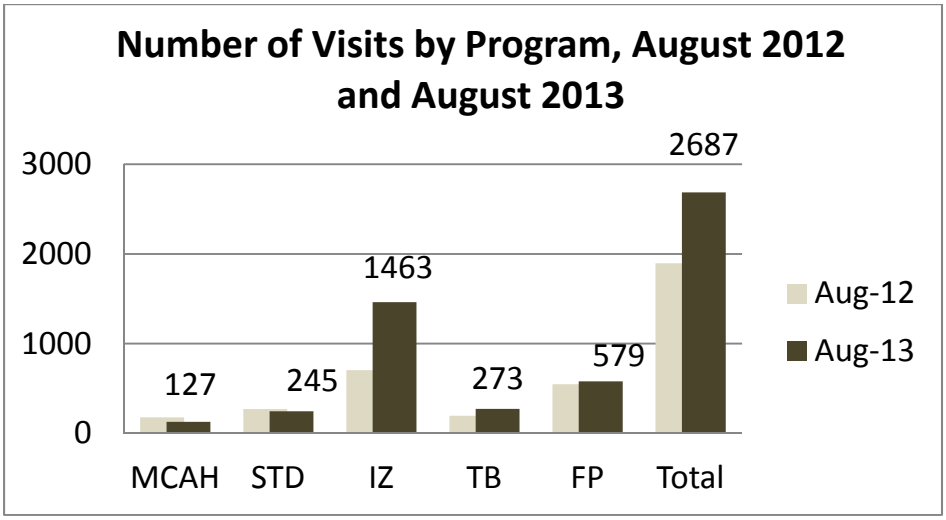
1. Divisional Update –

a. Affordable Care Act – The CCHS Division Director continues work on executing contracts with three qualified health plans (QHPs) on the Nevada Silver State Exchange, the insurance plans that will insure Nevadans as part of the Affordable Care Act (ACA). He also is working on designation as an Essential Community Provider (ECP) for the plans. QHPs are building their provider networks, and must ensure that they have a sufficient number of providers that serve predominately low-income, medically underserved individuals. These providers are considered ECPs. As a reminder, contracts with the QHPs as well as other health plans that are seen in CCHS programs are expected to improve reimbursement and revenue. Management will also be working with staff to better be able to provide information to clients so that they can enroll in a QHP.

b. School Based Health Centers (SBHC) – CCHS management and staff recently met with staff from the Community Health Alliance (merged HAWC and St Mary's Foundation programs) and the Washoe County School District to discuss SBHC, with respect to potential concerns surrounding sexual and reproductive health. To date a feasibility study has been conducted and the school board supports the project. Current plans are for parents and guardians to be given a consent with options to include/exclude various types of services. SBHC services will include primary care, mental and dental care services, which are desperately needed in the more at-risk schools. The current plan involves a pilot SBHC at Wooster High School through the use of a mobile medical van, providing services to Wooster students, and those from the feeder schools. CHA and WCSD stated that CCHS staff with expertise in sexual and reproductive health would likely be invited to a

meeting with the parent advisory board for this project. Staff and management are excited about this project, as it will benefit the students and their families, allowing for students to be able to better focus on school.

c. Data/Metrics –



Changes in data can be attributed to a number of factors – fluctuations in community demand, changes in staffing and changes in scope of work/grant deliverables, resulting in a reduction of direct services available.

2. Program Reports – Outcomes and Activities

a. **Sexual Health –** Staff continues to work diligently to improve data collection and submission processes for the STD and HIV programs. Improved collaboration between the Nevada State Division of Public and Behavioral Health (DPBH), formerly the Nevada State Health Division, and the WCHD to improve data quality are still in progress, with staff reporting increased efficiency and quality.

b. **Immunizations –** With influenza season quickly approaching, the program is prepared to administer a variety of vaccines, including a new quadrivalent presentation. The Immunization Program Coordinator, Lynnie Shore, is educating staff on the various presentations, responding to media requests for information, and ensuring adequate supplies of all vaccine types. Becky Koster is preparing for the fourth year of School Located Vaccination Clinics at approximately 50 schools for the 2013/2014 school year. This is an ongoing partnership with Immunize Nevada, the Washoe County School District and new this year, volunteers from the UNR School of Community Health Sciences. In addition to

influenza immunizations, students will also be offered Tdap to assure protection against vaccine preventable diseases, particularly pertussis in light of the emerging epidemic in Nevada.

Through a partnership with Public Health Preparedness and the area fire districts, Ms. Shore will train local EMTs and paramedics to successfully administer influenza vaccinations as a training exercise for future Point of Distribution (POD) events. A series of classes will be held in October to increase their knowledge and skills regarding the multiple presentations, indications for use, and risks for all population groups.

The HL7 connection between the Health District's EMR system, Insight, and Nevada WebIZ is functioning successfully, and staff is now conducting quality assurance activities to ensure accurate data entry and inventory levels.

c. **Tuberculosis Prevention and Control Program –** Staff continues work on two ongoing contact investigations. The TB program received assistance with the cost of the Quantiferon test (QFT) through Qiagen, Inc., the testing manufacturer. This reduced the operating expenses for testing with both of these investigations. The University of California, San Diego has offered to include the TB Program in a research study on videophone direct observed therapy which offers secure servers and applications to ensure HIPAA compliance, and free phones for clients. Staff are working with administration to obtain approvals to participate in this study. This project will benefit the program and the clients, as mobile technology solutions for direct observed therapy are an ongoing challenge.

