

**Washoe County District Board of Health
Meeting Notice and Agenda**

PLEASE NOTE LOCATION

Members

Kitty Jung, Chair
Dr. John Novak, Vice Chair
Oscar Delgado
Dr. George Hess
Kristopher Dahir
Michael D. Brown
Tom Young

Thursday, January 25, 2018
1:00 p.m.

Washoe County Administration Complex
Commission Chambers, Building A
1001 East Ninth Street
Reno, NV

**An item listed with asterisk (*) next to it is an item for which no action will be taken.
1:00 p.m.**

- 1. *Roll Call and Determination of Quorum**
- 2. *Pledge of Allegiance**
- 3. *Public Comment**

Any person is invited to speak on any item on or off the agenda during this period. Action may not be taken on any matter raised during this public comment period until the matter is specifically listed on an agenda as an action item.

- 4. Approval of Agenda – (For possible action)**
January 25, 2018

5. *Recognitions

A. Promotions

- i. Sonya Smith, Public Health Nurse I to Public Health Nurse II, 12/14/2017 - CCHS
- ii. Briana Johnson, Environmental Health Trainee to Environmental Health Specialist, 1/11/2018 - EHS
- iii. Ellen Messenger-Patton, Environmental Health Trainee to Environmental Health Specialist, 1/11/2018 - EHS

B. New Hires

- i. Jeff Jeppson, from EHS Vector to Air Quality Specialist, 1/8/2018 - AQM
- ii. Sheila Juskiw, Advanced Practice Registered Nurse, 1/22/2018 – CCHS

C. Years of Service

- i. Cynthia Arredondo, 5 years, hired 1/23/2013 – CCHS
- ii. Diane Freedman, 25 years, hired 1/25/1993 - CCHS

6. Consent Items – (For possible action)

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. Approval of Draft Minutes – (For possible action)

- i. December 14, 2017

B. Budget Amendments/Interlocal Agreements – (For possible action)

- i. Retroactive approval of Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through June 30, 2018 in the total amount of \$3,000 in support of the Environmental Health Services Division (EHS) Food Retail Standards Program – Dog Friendly Outdoor Patio Sign Project, IO 19078; and if approved, authorize the District Health Officer to execute the Agreement.
Staff Representative: Patsy Buxton

- ii. Retroactive approval of Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through October 31, 2018 in the total amount of \$2,914 in support of the Environmental Health Services Division (EHS) Food Retail Standards Program – Western Association of Food and Drug Officials (WAFDO) Conference and FDA Pacific Region Retail Food Seminar Project, IO 11467; and if approved, authorize the District Health Officer to execute the Agreement.
Staff Representative: Patsy Buxton

- iii. Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through September 30, 2018 in the total amount of \$50,000 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program IO# 11413; and authorize the District Health Officer to execute the Subgrant Award.
Staff Representative: Nancy Kerns Cummins

- iv. Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through December 31, 2018 in the total amount of \$72,449 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Surveillance Program IO# 10012 and authorize the District Health Officer to execute the Subgrant Award.
Staff Representative: Nancy Kerns Cummins

- v. Approve a Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in the total amount of \$109,099 (no required match) retroactive to January 1, 2018 through December 31, 2018 in support of the Community and Clinical Health Services Division (CCHS) Tuberculosis Prevention and Control Program, IO# 10016 and authorize the District Health Officer to execute the Notice of Subgrant Award.
Staff Representative: Nancy Kerns Cummins

- vi. Approve a Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in the total amount of \$129,630 (no required match) retroactive to January 1, 2018 through December 31, 2018 in support of the Community and Clinical Health Services Division (CCHS)

Sexually Transmitted Disease Prevention and Control Program IO# 10014 and authorize the District Health Officer to execute the Notice of Subgrant Award.

Staff Representative: Nancy Kerns Cummins

- vii. Accept Subgrant Amendment #1 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, retroactive to March 29, 2017 through March 28, 2018 for an additional amount of \$12,346 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Tobacco Prevention and Control Program IO# 11238; and if approved, authorize the District Health Officer to execute the Subgrant Amendment.

Staff Representative: Nancy Kerns Cummins

- viii. Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through December 31, 2018 in the total amount of \$287,496 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program IO# 10013 and authorize the District Health Officer to execute the Subgrant Award.

Staff Representative: Nancy Kerns Cummins

- C. Approve the modification of the Community and Clinical Health Services Fee Schedule to add Human Papillomavirus (HPV) Genotype (16 18 45) Testing. – **(For possible action)**

Staff Representative: Nancy Kerns Cummins

- D. Approve Agreement between the Washoe County Health District and Keep Truckee Meadows Beautiful in the amount of \$100,000 for the period January 25, 2018 through December 31, 2018 in support of the Recycling and Solid Waste Management Plan program activities; Approve FY18 Purchase Requisition #3000034667 issued to Keep Truckee Meadows Beautiful in the amount of \$100,000 on behalf of the Environmental Health Services Division of the Washoe County Health District; and if approved, authorize the Chair to execute the Agreement. - **(For possible action)**

Staff Representative: Patsy Buxton

- E. Approve donation of five (5) Dell Latitude E6520 laptops with a current market value estimated at \$0- to Amateur Radio Emergency Service (ARES). – **(For possible action)**

Staff Representative: Patsy Buxton

- F. Recommendation for the Board to Uphold Notice of Violation Citation No. 5994 Issued to Sandra Nimmo, Case No. 1199, for a violation of the District Board of Health Regulations Governing Air Quality Management with a \$3400.00 Negotiated Fine. - **(For possible action)**

- i. Sandra Nimmo, Case No. 1199, Notice of Violation No. 5594

Staff Representative: Charlene Albee

- G. Request to provide a 60 day continuance from January 25, 2018 to March 25, 2018, to the temporary program in which septic repair fees are not collected on single family homes affected by Swan Lake (and the immediate vicinity) flooding in Lemmon Valley, in the instance where verification is provided in writing by the insurance carrier that permit cost for repairs is not covered by the applicable insurance policy as approved on May 25, 2017. This action applies to the owner of record as of February 1, 2017, on the following Assessor Parcel Numbers, with a building permit application deadline of July 1, 2020 or Washoe County Health District (WCHD) permit application deadline of March 25,

2018: (APN 086-303-18, 086-303-19, 086-303-22, 086-305-02). All associated costs will be covered through the Health Fund Account. - **(For possible action)**

Staff Representative: James English

H. Acknowledge receipt of the Health Fund Financial Review for December, Fiscal Year 2018 – **(For possible action)**

Staff Representative: Anna Heenan

7. Review, discussion and possible adoption of the Business Impact Statement regarding Proposed Revisions to the District Board of Health Regulations Governing Air Quality Management, Section 040.080 (Gasoline Transfer And Dispensing Facilities) with a finding that the revised regulations do not impose a direct and significant economic burden on a business; nor do the revised regulations directly restrict the formation, operation or expansion of a business; and set a public hearing for possible adoption of the proposed revisions to the Regulations for February 22, 2018 at 1:00 pm. – **(For possible action)**

Staff Representative: Charlene Albee

8. Regional Emergency Medical Services Authority

Presented by: JW Hodge

A. Review and Acceptance of the REMSA Operations Report for December, 2017 – **(For possible action)**

B. *Update of REMSA's Public Relations during December, 2017

9. Presentation, discussion and possible approval of the Regional Emergency Medical Services Authority (REMSA) Franchise Compliance Report for the period of 7/1/2016 through 6/30/2017. – **(For possible action)**

Staff Representative: Brittany Dayton

10. *Regional Emergency Medical Services Advisory Board January Meeting Summary

Staff Representative: Christina Conti

11. *Disaster Preparedness in Washoe County

Staff Representative: Christina Conti

12. Review and possible approval of 2018-2020 Community Health Needs Assessment – **(For possible action)**

Staff Representative: Catrina Peters

13. *Staff Reports and Program Updates

A. Air Quality Management, Charlene Albee, Director

Program Update, Divisional Update, Program Reports

B. Community and Clinical Health Services, Steve Kutz, Director

Divisional Update – 2017 Year in Review; Data & Metrics; Program Reports

C. Environmental Health Services, Chad Westom, Director

EHS Division and Program Updates – Child Care, Community Development, Food, Land Development, Safe Drinking Water, Schools, Vector-Borne Disease and Waste Management

D. Epidemiology and Public Health Preparedness, Dr. Randall Todd, Director

Program Updates for Communicable Disease, Public Health Preparedness, and Emergency Medical Services

E. Office of the District Health Officer, Kevin Dick, District Health Officer

District Health Officer Report – Water Projects, FY19 Budget, Strategic Planning Update, Public Health Accreditation, Quality Improvement, Community Health Needs Assessment, Community Health Improvement Plan, Truckee Meadows Healthy Communities, Other Events and Activities and Health District Media Contacts.

