2019 ANNUAL REPORT

Prevent Promote Protect

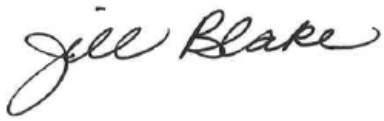
NEVADA COUNTY
Public Health

Nevada County Public Health Department | Nevada County, California

Message from the Director

I am happy to share with you the Nevada County Public Health Department's inaugural Annual Report. My hope is that this report will give you a sense of what the Nevada County Public Health Department (NCPHD) has accomplished over the past year and what we intend to address in the coming year.

The small but mighty NCPHD team implements over 30 programs, supports various initiatives, and conducts policy, systems and environmental change work. Together we serve children, women, families, adults, and seniors, and we support local businesses. I am incredibly proud of how this dedicated team works to prevent disease and injuries, promote healthy behaviors and environments, respond to disasters and emergency events, and deliver quality, caring safety net health services. I am also proud of how each member of our team collaborates and partners with others in government and in the community, as there is no public health issue that we can tackle on our own. Every one of us is a part of our local public health system, as we all contribute collectively to the conditions in our community that allow everyone to achieve optimal health. I thank you for your contributions and hope you enjoy reading about ours.

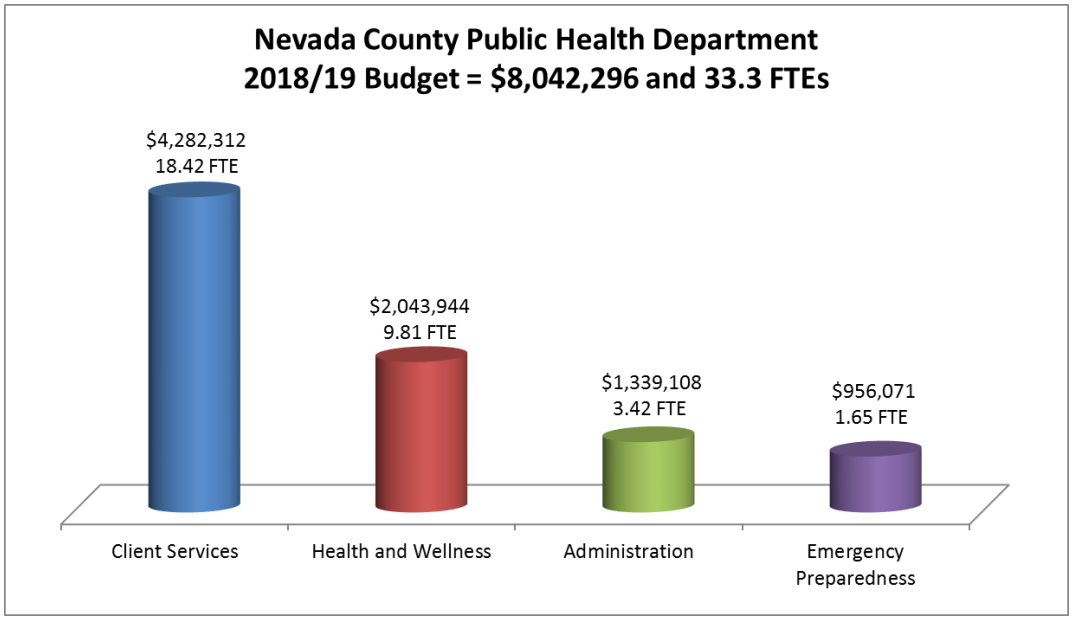


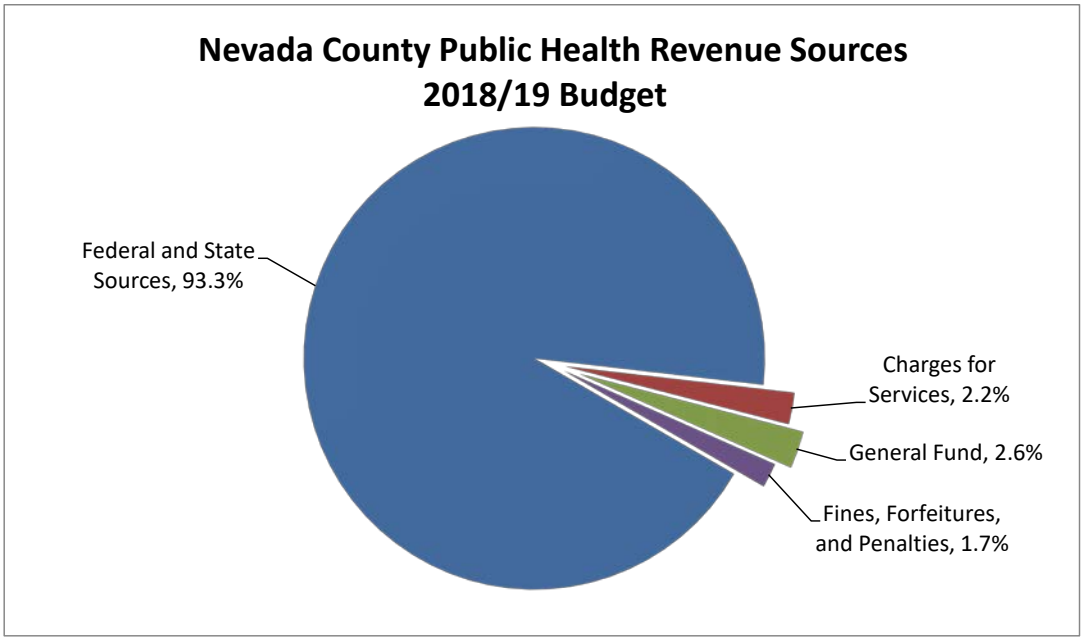
NCPHD – Who We Are

NCPHD serves the entire county and maintains a focus on population-level health. Our vision is for safe, healthy and thriving communities, and our mission is to prevent disease and injury, promote optimal health and wellness, and protect the community against disasters. We strive to let our core values guide all the work we do. Our values include wellness, caring, equity, quality, teamwork, diversity, enjoyment, communication, and appreciation.

Our department is made up of four divisions: Administration, Client Services, Health and Wellness, and Public Health Emergency Preparedness. Though these divisions exist on paper and in some practical ways as well, all NCPHD staff work across those imaginary lines to accomplish their goals and to effectively serve clients. Silos exist everywhere, and even when we think we've gotten rid of them, they pop up again, so we acknowledge that our silo-busting and bridge-building work is never-ending.

On the next page are two graphs that illustrate NCPHD's staffing and budget break out for Fiscal Year 2018-2019.


Nevada County Public Health Department
2018/19 Budget = $8,042,296 and 33.3 FTEs
$4,282,312
18.42 FTE
$2,043,944
9.81 FTE
$1,339,108
3.42 FTE
$956,071
1.65 FTE
Client Services
Health and Wellness
Administration
Emergency Preparedness


Nevada County Public Health Revenue Sources
2018/19 Budget
Federal and State Sources, 93.3%
Charges for Services, 2.2%
General Fund, 2.6%
Fines, Forfeitures, and Penalties, 1.7%

Accreditation

NCPHD is seeking National Accreditation through the Public Health Accreditation Board. This process is, at its core, a quality improvement process, and NCPHD has approached it as such. The goal of accreditation is to improve and protect the health of the public by advancing the quality and performance of public health departments. Accreditation consists of the adoption of a set of standards and a process to measure department performance against those standards. Through this process, NCPHD has identified and continues to identify its strengths and successes as well as opportunities for improvement, and has begun to evaluate performance on a continual basis. The department is already more efficient and improved because of these efforts and our community is better served as well!

HIGHLIGHTS

Updated our Quality Improvement (QI) Plan.

Expanded our use of the Performance Management System to track progress on departmental goals and objectives.

Worked on a new countywide Community Health Assessment (CHA) with Sierra Nevada Memorial and Tahoe Forest hospitals.

Reviewed and revised the Community Health Improvement Plan (CHIP).

Conducted multiple community presentations on new data, the new CHA, and the CHIP.

For more information about Accreditation, visit
https://www.mynevadacounty.com/2814/Accreditation

Strategic Plan

The NCPHD Strategic Plan was adopted in May 2018. NCPHD already had numerous strategic or work plans in place, most of which are required by funders. This Plan, therefore, is intended to be an overlay to all of the existing plans, and to help guide all of our departmental efforts; to help make our department financially, organizationally and programmatically resilient; and to foster collaborations with county and community partners to provide quality, customer-focused, integrated services to the community. The Strategic Plan includes the six Strategic Priorities listed below.

Engage partners to improve community health – The goal of this priority is to ensure that children have a safe and healthy environment to maximize their developmental potential.

Advance health equity to eliminate health disparities – The goal of this priority is to strengthen department programs, services, and policies to better address health equity. (*NCPHD's current working definition of health equity is when everyone has access to the goods, services, resources and power they need for optimal health and wellbeing.*)

Strengthen prevention and response to current and emerging public health issues – The goal of this priority is to strengthen the department's ability to respond to emergency events and disease outbreaks.

Strengthen organizational capacity for positive work environment, internal collaboration, and staff expertise – The goal of this priority is to improve our facilities to meet current and future operational needs and to improve the work environment.

Successfully communicate the value of the public health department and public health – The goal of this priority is to establish and implement strategies that increase knowledge about public health and NCPHD initiatives.

Promote a robust, prevention-oriented, evidence-based countywide continuum of care – The goal of this priority is to address gaps identified in the local continuum of care.

Though this plan is just over a year old, NCPHD has made terrific progress towards these goals and their corresponding objectives. See Appendix A for a report on our progress to date.

CHIP

NEVADA COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

NCPHD's 2017 Community Health Improvement Plan (CHIP) documents a long-term, systematic effort to address public health in Nevada County. This plan was developed using the results of NCPHD's Community Health Assessment and an inclusive community process to identify priority issues, goals, and strategies.