d. **Family Planning/Teen Health Mall –** The Title X 2012 Corrective Action Plan was closed on September 11, 2013. All corrections were met, and staff is in the process of initiating the perpetual inventory system. Once this system has been fully implemented the staff will update Region IX.

e. **Chronic Disease Prevention Program –** On September 12, 2013, program staff presented at the Nevada Public Health Association Conference on "Engaging Non-Traditional Partners: Improving Public Health Through Policy, Systems, and Environmental Change at the Local Level". The 5th Annual Obesity Forum was held on September 19, 2013 at UNR. New this year in conjunction with the Obesity Forum, are Healthy Living Week activities, including Parent Night at the Boys & Girls Club, and a screening of *Weight of the Nation* at UNR.

f. **Maternal, Child and Adolescent Health (MCAH) –** The DPBH has granted authority to the Health District to conduct Fetal Infant Mortality Review (FIMR)

activities in Washoe County. The goal of FIMR program is to enhance the well-being of women, infants and families by improving community resources and health delivery systems. The MCAH program is currently developing an implementation plan for this program, which will identify and addresses health concerns preceding fetal and infant deaths. A press release on FIMR activities will soon be released. The Pregnancy Connection program continues to meet grant deliverables and high risk home visitation referrals continue to be received.

Washoe County Health District

ENVIRONMENTAL HEALTH SERVICES DIVISION

DATE: September 13, 2013

TO: District Board of Health Members

FROM: Robert O. Sack, Division Director, Environmental Health Services (EHS)

SUBJECT: Environmental Health Services Division Report for September 2013

Food Program

- Staff approved the first 'Train the Trainer' course in approximately 10 years. Sandi Marcell's Train the Trainer course is for those wishing to become Certified Food Protection Instructors.

Vector-Borne Disease Program

- On September 4, over 700 acres were treated via the final aerial helicopter application. West Nile virus is still with us as two more positive samples were found in the Double Diamond area the first week of September. This gives us a total of ten samples this summer season. Upon discovery of these positive mosquito samples, staff began fogging the areas of Damonte Ranch, Rosewood Lakes, and Bella Vista Ranch. This week the Double Diamond and South Meadows areas were fogged and iIncreased adult activity was reported by staff at Lazy 5 Regional Park. Additional fogging treatments are planned the week of September 16. We need colder weather and a frost to get us out of this virus transmission zone.

- The public health interns started back to school and their part-time schedule is still allowing the Program to continue with catch basin sampling and treatment activities. The interns are sampling hundreds of mosquito larvae in catch basins in Caughlin Ranch, Northwest Reno, Reno High School vicinity, and Edison / Mill Street areas. One of the positive samples collected at the Damonte Ranch in July this year is the same mosquito type found in these catch basins. Over 6,700 catch basins have been sampled and treated this season.

- Dr. Scott Berhardt of Utah State University contacted the Vector-Borne Diseases Program (VBDP) to collect a specific flea for a population genetics study at the CDC Plague Branch in Fort Collins, Colorado. Over the past several weeks, staff trapped ground squirrels and collected the requested Oropsylla montana flea that is common in Washoe County and a competent vector of plague. So far over 100 O. montana fleas have been collected for the study. VBDP staff plans one additional day of trapping at Sand Harbor the week of September 16.

- Building permits have picked up in the past several weeks. Staff has been busy inspecting project sites requiring our design standards and making certain contractors comply. So far this year, 35 projects have been signed off.

Waste Management Program

- HR began recruitment for the Licensed Engineer position.

EHS 2013 Inspections

The numbers listed below do not represent all programs and inspections conducted by staff in EHS.

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	YTD
Child Care	15	9	11	6	15	19	18	26	**119**
Complaints	144	90	149	120	137	78	115	109	**942**
Food	239	404	438	383	378	365	397	412	**3,016**
General *	103	62	109	83	217	170	225	240	**1,209**
Plans (Comm. Food/Pools/Spas)	9	11	11	19	10	6	13	7	**86**
Plans (Residential Septic)	18	15	19	45	36	44	19	41	**237**
Wells	4	13	4	14	0	15	14	20	**84**
Waste Management	8	17	8	18	9	16	11	10	**97**
TOTAL	**540**	**621**	**749**	**688**	**802**	**713**	**812**	**865**	**5,790**

*General Inspections Include: Invasive Body Decorations; Mobile Homes/RVs; Public Accommodations; Pools; Spas; RV Dump stations; and Sewage/Wastewater Pumping.

Robert O. Sack, Division Director
Environmental Health Services Division

Health inspectors keep Sparks Rib Cook-off safe

Aug. 31, 2013 | RGJ

Health inspection of Best in the West Nugget Rib C...: We follow Jim English, environmental health supervisor for the Washoe County Health District, as he inspects Chicago BBQ Co. at the 2013 Best in the West Nugget Rib Cook-off. Chicago BBQ was the 2012 winner of the food festival. Yun Long/RGJ Media

Washoe County environmental health specialist supervisor James English, left, checks the temperature of the ribs at the Checkered Pig booth on Wednesday. Checkered Pig employee Ronnie Foster waits to get back to work. / Tim Dunn/RGJ

If you go

WHAT: Twenty-four rib vendors compete for first place at the Best in the West Nugget Rib Cook-off, with dozens more selling arts and crafts, other food and beverages
WHEN: 11 a.m. to 9 p.m. today through Sunday; 11 a.m. to 5 p.m. Monday
WHERE: Victorian Square, Sparks
DETAILS: www.nuggetribcookoff.com
Click on “Our Video Picks” to watch a video about the process of inspecting the Nugget Rib Cook-off.