14. *Board Comment

Limited to announcements or issues for future agendas.

15. *Public Comment

Any person is invited to speak on any item on or off the agenda during this period. Action may not be taken on any matter raised during this public comment period until the matter is specifically listed on an agenda as an action item.

16. Adjournment – (For possible action)

Possible Changes to Agenda Order and Timing. 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 agenda.

Special Accommodations. 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.

Public Comment. During the “Public Comment” items, anyone may speak pertaining to any matter either on or off the agenda, to include items to be heard on consent. For the remainder of the agenda, public comment will only be heard during items that are not marked with an asterisk (*). Any public comment for hearing items will be heard before action is taken on the item and must be about the specific item being considered by the Board. In order to speak during any public comment, each speaker must fill out a “Request to Speak” form and/or submit comments for the record to the Recording Secretary. Public comment and presentations for individual agenda items are limited as follows: fifteen minutes each for staff and applicant presentations, five minutes for a speaker representing a group, and three minutes for individual speakers unless extended by questions from the Board or by action of the Chair.

Response to Public Comment. 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.”

Posting of Agenda; Location of Website.

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
Downtown Reno Library, 301 S. Center St., Reno, NV
Washoe County Health District Website www.washoecounty.us/health
State of Nevada Website: <https://notice.nv.gov>

How to Get Copies of Agenda and Support Materials. Supporting materials are available to the public at the Washoe County Health District located at 1001 E. 9th Street, in Reno, Nevada. Ms. Laura Rogers, 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. Ms. Rogers is located at the Washoe County Health District and may be reached by telephone at (775) 328-2415 or by email at lrogers@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 District Board of Health Meeting Minutes

Members

Kitty Jung, Chair
Dr. John Novak, Vice Chair
Oscar Delgado
Dr. George Hess
Kristopher Dahir
Michael D. Brown
Tom Young

Thursday, December 14, 2017
1:00 p.m.

Washoe County Administration Complex, Building B
Health District South Conference Room
1001 East Ninth Street
Reno, NV

1. *Roll Call and Determination of Quorum

Chair Jung announced she had a meeting with Senator Heidi Gansert at 2:30 p.m. and would leave this meeting should it not be concluded by that time, and would turn the meeting over to Vice Chair Novak.

Chair Jung called the meeting to order at 1:00 p.m.

The following members and staff were present:

Members present: Kitty Jung, Chair (departed 1:58 p.m.)
Dr. John Novak, Vice Chair
Oscar Delgado (departed 1:59 p.m.)
Michael Brown
Tom Young (arrived 1:01 p.m.)
Dr. George Hess
Kristopher Dahir

Members absent: None

Ms. Rogers verified a quorum was present.

Staff present: Kevin Dick, District Health Officer, ODHO
Leslie Admirand, Deputy District Attorney
Charlene Albee
Steve Kutz
Chad Westom
Dr. Randall Todd
David McNinch

2. *Pledge of Allegiance

Mr. Tom Young led the pledge to the flag.

3. *Public Comment

Mr. Tom Clark, representing Pignic Pub & Patio, reminded those present of his initial comments at the October 26, 2017 District Board of Health Meeting where he made note of the Cease and Desist Order that had been issued to Pignic Pub and Patio. The Order suspended Pignic's outdoor operations for patrons to bring in their own food and grill and consume it amongst their own party. Since that time, he stated that Pignic had worked diligently with Health District staff and stated that progress was being made. Mr. Clark informed that he had not been able to find another instance in the country of this type of business model. It appears that Washoe County Health District is the first to allow this type of consumer experience, and he opined it demonstrates that Washoe County is on the cutting edge of innovative businesses.

Mr. Clark stated that the process now involves the request for variance from the Food Protection Hearing and Advisory Board (FPHAB). He noted that a meeting set for December 7th to hear this issue could not be held due to lack of quorum. He informed that there is an item on the current agenda for this District Board of Health Meeting to appoint new FPHAB Members to replace those who had resigned. He hoped this would be able to be accomplished to allow a new meeting of the FPHAB next week.

Mr. Clark opined the Health District staff and Pignic are in agreement for next steps. He noted that Pignic will have to apply for a new outdoor food establishment permit, and the FPHAB will decide whether to allow a variance that would allow Pignic's patrons to bring in food to prepare and consume.

Mr. Clark informed that one of the issues has been the definition of approved food. He stated that meat would be allowed to be brought in by patrons but would have to be in original packaging with a receipt to demonstrate that it is a commercially purchased product. He informed that an Operations Plan has been worked on and there is understanding between Health District and Pignic staff regarding the other elements of Pignic's operation. Mr. Clark stressed that public safety is of primary concern to both Pignic Pub & Patio and the Health District.

Chair Jung closed the public comment period.

4. Approval of Agenda

December 14, 2017

Mr. Brown moved to approve the agenda for the December 14, 2017, District Board of Health regular meeting. Dr. Novak seconded the motion which was approved unanimously.

5. Recognitions

A. Years of Service

- i. John Fuller – EHS – hired 11/5/1975, retired 2/14/2003. Hired as Intermittent Hourly Environmentalist II on 4/2/2004, retired 11/7/2017. Total of 40 years and 10 months.

Mr. Dick informed that it is not standard practice to recognize intermittent hourly employees, but that there are two that will be recognized due to their exceptional number of years of service between their careers at the Health District and years served as intermittent hourly employees.

Mr. Dick stated he wished to recognize years of service for Mr. Fuller who has a total of forty years and ten months of service with the Health District. Mr. Dick informed that he actually started with the Health District forty-two years ago, but had a bit of retirement before coming back as an intermittent hourly employee.

Mr. McNinch introduced himself as a Supervisor in the Environmental Services Division, and stated he wished to express the appreciation of the entire EHS staff for Mr. Fuller's contributions. Mr. McNinch stated that there was not enough time to review all of Mr. Fuller's accomplishments, but that Mr. Fuller has moved the dial in our community's public health. Mr. Fuller started with the Health District in 1975 and has been a mentor to many of the Environmental Health staff members. Mr. McNinch thanked Mr. Fuller for everything he's done for Environmental Health and the Health District.

Mr. Young informed that Mr. Fuller had been instrumental in working through permitting of his brewery which was the first to open in Nevada and thanked him for his service.

Mr. Dick added that Mr. Fuller was responsible for winning the National WasteWise Award in Washoe County during his career for his efforts in waste reduction and the recycling program that the County established.

Mr. Fuller stated that when Washoe County joined the EPA's WasteWise Program, there were one hundred fifty local governments involved. He informed that Washoe County was Number One for three years in a row. Mr. Fuller expressed that staff did a good job. Chair Jung stated that he had done a good job as well, and thanked him for his service.

ii. Judith Saum – EHS - hired 8/22/1994, retired 8/25/2009. Hired as Intermittent Hourly Environmentalist II on 1/31/2011, retired 10/31/2017. Total of 28 years and six months.