The comprehensive CHIP is a five-year document, and includes an Implementation Plan to begin our work with eight prioritized strategies.

HIGHLIGHTS

NCPHD and various community partners achieved significant progress towards five key strategies.

Reported to the CHIP Steering Committee, which is made up of community members, and the general public on progress made to date.

Conducted five presentations on the CHIP to various community groups.

Reviewed and revised the CHIP's Implementation Plan to reduce the number of prioritized strategies from eight to five, due to capacity issues of all organizations involved in CHIP implementation. Five priorities are feasible for the coming year's work as well.

Provided training on the use of NCPHD's Performance Management System to NCPHD staff and community partners so they could directly enter data into the web-based system.

Reports on progress made on implementing the CHIP can be found in Appendix B.

Quality Improvement

NCPHD QILT Team Members!

In January 2017 NCPHD adopted a Performance Management Policy and Quality Improvement Plan, and later that year we established our Quality Improvement Learning Team (QILT). The goals of the QILT are to cultivate and sustain a culture of quality improvement, develop QI champions throughout the department, and saturate the department with staff who are proficient in the QI methodologies.

Primarily using the Plan, Do, Check, Act (PDCA) cycle tool, the QILT has completed six projects and has several others that are in-process. We continue to refine and increase our knowledge of QI and are becoming more familiar and proficient in using the many different QI tools (e.g., Lean, flow charts) available when working on projects.

HIGHLIGHTS

To date, the QILT has designed and completed six projects including improving the department's Immunization (IZ) Clinic processes, the IZ webpage, Vitals Office processes, travel forms used by all NCPHD staff, the Medical Marijuana Identification Card processes, and the California Children's Services processes.

Each project resulted in improved customer service and netted the department savings in both time and money, and as more and more staff see and reap the benefits of QI, we gain more buy-in to the department's QI work.

After attending a Lean Six Sigma training, the QILT brought a free Lean training to the County. The training was attended by 7 NCPHD staff and 12 staff from other County departments.

Examples of QI Success Stories can be found in Appendix C.

Client Services

Client Services Programs Include:

Maternal, Child and Adolescent Health (MCAH) Program

California Home Visiting Program

Moving Beyond Depression

Project LAUNCH

Rural Health Opioid Program

Truckee Clinic

HIV Case Management

California Children's Services

Medical Therapy Unit

Child Health and Disability Prevention (CHDP) Program

Immunization Outreach, Education and Clinics

Communicable Disease Control

Childhood Lead Poison Prevention Program

HIV/Hepatitis C Testing, Education and Referral Clinics

Naloxone Distribution Program

Senior Outreach Nursing Program

Health Care Program for Children in Foster Care

Client Care Services includes programs that provide various levels of prevention to keep Nevada County residents and communities safe and healthy. Most programs have objectives related to primary prevention (keeping bad things from happening), secondary prevention (finding out early if bad things are happening), and tertiary prevention (reducing the consequences when bad things happen). Client Care Services staff are often the safety net for community members who do not have other resources to meet their health care needs in areas such as immunizations, children with special health care needs, family planning, communicable disease control, and living with HIV/AIDS.

HIGHLIGHTS

Provided home visiting services to 165 families.

Provided in-home cognitive behavioral therapy services through Moving Beyond Depression services to 23 eligible families.

At the Truckee clinic, provided family planning services and education to 850 clients.

Continued to provide case management for an average caseload of 58 children in foster care.

Conducted nursing assessments and provided follow-up on those requiring medical oversight for 231 children or youth referred to CPS.

Administered over 1,000 vaccinations to Nevada County's more vulnerable children and adults, including those experiencing homelessness.

For more information about immunizations, visit https://www.mynevadacounty.com/609/Immunization-Program

Health and Wellness

Health and Wellness Programs Include:

Tobacco Use Prevention Program

Alcohol and Other Drug Prevention Program

Supplemental Nutrition Program for Women, Infants and Children (WIC)

Nutrition, Education and Obesity Prevention (NEOP)

Prediabetes Prevention Program

Local Oral Health Program

Suicide Prevention Education Program

Adolescent Health

The Health and Wellness Division works to prevent and mitigate the effects of chronic diseases by supporting, and catalyzing change where we work, live, and play. This work often focuses on the broad systems, policies and environmental conditions that surround us and with which we interact throughout our lives. To that end, the Health and Wellness Division creates and implements prevention, health education, wellness and youth advocacy programs based on community opportunities and local needs assessments.

HIGHLIGHTS

Partnered with Connecting Point to reduce tobacco use in the community with through cessation classes offered at no-cost to the community.

Partnered with NEO Youth Center to develop and provide a spoken word program for youth focusing on the negative health impacts of tobacco use.

Provided support to 40 at-risk youth at local high schools through peer support, risk behavior reduction, and stress reduction techniques.

Provided physical activity lessons to over 1,400 CalFresh eligible residents and nutrition education to over 2,000 CalFresh eligible residents.

Provided prediabetes outreach, education, and services to 225 individuals at three food pantries in Western and Eastern County.

Served an average of 1,243 WIC participants monthly, providing WIC healthy food vouchers, breastfeeding support, and nutrition education.

For more information about Health & Wellness programs, visit https://www.mynevadacounty.com/678/Healthy-Community-Programs

Emergency Preparedness

Part of NCPHD's work is to help plan and prepare for disasters before they strike. The Emergency Preparedness staff coordinates a critical Emergency Preparedness and Response Partnership, which is comprised of multiple agencies including law enforcement, fire departments, two hospitals, clinics, long-term care facilities, Nevada County Office of Emergency Services (OES) and Environmental Health Department, and other community agencies. Should disaster strike, these preparedness efforts will indeed save lives.

HIGHLIGHTS

90% of EPIC members now have an emergency preparedness plan that meets the federal standards.

Mapped the All Hazards Emergency Response Plan to the Public Health Accreditation Board (PHAB) Standards and Measures; identified and addressed any existing gaps between the standards and the plan. Conducted an exercise of the plan.

Working with an interagency planning team, conducted a full-scale exercise involving healthcare facilities, OES, Behavioral Health Department, Fire, EMS, and law enforcement for a Mass Casualty Incident involving chemical and burn injuries.

Conducted four communication drills with local healthcare facilities with over 80% participation.

Emergency Preparedness Grants and Programs Include:

Public Health Emergency Preparedness Program

Hospital Preparedness Program

Pandemic Influenza Preparedness

Emergency Preparedness Interagency Coalition (EPIC)

Liaison for Nevada County's Emergency Medical Care Committee (EMCC)

Community Emergency Response Team (CERT) Support

For more information about Public Health Emergency Preparedness, visit https://www.mynevadacounty.com/753/Emergency-Preparedness-Planning

Program Highlight

Why Naloxone?

In the late 1990s, prescriptions for opioid medications began to increase dramatically. This increase has been associated with aggressive and misleading marketing from pharmaceutical companies, and it led to widespread misuse of both prescription and non-prescription opioids.

In 2017, the U.S. Department of Health and Human Services declared a public health emergency and announced a 5-point strategy to combat this opioid crisis. One of those points is "promoting the use of overdose-reversing drugs." Naloxone is just that, and it saves lives across this country every day. Every person lost to opioids is someone's child, parent, or loved one, and each life lost is one too many.

Today the U.S, Surgeon General emphasizes the importance of naloxone and states that for those who use opioids as well as family and friends of those who use opioids, knowing how to use naloxone and keeping it within reach can save a life.

NCPHD's **Naloxone Distribution Program** is one that engages every division of our department, as well as community partners and other government entities, and is a good example of how partnerships are key to our success and to improving community health.

Naloxone is a medication that works almost immediately to reverse opiate overdose. It has few known adverse effects, no potential for abuse, and can be rapidly administered via nasal spray.

HIGHLIGHTS

Received 282 doses of Narcan (a brand name for naloxone) Nasal Spray from the State allowing NCPHD to develop and implement a distribution program.

Distributed 20 doses of Narcan to first responders, at Grass Valley Fire and Washington Fire and Rescue.

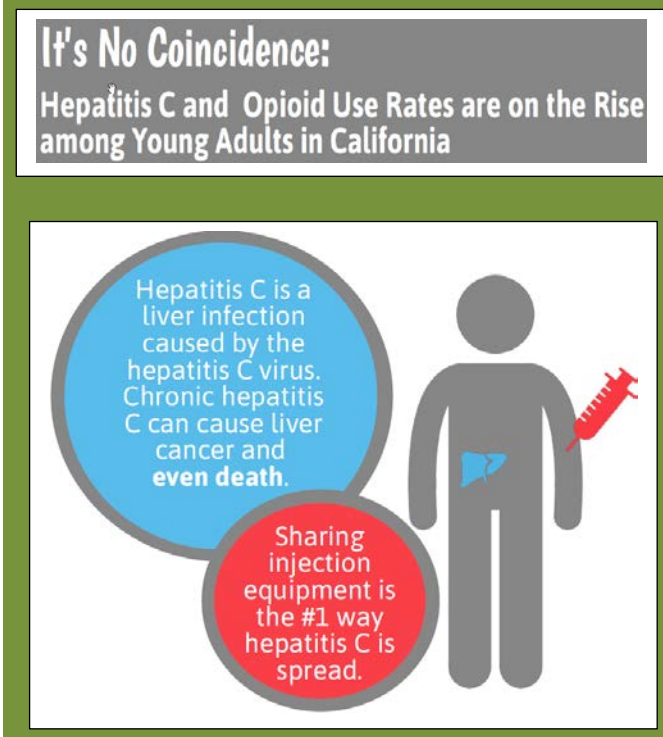
Via NCPHD's HIV/Hepatitis C Testing clinics, distributed over 80 doses of Narcan to those at risk of overdose, family and friends of people who have an opioid use disorder, and community members who may come into contact with people at risk of overdose.

Entered into a novel partnership with the Public Defender's Office to distribute Narcan and condoms to their clients and others who may utilize their services.