Days before the first person ever takes a bite of a pork rib during the Best in the West Nugget Rib Cook-off, the Washoe County Health District has inspected every inch of the food festival.

Eighteen health district employees have volunteered to work during the event, staffing it around the clock as ribs cook overnight.

Inspectors have been working at Victorian Square since Sunday checking booth construction, water lines, refrigeration and proper food storage for the 24 rib booths and the about 80 other food and beverage vendors.

“These facilities are so large,” said Jim English, an environmental health supervisor with Washoe County. “They’re producing as much food as most of the restaurants in town on any given day. So therefore, we make sure they meet our standards prior to doing any food prep whatsoever.”

In the 25 years of the event, no major foodborne illnesses have been reported, English said.

Booths in violation are issued a correction notice. Inspectors have shut down rib vendors in previous years because of cross-contamination or temperature issues. They opened a few hours later after addressing the issue.

As of Wednesday, no major violations had been reported for the year.

How it works

Each booth is considered a temporary restaurant and treated as such by inspectors. Opening inspections take about 15 to 20 minutes each.

The 24 rib booths will be inspected about three to five times a day during the festival. Criteria include overall cleanliness, temperature control and food storage.

“Our key concerns are refrigeration and hot holding,” English said. “... If food isn’t maintained at the proper temperatures, that is what causes foodborne illnesses.”

Bacteria like to grow within 70 to 120 degrees, he said. So inspectors check to make sure hot foods are held above 135 degrees, while cold items are stored below 40 degrees.

Since the meat has hit the smokers on Tuesday, inspectors work at all hours of the day to check the food safety. Because of the nature of the event, food prep, cooking and cooling occur overnight.

“Most of the cooking processes is a slow cooking process where it takes 10 to 18 hours to cook the food product,” English said. “So, they have to start a minimum full day ahead, otherwise, they wouldn’t have product to serve tomorrow.”

What they look for

Inspectors are looking for correct cooking and cooling temperature of food products, supplies stored off the ground and issues regarding refrigeration, electrical and power.

More than one dozen refrigeration trucks will house the meat and other food items throughout the event, and each one is constantly inspected.

John Ascuaga’s Nugget also is required to have backup units.

“This is the only event that we allow cooking and cooling to keep up with the actual rush in business,” he said.

About 500,000 people are expected to attend the event, which started Wednesday and ends Monday.

During other special events, food vendors must sell or dispose of any food that was cooked during the day, no holdovers. All special event vendors, including those at the rib cook-off, have to cook with fresh product at each festival.

All the other food booths, including the two dozen beverage carts, fried items and frozen treats, also are inspected. Inspectors will mainly be looking for overall cleanliness, food storage and use of ice scoops. Garbage and waste water disposal also will be inspected.

All food vendors will have a temporary permit from health department posted.

Washoe County Health District to Conduct Insecticide Fogging

Posted: Aug 20, 2013 4:56 PM PDT
Updated: Aug 21, 2013 2:22 PM PDT

The Washoe County Health District will conduct insecticide fogging early Wednesday morning to reduce mosquito activity.

The insecticide application will be conducted between U.S. Highway 395 (west), Rio Wrangler Road (East), Pembroke Drive (North), and Damonte Ranch Parkway (south) at 5am.

Staff will apply a pyrethrum fog using foggers mounted in the back of pickup trucks to eradicate adult mosquitoes.

Pyrethrum is a biological product produced primarily from the flowers of the Chrysanthemum plant. The Health District says the insecticide has low potential for systemic toxicity in mammals.

West Nile was first detected in this area in 2004.

Mosquito season in this area usually ends with the first killing frosts in October.

Until then, area residents are reminded to take the following precautions during summer months to prevent an increase in the mosquito population in and around their homes:

•Clear the yard area of any free-standing water that may become a mosquito breeding-ground

•Wear long sleeves and long pants in mosquito prone areas

•Use mosquito repellant and follow label precautions

•Repair any window screens that provide entry for mosquitoes

•Vaccinate horses for Western Equine Encephalitis (WEE)

•Vaccinate horses for West Nile Virus (WNV). Four effective vaccines exist for horses, but vaccine development for humans is still underway with currently no available product in sight.

•Report night-time mosquito activity to the District Health Department at 328-2434

The Dept. of Agriculture says products containing the below active ingredients typically provide reasonably long -lasting protection:

• DEET (Chemical Name: N,N-diethyl-m-toluamide or N,N-diethly-3-methyl-benzamide)
• Picaridin (KBR 3023, Chemical Name: 2-(2-hydroxyethyl)-1-piperidinecarboxylic acid 1-methylpropyl ester)
• Oil of Lemon Eucalyptus* or PMD (Chemical Name: para-Menthane-3,8-diol) the synthesized version of oil of lemon eucalyptus
• IR3535 (Chemical Name: 3-[N-Butyl-N-acetyl]-aminopropionic acid, ethyl ester)

EPA characterizes the active ingredients DEET and Picaridin as "conventional repellents" and Oil of Lemon Eucalyptus, PMD, and IR3535 as "biopesticide repellents", which are derived from natural materials. For more information on repellent active ingredients, please visit:
http://www.epa.gov/pesticides/health/mosquitoes/ai_insectrp.htm.

For other information, visit the WCHD web site at **www.washoecounty.us/health** or the Centers for Disease Control and Prevention at **www.CDC.gov**.

Washoe County Health District

DBOH AGENDA ITEM NO. 17.D

Director's Report AUGUST 2013

Air Quality Management Division

Washoe County Health District

American and Rim Fires

Wildfires are part of life in the western United States. Although this year's fire season began quietly, two fires in California that started in August significantly affected our air quality.