Ms. Saum was not present. Mr. Dick announced that Ms. Saum had been with the Health District a total of twenty-eight years and six months.

iii. Angela Tibaduiza. 25 years, hired 12/28/1992 – CCHS

Mr. Dick congratulated Ms. Tibaduiza on her twenty-five years of service with WIC where she served as a Human Support Specialist II. He announced that he would be combining her recognition for years of service with that of her retirement. Mr. Dick stated that she would be presented with a clock from the Washoe County Health District as a token of appreciation for her service.

iv. Kelli Goatley-Seals, 15 years, hired 11/4/2002 – CCHS

Mr. Dick recognized Ms. Goatley-Seals for fifteen years of service, and informed that Ms. Goatley-Seals is a great champion for the Health District's Chronic Disease Program.

v. David Gamble, 5 years, hired 12/3/2012 – EPHP

Mr. Dick introduced Mr. Gamble as the Medical Reserve Corps Coordinator for the Health District's Preparedness Planning Program and stated that he has been with the Health District for five years.

B. Retirements

i. Angela Tibaduiza, 12/14/2017, WIC Human Support Specialist II - 25 years – CCHS

C. New Hires

i. Chad Westom, 10/30/2017, EHS Division Director – EHS

Mr. Dick informed that he had introduced Mr. Westom to the District Board of Health Members at the Strategic Planning Retreat on November 2nd, but wanted to recognize him today for the benefit of the viewing audience of this meeting. Mr. Dick stated that Mr.

Westom is the new Environmental Health Division Director and was most recently a Bureau Chief at the State Division of Public and Behavioral Health.

6. Proclamations

Radon Action Month Proclamation

Mr. Dick informed that Ms. Susan Howe was present to accept the Proclamation for the University of Nevada Reno Cooperative Extension. Mr. Dick read the Proclamation to those assembled, designating January 2018 as Radon Action Month in Washoe County. Ms. Howe spoke of the dangers of radon, the importance of testing and percentage of homes by zip code in Washoe County that may have elevated levels of radon. She informed that shipping was now being charged on those kits sent via the mail, but the Cooperative Extension was providing free radon test kits in January and February and provided information on locations where they could be picked up. Ms. Howe noted that the kits would also be available at several upcoming presentations that were listed on a flier she had provided.

Ms. Howe announced that the International Building Code and the International Residential Code for 2018 would be voted on in 2018, and expressed her hopes that Appendix F of the International Residential Codes for radon control methods in new homes would be supported by the Health District.

Chair Jung asked that there be a letter drafted in support of this initiative on behalf of the District Board of Health to be sent to all three jurisdictions.

Dr. Novak motioned to accept the Proclamation for Radon Action Month. Mr. Dahir seconded the motion which was approved unanimously.

7. Consent Items

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. Approval of Draft Minutes

- i. October 26, 2017
- ii. November 2, 2017

B. Budget Amendments/Interlocal Agreements

- i. Approve a Sub-Grant Award from the State of Nevada Department of Health and Human Services, Division of Welfare and Supportive Services retroactive to October 1, 2017 through September 30, 2018 in the total amount of \$82,963 (\$25,000 non-federal match required) in support of the Community and Clinical Health Services Division Chronic Disease Prevention Program IO#11452 and authorize the District Health Officer to execute the Sub-Grant Award.
Staff Representative: Nancy Kerns-Cummins
- ii. Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public and Behavioral Health retroactive to October 1, 2017 through September 30, 2018 in the total amount of \$15,000 (no match required) in support of the Community and Clinical Health Services Division Tuberculosis Prevention Program IO#11457 and authorize the District Health Officer to execute the Subgrant Award.
Staff Representative: Nancy Kerns-Cummins
- iii. Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public and Behavioral Health retroactive to October 1,

2017 through September 30, 2018 in the total amount of \$25,001 (no match required) in support of the Community and Clinical Health Services Division (CCHS) Chronic Disease Prevention Program IO#11454 and authorize the District Health Officer to execute the Subgrant Award.

Staff Representative: Nancy Kerns-Cummins

- iv. Retroactive approval of Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, for the period August 1, 2017 through July 31, 2018 in the total amount of \$170,522 in support of the Centers for Disease Control and Prevention (CDC) Epidemiology and Laboratory Capacity Program; and if approved authorize the District Health Officer to execute the Subgrant Award.

Staff Representative: Patsy Buxton

- v. Approve Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through June 30, 2018 in the total amount of \$2,673 in support of the Environmental Health Services Division (EHS) Food Retail Program Standards Program – Joint Nevada Food Safety Task Force and NevEHA Annual Educational Conference Project, IO TBD; and if approved, authorize the District Health Officer to execute the Agreement.

Staff Representative: Patsy Buxton

- C. Approve the modification of the Community and Clinical Health Services Fee Schedule to add Lidocaine with Epinephrine, Naproxen and Herpes Simplex 1 and 2 testing.

Staff Representative: Nancy Kerns-Cummins

- D. Review and possible approval of the Department Emergency Operations Plan

Staff Representative: Christina Conti

- E. Approval to donate evacuation and triage tags to skilled nursing, long-term care, hospital and EMS partner agencies not to exceed a total amount of \$3,000 funded by the Assistant Secretary for Preparedness and Response Grant (Fed ID#1NU90TP921907-01-00).

Staff Representative: Andrea Esp

- F. Recommendation for the Board to Uphold Notice of Violation Citation No. 5658 Issued to Harry Stewart, Case No. 1198, for a violation of the District Board of Health Regulations Governing Air Quality Management with a \$3450.00 Negotiated Fine.

- i. Harry Stewart, Case No. 1198, Notice of Violation No. 5658

Staff Representative: Charlene Albee

- G. Acknowledge receipt of the Health Fund Financial Review for November, Fiscal Year 2018

Staff Representative: Anna Heenan

Dr. Novak moved to accept the Consent Agenda as presented. Mr. Brown seconded the motion which was approved unanimously.

8. * Presentation– Washoe County Health District Board Scholarship Recipients

Presented by: Kara Mays

Ms. Mays introduced herself as the Assistant Director of Development and Alumni Relations for the School of Community Health Sciences at the University of Nevada Reno. She stated that she has the pleasure of working with Dr. Trudy Larson and Mr. Dick who is on the Community Advisory Board.

Ms. Mays informed that the scholarship recipients were present today and would be speaking later.

Dr. Trudy Larson is now the Dean of the School of Community Health Sciences. Ms. Mays informed that she has been the School's Director for the past six years and opined that her new role as Dean is an important step in a positive direction for the School and for Dr. Larson, and that Dr. Larson sends her regards.

Ms. Mays stated that the School became independent of the Division of Health Sciences in July of 2017 which created the Dean role and provided heightened research opportunities and a stronger national presence.

Ms. Mays informed that the School's Masters in Public Health (MPH) Programs were Council on Education for Public Health (CEPH) accredited in 2011. It is Dr. Larson's priority for the School to become a fully accredited School of Public Health by the year 2020, and Ms. Mays informed that the application for accreditation has been submitted.

Ms. Mays stated that the rate of growth has increased dramatically, with their total enrollment totaling nearly ten percent of the University of Nevada Reno's entire student body. This rapid growth is due in part to the merger with the Substance Abuse Technology Center, the inclusion of pre-nursing students and the overall growth of the health field.

In review of the academic programs, Ms. Mays highlighted the new MPH Online Program that allows flexibility for working professionals.

Ms. Mays informed that a key component for their students to graduate is the internship requirement, and expressed gratitude for the one hundred thirty-three partnering sites in Northern Nevada that allow students opportunities to fulfill this requirement. Over 37,000 hours of community service in Northern Nevada was performed by the students last year. It is common for students who have completed internship with a partnering site to be employed by them upon graduation.

Ms. Mays stated that the School also provides continuing education and professional development opportunities. The Nevada Public Health Training Center provides that opportunity to their workforce. The Center trains Public Health Professionals to be proficient in all areas of Public Health and Community Wellness with the goal of constantly improving the community's Public Health workforce.

Scholarship recipients Allyson Updike and Larissa White expressed gratitude for the assistance the Scholarship provided them and gave an overview of their focus of study and internship experiences.

Ms. Mays reported the market value of the Scholarship Endowment at \$18,000, and informed that a fully endowed Scholarship at the University is \$25,000 for a \$1,000 award each year. She inquired if the Board would consider growing this fund to the \$25,000 level to continue to support Community Health Sciences students in such a meaningful way.

Mr. Young inquired what the process is for a student to be selected for internship at one of the partnering sites, and indicated that he would be interested in his brewery becoming a partnering site. Ms. White informed that the student interviews at the partnering site, just as one would for a job interview.