Working with Behavioral Health and Sheriff's departments to expand Narcan distribution for those most at risk of experiencing or witnessing an overdose.

For information about preventing an opioid overdose, visit https://www.cdc.gov/drugoverdose/pdf/patients/Preventing-an-Opioid-Overdose-Tip-Card-a.pdf

Emerging Issues and Opportunities



Infographic images above were created by the California Department of Public Health.

NCPHD makes an effort to remain nimble enough to respond to emerging public health issues and opportunities, including those identified in our Community Health Assessment. Following are two examples of recent actions and successes.

Hepatitis C Elimination Program

In response to increasing rates of Hepatitis C, which is now curable, NCPHD worked with Sierra Nevada Memorial Hospital (SNMH), FREED, and Sierra Gastroenterology to develop and implement a Hepatitis C Elimination Program. NCPHD now offers free and confidential Hepatitis C testing, and has worked with two local clinics to institute routine testing for Hepatitis C there as well. Those who test positive can now be referred to client navigation services funded by SNMH and provided by FREED, with an ultimate goal of enrolling clients in treatment services at Sierra Gastroenterology. And because it is a critical component to preventing the spread of the Hepatitis C Virus, NCPHD also continues to actively support the planning and implementation of syringe exchange and disposal services.

Public Health Funding

Along with other local health departments and our professional associations, NCPHD sent letters of support to state legislators for funding for Local Health Department Communicable Disease Infrastructure. These collective efforts resulted in success, and the Fiscal Year 2019-20 State budget includes $40 million for this purpose. This funding will undoubtedly contribute to bolstered public health and safety.

For more information about Hepatitis C, visit https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/HepatitisC.aspx

On the Horizon…

In addition to managing the day-to-day responsibilities of the department, NCPHD also works to keep an eye out for issues that will impact the public health of Nevada County. Following are two such issues on the foreseeable public health horizon.

Climate Change

The California Department of Public Health published a "Climate Change and Health Profile Report" providing climate change projections and identifying vulnerabilities for each county. Projections for Nevada County include continued increases in average temperature, changes in precipitation patterns with more volatile weather events, increases in the incidence of heat waves, decreases in the snowpack, and increases in wildfire risk. Anticipated impacts on human health from climate change include extreme weather related injuries (from storms, floods, and fires); increased heat-related illness especially in those with chronic illness, the very young or very old, and those without the ability to seek cooler shelter; worsening of respiratory illnesses such as asthma from exposure to air pollution; water quality impacts from drought and harmful algal blooms; changes in vector borne diseases; and mental health effects from stress and displacement due to natural disasters. Moreover, climate change is likely to magnify existing health inequities.

Immunizations (IZs)

Nevada County has had one of the lowest IZ rates in the state, due primarily to high Personal Belief Exemptions (PBEs). With legislative changes removing the PBE option, we saw a significant increase in IZ rates. While the current rate of all-required IZs of 80.3% is much improved, the last 3 school years have seen a plateau in this rate. This is associated with a large increase in the percentage of students with a Permanent Medical Exemption (PME). The current PME rate of 10.6% is the highest in California, and much higher than the state rate of 0.9%. For some communicable diseases such as measles, it takes high levels of immunizations, close to 95%, to provide community immunity. Until Nevada County's IZ rates improve, our community remains at high risk for certain disease outbreaks.

Nevada County's Immunization Rates

In 2011-2012, 67% of western county kindergarten students had all of their required school immunizations; that rose to 80% of kindergarten students 2018-19.

In 2011-2012, 22% of kindergarten students had Personal Belief Exemptions and were not required to arrive to school vaccinated; in 2018-19, over 10% of kindergarten students had Permanent Medical Exemptions and were not required to be vaccinated.

Community immunity occurs when enough community members are immunized or immune to a disease so that others are protected from infection because there is little opportunity for the disease to spread.

It can take high levels of immunizations to provide community immunity. Given the years of low immunization rates, western Nevada County lacks such immunity, leaving those who cannot be vaccinated more vulnerable.

Appendix A

Strategic Plan Progress Update

Operational Plan Report

Nevada Co Public Health | 1-Strategic Plan - Strategic Plan

[7/25/2019]

1-Strategic Plan Vision: *Safe, healthy and thriving communities*

1-Strategic Plan Mission: *Prevent disease, promote and support optimal health and wellness, and protect the community against disasters*

Group: --- 1-Strategic Plan | --- Strategic Plan

Service 1: Engage Partners to improve community health

Goal 1.1: Ensure children have a safe and healthy environment to maximize their developmental potential.

Objective 1.1.1: By December 2019, begin formal utilization of ACEsConnection by developing a Nevada County page in order to provide a larger platform to work from and to better foster resiliency-focused and Aces-related coalitions and networks. **Lead:** Wilson, Cynthia **% Done:** 50

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	1.1.1.1	[L] Wilson, Cynthia Weiss-Wenzl, Charlene	Attend ACEsConnection Presentation	[Project] By June 2018 Attend ACEsConnection Presentation at the Community Support Network Partner Meeting [between 6/1/2018 and 6/30/2018]	100% Complete	
	1.1.1.2	[L] Wilson, Cynthia Weiss-Wenzl, Charlene	Attend Training on ACEs	[Project] The MCAH Director, MCAH Coordinator and the Health Officer will attend training on ACEsConnection by October 31, 2018 [between 10/1/2018 and 10/31/2018]	100% Complete	
	1.1.1.3	[L] Wilson, Cynthia Weiss-Wenzl, Charlene	Present on ACEs at Youth Wellness Forum	[Project] Present on ACES and Social Determinants of Health at Youth Wellness Forum scheduled for March 26, 2019 [between 3/26/2019 and 3/26/2019]	100% Complete	
	1.1.1.4	[L] Wilson, Cynthia Weiss-Wenzl, Charlene	Attend ACEs Presentation to the Board of Supervisors	[Project] Attend presentation on ACEs given by the Child Abuse Prevention Council (CAPC) Board / CSN Steering Committee to Board of Supervisors. (also includes community partners) [between 4/9/2019 and 4/9/2019]	100% Complete	
	1.1.1.5	[L] Wilson, Cynthia Weiss-Wenzl, Charlene	Participate in ACEs workgroup from Youth Wellness Forum	[Project] Participate in ACEs workgroup from Youth Wellness Forum [between 5/1/2019 and 10/31/2019]	85% Complete	3/26/19 - The Youth Wellness Forum took place. Cindy Wilson, DPHN, presented on Social Determinants of Health, ACEs, and Resilience; priority areas were identified, with ACEs being one of them. 4/8/19 - The Community Support Network Steering Committee (CSNSC) and Child Abuse Prevention Council (CAPC) discussed taking the lead on ACEs as a priority area identified at The Youth Wellness Forum and identified `Be the One` as an initiative to raise community awareness and address

						ACEs prevention. 4/9/19 - Marina Bernheimer, from the CSNSC/CAPC presented on ACEs to the Nevada County Board of Supervisors. 5/16/19 - Key stakeholders met for a follow-up meeting for next steps following The Youth Wellness Forum. The group decided to pursue creating one umbrella organization for the various entities that provide services to children and youth.
	1.1.1.6	[L] Wilson, Cynthia Weiss-Wenzl, Charlene	Participate in CAPC Board / CSN Steering Committee `Be the One` Community Campaign outreach	[Project] Participate in CAPC Board / CSN Steering Committee `Be the One` Community Campaign outreach Sep-Oct 2019 [between 9/1/2019 and 10/31/2019]	% Complete	
	1.1.1.7	[L] Wilson, Cynthia Weiss-Wenzl, Charlene	Attend Youth Wellness Forum Follow up Meeting	[Project] Attend Meeting scheduled for Oct ? [between 10/1/2019 and 10/31/2019]	% Complete	
	1.1.1.8	[L] Wilson, Cynthia Weiss-Wenzl, Charlene	Join ACEsConnection and establish Nevada County Page	[Project] Join ACEsConnection and establish Nevada County Page [between 11/1/2019 and 11/30/2019]	% Complete	

Service 2: Advance health equity to eliminate health disparities

Goal 2.1: Strengthen department programs, services and policies to better address health equity.

Objective 2.1.1: By December 2019 provide formal training to all NCPHD staff that addresses the concepts and practices of health equity, in order to increase individual knowledge and related skills. **Lead:** Blake, Jill **% Done:** 70

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	2.1.1.1	[L] Blake, Jill	Join Government Alliance for Race and Equity (GARE), enroll an NCPHD team in the Northeast CA cohort and complete all assigned cohort work.	[Project] By 06/30/19, NCPHD GARE team will have received an introduction to racial equity concepts, completed a racial history of Nevada County, completed the Racial Equity Tool, and begun a NCPHD Racial Equity Action Plan. [between 12/5/2018 and 6/30/2019]	100% Complete	GARE`s Northeast CAÂ Cohort come to an end in June 2019, and the NCPHD team completed all assigned GARE work. NCPHD staff are now considering how to continue and expand our equity work, which will likely pick up again in late October. In September, NCPHD is sending a team of three staff to the GARE 2019 California Convening in order to further increase knowledge and equity-related skills, which will benefit the presentation that is to be completed by December. In addition, the HHSA Director has asked that the NCPHD GARE team work with members of a local tribe later this year on improving access to and utilization of HHSA services.
	2.1.1.2	[L] Blake, Jill	Develop presentation for PH All Staff on GARE work and practical implications of NCPHD`s equity work.	[Project] By 12/31/19, provide introductory training to all public health staff and HHSA leadership. [between 6/30/2019 and 12/31/2019]	25% Complete	NCPHD`s GARE team collected and prepared materials that will contribute to the December training, and the September GARE 2019 California Convening will offer more opportunities to influence the training that we`ll design and finalize in November for the December presentation.