The American Fire near Foresthill began on Saturday, August 10 with the first impacts to our area seen on August 11. The fire was located approximately 50 mile southwest of the Truckee Meadows. For the next few days the weather pattern generally transported smoke in a northerly direction until afternoon Zephyrs brought smoke into Washoe County. Air pollution levels changed rapidly and Air Quality Index levels during the worst portions of the day occasionally reached Unhealthy levels (above 150).

August 18 illustrated how fast air pollution levels can change when outflow wind from a thunderstorm pushed a wall of smoke into the Truckee Meadows. The National Weather Service in Reno captured this event through a 9 second time lapse video (http://youtu.be/eUPdNu0nDW0). Fine particulate matter levels increased dramatically as the smoke rolled into the valley. The American Fire was fully contained on August 29 after consuming more than 27,000 acres.

The Rim Fire started on August 17 near Yosemite National Park approximately 100 miles south of the Truckee Meadows. The fire grew quickly and produced a thick plume of smoke. A change to the weather pattern shifted winds and began transporting smoke into the Truckee Meadows on August 22.

Single hour concentrations of fine particulate matter exceeded 200 ug/m3. Pollution levels changed rapidly fluctuating between the Moderate and Very Unhealthy (AQI above 200) ranges. As of September 10, the Rim Fire was 80 percent contained and had burned over 254,000 acres.

In response to these pollution levels, the Washoe County School District and Nevada Interscholastic Activities Association implemented precautionary measures to protect the student's health such as indoor recesses and cancelling outdoor activities including football games.

AIR QUALITY COMPARISON FOR AUGUST

Air Quality Index Range		# OF DAYS AUGUST 2013	# OF DAYS AUGUST 2012
GOOD	0 to 50	7	14
MODERATE	51 to 100	11	17
UNHEALTHY FOR SENSITIVE GROUPS	101 to 150	7	1
UNHEALTHY	151 to 200	6	0
VERY UNHEALTHY	201 to 300	0	0
TOTAL		31	31

How does this wildfire episode compare with other recent events?

In June 2008, thousands of lightning strikes hit northern California which started dozens of large wildfires. Smoke blanketed California and periodically blew into the Truckee Meadows. The table below compares three air quality parameters for the 2008 and 2013 episodes. Please see the notes below that address improvements to the fine particulate monitoring program since 2008.

	2008[1]	2013[2]
Highest AQI value[3]	211	209
Number of days (rolling 24-hrs) when AQI was Unhealthy or above[4]	7	6
Number of days (midnight to midnight) exceeding 24-hr NAAQS[5]	4	7

1. June 23 through July 31, 2008.
2. August 11 through September 9, 2013.
3. In 2008, this was reported as the highest rolling 24-hr period. In 2013, this was the AQI as reported by AirNow for a specific hour. AirNow's AQI calculations are updated each hour and give more weight to shorter-term (less than 24-hr) concentrations.
4. AQI above 150.
5. EPA's data handling convention specifies that 24-hr averages be from midnight to midnight for comparison to National Ambient Air Quality Standards.

A major difference between these two events is when these fires occurred. The 2008 event occurred in June/July while the 2013 event occurred in August/September. The 2013 smoke event directly affected school children by cancellation of outdoor activities ranging from recess to high school football games.

Communication of Air Quality Information

The AQMD monitors the air continuously and provides that information each day via email, website, social media, and a telephone hotline. More frequent updates are provided during episode such as these wildfires. The AQMD coordinated with the National Weather Service and local media to provide accurate and timely information to the public.

The website and social media activity tracked closely with air pollution levels with peak activity occurring on August 23. AQMD's homepage/ourcleanair.com was the second most visited County page for the month of August. The AQMD also developed an AQI vs. Activity chart (attached to the Director's Report) for the WCSD. This chart is an additional tool for the school district to use in their decision making process related to air pollution levels. The NIAA has also developed a similar chart.

Areas in and around the American and Rim Fires will continue to produce some amount of smoke until the season's first significant rain. As long as these fires produce smoke, there is a potential for that smoke to impact the Truckee Meadows.

Air Quality

HIGHEST AQI NUMBER BY POLLUTANT

POLLUTANT		AUGUST 2013	YTD for 2013	AUGUST 2012	Highest for 2012
CARBON MONOXIDE	(CO)	18	24	12	29
OZONE 8 hour	(O3)	87	93	100	104
PARTICULATES	($PM_{2.5}$)	174	174	89	105
PARTICULATES	(PM_{10})	97	97	44	74

For the month of August 2013, the highest Air Quality Index (AQI) values reported was one hundred seventy-four (174) for PM2.5, eighty-seven (87) for Ozone, and ninety-seven (97) for PM10, due to the American fire and Rim fire. There were no exceedances of Carbon Monoxide. There were seven (7) days the air quality was in the good range, eleven (11) days in the moderate range, seven (7) days in the Unhealthy for Sensitive Groups range, and six (6) days the air quality fell into the Unhealthy range.

Planning & Monitoring Activity

Monitoring:

EPA completed a three day Technical Systems Audit of the ambient air monitoring program. The TSA strengthens defensibility of monitoring data by ensuring that the program meets Code of Federal Regulation requirements.

Planning:

Staff will be preparing an exceptional events request to be submitted to EPA Region IX for the American and Rim Fire episode. The request will be to exclude specific ambient air monitoring data influenced by the fires when comparing to the National Ambient Air Quality Standards.