Mr. Dahir inquired what could be done to retain graduates in the workforce locally. Ms. White opined that, other than the pay scale, it is important to graduates that they work for an entity with good organizational structure for their efforts to have the greatest impact in the community.

Chair Jung thanked Ms. Mays for her presentation and inquired if it would be a one-time gift of \$7,000 to increase the scholarship to the \$25,000. Ms. Mays confirmed that to be

correct, that the principal amount is not touched and scholarships are taken from the accrued interest. Chair Jung noted that if each of the Board Members was to contribute \$1,000, the goal would be met.

9. *Presentation – Eddy House

Presented by: Michele Gehr

Ms. Gehr introduced herself as the Executive Director of Eddy House, located at 423 E. 6th Street in Reno, and that they act as the central intake and assessment facility for all homeless youth in Northern Nevada. She informed that they serve primarily non-system youth, meaning that they are not associated with any other organization, agency or non-profit.

Ms. Gehr gave an update on the numbers from this presentation. In the first eight months of 2017 the Eddy House saw 625 individual homeless youth, but that number is growing. She stated that they see sixty youth per day in a space of less than 1,000 square feet, and saw eighteen new youth just last week. She informed that they've had more than 7,000 youth interactions in 2017, the number climbing now to nearly 8,000.

Ms. Gehr informed that they do not duplicate services, but partner with about twenty-five different agencies to bring services onsite to Eddy House. She stated that these partners include the Food Bank, Notables Music Therapy, art therapy, mental health providers, job skills and life skills, to name a few. Other services include addiction support groups, healthy relationship training, anger management and grief and loss counseling.

Ms. Gehr stated that approximately 90% of their youth population has lost a parent or primary care giver due to death, incarceration or abandonment. Nearly 50% have been in the foster care system with 20% having aged out of foster care. 83% of Eddy House youth have moved more than five times as a child.

She informed that the largest percentage of their youth is between eighteen and twenty-four years of age for which there seems to be a gap in available services in this community.

Data shows that homeless youth should not be served at the same location as the adult homeless population. Ms. Gehr informed that they are homeless for different reasons and statistics show that the adults will prey on the youth.

Of the homeless youth seen at Eddy House, 71% are from Washoe County and 8% are from rural Nevada.

Ms. Gehr stated that their initial focus is being a safe place physically and psychologically, and that Eddy House is 100% trauma effective to serve the majority of youth with Post-Traumatic Stress Disorder. She informed that Eddy House provides showers, clothing and food, and assists with essential documents for medical or dental care and education. Another focus is to assist them in obtaining a GED or other high school equivalency which increases opportunities for employment.

Ms. Gehr informed that 70% of the youth seen at Eddy House report they are safer living on the street than at home, and that 58% have been trafficked for sex or labor.

Ms. Gehr stated that Nevada now has the fastest growing rate of homeless youth and is fast approaching a public health crisis. Nevada ranks fifth in the nation for unsheltered homeless. She informed that the Council on Homelessness estimates the annual cost to a city for one homeless person between \$30-50K and could be a collective cost to the local jurisdictions of over \$12M/year. She stated that less than eight percent of the homeless youth seen at Eddy House will use the Volunteers of America homeless shelter, citing safety concerns.

Ms. Gehr reiterated that Eddy House sees sixty youth per day, with the largest count being seventy-four in a single day in an area of less than one thousand square feet, and that

there has been no conflict. She credited her amazing staff and the fact the youth love having a safe place to be.

Ms. Gehr announced their plan for the next year to have a twenty-four hour drop-in center located in downtown that would accommodate fifty youth per night, as well as continue the drop-in services. She stated that, ideally, this center would have a commercial kitchen to allow them to prepare and serve nutritious meals. They hope to also have classroom space, therapy space, and have showers and lockers.

Ms. Gehr stressed that their goal is not to manage this crisis, but to end youth homelessness, and that she sees Reno, Sparks, Northern Nevada and the Eddy House as a national model to end the problem of youth homelessness. She stated that seven hundred youth is a manageable problem, but that it will take the community working together to accomplish the goal and expressed hope for that collaboration.

To accomplish Eddy House's goal, they need to strengthen their current programming and funding streams. Current support has been through donations from local persons and entities. She informed that Eddy House is a data-driven agency and is likely the largest data collection source for this population in the county. Ms. Gehr informed that they are ready to share this data with County, City and State agencies.

She informed that they want to increase operation hours at their current location, work on partnerships and the continuum of care, and expand into a larger facility to provide a safe, warm place for more of the homeless youth.

Ms. Gehr detailed ways to help, including touring Eddy House, networking to inform the community of the need and of Eddy House operations and goals, both in person and on social media.

Mr. Dahir expressed his interest and stated that he would tour Eddy House. He informed that there are many initiatives to curb homelessness in general, but stated it would be wonderful to see their operation in benefit of homeless youth. Ms. Gehr informed that they focus on prevention, because data shows if there is intervention before the age of twenty-five, the individual is less likely to continue to be homeless as an adult.

Dr. Hess expressed that their plan to end youth homelessness wasn't clear to him, and inquired what that plan is. Ms. Gehr stated their plan is for a twenty-four hour center, since data shows if they are stable at night, they go back to school and have successful jobs. She informed of their job skills program; since April of 2016, one hundred sixty of their youth have managed to secure employment. She stressed that it is difficult to retain employment if there is no safe place to sleep, underscoring the importance of a twenty-four hour center. Dr. Hess inquired what size building they were looking for. Ms. Gehr replied a space of at least 10,000 square feet, located near downtown, with space for fifty beds would be ideal. Dr. Hess inquired how the Health District could help. Ms. Gehr stated that assistance in developing programming for nutrition, medical care and other needs the youth require but do not have access to would be their ask.

Chair Jung encouraged the Board to take a tour of Eddy House, and commended Ms. Gehr on their data driven approach. She informed that she and a group of constituents wanted to adopt her for a night of dinner, and asked Ms. Gehr to explain that concept to the Board. Ms. Gehr informed that a major objective when she returned to Nevada and Eddy House was for the youth to become involved and invest themselves in what Eddy House was trying to accomplish. One way to do this was the Friday Family Meals. She informed that, every Friday at 2:30 p.m., a group, individual or organization provides a hot meal for sixty-five persons. They incentivize throughout the week with raffle tickets. During the meal there is a feedback session and a raffle for five \$10 gift cards. This interaction creates a bond

and family atmosphere.

Chair Jung asked what kind of clothes was needed for the youth, and Ms. Gehr stated that socks and underwear were their only need at the moment.

Chair Jung also inquired if they had received a VOCA Grant, and Ms. Gehr confirmed that they have a VOCA Grant in place and had submitted for additional funding to hire a full time marriage and family therapist, but response hadn't yet been received.

Chair Jung expressed her appreciation of Ms. Gehr and the work she is doing. She offered the Board's assistance and asked they be kept apprised of any assistance they could give to avert this public health crisis.

Chair Jung informed that the start time to her previously mentioned meeting is 2:00 p.m., not 2:30 p.m., and so would need to depart and turn the meeting over to Vice Chair Novak. She noted that she was in favor of the upcoming item for the REMSA increase although she would not be present to vote. She departed at 1:58 p.m.

Mr. Delgado departed at 1:59 p.m.

10. Presentation, Discussion, and possible approval of REMSA's request for an increase of 3% a year over four years to the average allowable bill.

Presented by: Dean Dow

Mr. Dow introduced himself as the President and CEO of REMSA and Care Flight. He informed that REMSA's mission includes contributing to the health of the communities they serve, and currently holds five accreditations across all major service lines in their organization.

Mr. Dow stressed that accreditations are the backbone of quality and safety throughout the organization, and represent REMSA's commitment to meeting national and international standards. These standards insure the highest quality of service for their patients and the community. He detailed the areas in which REMSA is accredited.

Mr. Dow informed REMSA has seen an 8-12% increase in overall call volume and a 15% increase in Medicaid patients since the introduction of Health Care Reform through the passing of the Affordable Care Act.