Objective 2.1.2: By December 2019, and every three years thereafter, partner with Dignity Health and Tahoe Forest Hospital to develop a joint CHA/CHNA that identifies population groups with particular health issues and inequities, and a joint CHIP that addresses those population groups experiencing inequities and health disparities. **Lead:** Blake, Jill **% Done:** 85

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	2.1.2.1	[L] Blake, Jill	Enter into a contract with Dignity Health for consultant services with Community Health Insights (CHI) who will work with both parties to develop and implement a joint CHA/CHNA process.	[Project] By 12/31/18, bring a finalized contract to the Nevada County Board of Supervisors for approval. [between 5/1/2018 and 4/30/2019]	100% Complete	The contract with Dignity Health was finalized in early 2019. NCPHD contracted with Dignity Health, and Dignity Health contracted with Community Health Insights, who served as a consultant to both NCPHD and Sierra Nevada Memorial Hospital/Dignity Health. All contract deliverables were met, and the contract was paid in full in May 2019. Dignity Health`s version of the CHA went to the Sierra Nevada Memorial Hospital Board for approval in the spring of 2019, and NCPHD is in the process of circulating its draft for community feedback.
	2.1.2.2	[L] Blake, Jill	In consultation with Tahoe Forest, Dignity Health and CHI, finalize CHA/CHNA Indicators.	[Project] By 12/31/18 we will have finalized indicators for inclusion in the joint CHA/CHNA [between 5/1/2018 and 12/31/2018]	100% Complete	The NCPHD Director and Epidemiologist worked with Dignity Health staff and representatives from Sierra Nevada Memorial Hospital to finalize a list of indicators to be used in crafting the CHA. Because it was a priority for NCPHD that the CHA be a valuable and usable resource to other groups and organizations within the county, NCPHD argued to include more indicators than was originally proposed. Dignity Health representatives were very receptive to this request and together the group found a healthy compromise that met both organization`s needs.
	2.1.2.3	[L] Blake, Jill	In consultation with Dignity Health and CHI, finalize data sources to be utilized in the development of the joint CHA/CHNA	[Project] By 12/31/18 we will have finalized indicators for inclusion in the joint CHA/CHNA. [between 5/1/2018 and 12/31/2018]	100% Complete	The data sources were finalized prior to the deadline we set for ourselves. Some of the data sources and data were provided by NCPHD, and the group collectively determined sources for primary data collection.
	2.1.2.4	[L] Blake, Jill	Collect primary data from western county residents that mirrors data collected in Truckee by Tahoe Forest Hospital and the 2015 community survey questions.	[Project] By 01/31/19, conduct a community health survey in Western County that utilizes questions used by Tahoe Forest in Eastern County and NCPHD in 2015. [between 5/1/2018 and 1/31/2019]	100% Complete	NCPHD crafted and distributed a Community Health Survey that included questions from its 2015 community survey and questions from Tahoe Forest Hospital's recent community survey. Tahoe Forest had recently completed a survey as part of its Community Health Needs Assessment process. NCPHD and Dignity Health staff reviewed their survey tool and determined which questions to use in a western county survey. NCPHD implemented the finalized community survey in ways similar to its 2015 process. The results were used as were the results from Tahoe Forest`s recent survey in order to create countywide survey feedback. This primary data collection effort was a critical component of the CHA process.
	2.1.2.5	[L] Blake, Jill Whittaker, Holly	Provide an opportunity for the local community at large to review and contribute to the draft assessment.	[Project] By 07/31/19, present preliminary findings of the CHA/CHNA to the community and collect community feedback. [between 3/1/2019 and 7/31/2019]	65% Complete	In early July, NCPHD staff presented a summary of the key findings of the new draft CHA to the Nevada County Health Collaborative, and invited all attendees to access our draft document online and offer feedback on the document. NCPHD staff also offered to provide hard copies of the document to anyone who wanted one for themselves or for review at their workplace. In addition, four hard copies were provided to the local libraries so that patrons could

						review the document while visiting any four of the county`s libraries. These hard copies include blank pages where community members can leave feedback, and a link to an electronic survey where feedback can be provided is also included. Additional presentations and outreach are planned through the end of July 2019 in order to create broader community awareness of the draft CHA and to get more community feedback.
	2.1.2.6	[L] Blake, Jill	Finalize the NCPHD version of the joint CHA/CHNA	[Project] By 09/30/19, present to the Board of Supervisors and the community at large the finalized CHA/CHNA. [between 5/1/2018 and 9/30/2019]	65% Complete	We are on track to finalize the 2019 CHA by the end of September, but a presentation to the Nevada County Board of Supervisors will likely occur later than September 30, 2019. The 2019 CHA delves deeper than our 2016 CHA did into health disparities and their underlying causes. We hope to improve this section and our understanding with every new CHA.

Service 3: Strengthen prevention and response to current and emerging public health issues

Goal 3.1: Strengthen the department`s ability to respond to emergency events and disease outbreaks.

Objective 3.1.1: By June 2019, increase by 50% the number of local registered volunteers in the Disaster Healthcare Volunteers Database in order to improve our capacity to respond to an emergency or emerging event.

Notes: As of January 2019 there were 11 RN registrants in the DHV database.

Lead: Wilson, Cynthia

% Done: 85

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	3.1.1.1	[L] Wilson, Cynthia	Determine how many RN Registrants we have in the Disaster Healthcare Volunteers (DHV) Database.	[Project] Determine baseline of current DHV RN registrants. [between 5/1/2018 and 5/31/2018]	100% Complete	
	3.1.1.2	[L] Wilson, Cynthia Blake, Jill	Obtain CEO/HR approval to utilize DHV database volunteers to increase the department`s capacity during an emergency.	[Project] By July 30, 2018 request and obtain CEO/HR approval to utilize the DHV database for increased capacity. [between 5/1/2018 and 7/31/2018]	100% Complete	
	3.1.1.3	[L] Wilson, Cynthia	Distribute DHV flyers and information at Nevada County Fair August 2018	[Project] With the help of the UC Davis Nursing Students, distribute DHV flyers and information at NC Fair August 2018. [between 8/1/2018 and 8/31/2018]	100% Complete	
	3.1.1.4	[L] Wilson, Cynthia	Present information on the DHV database at School/Community Nurses meeting.	[Project] Present DHV at School/Community Nurses meeting October 2018 [between 10/1/2018 and 10/31/2018]	100% Complete	
	3.1.1.5	[L] Wilson, Cynthia	Present information on DHV database on KNCO	[Project] In January, 2019, present information on DHV database on KNCO [between 1/1/2019 and 1/31/2019]	100% Complete	
	3.1.1.6	[L] Wilson, Cynthia	Director and DON to complete DHV administrator training in order to become an administrator.	[Project] By May 31, 2019 complete training and take test to become administrator. [between 4/29/2019 and 5/31/2019]	50% Complete	5/15/19 - The DPHN and DD received webinar training to become DHV administrators. 5/21/19 - The DPHN received notification that her administrator application had been approved.

Objective 3.1.2: By December 2019 increase DHV registrants by 10 additional RNs & utilize

Notes: In December, determine the number of DHV RN Registrants

Lead: Wilson, Cynthia

% Done: 40

registrants in an exercise

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	3.1.2.1	[L] Wilson, Cynthia Blake, Jill Cross, Cathy	Include as a priority, an increase of 10 participants in the DHV for SBU 40114 for FY 19/20	[Project] Include DHV increase of 10 as a priority for SBU 40114 for FY 19/20 January 2019 [between 1/1/2019 and 1/31/2019]	100% Complete	
	3.1.2.2	[L] Wilson, Cynthia	Write DHV article for submission to Nevada County News	[Project] Write DHV article for submission to Nevada County News February 2019 [between 2/1/2019 and 2/28/2019]	100% Complete	This included Rick Foster (SMU student)
	3.1.2.3	[L] Wilson, Cynthia	Present information on DHV database at Emergency Preparedness Tabletop Exercise	[Project] Present DHV at Emergency Preparedness Tabletop Exercise March 2019 [between 3/1/2019 and 3/31/2019]	100% Complete	
	3.1.2.4	[L] Wilson, Cynthia	Present DHV information at various community partners meetings and/or community events	[Project] Present at the Hospice of the Foothills May staff meeting May 2019 Present at Surgical Center staff meeting. Present at CSN Partner meeting - June 2019 [between 5/1/2019 and 9/30/2019]	30% Complete	5/1/19 - The DPHN presented at the Hospice of the Foothills staff meeting.
	3.1.2.5	[L] Wilson, Cynthia Blake, Jill Weiss-Wenzl, Charlene Whittaker, Holly	Provide training and utilize 6-8 DHV RN registrants at the October POD drive through.	[Project] By the October POD drive through (Oct 21, 2019) identify, train and use DHV RN Registrants. [between 4/29/2019 and 10/31/2019]	0% Complete	

Service 4: Strengthen organizational capacity for positive work environment, internal collaboration and staff expertise

Goal 4.1: Improve our facilities to meet current and future operational needs and to improve the environment.

Objective 4.1.1: By December 2019, develop and implement a NCPHD staff satisfaction survey, and administer the survey annually thereafter. The results of the initial survey will be used to develop targets. **Lead:** Cross, Cathy **% Done:** 20

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	4.1.1.1	[L] Cross, Cathy Matson, Liz	Develop employee survey	[Project] By June 30th decide whether to use the County Survey data (broken down for our department) or the survey Liz developed. [between 4/29/2019 and 6/30/2019]	50% Complete	5/23: Staff survey drafted by L Matson, reviewed by C Cross. Waiting on disaggregated County staff survey by department to determine possible additional foci or revisions.
	4.1.1.2	[L] Cross, Cathy Matson, Liz	Release survey	[Project] If we are not going to use the County Survey data, release the survey Liz developed by July 31, 2019 [between 4/29/2019 and 7/31/2019]	0% Complete	
	4.1.1.3	[L] Cross, Cathy Matson, Liz	Analyze survey data and develop targets.	[Project] By September 30, 2019 analyze data and develop performance measure targets. [between 4/29/2019 and 9/30/2019]	0% Complete	

Service 5: Successfully communicate the value of the public health department and public health

Goal 5.1: Establish and implement strategies that increase knowledge about public health and NCPHD initiatives.