Dan Inouye, Branch Chief
Planning and Monitoring

Permitting Activity

TYPE OF PERMIT	2013		2012	
	AUGUST	YTD	AUGUST	ANNUAL TOTAL
Renewal of Existing Air Permits	98	967	99	1339
New Authorities to Construct	3	54	11	88
Dust Control Permits	10 (96 acres)	85 (785 acres)	8 (25 acres)	105 (1420 acres)
Wood Stove Certificates	42	230	39	329
WS Dealers Affidavit of Sale	13 (7 replacements)	58 (36 replacements)	3 (2 replacements)	134 (83 replacements)
WS Notice of Exemptions	342 (3 stoves removed)	5287 (52 stoves removed)	433 (4 stoves removed)	7346 (83 stoves removed)
Combined Total for both: Asbestos Assessments and Asbestos Demo and Removal (NESHAP)	112	744	82	1148
Asbestos Assessments	97	592	-	-
Asbestos Demo and Removal (NESHAP)	15	152	-	-

Compliance & Inspection Activity

Staff reviewed twenty-four (24) sets of plans submitted to the Reno, Sparks or Washoe County Building Departments to assure the activities complied with Air Quality requirements.

Staff conducted thirty-six (36) stationary source renewal inspections in August 2013. Staff also conducted inspections on asbestos removal and construction/dust projects.

Permitting & Enforcement Activity

On August 13th and 14th, a four member panel including three members of the Permitting & Enforcement Staff and a member of the CCHS staff completed the interview and selection process to fill the vacant Air Quality Specialist II position in the Enforcement Program. The panel was very pleased with the seven (7) highly qualified candidates. In the end, Joshua Restori was selected as the final candidate and he has accepted the position. Joshua comes to Washoe County with four (4) years of experience as an Air Quality Inspector working for Clark County Department of Air Quality. His training and experience will be a great asset to the program and we look forward to his September 9th start date.

The Enforcement Staff continues to be busy with asbestos abatement projects, specifically the final push to complete all of the school projects prior to the early start date of August 11th . The Cal Neva Resort Spa & Casino began the first phase of a facility wide asbestos abatement project associated with a complete renovation of the property. The facility will be closed for the next year while the asbestos abatement and renovation activities are completed.

On August 22nd, Air Quality Staff made a presentation on the recently amended Woodstove and Hydronic Heater regulations to the Association of Title Companies. After a presentation on the amendments to the regulations, the group participated in a lively question and answer session. The response was very positive and will hopefully help to clear up any questions regarding the Woodstove Program. All of the participants were very appreciative of the opportunity to put a face with a name.

The U.S. EPA Office of Enforcement and Compliance Assurance made a national request for participants to assist with the design of the new Integrated Compliance Information System (ICIS). The ICIS System currently provides the public with compliance data from Federal/State/Local/Tribal Water Pollution Control and RCRA Waste Management programs. In compliance with the Congressional directive, the final phase of the system is to include air quality compliance and enforcement programs so that the public will have access to all environmental compliance data in a single location. I volunteered to represent the Nevada Air Agencies on the Web Design Committee since we do input data on-line rather than through a batch submittal form like most larger air agencies. I've been attending weekly conference calls and webinars reviewing the system design and functionality. We will be Beta Testing the various modules of the new ICIS-AIR system from October 7, 2013 through June 2, 2014 and Validation Testing from October 15, 2013 through May 2, 2014. The ICIS-AIR system is projected to go into production nationally on September 24, 2014. This is the final phase of a project that has been in development for no less than 15 years.

Charlene Albee, Branch Chief
Permitting & Enforcement

Enforcement Activity

COMPLAINTS	2013*		2012		
	AUGUST	YTD	AUGUST	YTD	Annual Total
Asbestos	6	19	1	13	18
Burning	0	3	0	5	8
Construction Dust	7	21	1	24	30
Dust Control Permit	0	9	0	4	7
General Dust	3	36	7	34	46
Diesel Idling	0	1	0	4	8
Odor	2	12	1	7	16
Spray Painting	0	6	0	2	5
Permit to Operate	2	13	5	38	55
Woodstove	0	9	0	14	16
TOTAL	**20**	**129**	**15**	**145**	**209**
NOV'S	**AUGUST**	**YTD**	**AUGUST**	**YTD**	**Annual Total**
Warnings	4	19	3	34	46
Citations	4	22	4	24	40
TOTAL	**8**	**41**	**7**	**58**	**86**

* Discrepancies in totals between monthly reports can occur because of data entry delays.

Notices of Violation (NOVs):

There were eight (8) Notice of Violations (NOV's) issued in the month of August, 2013. There were four (4) NOV Warnings and four (4) NOV Citations.

Recommendations for Schools and Child Cares on Poor Air Quality Days
Air Quality Index (AQI) Table for Ozone and $PM_{2.5}$ with Visibilities for Wildfire Smoke[1]