Mr. Dow informed that data from the Washoe County Health District 2016 Community Health Improvement Plan indicates that one third of the Washoe County residents live in a primary care shortage area, and all Washoe County residents live in a mental health provider shortage area.

Because of the increase in insured patients and the lack of healthcare providers in our region, many of those healthcare providers do not accept Medicaid. Mr. Dow informed that there is an overall increase in patients using EMS and Emergency Departments to access healthcare, and that REMSA has become the community's healthcare safety net.

Mr. Dow stated that all patients who call are not transported, but can receive treatment. This non-transport response happens with about one third of calls annually, which is approximately 24,700 calls that REMSA cannot be compensated for. Population growth has resulted in expanded service areas, and thirty-four additional field providers have been hired since 2013. This number doesn't include positions replaced due to attrition.

REMSA is focused on employee retention, it being critical to recruit and retain high quality EMS providers to maintain the level of clinical expertise it is known for. Mr. Dow informed that REMSA launched a competitive compensation program, increasing pay to clinical providers to align them in a Step Progression Plan while maintaining a strong benefits package.

To accommodate growth coming to this region, a new Franchise Response Map was

implemented along with new response requirements based on geographic demand and population density. To assure compliance with these requirements, REMSA added three fixed stations and ambulances dedicated to those areas at a total annual operating cost of \$1.5M. Mr. Dow informed that, since 2015, REMSA has added an additional eleven staffed ambulances per year, which is an approximate 18% increase over the past two years.

Despite efforts to educate the populace to the proper use of 911, many continue to call for medical assistance in non-emergent instances. In response to an increase in 911 calls, REMSA identified two additional innovative solutions, the Nurse Health Line and Omega Protocols. Both use medically trained registered nurses and communications specialists to facilitate getting patients to the right level of care which may include sending an ambulance or may include recommending a visit to an urgent care or primary care office.

In light of growth in the community, Mr. Dow informed that REMSA has been challenged to respond to more than just 911 calls. Special programs were implemented to meet the changing needs of the community outside of the traditional EMS response. These programs use highly trained staff without fees for services and include the Technical Emergency Medical Services, or TEMS Team, trained to attach to SWAT Teams to provide care at active scenes, the Search and Rescue Paramedics that support the Washoe County Search and Rescue Team, and the Advanced Life Support Bike Team used to service high volume weekends and cover high density populations during events. Responses to events such as the Air Race crash and the recent active shooter incident at the Montage are examples of meeting the community's needs to provide high quality resources in non-traditional ways.

It is critical for REMSA to stay current and provide up-to-date technology for patient care. Mr. Dow informed that, in the last two years, REMSA has invested more than \$5M in capital improvements and upgrades. Of that amount, \$2.1M was for ambulance related purchases, upgrades and refurbishments, and \$2.2M was used in capital investments to enhance the REMSA Medical Dispatch Center and radio infrastructure. He informed that over \$700K was invested in IT improvements and other vital medical equipment.

Mr. Dow stated the proposed rate increase will impact patients with private insurance. 70% of REMSA patients are on Medicaid and Medicare and will not be impacted by the increase. He informed that REMSA only receives 34 cents on every billed dollar. He stated the rate increase REMSA is seeking is 3% per year for four years. He informed the impact will be \$34 to the average allowable bill for the first year of the increase. The actual payment from insurers will be subject to lower reimbursement based on what they actually pay.

Mr. Dow stressed that REMSA remains committed to transparency, and the ability to monitor the impact this increase will have for REMSA overall's performance will be possible through the annual financial audit that is presented to the EMS Oversight Office.

Mr. Dow informed that REMSA also presents its average allowable bill as part of the monthly compliance report presented to the District Board of Health. In addition, Mr. Dow stated they will provide an annual update to the Board highlighting the ongoing infrastructure investments as well as REMSA's growth across the region.

Mr. Dow thanked the Board for their time, and expressed his appreciation for the partnership that REMSA and Care Flight has had with the District Board of Health as well as their other community partners. He offered to answer any questions.

Mr. Young inquired what could be done to reduce the number of non-transport calls. Mr. Dow informed they are currently working with the Nurse Health Line and the Omega Call structure. A person calling 911 is routed through an Emergency Medical Dispatch process, and utilizing the EMD dispatchers and the nurses in the call center, REMSA can help direct

non-emergent calls to into other healthcare pathways. Mr. Young inquired if this process would lower the number of non-transport calls. Mr. Dow informed that it will actually increase the number of non-transport calls, but that it is a benefit to the health system overall to direct the non-acute patients to the appropriate level of care.

Dr. Hess expressed concern regarding the 3% increase over four years without knowing what the financial situation will be at that time. He informed this increase would exceed the cost of living increase and opined that requesting an increase for four years in succession could be premature. Mr. Dow informed that it is REMSA's strategy is to estimate their future budget as closely as possible. He stated that REMSA has done an analysis over the last four years and results show their costs increasing at a rate an average of 4% per year over the last four years. Dr. Hess inquired if that increase was in cost per transport, and if costs associated with the growth of the County was removed from the equation. Mr. Dow informed that as the population increases so does the utilization of the 911 System, but not necessarily the number of transports.

Per information provided by Mr. Dow, Mr. Brown recapped that 70% of transports were Medicare and Medicaid, leaving 30% for private insurance and self-pay. Mr. Brown informed that 4% was the projected budget increase per year used as an estimate by the ambulance company he had managed, and it still didn't keep up with increasing costs of operation. He opined that the proposed increase might not be enough to cover their needs, but would be supportive of the amount requested in this item, especially in light of the fact that the increase would only affect the private insurance and self-pay transport bills.

Mr. Dahir stated that there have been no substantial requests for rate increase in REMSA's services in some time, and Mr. Dow confirmed it had been approximately ten years. Mr. Dahir opined that the request was within reason, and agreed with the importance of retaining quality employees.

Mr. Dahir moved to approve REMSA's request for an increase of 3% a year over four years to the average allowable bill. Mr. Brown seconded the motion which was approved four in favor and none against.

Vice Chair Novak noted that Mr. Delgado and Chair Jung were also in support of this item.

11. Regional Emergency Medical Services Authority

Presented by: JW Hodge

Mr. Hodge noted that there are two Franchise Compliance Reports included in his presentation, and that he would like to thank Mr. Dick for noticing one of the charts differed in data between the October and November reports for early spring 2017. He informed that a corrected chart had been provided.

A. Review and Acceptance of the REMSA Operations Report for October 2017

Mr. Brown moved to accept the REMSA Operations Report for October 2017. Mr. Young seconded the motion which was approved four in favor and none against.

B. *Update of REMSA's Public Relations during October, 2017

Mr. Hodge offered to answer any questions. Mr. Dahir requested Mr. Hodge to provide an overview of the use of Flirtey drones as mentioned in the October Public Relations and Social Media report. Mr. Hodge informed they had entered into a partnership with Flirtey in response to the concept they proposed of delivering a defibrillator via drone to certain areas more quickly than it could reach the patient by ambulance. By using REMSA and Washoe

County data, Heather Kerwin from the Health District EMS helped Flirtey identify areas in the region that could benefit from drone delivery of a defibrillator (AED). Mr. Hodge explained that if ArcCAD recognizes a cardio arrest situation, it would automatically launch a drone to the destination with an AED. This action would be coupled with instructions given by REMSA Dispatch Center to provide pre-arrival instructions for the use of the AED, as well as other pertinent information. Mr. Hodge informed that they are hoping to launch tests in early 2018. Mr. Dahir requested updates as to the progress of this operation.

Dr. Novak inquired how the drone would be recovered if it should become misdirected. Mr. Hodge stated he'd be happy to bring in a Flirtey representative to provide information on how the drones are tracked. He informed that these commercial drones are flying with technology similar to aircraft.

Ms. Admirand informed Vice Chair Novak of a request from staff to re-open Item 10 and direction be given as to the effective date of the rate increase for REMSA. Vice Chair Novak requested Mr. Dow to provide that information. Mr. Dow responded that January 1, 2018 would be an acceptable start date.