Objective 5.1.1: By June 2019, develop and begin implementation of a plan for regular communications with the Nevada County Board of Supervisors in order to improve members` knowledge of public health and local public health programs. **Lead:** Blake, Jill **% Done:** 80

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	5.1.1.1	[L] Blake, Jill Guevin, Toby	Map out plan for regular communications with the BOS that meets the needs and objectives of	[Project] By 06/01/19, finalize a NCPHD/BOS Communication Master Plan [between 5/1/2018	99% Complete	

		Matson, Liz	NCPHD	and 6/1/2019]		
	5.1.1.2	[L] Blake, Jill Guevin, Toby Matson, Liz	Develop newsletter template	[Project] By June 30, 2019 we will have a Public Health Newsletter template finalized [between 4/29/2019 and 6/30/2019]	100% Complete	5/1: Matson consults with Blake re: best approaches and style of newsletter required. Determined that we want something we can do as an `email blast` via a list of addresses that people can sign up for or we can sign them up for, as well as a static link on a webpage. Matson and Guevin develop draft of newsletter template in MailChimp. Blake gives draft the thumbs up! Template is approved and finalized.
	5.1.1.3	[L] Blake, Jill Guevin, Toby Matson, Liz	Develop newsletter timeline and distribution of duties	[Project] By August 30, 2019, we have a Public Health Newsletter timeline for 2019-20 finalized, including designated staff by role [between 4/29/2019 and 8/30/2019]	40% Complete	Early May, 2019: Prelim conversations with Jill and Liz re: how content is created (Jill) and who populates the newsletter (Toby). Still some outstanding question on what email address to use as the bounce back and who will get the email responses. Liz is to ask IS if the Public Health Department can have a forwarding-only email address. Also outstanding: who will write Friday Memos/Nevada County News for the three-yearly newsletters?

Objective 5.1.2: By December 2019, finalize, provide training on and implement department communication plan and guidelines, including a department-specific branding strategy. **Lead:** Blake, Jill **% Done:** 2

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	5.1.2.1	[L] Matson, Liz Guevin, Toby	Develop communication plan and guidelines for use.	[Project] By August 30, 2019, we have a communication plan, including use guidelines finalized [between 4/29/2019 and 8/30/2019]	5% Complete	5/3: Preliminary conversation between Liz and Toby re communication plan.
	5.1.2.2	[L] Matson, Liz Guevin, Toby	Train Public Health staff on communication plan	[Project] By November 30, 2019, train Public Health staff on communication plan and use guidelines [between 4/29/2019 and 11/30/2019]	0% Complete	

Service 6: Promote a robust, prevention-oriented, evidence-based county-wide continuum of care

Goal 6.1: Address gaps identified in the local the continuum of care.

Objective 6.1.1: By June 2019, work with community partners to develop, implement and evaluate a Hepatitis C testing, referral and client navigation program. **Lead:** Blake, Jill **% Done:** 100

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	6.1.1.1	[L] Blake, Jill Winders, Jen	Meet with necessary partners including Sierra Gastroenterology, FREED, and Sierra Nevada Memorial Hospital to map out a testing, referral, navigation and treatment model.	[Project] By 06/30/19, finalize a navigator referral process and corresponding Program Opt-In Form. [between 5/15/2018 and 6/30/2019]	100% Complete	NCPHD convened five meetings in 2018 with Sierra Gastroenterology, FREED and Sierra Nevada Memorial Hospital staff, and together developed and began implementing a testing, referral, navigation, and treatment model of service for Nevada County residents. Part of this process included determining the process for referrals from the testing entity to the navigation entity. It was determined that an Opt-In Form from FREED would be offered to clients who test positive for Hepatitis C Virus (HCV). This form is given to FREED by the client, so NCPHD and other referring entities are not required to collect or share client PHI.
	6.1.1.2	[L] Blake, Jill Winders, Jen	Arrange for necessary training and introductions for Navigator, so that she has adequate information to help referred clients navigate various County systems.	[Project] By 06/30/19, the FREED Navigator will have met and been trained by staff at Public Health, Social Services, and Behavioral Health. [between 5/15/2018 and 6/30/2019]	100% Complete	The NCPHD Director arranged for introductions to staff from the Social Services Department and for Navigator training on Medi-Cal enrollment processes. In addition.

						she also arranged for introductions to and information sharing by staff from the Behavioral Health Department. The information sharing included Behavioral Health`s process for assessing and enrolling clients in substance use treatment services. The NCPHD Director also developed and walked NCPHD staff and the Navigator through a notification protocol to be followed by NCPHD and FREED (the organization that employs the Navigator). This process required additional education and review from the NCPHD Health Officer with the Navigator. As a result of these introductions and information sessions, the Navigator is better prepared to help clients navigate various county systems and services.
	6.1.1.3	[L] Blake, Jill Winders, Jen	Begin a pilot phase of testing and referral services at NCPHD HIV/HCV Testing Clinics.	[Project] By 06/30/19, implement HCV testing twice monthly and have modified NCPHD`s HIV Quality Assurance Manual to incorporate HCV testing protocol and practices. [between 5/15/2018 and 6/30/2019]	100% Complete	Prior to developing the Hepatitis C Elimination Program with its community partners, NCPHD did not provide HCV testing because there was no referral mechanism in place. With this mechanism now established, NCPHD staff began implementing HCV testing at its twice monthly HIV Testing, Education and Referral Clinics. At these clinics, staff were already serving high-risk clients who are at risk of contracting HCV, and once the clinic began offering HCV testing, clients quickly accepted the free and confidential service. Prior to offering these new services, NCPHD staff revised its HIV Testing Quality Assurance Manual to include processes for HCV testing. This service has been received well by clients.
	6.1.1.4	[L] Blake, Jill Winders, Jen	Conduct education and outreach to local FQHCs in order to educate providers on the increase in HCV rates and to introduce the practice of testing for HCV as a matter of routine vs. as an exception.	[Project] By 06/30/19, have an outreach an education plan for Dr. Chang and Dr. Cutler so that they may begin to conduct outreach to Western Sierra Medical Clinic and Chap De Indian Health and encourage routine testing and use of the FREED Navigator. [between 5/15/2018 and 6/30/2019]	100% Complete	Together, Dr. Chang of Sierra Gastroenterology and Dr. Cutler, Nevada County Health Officer, developed a plan to conduct outreach and education to local clinics. They began their efforts by reaching out to Chapa De Indian Health, followed by outreach to Western Sierra Medical Clinic. In their presentations to the clinics, Dr. Chang focused primarily on Hepatitis C and current treatment options, while Dr. Cutler focused primarily on the public health impacts of Hepatitis C and the importance of linkages to care. Their presentations were followed by requests to screen and test for HCV more routinely and to utilize the Navigator services that are now available in the community. Both clinics were receptive to the presentations and requests. Doctors Chang and Cuter, FREED and NCPHD staff, however, may conduct additional outreach to each clinic

Appendix B

CHIP Progress Update

Operational Plan Report

Nevada Co Public Health | CHIP 2 - Community Health Improvement Plan - Implementation

[7/25/2019]

CHIP 2 Vision:	*A vibrant, diverse, connected, and healthy community*
CHIP 2 Mission:	*Fully implement the Nevada County CHIP plan to achieve the vision*
CHIP 2 Values:	
Fairness	*Fairness addresses institutional disparities and barriers to optimal health by providing equitable access to knowledge, education, services, and supports.*
Compassion	*Services and supports for people at every stage of life are compassionate and respectful.*
Holism	*Health is holistic, with physical, mental, cultural, social, spiritual, environmental, and economic health connected. We work together for long-term, sustained results.*
Relationships	*Intergenerational connections strengthen each person's social, emotional, and physical well-being. We share responsibility for each other's physical, mental, cultural, social, spiritual, and economic health.*
Leadership	*Strategic and proactive leadership is prepared to address community health challenges including predictable and unexpected events.*
Excellence	*Individually and collectively, we strive for excellence and accountability.*
Natural Environment	*Publicly accessible open spaces are valued, protected, and utilized to renew health and wellness.*

Group: --- CHIP 2 | --- Community Health Improvement Plan - Implementation

Service 1: Healthy Lifestyles

Goal 1.1: People in Nevada County are happy, connected, and physically active. They attend to personal health, eat a healthy diet, care for others, and live with a sense of purpose and meaning.

Objective 1.1.1: Promote, leverage and expand community partnerships, to provide access to healthy food, nutrition education, and WIC/SNAP benefits; address policies and ordinances that promote healthy lifestyles; and, create a full circle of opportunities for developing healthy habits.