Activity	Good=0 to 50 (Visibility 11 miles and up)	Moderate=51 to 100 (6 to 10 miles)	Unhealthy for Sensitive Groups*= 101 to 150 (3 to 5 miles)	Unhealthy=151 to 200 (1.5 to 2.75 miles)	Very Unhealthy= 201 to 300 (1 to 1.25 miles)	Hazardous= 301 to 500 (less than 1 mile)
Recess (15 min)	No Restrictions	No Restrictions	Make indoor space available to all children especially those with lung/heart illnesses or who complain about difficulty breathing.	Restrict outdoor activies to all children and limit prolonged or heavy exertion.	Restrict outdoor activities to all children and limit indoor activities to light to moderate exercise.	Keep everyone indoors and limit indoor activity to light exercise.
P.E. (1 hr)	No Restrictions	No Restrictions	Make indoor space available to all children. High school students with lung/heart conditions should limit prolonged or heavy exertion.	Restrict outdoor activies to all children and limit prolonged or heavy exertion.	Restrict outdoor activities to all children and limit indoor activities to light to moderate exercise.	Keep everyone indoors and limit indoor activity to light exercise.
Scheduled Sporting Events	No Restrictions	Unusually sensitive children and high school students should limit prolonged or heavy exertion during scheduled sporting events.	High school students with asthma or other respiratory or cardiovascular illness should be medically managing their condition. Increase rest periods and substitutions to lower breathing rates.	Consideration should be given to rescheduling or relocating the event.	Event should be rescheduled or relocated.	Event should be rescheduled or relocated.
Athletic Practice and Training (2 to 4 hrs)	No Restrictions	Unusually sensitive children and high school students should limit prolonged or heavy exertion during practice or training.	High school students with asthma or other respiratory or cardiovascular illness should be medically managing their condition. Increase rest periods and substitutions to lower breathing rates.	Activities over 2 hours should decrease intensity and duration. Add rest breaks or substitutions to lower breathing rates.	Practice or training should be rescheduled or relocated.	Practice or training should be rescheduled or relocated.

[1] Visibility conversions to AQI were taken from "Wildfire Smoke: A Guide for Public Health Officials" (Rev. July 2008 with 2012 AQI updates)

*Children are anyone from Infant to 8th Grade. High School Students are indicated and assumed to be the participants for Scheduled Sporting Events and Practice and Training activities. For children, consideration for relocation or rescheduling should be given at the Unhealthy for Sensitive Groups range for Sporting Events and Practice and Training activities.

This guidance was developed by the Washoe County Health District, Air Quality Management Division.
The AQI table was adapted from the Sacramento Metropolitan Air Quality Management District "Air Quality Guidelines for Schools."
Revised August 28, 2013

How to use this AQI Table

The use of this AQI table by Washoe County Schools and Child Care Facilities is voluntary, but is recommended by the Washoe County Health District, Air Quality Management Division (AQMD) based on the Environmental Protection Agency's (EPA) guidelines for Ozone and $PM_{2.5}$.

How to use this AQI table:
The following steps are an example situation:
Step 1: Check the AQI forecast for Tuesday on Monday especially during potentially poor air quality days. Forecast AQI information is found on AirNow (airnow.gov). Forecasts are also available on ourcleanair.com, the AQI Hotline 785-4110, and on facebook and twitter.

Step 2: If the forecast is "Very Unhealthy", follow the guidance in the AQI table; for recess and P.E. restrict outdoor activities to all children and limit exercise indoors to light to moderate exercise; Sporting events, training, and practice should be relocated or rescheduled.

Step 3: On Tuesday, check the current AQI on AirNow before an activity like recess, P.E., scheduled event, or practice/training and use the AQI table provided.

(Only during wildfires) Step 4: In addition to the current AQI provided by AirNow, go outside and find a permanent structure or geologic feature (hill, mountain) that has a known distance from school or child care. For example, if the structure or feature is 1 mile away and it cannot be seen, we are most likely in the "Very Unhealthy" or "Hazardous" ranges. Follow the AQI table guidelines, for the category indicated based on your visibility.

Limitations of AirNow
Data for AirNow is sent every hour by AQMD to the website at the top of the hour. The AQI based on this data is typically updated at the bottom of that same hour. This lag is an important limitation and must be considered when determining important health decisions. Conditions can change rapidly during poor air quality days (wildfire smoke, inversions, dust storms, etc.). Generally, if you see or smell the smoke or dust, stay indoors. As always with technology, there can be malfunctions and glitches that are temporary in which our AQI calculations will be provided as needed by phone, email, facebook, and twitter.

Ozone
Ozone (O_3) is an invisible pollutant and a strong irritant that can cause constriction of the airways, forcing the respiratory system to work harder in order to provide oxygen. For Washoe County, ozone is a summertime, regional pollutant in which all Washoe County schools and child cares will experience similar levels. Ozone usually reaches its highest level during the afternoon and early evening hours, and the highest concentrations are often downwind of the urban area. Indoor levels of ozone are usually less than outdoor air.

Fine Particulates ($PM_{2.5}$)
In Washoe County, fine particulate (2.5 microns and smaller) levels in outdoor air generally are highest during the fall and winter months due to woodstove and fireplace use especially during cold air inversions. Children who are exposed to fine particles may experience respiratory symptoms such as asthma symptoms and difficulty breathing. Small particles may enter deep parts of the lung and cross into the bloodstream and circulate in the body. Smoke from wildfires is primarily made up of $PM_{2.5}$. ***The visibility to AQI conversion can only be used during wildfire smoke events.***

AQI versus Burn Code
Unique to Washoe County, the wintertime Burn Codes (Nov. 1 – Feb. 28) are issued each morning and afternoon or as conditions change. The program began in the mid 1980s to help with particulate matter levels and is still used. The Green, Yellow, and Red color scheme was implemented for the public to understand when to burn or not. Burn Code colors are ***NOT*** AQI colors. The Air Quality Index for $PM_{2.5}$ was developed by the EPA more recent and adopted its own color scheme. A Red Burn Code does not equal a red AQI (Unhealthy 151-200) and a yellow AQI (Moderate 51-100) does not equal a Yellow Burn Code. Burn Codes, although designed to protect human health, are not AQIs.