Mr. Dahir inquired if he needed to include the start date in the motion and Ms. Admirand confirmed that to be correct.

Mr. Dahir moved to add January 1, 2018 as the effective date for the REMSA rate increase to the original motion. Mr. Young seconded the motion which was approved four in favor and none against.

C. Review and Acceptance of the REMSA Operations Report for November, 2017

Pursuant to a question from Mr. Brown, Mr. Hodge informed the reason dates appear for prior months in the Dates of Service Column for Comments Received are due to individuals calling back on an older issue or that they receive new comments from previous month.

Mr. Brown moved to accept the REMSA Operations Report for November 2017. Dr. Hess seconded the motion which was approved four in favor and none against.

D. *Update of REMSA's Public Relations during November, 2017

There was no comment made on the Public Relations report.

12. Presentation and Possible Acceptance of Revised Strategic Plan

Staff Representative: Catrina Peters

Ms. Peters stated she would be presenting the Revised Strategic Plan for the Board's approval. She informed that there were a few minor revisions to discuss, the first being the addition of a summary of the new information shared at the November 2, 2017 Strategic Planning Retreat. New Outcomes were added from information shared regarding the Community Health Needs Assessment and other emerging Strategic Priorities. She informed that she had updated staffing assignments due to turnover, and had added a table to show cross-divisional collaboration. Ms. Peters detailed the Outcomes that were added and the information on cross collaboration table.

Mr. Dahir stated his belief that families are the Health District's first line of defense for a healthier community. He agreed there were activities in the Health District's operation that focus on families, but would like to see more initiatives be developed to support families through parenting classes and other means incorporated in the Strategic Plan.

Mr. Dick responded to Mr. Dahir, stating he believed his comments at the Retreat were heard and appreciated. He informed that Mr. Kutz' upcoming monthly report contains information on opportunities being pursued that are in alignment with Mr. Dahir's objective.

Mr. Young moved to accept the Revised Strategic Plan as presented. Mr. Brown seconded the motion which was approved four in favor and none against.

13. Possible approval of the proposed 2018 Washoe County District Board of Health Meeting Calendar

Staff Representative: Kevin Dick

Mr. Dick informed the proposed calendar of 2018 District Board of Health Meeting dates include the standard meeting dates of the fourth Thursday of each month with the exception of November and December. The November meeting is listed on the calendar as tentative to be omitted if not necessary, and the December meeting is scheduled for the second Thursday due to the Christmas holiday. Also included on the calendar, Mr. Dick informed, is the proposed date of November 1st, 2018 for the Strategic Planning Retreat.

Mr. Dahir moved to approve the 2018 District Board of Health Meeting Calendar. Dr. Hess seconded the motion which was approved four in favor and none against.

14. Possible approval of the proposed appointment of two new Food Protection Hearing and Advisory Board Members to replace those who have resigned. Possible appointees are Mr. Chris Thompson, Mr. George Heinemann and Mr. Jesus Gutierrez.

Staff Representative: Chad Westom

Mr. Westom stated that there are two vacancies on the Food Protection Hearing and Advisory Board (FPHAB) created by the resignation of Mr. Vern Martin and Mr. Jerry Montoya. He informed there are three prospective replacements for the District Board of Health's consideration; all three have experience in the food service industry as shown by the resumes provided, of these, Mr. Thompson was recommended as an appointee by Mr. Martin. He reviewed the qualifications of all three persons interested in becoming a FPHAB Board Member.

Mr. Westom informed the purpose of the FPHAB is to consider appeals by aggrieved persons and applications for variance in the Washoe County Regulations Governing Food Establishments.

Mr. Westom stated that Environmental Health recommends that the District Board of Health appoint Mr. Chris Thompson to the Food Protection Hearing and Advisory Board, and would also support the appointment of either Mr. George Heinemann or Mr. Jesus Gutierrez for the remaining vacancy.

Mr. Dahir moved to appoint Mr. Christopher Thompson and Mr. George Heinemann to the Food Protection Hearing and Advisory Board. Mr. Brown seconded the motion which was approved four in favor and none against.

Mr. Brown thanked all three gentlemen that showed interest in participating on the Food Protection Hearing and Advisory Board, and stated that it takes commitment to participate on a board. He expressed appreciation of their willingness to participate.

Mr. Dahir stated his appreciation of the applicants as well and requested Mr. Gutierrez be thanked for his interest and that he be considered for any future openings on this Board. Mr. Westom stated that he would do so and would encourage him to participate in other ways as well.

15. *Staff Reports and Program Updates

A. Air Quality Management, Charlene Albee, Director

Program Update, Divisional Update, Program Reports

Ms. Albee informed that November 1st began the “Know the Code” season, the woodstove peak season program, and has a new radio ad that has received positive reaction from the community. She shared the ad with those present.

She informed there had not been a red no-burn day to date, when historically there would have been with the first major inversion of the year. She opined this is due to the effectiveness of their woodstove program which includes replacement of old woodstoves with change of ownership and the rebate program which incentivizes citizens to upgrade to new models. The various outreach programs have also contributed to the program’s success by informing citizens of the burn forecast.

Ms. Albee informed that, as the packet was being prepared to submit to EPA for the regulations for gasoline dispensing facilities and the removal of Phase Two, it was discovered that the notice needed to be published three times instead of the two it had been. This was due to the finding that this is a State Implementation Plan (SIP) submittal. The publications are now being submitted in December with notification that another workshop could be held if requested. This item will be brought before the Board again as a Business Impact Statement in January and possible approval of regulations in February.

Ms. Albee informed of a policy change she instituted that any item required to be posted will be posted three times.

Mr. Dahir commended Ms. Albee on a job well done for efforts that resulted in a 10% increase in the state/local air grants. Ms. Albee informed that the Federal Administration is still considering the reduction of the EPA’s budget, but letters sent to the Nevada Congressional members prompted support in the House and Senate to support either level funding or a 10% increase to compensate the state for work that will become their responsibility. She stressed that the budget isn’t final but that staff would remain vigilant.

B. Community and Clinical Health Services, Steve Kutz, Director

Divisional Update – World AIDS Day; Nurse Family Partnership; Data & Metrics; Program Reports

Mr. Kutz stated there was an exciting opportunity to share with the Board, as well as inform of a family related program that Ms. Howell, Sexual Health Program Coordinator, had reminded him that is provided. He explained that the Sexual Health Program provides monthly STD/HIV testing at the Eddy House, which is a great way to build rapport and intersect with the youth and teens to hopefully prevent issues rather than treat them. Mr. Kutz expressed his appreciation for Ms. Howell and her staff for their work at the Eddy House and other off-sight community testing.

Mr. Kutz informed that it was World AIDS Day on December 1st and of the importance of medications that halt the transmission or acquisition of HIV. He stated that this is an unprecedented step on the path to eliminate the epidemic.

In response to Mr. Dahir’s request to see more focus on the education and support of the family unit, Mr. Kutz informed of an opportunity to increase that interaction with families through the Nurse Family Partnership, and expanded on information included in his report. He stated that the Nurse Family Partnership’s (NFP) mission is to “positively transform lives of vulnerable babies, mothers and families”, and their vision is “a future where all children are healthy, families thrive, communities prosper and the cycle of poverty is broken”.

Mr. Kutz informed that this is a voluntary program, that the typical client is a first time mother who meets low-income criteria and receives her first home visit by the end of her twenty-eighth week of her pregnancy. He stated that the mother is visited throughout her pregnancy and through the baby's first two years of life with gradually decreasing frequency of visitation. Mr. Kutz informed that the nurses would carry a case load of 25-30 active clients each, and the Program Supervisor would provide weekly one-on-one clinical supervision visits, hold weekly case conference and team meetings and joint home visits. He stated that there would also be a Community Advisory Board established that would meet at least quarterly, and that Renown Health was very interested in being part of this Board.

Regarding community impact points, Mr. Kutz stated that NFP addresses family, poverty, educational attainment, school success, crime rates, etc.; all of which have been mentioned as priorities in the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). Mr. Kutz opined that this intersection between NFP, the Health District, CCHS and the CHIP provides an excellent opportunity to positively impact the community.