Notes:

Lead: Lacroix, Lynne **% Done:** 100

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	1.1.1.1	[L] Lacroix, Lynne	Identify existing partnerships.	[Project] 1. Existing partnerships identified and documented via HCS invite list. 2. Identify potential new partners at Healthy Community Summit	100% Complete	Partners to engage: 211 Nevada County, Area Hospitals and Clinics, CNAP group, Environmental Health Dept., Food Pantries, Local Food Policy Council, NEOP, Primary

				3. Leverage partners to serve/bring Health and Wellness programs to CalFresh eligible clients. [between 3/22/2018 and 3/31/2019]		Care Providers, Sierra Harvest, Department of Social Services. Other partners include WIC, Libraries, Family Resource Centers, NEO, Bear Yuba Land Trust, and United Way. As new partners are identified they will be added.
	1.1.1.2	[L] Lacroix, Lynne	Host Healthy Community Summit	[Project] 1. By April 30th identify Key Note Speaker 2. By May 30th Identify goals and objectives for the conference [between 3/22/2018 and 12/31/2018]	100% Complete	February - June 2018: We created a timeline of action oriented tasks to stay on track. Team is working on logistics and have secured a venue and caterer. Key note speaker contacted and accepted to speak at the Healthy Communities Summit. A written description was utilized in a Save the Date flyer, and online registration program. July 23, 2018: Save-the-date email sent to 144 recipients. August 2018: Created invitation, included more people, invited speakers. Sept 2018: Last minute preparations; hosting Healthy Communities Summit on Sept 28, 2018. Sept 28, 2018. Nevada County Health Communities: A Partnership Summit. Seventy-six people in attendance. Our keynote speaker, Dr. David Erickson, from the Fed Reserve Bank kicked off the day. There were two panel discussions: 1) Cultivating and Maintaining a Healthy Community; and 2) Success Stories. The follow-up was that Dr. Erickson stated he would be willing to come back to meet with a group that is working on healthy community development projects.
	1.1.1.3	[L] Lacroix, Lynne	Determine gaps or opportunities to expand service connection.	[Project] Complete MOU between WIC and DSS so that WIC can enroll clients into Cal Fresh [between 3/22/2018 and 3/31/2019]	100% Complete	April 24, 2018: United Way convened a meeting with key players who work on food insecurity. Stakeholders who attended the meeting were: Interfaith Food Ministry, Food Bank of Nevada County, Sierra Harvest, Project Mana, and the Public Health Department (NEOP). During the first meeting agencies shared their programs, and there was some discussion on gaps in service. United Way proposed that the group meet again in two months to deepen the gaps conversation. Jan - June 2018: Public Health is coordinating diabetes educational efforts with primary stakeholders in Nevada County, as there was a gap in service for this specific audience. Efforts are designed to link low-income people with pre-diabetes and diabetes diagnosis to nutritional/medical educational classes. June 11, 2018: WIC / DSS MOU signed. July 23, 2018: United Way is in the preliminary stages of organizing a CA Care Force free clinic event in 2019 to meet the medical and dental needs of under-served residents. Nevada County Public Health will play a role in providing some services (e.g., vaccinations). July - September, 2018: NEOP coordinated with PH nurses to give out flu shots at the

						September Grass Valley Food Bank Distributions. A CMSP, NEOP and Tobacco Prevention staff tabled at the food pantries promoting Tobacco Cessation classes as well as Diabetes Education classes. Â January 9, 2019. Community school partners met to discuss nutrition education and physical activities in schools. Discuss gaps in services and program expansion.
	1.1.1.4	[L] Lacroix, Lynne	Identify any policies or local ordinances that are in alignment with healthy habits.	[Project] 1. A list of policies or local ordinances identified by September 28, 2018, e.g., healthy walking, healthy meetings, food pantry nutrition policy, no smoking policies, etc. [between 3/22/2018 and 3/31/2019]	100% Complete	September 24, 2018: Local policies and ordinances identified and documented.
	1.1.1.5	[L] Lacroix, Lynne	Work with community leaders to champion changes to policies that need change and introduce new healthy living policies.	[Project] [between 3/22/2018 and 3/31/2019]	100% Complete	March 12, 2018: At the Food Policy Council (FPC) meeting, the subject of barriers to creating healthy foods (e.g., home cottage industry) were highlighted. This is one primary focus of this group to overcome barriers in order create a more sustainable community. April 17, 2018: The Food Policy Council hosted its first political forum that focused on food issues. Local and US congressional candidates were invited to participate and were asked food and agricultural related questions. January 28, 2019: The Director of Nevada County Environmental Health, Amy Irani, will attend roundtable Q&A at the Food Policy Council meeting. Jan - April 2019. NEOP worked with community partners to develop new CDPH grant work plan for FY20-22. Plan includes physical activity components and Safe Routes to School Programs (leading into policies). Plan states engagement with Active Transportation Commission for creating infrastructure to allow more alternative modes of transportation for students to and from school.

Objective 1.1.2: Provide community and youth information and education about smoking and vaping. **Lead:** Glaz, Shannon **% Done:** 80

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	1.1.2.1	[L] Glaz, Shannon	Catalogue what is currently in place, including prevention, education and cessation.	[Project] 1. Develop a list of available resources broken out by youth and adults. [between 5/14/2018 and 6/30/2018]	100% Complete	Connection Point is Nevada County's resource hub for services including prevention and cessation services. Attached is the link that provides a current list of resources for youth and adults. http://211connectingpoint.org/substance-abuse/alcohol-drug-smoking-education-prevention/
	1.1.2.2	[L] Glaz, Shannon	Promote existing education and training to partners.	[Project] 1. Share and/or distribute resource listings Community Partners. 2. Promote Public Health sponsored cessation focused training (scheduled for June 14, 2018) to BH service providers [between 6/1/2018 and 12/31/2018]	100% Complete	1. The Nevada County Tobacco Prevention Program created and distributed a nicotine cessation resource guide to all Nevada County Behavioral Health providers. A separate resource guide was created and distributed to local health care providers and dentist throughout Western and Eastern

						Nevada County. 2. The Nevada County Tobacco Prevention Program contracted with Connecting Point to provide smoking cessation classes to Western Nevada County community members, free of charge. As of 5/1/2019, there have been four 8-week sessions conducted, with between 5 and 15 participants during each session. 3. The Nevada County Tobacco Prevention Program provided *A Strategic Approach to Tobacco Cessation for Substance Use and Behavioral Health Agencies* on June 14, 2018 lead by Dr. Chad Morris. Approximately 95 health service providers attended the training.
	1.1.2.3	[L] Glaz, Shannon	Utilize state and local funding for campaign.	[Project] Per the Nevada County Comprehensive Tobacco Control Plan, utilize state and local funding to develop and implement 3 campaigns with the following emphasis. 1. Youth and Prevention 2. Adults and Cessation 3. Outdoor Smoke Free Policies [between 5/14/2018 and 6/30/2019]	65% Complete	1. Youth and Prevention: - The Nevada County Tobacco Prevention Program will create and maintain a culturally diverse youth coalition with a goal of at least 8 youth. The coalition members will be trained and educated to advance tobacco control efforts, and will participate in a minimum of 10 coalition meetings and 4 non-meeting activities annually. During this recruitment period 3 high school youth coalition members where recruited. An alumnus youth coalition member helped with recruitment and creating flyers that were sent home in the school orientation packet to all students attending North Point Academy. The Alumnus conducted presentations in classes and invited kids to an orientation meeting. A skill and interest questionnaire was distributed to the new recruits to better understand the skillset and motivations of the group, and to guide future meetings and trainings. Recruitment has also begun at the middle school level, which will involve a collaborative effort of the Club Live/TUPE program at Lyman Gilmore. This will be a project specific program that will be ongoing, throughout the school year with engagement of approximately 10-14 youth. The middle school project supports the current strategy to engage younger students to increase retention in the youth coalition as they enter high school. - During this report period there was consistent collaboration with community partners from Tobacco Use Prevention and Education (TUPE) and the Coalition for a Drug Free Nevada County. All partners attended monthly planning meetings, where coordinated activities, trainings and events were planned. Planned activities included Parent U, a peer education summit, and advisor trainings, in addition to the ongoing peer education clubs. - The Nevada County Tobacco Prevention Program collaborated with local youth center, NEO, to offer a spoken word workshop series. The workshop consisted of four, 1.5 hour

						workshops and a final *Poetry Slam* performance held at the conclusion of the series. A total of 4 participants participated in the workshop and 3 tobacco related pieces were created. The participants' final spoken word pieces will be posted on social media sites to create awareness about the consequences and dangers of tobacco. - Leading up to the celebration of Kick Butts Day, a poster and bookmark contest was conducted. Tobacco staff created a contest application, and promotional flyer to market contest, which was promoted through the Nevada County website, all local libraries, TUPE school advisors, and local middle and high schools. The contest was kicked off during Red Ribbon Week with a total of six entries submitted, two from high school and four from middle school youth. The R.O.S.E. youth coalition conducted a submission review panel and the winners were announced through the *Nevada County News*, Nevada County's weekly online newsletter. Awards were given to the winning participants. The winning designs are in the process of being printed for ads, posters, and bookmarks that will be distributed during Kick Butts Day in March, in an effort to promote education, cessation and the California Smokers Helpline. 2. Adults and Cessation: - Nevada County Tobacco Prevention program staff and coalition members assembled 200 *quit* kits to be distributed to community members and partners, in conjunction with program outreach and collaboration efforts. Collaborating partners include: Connection Point, Community Recovery Resources, Community Beyond Violence, Chape-De Indian Health Clinic, Turning Point Behavioral Health, Western Sierra Medical Clinic, WIC, Silver Springs Alternative High School, Truckee Teen Clinic, and the Utah Philips House. - Over 130 *quit kits* have been distributed to local partners and ongoing tracking systems for distribution have been devised. Program staff have also distributed educational packets about nicotine dependence and tobacco treatment options to over 31 agencies including dentist, pharmacies, medical clinics and veterans services. - On June 14th, 2018 the Tobacco Use Prevention Program hosted two in-person, 3 hour, trainings on *The Strategic Approach to Tobacco Cessation*, facilitated by Dr. Chad Morris, PHD. There were 60 community partners in attendance in the training. - In partnership with Connecting Point, two tobacco cessation 8-week courses where held during this report period. The classes provided 13 community members cessation services. Connecting Point now has three

						freedom from smoking certified staff available to run the evidenced-based curriculum. The free courses are gaining popularity each time a session is advertised, and as more referrals are being made from partners in the community that become aware of the resource. 3. Outdoor Smoke Free Policies: - Two presentations on smoking and vaping research were given during this report period. One presentation included a 30-minute talk and panel given by Truckee Tobacco Program staff at the Athlete Committed Code Night, with 80 students and 38 parents in attendance. The second presentation was a 20-minute presentation given to the Tahoe Forrest Health System (TFHS) Million Hearts Committee to gain support from the group and discuss ways to work collaboratively on the tobacco free downtown policy. - Program staff also conducted a 2-hour strategic planning session with coalition members and community partners to complete the Midwest Academy Strategy Chart (MASC) for the Town of Truckee to determine goals, constituents, allies and opponents, targets and tactics. Tobacco staff conducted a presentation for approximately 15 minutes to the Tahoe Donner Merchants Association (TDMA) during their monthly meeting. Staff reported on the results of the business owner survey, and educated them on the current or lack of smoke-free policies for the town of Truckee. Staff has had follow-up conversations with the TDMA Chair regarding next steps and recruitment of stakeholders to be part of a sub-committee. - Program staff used Anti-tobacco television (TV), digital, radio, print and/or outdoor advertising ads developed by CDPH, TECC or other state and federal agencies about second hand smoke and vaping, along with dangers of flavored tobacco products, and provide paid placement of the ads to best reach the target audience. An annual Communication Plan has been prepared detailing specific ads and placement in coordination with the California Tobacco Control Media Unit. To date a five week span of digital and newspaper ads were run in the Sierra Sun.