This guidance was developed by the Washoe County Health District, Air Quality Management Division.
The AQI table was adapted from the Sacramento Metropolitan Air Quality Management District "Air Quality Guidelines for Schools."
Revised August 28, 2013

Washoe County Health District

Public Health
Prevent. Promote. Protect.

September 19, 2013

TO: Members District Board of Health

FROM: Eileen Stickney

SUBJECT: Report for September 2013 Administrative Health Services Division

Technology Update – 2013 Accela Engage Conference Report:

Accela, Inc. (Accela) is the vendor for Permits Plus, the application that the Health District and Washoe County uses for permitting and inspections and is the vendor for Accela Automation, the permitting software that we are looking at migrating to. Accela holds an annual user conference containing sessions showing features of current releases of their software, future feature plans, and sessions with government agencies showing what they are doing with their software.

As we are looking at moving to Accela Automation, the sessions Steve Fisher focused on dealt mainly with how people are doing things in Accela Automation, the challenges they came across, and the innovations they came up with. Steve also attended hands-on training sessions with a focus on creating reports, configuring business logic, fee configuration, and configuring the online portal where constituents can apply for permits, schedule inspections, and look up record information.

One session focused on a jurisdiction's use of Accela Mobile Inspector and mobile printing in the field, a direction that we wish to head in. The printer they ended up using is the one Steve found through independent research.

Also of interest was Accela Automation's enhancements to Ad-Hoc Reporting, allowing users to create reports on-the-fly with various types of charts and graphs.

The hands-on training sessions helped prepare me for an implementation of Accela Automation for both the Environmental Health Services and Air Quality Management divisions as well as implementing any new needs for both divisions when we are fully live on Accela Automation.

Conclusion:
This year's conference was highly useful for getting a better idea of what Accela Automation can do and how it may affect our current business processes. This will help during an Accela Automation implementation when mapping out our

current business processes to see how we might streamline them based on Accela Automation's capabilities.

WIC Program Update:

Number of WIC Participants Served* - July 2013:

Women Prenatal	Women Postpartum Non-breastfeeding	Women Postpartum Breastfeeding	Infants 0-12 Months	Children 1-5 Years	**TOTAL**
580	402	380	1,296	3,170	**5,828**

It takes a full month after the last day of the reporting month for final caseload counts as WIC is open daily and participants have 30 days to purchase their WIC foods.

A new WIC clinic site was opened in August at the Sparks Library located at 1125 12th Street as a pilot. It is a partnership between the Health District and the Washoe County Sparks Library beginning 2 days per month and will expand to meet the public's needs. Anyone can call for hours and days of operation at (775) 328-2299.

Eileen Stackury
Administrative Health Services Officer

WASHOE COUNTY HEALTH DISTRICT

Public Health
Prevent. Promote. Protect.

TO: District Board of Health Members

FROM: Kevin Dick
Interim District Health Officer

DATE: September 26, 2013

SUBJECT: September 2013 Interim District Health Officer Report

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REMSA / EMS

I continue to participate in the EMS working group to proceed with negotiations on changes to the REMSA franchise agreement. I have been meeting with the City and County Managers for their representatives to coordinate on approaches to modernize the franchise agreement, and to discuss and develop possible regional EMS Oversight structures. Additional information is contained in the EMS / REMSA DBOH Agenda item.

Fundamental Review

Scopes of work were revised to provide for a final report to be presented to the Board at the February 27, 2014 DBOH meeting. The initial site visit of the assessment team is planned for October 17th and 18th with a second phase visit planned for November 12th to 15th to provide follow-up on the self-assessment information provided to the assessment team by the Health District. The contract with Mr. Stefanak has been signed and a purchase order issued. The contract with the Public Health Foundation is on the agenda for approval under consent items at the September 26, 2013 DBOH meeting.

Staffing

An Air Quality Specialist II position was filled effective September 9th. Recruitments are in progress for a Public Health Nurse II positions in CCHS, a Senior Environmental Health Specialist in EHS, a Licensed Engineer in EHS, an EMS Coordinator in EPHP, and a Fiscal Compliance Officer in AHS. These positions are being filled as a result of vacancies due to retirements or promotions.

Permit Software Project

I continue to participate in the Negotiating Team for the regional business licensing and permitting software project. Accela Automation was selected as the top ranking vendor following the Request for Proposal process. The Negotiating Team is working on negotiating pricing, cost allocations across the participating jurisdictions, and potential funding mechanisms.

Cross Divisional Initiatives

ART / Quality Improvement / Process Improvement – The Accreditation Readiness Team (ART) has been working on development of a Quality Improvement / Process Improvement (QI) initiative for the Health District. Division Directors met with Ms.Frenkel and Ms. Jordan on August 23rd, and Division and Directors and Supervisor met with them on September 4 and 18th. These sessions focused on discussion of QI, the results of the District QI survey conducted in August, and how to roll out and engage staff in a QI initiative focused on continuous improvement and implementation of recommendations that my result from the District Fundamental Review. The QI survey results are attached.

Other Events and Activities

A regularly scheduled meeting with Division Directors was held on August 28th, and a meeting with Division Directors and Supervisors on September 16th. I also conduct individual meetings with the Division Directors on a bi-weekly schedule.

I attended the Obesity Forum held on September 19th and provided welcoming remarks.

I prepared and submitted a Health Officer report to the State Board of Health. The State Board of Health meeting scheduled for September 13th was cancelled.

I continue to serve as President of HomeFree Nevada / EnergyFit Nevada, the not-for-profit, Home Performance with Energy Star Provider for the State of Nevada.