In comparison with communities of a similar population, Mr. Kutz informed that NFP has seen an 18% reduction in pre-term births, 21% increase in breast feeding rates, and 19% increase in the number of children with current immunizations. As of 2016, he stated that NFP was serving clients in forty-two states in the United States.

Mr. Kutz informed that the State Division of Public and Behavioral Health will be working on Medicaid reimbursement for services, and grants such as the MIECHV (Maternal, Infant, and Early Childhood Home Visiting Program) to provide sustainability for the NFP Program.

Mr. Kutz stated that Southern Nevada Health District has also had the Nurse Family Partnership Program since 2008 and currently have seven home nurse visitors. He informed that they are applying for one additional nurse through the MIECHV Grant.

Mr. Kutz stated they were very excited about this opportunity and that he would be keeping the District Board of Health apprised as to the outcome of the grant application. He expressed thanks to the District Health Officer, Mr. Dick, as well as Ms. Heenan, Ms. Kerns-Cummings, and Ms. Gabor for their efforts to apply for this Grant, with a special thanks to Ms. Gabor who wrote the application. Mr. Kutz stated that he looks forward to being granted the funding for this program and for the positive impact it will have on the community.

Mr. Dahir expressed his thanks to Mr. Kutz.

C. Environmental Health Services, Chad Westom, Director

EHS Division and Program Updates – Community Development, Food, Land Development, Safe Drinking Water, Vector-Borne Disease and Waste Management

Mr. Westom informed that the Health District, NDEP and TMWA have been working diligently and have reached an agreement on the waiver regarding water main additions of 500 lineal feet or less for TMWA System 190, with the agreement having been signed on December 4th, 2017. He stated the agreement is between Washoe County, the Health District and TMWA with the support of NDEP.

Mr. Westom pledged that, should future issues with water plan review arise, that his Division would keep Board Members apprised and request direction from them.

Mr. Westom informed that the Health District is in discussion with NDEP and TMWA in regards to potentially expanding the current waiver or creating a new one with

the intent of reducing the amount of review needed for water development projects while protecting community water systems and the residents of Washoe County.

Mr. Dahir expressed appreciation for the expertise of Health District personnel, and stated that continued communication between staff and the Board regarding this issue would be the most beneficial way to solve any issues that may arise. Mr. Westom agreed, stating that transparency and communication have been and would continue to be of high priority.

Mr. Westom informed on the status of Pignic Pub and Patio's request for regulations variance from the Food Protection Hearing and Advisory Board (FPHAB) that would allow them to operate with their unique business model. Mr. Westom informed that they did have their food establishment permit suspended on November 17, 2017 due to non-compliance and concern of a substantial health hazard. He stated that their bar permit is still in effect.

Mr. Westom informed that there had been a hearing scheduled with the FPHAB on December 7, 2017, but the meeting could not proceed due to lack of quorum. He stated that there would be another hearing scheduled for the upcoming week.

Mr. Westom stated that they are working with Pignic to try to support their business model, and listed three sections of the Regulations of the Washoe County District Board of Health Governing Food Establishments that Pignic is requesting variance from.

D. Epidemiology and Public Health Preparedness, Dr. Randall Todd, Director

Program Updates for Communicable Disease, Public Health Preparedness, and Emergency Medical Services

Dr. Todd updated the seasonal influenza surveillance statistics through week forty-nine with the number of cases reported as one hundred sixty two; an increase of eleven cases from the date of the report. He informed that the percentage is now at 2.3%, just under the regional baseline, but forecast that our area would soon have enough cases to be listed as local or regional activity due to the rising case numbers.

E. Office of the District Health Officer, Kevin Dick, District Health Officer

District Health Officer Report – Water Projects, Strategic Planning Update, Public Health Accreditation, Quality Improvement, Community Health Needs Assessment, Community Health Improvement Plan, Truckee Meadows Healthy Communities, Other Events and Activities and Health District Media Contacts.

Mr. Dick stated the items needed for Accreditation at the time of his report had been twenty-four, but was happy to report that they now have forty-six of the required 213 documents that have passed the review process for items that will meet PHAB requirements.

Mr. Dick informed that Ms. Peters and Ms. Hilliard would be traveling back to the Public Health Accreditation Board Training in Washington DC in February, and that the electronic document submittal system would then be opened to the Washoe County Health District. Mr. Dick stated that the efforts to achieve Accreditation were going strong and that he would continue to report progress to the Board.

15. *Board Comment

Mr. Young opined that it would be interesting to see how the process of working with Pignic Pub and Patio's business model would unfold and opined there would be challenges.

Dr. Hess inquired if it would be of interest to the other Board Members to have the Emergency Operations Plan detailed for the Washoe County Health District and combined with the Plan for the Inter-hospital Council, because he noticed the one included in his packet was for the Inter-hospital Council only. The other members agreed this would be of interest to have presented at the next DBOH Meeting.

Dr. Hess requested the Board Members to keep the effort to fund the Public Health scholarship a priority.

Mr. Dahir inquired if the Health District has approached WNDD, the Western Nevada Development District, for grant funding. He informed that he serves on their board, and opined that there are federal grant funding opportunities for the Health District.

17. *Public Comment

As there was no one wishing to speak, Vice Chair Novak closed the public comment period.

18. Adjournment

Vice Chair Novak adjourned the meeting at 3:03 p.m.

Possible Changes to Agenda Order and Timing. 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 agenda.

Special Accommodations. 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.

Public Comment. During the “Public Comment” items, anyone may speak pertaining to any matter either on or off the agenda, to include items to be heard on consent. For the remainder of the agenda, public comment will only be heard during items that are not marked with an asterisk (*). Any public comment for hearing items will be heard before action is taken on the item and must be about the specific item being considered by the Board. In order to speak during any public comment, each speaker must fill out a “Request to Speak” form and/or submit comments for the record to the Recording Secretary. Public comment and presentations for individual agenda items are limited as follows: fifteen minutes each for staff and applicant presentations, five minutes for a speaker representing a group, and three minutes for individual speakers unless extended by questions from the Board or by action of the Chair.

Response to Public Comment. 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.”

Posting of Agenda; Location of Website.

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
Downtown Reno Library, 301 S. Center St., Reno, NV
Washoe County Health District Website www.washoecounty.us/health
State of Nevada Website: <https://notice.nv.gov>

How to Get Copies of Agenda and Support Materials. Supporting materials are available to the public at the Washoe County Health District located at 1001 E. 9th Street, in Reno, Nevada. Ms. Laura Rogers, 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. Ms. Rogers is located at the Washoe County Health District and may be reached by telephone at (775) 328-2415 or by email at lrogers@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.

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DBOH AGENDA ITEM NO 6Bi

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health

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

SUBJECT: Retroactive approval of Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through June 30, 2018 in the total amount of \$3,000 in support of the Environmental Health Services Division (EHS) Food Retail Standards Program – Dog Friendly Outdoor Patio Sign Project, IO 19078; and if approved, authorize the District Health Officer to execute the Agreement.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute agreements on the Board of Health's behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

The Washoe County Health District received the award letter from AFDO on December 4, 2017. A copy of the award letter is attached. The funding is considered a subaward of United States Food and Drug Administration (FDA) grant funds, CFDA 93.103.

District Health Strategic Objective supported by this item:

1. **Impactful Partnerships:** Extend our impact by leveraging partnerships to make meaningful progress on health issues.
2. **Organizational Capacity:** Strengthen our workforce and increase operational capacity to support a growing population.

PREVIOUS ACTION

The Board has accepted several awards in FY17 from AFDO to fund special projects related to the Retail Standards Grant Program.

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: Retail Standards Program – Dog Friendly Outdoor Patio Signs

Scope of the Project: The scope of work addresses the following:

- The Washoe County Health District has incorporated written policies for processing waiver requests and operational plan submittals for dog friendly outdoor dining areas into

the existing policies. Funding will support “Dog access approved” signs to be provided to operators whose operational plan and waiver requests have been approved by the Washoe County Health District.