Objective 1.1.3: Establish/expand Friendly Visitor program for seniors. (This program pairs homebound seniors with a visitor, and can also include therapy animals.) **Lead:** Kellermann, Seth **% Done:** 100

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	1.1.3.1	[L] Kellermann, Seth Acton, Ana	Conduct assessment to identify assets.	[Project] 1. A listing of community assets by organization. 2. A list of identified gaps. [between 12/22/2017 and 5/6/2019]	100% Complete	Conducted meeting with FREED Center for Independent Living (June 26th). Planned Meeting for larger conversation with community partners for August 2nd from 1-3pm at FREED.

						Planned planning meeting at FREED to prepare for the August meeting (July 10 from 4-5pm). We have been conducting monthly meetings at FREED for leaders from various local programs. Our first meeting on August 2nd was a huge success with more than 20 different people who are involved already in dispelling loneliness. One of the primary conclusions of this event was the need to use 211 as a central contact point for requests for visitors/volunteers. At the subsequent meeting our numbers had dropped off somewhat, perhaps due to the breadth of the goal and the group's undefined structure. We have a stable 4-8 people at the meetings and have conducted a survey of local churches to determine how many of them were doing this work of visiting the lonely. 2/3 of the respondents were and had an organized structure for carrying this out. All respondents were open to the idea of partnering with the county to care for the community. We also conducted a survey to determine the root causes of loneliness in our community, which will be helpful in determining responses. Next meeting is Thursday December 13th from 1-3pm.
	1.1.3.2	[L] Kellermann, Seth Acton, Ana	Use a cross-generational approach to make enhancements where there are gaps.	[Project] [between 4/1/2018 and 12/31/2018]	100% Complete	Invited Nevada Union Senior to the August meeting who wants to do a project like this for her Senior Project. This area continues to prove to be problematic due to safety concerns and legal requirements. We are also discussing a long-term goal of building a community center to provide a safe place for youth and adults to interact with one another. It was determined that given the complexities and security concerns of utilizing youth that this portion of the program will not be implemented at this time.
	1.1.3.3	[L] Kellermann, Seth Acton, Ana	Implement program and make changes as needed.	[Project] [between 4/1/2018 and 6/30/2019]	100% Complete	We are a long ways from implementation, although many organizations are already doing this work independently, so we will continue to help organizations work collaboratively on their shared goal. This activity program has been completed with the use of the Friendly Visitor Program through FREED. Other local churches and individuals have been invited to take part in FREED`s program as part of the initiative to combat loneliness in the county. In addition,

						this program has sparked similar initiatives in some churches to expand the work they are already doing. Also, Connecting Point will introduce its Volunteer Hub soon which will help connect volunteers with existing visiting programs and also offer volunteering opportunities to those who are experiencing loneliness or isolation.

Service 2: Behavioral Health

Goal 2.2: People in Nevada County have the resiliency to achieve their optimal well-being, live joyfully, and contribute to their community.

Objective 2.2.1: Explore and implement evidence-based strategies for prevention, including strategies of the drug-free coalitions to reduce youth's easy access to alcohol and drugs, as appropriate.

Notes: Proposed Performance Measures for this strategy:
- Formal partnerships in place
- No. and % of new partners implementing screening
- No. and % of people served through new/expanded programming
- Drug overdose deaths (number of drug poisoning deaths per 100,000 population)

Lead: Not currently active

% Done: 0

Objective 2.2.2: Offer more positive alternatives for kids, e.g.: youth center.

Notes: Proposed Performance Measures for this strategy:
- Meetings attendance, including youth participants.
- No. and % of youth served through new / Expanded programming.
- No. and % of students in 7th, 9th, and 11th grade that have constant feelings of sadness or hopelessness.

Lead: Not currently active

% Done: 0

Objective 2.2.3: Work with partners to develop a pilot for integrated health care (mental, oral, physical, and substance use).

Notes: Proposed Performance Measures for this strategy:
- Pilot project in place for integrated health care.
- No. and % of emergency room patients who received integrated care with other providers and services.
- Formal partnerships in place.

Leads: Blake, Jill; Kreiter, Stephanie

% Done: 70

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	2.2.3.1	[L] Blake, Jill	Convene a task force to assess feasibility of integrated health care in Nevada County.	[Project] By 09/30/18, engage the members of the Nevada County Health Collaborative to begin discussions about and an assessment of the feasibility of more integrated health care in Nevada County [between 4/1/2018 and 9/30/2018]	100% Complete	Jill Blake, NCPHD Director, and Stephanie Kreiter, Sierra Nevada Memorial Hospital`s Community Benefit Coordinator, became co-facilitators of the Nevada County Health Collaborative (NCHC). It was agreed that the NCHC would serve as the task force to

						assess and work towards integrated health in Nevada County. In late 2017, NCHC members developed, signed and ratified a formal MOU establishing mutually agreed upon goals related to improving health care access in Nevada County. Since establishing this MOU and since the finalization of our CHIP, two HRSA grants awards were awarded to collaborative organizations in Nevada County. These awards would not have been possible without this formal NCHC MOU as having such a formalized group in place was a requirement of the HRSA applications. Both HRSA grants fund new, integrated health services in the community, so the benefits of this collaborative group has proved to be significant.
	2.2.3.2	[L] Blake, Jill	Identify one or more partners to pilot and serve as a demonstration project.	[Project] By 12/31/18, work with Task Force/NCHC members to identify opportunities to implement pilot projects that focus on and/or work to improve integrated health care [between 4/1/2018 and 12/31/2018]	100% Complete	Via the NCHC meetings, NCPHD facilitated discussions about pilot projects that enhance integrated health care, and there have been several successes. For example, the HRSA grant that was awarded to Sierra Nevada Memorial Hospital Foundation was for a Rural Health Network Development Program, which funds several patient navigators that provide onsite services helping patients navigate and access other needed services. Another example is the Hepatitis C Elimination Program, which is a partnership between the Sierra Nevada Memorial Hospital Foundation, NCPHD, FREED and Sierra Gastroenterology, and provides integrated services to clients so that there is a continuum from testing to treatment, with client navigation supports available in between if needed. Both demonstration projects have resulted in improved patient care and stronger linkages and referral mechanisms between service providers
	2.2.3.3	[L] Blake, Jill	Evaluate pilot, and as appropriate, expand the projects to health care providers.	[Project] By 06/30/19, develop an evaluation component for at least one pilot or demonstration project or program, and share evaluation results with the NCHC. [between 4/1/2018 and 6/30/2019]	75% Complete	Both the Rural Health Network Development Program and the Hepatitis C Elimination Program have developed evaluation components. There was a recent vacancy and then change in staffing at Sierra Nevada Memorial Hospital. Their new Community Benefits Coordinator, who oversees SNMH`s Rural Health Network Development Program, is scheduled to present to the NCHC at the September 2019 meeting on the program evaluation results to date. Staff from NCPHD and FREED are scheduled to meet with Sierra Gastroenterology in early August to review preliminary program evaluation results and then NCPHD and FREED staff will present their results at NCHC`s November 2019 meeting. These activities are on track, but the presentations will occur after the end date set for this activity.
	2.2.3.4	[L] Blake, Jill	Integrated Emergency Department (ED) implementation (e.g., case manager + CoRR counselor in ED for motivational interviewing, MAT)	[Project] By 09/01/19, more integrated services will be implemented at Sierra Nevada Memorial Hospital`s Emergency Department. These services, at a minimum, will include case management and patient navigation. [between	25% Complete	Due to a staff vacancy at SNMH, this activity will be reported on after the September 2019 Nevada County Health Collaborative meeting.

				4/1/2018 and 12/31/2019]		
	2.2.3.5	[L] Blake, Jill	The members of the Nevada County Health Collaborative (NCHC) will explore the possibility of offering Primary Care with tele-med capacity in Western Nevada County.	[Project] By 6/30/20, the NCHC will seek to host formal presentations and seek to make determinations about offering primary care via Telemedicine in Western Nevada County. Presentations could include topics such as state laws and Telemedicine regulations, administrative requirements, and HIPAA guidelines on Telemedicine. [between 4/1/2018 and 6/30/2020]	0% Complete	No real progress has been made to date. Tele-medicine has been briefly discussed at 2018 NCHC meetings, but no formal exploration has occurred yet with NCHC members. This activity will be placed on an NCHC meeting agenda in early 2020.

Service 3: Socio-Economics

Goal 3.3: People in Nevada County have the resources they need to meet their basic needs, live in safe and permanent homes, lead enriching lives, have economic security, and have the ability to invest in the future.

Objective 3.3.1: Expand/increase partnerships with the Planning Department for housing and to expand resources and supports/supportive services.