Health District Media Contacts and Outreach

Health District Media Contacts: August 16 - September 18, 2013

DATE	MEDIA	REPORTER	STORY
9/17/2013	KTVN-CH 2 CBS - Reno	Rebecca Kitchen	**Pertussis** - Paulsen
9/17/2013	KRXI-CH21 FOX - Reno	Ryan Kern	Healthy Living Week - Seals
9/16/2013	KOLO-CH8 ABC - Reno	Jennifer Burton	Immunizations - Ulibarri
9/12/2013	Sparks Tribune	Sami Edge	Food Policy - Wagner
9/11/2013	Wolf Pack Online	Beau Smith	Rim Fire - Schnieder
9/6/2013	Nevada Media Alliance	Cambria Roth	Rim Fire - Inouye
9/3/2013	UNIVISION	Raul Delgado	Needle Exchange - Howell
9/3/2013	KXJZ FM Radio - Capitol Public Radio	Ky Plaston (Sacramento)	Rim Fire - Inouye
8/30/2013	Nevada Sagebrush	Alex Mosher	Fire and Masks - Schnieder
8/30/2013	KOLO-CH8 ABC - Reno	Terri Russell	Immunizations - Ulibarri/Mertz/Dickens
8/30/2013	Reno Gazette - Journal	Jeff Delong	Rim Fire - Inouye
8/30/2013	KGO Radio CH810AM Bay Area	Mel Baker	Rim Fire - Inouye
8/29/2013	KOH AM Radio ABC-Reno	Monica Jay	Preparedness Month - Todd
8/28/2013	Reno Gazette - Journal	Yen Long	Food Inspections - English
8/27/2013	Reno Gazette - Journal	Bill Driscoll	Rim Fire - Ulibarri
8/26/2013	Sacramento Bee	Peter Hecht	Rim Fire - Inouye
8/26/2013	KRNV-CH 4 NBC - Reno	Madison Courtney	Remediation - Sack/Ulibarri
8/26/2013	UNIVISION	Laura Calzada	Rim Fire - Inouye

8/23/2013	KOLO-CH8 ABC - Reno	Colin Lygren	Rim Fire - Inouye
8/23/2013	KTVN-CH 2 CBS - Reno	Erin Breen	Rim Fire - Inouye
8/23/2013	Associated Press	Scott Sonner	Rim Fire - Inouye
8/23/2013	Reno Gazette - Journal	Jeff Delong	Rim Fire - Inouye
8/23/2014	KRNV-CH 4 NBC - Reno	Samantha Boatman	Rim Fire - Inouye
8/23/2013	KOLO-CH8 ABC - Reno	Erin Breen	Rim Fire -Timmons
8/22/2013	UNIVISION	Raul Delgado	Mosquitos - Ulibarri
8/22/2013	ABC News Radio San Francisco	Anna Maria Gibson	Rim Fire - Interim Health Officer Dick/Ulibarri
8/22/2013	KXJZ FM Radio - Capitol Public Radio	Ky Plaston (Sacramento)	Rim Fire - Inouye
8/22/2013	KOLO-CH8 ABC - Reno	Chris Buckley	Rim Fire - Inouye
8/22/2013	KRNV-CH 4 NBC - Reno	Madison Courtney	Rim Fire - Inouye
8/22/2013	KUNR FM Radio - NPR Reno	Will Stone	Ozone - Ulibarri/Inouye
8/21/2013	KTVN-CH 2 CBS - Reno	Adam Varahahaikol	Fire and Masks - Ulibarri/Inouye
8/21/2013	Reno Gazette - Journal	Steve Timko	Air Quality Hours - Ulibarri
8/21/2013	Reno Gazette - Journal	Jeff Delong	Rim Fire - Inouye
8/19/2013	KRXI-CH21 FOX - Reno	Ryan Kern	Air Quality American Fire - Inouye
8/19/2013	Reno News & Review	Brian Burkhardt	Air Quality American Fire - Inouye
8/19/2013	KTVN-CH 2 CBS - Reno	Adam Rasmussen	Air Quality American Fire - Inouye
8/19/2013	KRXI-CH21 FOX - Reno	Ryan Kern	Air Quality American Fire - Inouye
8/19/2013	Reno Gazette - Journal	Siobahn McAndrew	Air Quality American Fire - Inouye
8/16/2013	Reno Gazette - Journal	Emerson Marcus	Air Quality American Fire - Schnieder
8/16/2013	KOLO-CH8 ABC - Reno	Chris Buckley	Air Quality American Fire - Inouye

Press Releases/Media Advisories/Editorials

9/10/2013	Press Release	PIO Ulibarri	Healthy Living Week
9/3/2013	Media Advisory	PIO Ulibarri	Mosquito Abatement - Aerial Larvicide
8/30/2013	Media Advisory	PIO Ulibarri	1 Week Forecast - Air Quality – Moderate - Very Unhealthy
8/29/2013	Press Release	PIO Ulibarri	Obesity Forum
8/27/2013	Media Advisory	PIO Ulibarri	Air Quality - Very Unhealthy
8/27/2013	Media Advisory	PIO Ulibarri	1 Week Forecast - Air Quality - Unhealthy
8/23/2013	Media Advisory	PIO Ulibarri	1 Week Forecast - Air Quality - Very Unhealthy
8/22/2013	Media Advisory	PIO Ulibarri	Air Quality - Very Unhealthy
8/22/2013	Media Advisory	PIO Ulibarri	Air Quality - Unhealthy
8/20/2013	Media Advisory	PIO Ulibarri	Mosquito Abatement - Fogging
8/20/2013	Media Advisory	PIO Ulibarri	AQMD New Hours

Kevin Dick
Interim District Health Officer