Notes: Proposed Performance Measures for this Strategy:
- Visibility of health in housing meetings, as evidenced by attendance at meetings.
- No. and % of new policies that align to health.
- No. and % of affordable housing (based on cost burden)
- No. and % of over-crowded / inadequate housing

Lead: Not currently active **% Done:** 0

Objective 3.3.2: Promote infants` early health/ nutritional outcomes.

Leads: Wilson, Debra; Ash, Joyce **% Done:** 75

Status	Number	Activity Team	Activity	Performance Metric	Status	Notes
	3.3.2.1	[L] Wilson, Debra Ash, Joyce	Review and identify gaps in nutrition/health services/resources for families with infants and young children.	[Project] 1. Develop inventory list or catalogue of health and nutrition resources for local providers. 2. Review inventory/catalogue with Community Advisory Board members to identify gaps in services. 3. Identify and engage partners/service representatives currently not involved with the Community Advisory Board. 4. If gaps are identified, work with CAB to discuss strategies to fill identified service gaps. [between 4/1/2018 and 3/31/2019]	100% Complete	05/22/18-Public Health Director, Jill Blake attended Foothills/Truckee Healthy Babies Community Advisory Board to present the CHIP and the CAB`s role. Twelve were in attendance. CAB members to develop list of materials and resources for our target population and contributing the CHIP objective. Next meeting scheduled 8/28/18 to review draft resource/referral list and identify gaps and other partners to assist in this objective. 8/28/18 Started cataloging known community referrals, resources, and programs available for pregnant women, babies up to 2 years in both eastern and western county. CAB members are to review and identify any missing information. 11/27/18 Continued to review and catalog known referral resources for families with children up to 2 years and any identified gaps in services for both western and eastern regions within Nevada County. 12/20/18 Clarified breastfeeding support resources on the referral catalog with Joyce Ash and Kathleen Barale. 05/28/19 -Meeting - Updated list to include - Dignity Health`s My Baby App to inventory.

						name change identified for CORR to Granite Wellness, Tahoe Safe Alliance, NCPH Truckee Reproductive Clinic services. Identified Lactation Specialists at WIC and Nest. Discontinued parent support group at Sierra Care Physicians. New OB/GYN providers at WSMC without hospital delivery privileges. No referral mechanism or procedure from SNM Hospital to refer WIC. Further discussed and identified nutrition/health gaps in services and/or underutilized programs. Ann Erdmann invited both Debra Wilson, WIC and Char Weiss-Wenzl, MCAH to present information at nursing staff meetings in June/July 2019. Dr. Woerner stated providers need and want community referral binder or electronic referral mechanism. They don`t have time/resources to put it together. Joyce Ash, CAB co-chair emailed Child Advocates` Resource Directories for both Eastern and Western Nevada County to all members of CAB. Susan Train RN, IBCLC from Tahoe Forest will share/copy her Eastern County Resources binder with Dr. Woerner at WSMC in Kings Beach. Susan Train and Joyce Ash are working to clarify the Truckee Healthy Babies referrals through Tahoe Forest Women`s Center and Hospital. TFH just took the TF Women`s Center last year and they`ll review MOU with Joyce at upcoming meeting.
	3.3.2.2	[L] Wilson, Debra Ash, Joyce	Promote and increase referrals and/or access to health/nutrition programs and community resources for families with infants and young children.	[Project] 1. Identify and engage local health care providers with CAB outside of quarterly meetings. 2. CAB to address service gaps and/or referral barriers to under-utilized nutrition/health program referrals with providers. 3. CAB to strategize feasible mechanisms to minimize referral barriers and increase referrals. 4. CAB to implement 1-2 strategies to increase rapid referrals and facilitate information-sharing between birthing centers and community support programs. [between 4/1/2018 and 3/31/2019]	75% Complete	Sierra Nevada Hospital starting to provide additional breastfeeding training to L&D nurses (15 hours) August 2018. Representation from SNMH was not at the August 2018, November 2018, nor February 2019 meetings to obtain update status on this. In October 2018, Dignity representative with SNMH verified and updated their list of local referrals and resources (with Debra Wilson) for WIC. Currently, there are no mechanisms for rapid referrals or information sharing with SNMH and WIC, whereas, there is a Dignity MOU with Mercy San Juan and WIC in Sacramento. NC WIC does receive referrals from SNMH but the referrals have come through CRP WIC. Currently, Dignity social workers are referring directly to FHTHB. WIC lost newborn referrals with closure of Welcome Baby program. SNMH currently has MOU with Foothills Healthy Babies to include the self-screen/referral in their registration packet. It is anticipated that this activity will not be completed until November 2019. Since the CAB meets only quarterly, we reviewed a proposal to increase outside discussions/phone conference with the FTHB Program Manager, MCAH Coordinator, Director of Nurses of SNMH and the WIC Coordinator. We all agreed to this but not date was set. Recent loss of several local OB providers in

						Grass Valley, Dr. Sarah McKenzie, Dr. Genobaga, and Vanita Lott CNM. Dr. Woerner said there is a new OB provider named Dr. Pundi; however this provider will not have deliver at the hospital. Discussed having a group meeting (FHB, PH-MCAH, & WIC) with Dr. Pundi to educated provider on community resources/referrals. No date set yet. May 28th, 2019 also discussed identified nutrition/health gaps, barriers to referrals and continuity of care; discuss strategies for rapid referral processes, and mechanisms for information sharing between hospitals and community partners, such as WIC & FTHB. MCAH Char, WIC Deb, FTHB Joyce, TFH Susan and SNMH Ann to plan conference call in July to improve mechanisms for rapid referrals. Char, Joyce, and Deb to plan group visit to WSMC with new OB providers, Dr. Pundi - (no date yet) and Certified Nurse Midwife Drea Gekas coming on-board WSMC also in July. Dr. Woerner requested an easy to use referral binder or electronic referral document specifically for pediatric HCPs; FHB provided an electronic version of their referral/resource directory to all CAB members. Susan Train will provide Dr. Woerner a copy of her resource/referral binder for Eastern County. Char MCAH, and Deb WIC are to provide SNMH nursing staff in-service in both June and July 2019 to work on local referrals.

Appendix C

Quality Improvement Successes

Quality Improvement Success Story

Immunization Clinic Improvements

The Problem

What started out as pretty straight forward charge to start billing for immunizations turned into a full scale assault to make our immunization clinics a better, more professional experience for customers and clinicians alike. Over the course of 12 months we completely overhauled the process. Clinics were a pen and paper exercise. We did not check for eligibility or bill for immunizations. Children's clinics were conducted off site when the infrastructure, exam rooms, computer, cash register, etc. was available on site. Vaccine had to be inventoried, logged and transported in temperature controlled coolers/freezers. Immunization records were being reviewed twice, once by the MA and again by the Nurse. Manual entry of immunizations given into state registry. Manual tracking and reconciliation of immunization inventory.

The Action

Phase One (Fall 2015):

Positioned staff at front counter to greet clients and build the client record and check eligibility at check-in. Removed duplication of immunization record review. Shifted taking payment to the very end of the process.

Phase Two (Winter/Spring 2015-16):

For two months tested bringing the children's clinic back to Crown Point. Built Vaccine inventory in EHR. Set up interface between EHR and state registry. Began charting in the EHR in real time. Started scanning IZ consent form, Insurance card and IZ shot records directly into EHR at check-in. In January of 2016 it was decided that the Children's clinic would be relocated to Crown Point permanently.

Phase Three (Spring/Summer 2016)

Began to scan consent forms from previous visits into the EHR.

Ongoing

Continuing to monitor & track progress
Make further refinements to processes

The Result

Increased billing revenue from $0 in 2014-15 to $10,000 for FY 2016-17. A more streamlined process free of multiple duplications of effort. A positive patient experience. A more professional experience for staff, leading to increased job satisfaction. A more efficient and effective use of existing resources. Reduced risk of injury to staff. Increased adherence to the Vaccine for Children program eligibility standards. Reduced vaccine waste. A desire to build upon the success of the changes made to date; constantly looking for ways to improve the quality of our clinics.

The Connection

Nevada County Public Health works to improve resource efficiencies and customer satisfaction by:

- ⇒ Providing a more Safe, Suitable and Professional clinic environment.
- ⇒ Leveraging existing technology
- ⇒ Eliminating redundancies
- ⇒ Reducing vaccine waste

Contributors:
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Cynthia Wilson
Carol Smith
Lisa Lehr
Judy Caldwell
Cathy Cross

December 2016

Quality Improvement Success Story

Vitals Project

The Problem

Death records are initiated and finalized in the Electronic Death Record System (EDRS). The State, typically within 30 days, downloads the data from EDRS to the AVSS system. Vitals staff runs reports monthly out of AVSS to provide to various other County departments and entities within the County. In order to make sure the Information was up to date in AVSS, vitals staff manually entered death records into AVSS to ensure timeliness of reports. Vitals staff calculated 8 minutes per record to enter, representing 154 hours entering data for the 1,155 deaths reported in 2017.

The Action

Found the EDRS manual online and downloaded the raw data to both ACESS and EXCEL; built report templates and numerous pivot tables to provide customers reports in the accustomed format; reviewed as a group the canned reports available in EDRS; determined the EDRS canned reports as sufficient in detailing the necessary information included in the AVSS reports, and to be completely acceptable. Vitals staff receiving training to improve Excel skills for the purpose of running ad hoc reports requested by staff. Vitals staff notified customers that beginning with the January 2018 monthly reports, the new reports will look slightly different, but all the same data elements are present.

The Result

1) Redirection of time. Before: approximately 154 hours per year spent re-entering data into AVSS that already exists in EDRS. After: 0.
2) Improved job satisfaction due to streamlining and simplifying tasks.
3) Improved skill set including increased proficiency with Excel.
4) Improved efficiencies with no change in service delivery to consumers.
5) Preparation for eventual phase-out of the AVSS system.

The Connection

Nevada County Public Health works to improve resource efficiencies by:

⇒ Eliminating redundancies

⇒ Leveraging existing technology

⇒ Reducing time waste

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January 2018