- **Benefit to Washoe County Residents:** This Award supports the EHS Food Program effort to achieve conformance with the FDA Voluntary National Retail Food Regulatory Program Standards. Implementing the standards benefits the community by reducing or eliminating the occurrence of illness and death from food produced in Washoe County food establishments. Reduction in the percentage of foodborne illness risk factors in food establishments has been identified as a goal in the Washoe County Health District Strategic Plan.

On-Going Program Support: These funds will be used for one-time program expenditures.

Award Amount: Total award is \$3,000 (\$3,000 direct/\$0 indirect)

Grant Period: January 1, 2018 – June 30, 2018

Funding Source: Food and Drug Administration (FDA)

Pass Through Entity: Association of Food and Drug Officials (AFDO)

CFDA Number: 93.103

Grant ID Number: G-SP-1709-05316

Match Amount and Type: None

Sub-Awards and Contracts: No Sub-Awards are anticipated.

FISCAL IMPACT

The Board of County Commissioners will be requested to approve the following:

As this award was not anticipated in the FY18 budget, a budget amendment in the amount of \$3,000 is necessary to bring the Award into alignment with the direct program budget.

Should the BCC approve these budget amendments, the FY18 budget will be increased by \$3,000 in the following accounts:

<u>Account Number</u>	<u>Description</u>	<u>Amount of Increase/(Decrease)</u>
2002-IO-19078	-431100 Federal Revenue	\$3,000
	Total Revenue	\$3,000
	-710100 Other Prof Services	\$ 200
	-710300 Operating Supplies	\$2,800
	Total Expenditures	\$3,000

Subject: Approval of Award – AFDO – Retail Standards Program –Dog Friendly Outdoor Patio Signs

Date: January 25, 2018

Page 3 of 3

RECOMMENDATION

Staff recommends that the District Board of Health retroactively approve Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through June 30, 2018 in the total amount of \$3,000 in support of the Environmental Health Services Division (EHS) Food Retail Standards Program – Dog Friendly Outdoor Patio Sign Project, IO 19078; and if approved, authorize the District Health Officer to execute the Agreement.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to retroactively approve Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through June 30, 2018 in the total amount of \$3,000 in support of the Environmental Health Services Division (EHS) Food Retail Standards Program – Dog Friendly Outdoor Patio Sign Project, IO 19078; and if approved, authorize the District Health Officer to execute the Agreement."

VOLUNTARY NATIONAL RETAIL FOOD
REGULATORY PROGRAM STANDARDS
(RETAIL STANDARDS) GRANT PROGRAM



November 30, 2017

Grant Number: G-SP-1709-05316
Project Title: Dog Friendly Outdoor Patio Sign
Award Value: \$3,000.00
Project Period: January 1, 2018 to June 30, 2018

Amber English
Senior Environmental Health Specialist
Washoe County Health District
1001 East 9th Street
Reno, Nevada 89512

Dear Amber English:

We have approved your application for Dog Friendly Outdoor Patio Sign as part of the Retail Standards Grant Program, funded by the United States Food and Drug Administration (FDA). Approval is based on review of the application submitted by you on behalf of Washoe County Health District to the Association of Food and Drug Officials (AFDO).

As part of your application your agency has made an assurance that it will comply with all applicable Federal statutes and regulations in effect during the grant period, including applicable parts of 45 CFR Parts 74 and 92. Acceptance of this award and/or any funds provided by the Retail Standards Grant Program acknowledges agreement with all of the terms and conditions in this award letter.

Your award is based on the above-title project application, submitted to and approved by AFDO, and is subject to the following terms and conditions:

- **The grantee must complete the full scope of work and all tasks outlined in the approved grant application by June 30, 2018 unless a written exception is granted by the AFDO Programmatic Point of Contact for this grant award.**
- **Any changes to the scope, tasks, deliverables, or expenses of this project must be approved in advance and in writing by the AFDO Programmatic Point of Contact prior to work being modified or completed.**
- The grantee must abide by the grant guidance for the program, available as a PDF file on the Retail Standards Grant Program portal at <http://afdo.org/retailstandards>. This portal is also the site where you can find additional information/updates regarding this grant program, and where you can log in for project status and submission of required reports.
- Per United States Department of Health and Human Services Grants Policy, expenses for food or beverage are generally not allowed unless it is part of a per diem allowance provided in conjunction with allowable travel.
- A Final Project Report must be submitted through the online grants portal no more than 45 days after June 30, 2018. As part of the final report, the grantee must provide a full accounting of all expenditures made with funds from this grant award, accompanied by the documentation specified in the reporting section of the grant guidance.
- As a reminder, recipients of funding through this program are required to assure that project activities achieve greater conformance with the FDA Voluntary National Retail Food Retail Program Standards, available at: http://afdo.org/fda_vnrfrps.

The amount of \$3,000.00 represents the full amount of funds to which you are entitled. Grant awards are made with the understanding that Retail Standards Grant Program staff may require clarification of information within your application, as necessary, during the application, project, or reporting periods. These inquiries may be necessary to allow us to appropriately carry out our administrative responsibilities.

Please note, the Catalog of Federal Domestic Assistance (CFDA) number for this United States Food and Drug Administration grant, awarded to the Association of Food and Drug Officials (AFDO) on 8/11/2016, is 93.103. Your grant is considered a subaward under this AFDO grant.

If you have questions about this award, please contact your AFDO Programmatic Point of Contact. Additionally, the Retail Food Safety Specialist from your FDA Region is an integral part of your jurisdiction's successful completion of Retail Standards activities, and is available to assist with your funded project. Contact information for both individuals is listed below.

We appreciate your ongoing commitment to achieving greater conformance with the Voluntary National Retail Food Regulatory Program Standards.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Corby". The signature is fluid and cursive, with the first name "Joe" being larger and more prominent than the last name "Corby".

Joe Corby
Executive Director
Association of Food and Drug Officials
2550 Kingston Road
Suite 311
York, PA 17402

AFDO Programmatic Point of Contact:

Michael Turner
retailstandards@afdo.org
(850) 583-4593

Follow the link below to obtain contact information for the FDA Regional Food Specialist assigned to assist your jurisdiction:

<http://afdo.org/retailstandards/fdaregionalcontacts>

cc: Daniel Lukash (daniel.lukash@fda.hhs.gov)
Catherine Hosman (catherine.hosman@fda.hhs.gov)

DD	<u>AH</u>	-
DHO	<u>KD</u>	-
DA		-
Risk		-

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health

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

SUBJECT: Retroactive approval of Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through October 31, 2018 in the total amount of \$2,914 in support of the Environmental Health Services Division (EHS) Food Retail Standards Program – Western Association of Food and Drug Officials (WAFDO) Conference and FDA Pacific Region Retail Food Seminar Project, IO 11467; and if approved, authorize the District Health Officer to execute the Agreement.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute agreements on the Board of Health’s behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

The Washoe County Health District received the award letter from AFDO on December 4, 2017. A copy of the award letter is attached. The funding is considered a subaward of United States Food and Drug Administration (FDA) grant funds, CFDA 93.103.

District Health Strategic Objective supported by this item:

1. **Impactful Partnerships:** Extend our impact by leveraging partnerships to make meaningful progress on health issues.
2. **Organizational Capacity:** Strengthen our workforce and increase operational capacity to support a growing population.

PREVIOUS ACTION

The Board has accepted several awards in FY17 from AFDO to fund special projects related to the Retail Standards Grant Program.

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: Retail Standards Program – WAFDO Conference and FDA Pacific Region Retail Food Seminar

Scope of the Project: The scope of work addresses the following:

- Attend the WAFDO conference and FDA Pacific Region Retail Food Seminar. These two conferences have been held together as a joint conference for the last several years. General objectives are to provide an opportunity for staff to learn changes to regulations and policies related to food safety including the FDA Food Code, changes to the FDA Program Standards, federal, state, local and tribal food safety initiatives, industry food safety initiatives, and emerging food safety science and technology.
- **Benefit to Washoe County Residents:** This Award supports the EHS Food Program efforts to achieve conformance with the FDA Voluntary National Retail Food Regulatory Program Standards. Implementing the standards benefits the community by reducing or eliminating the occurrence of illness and death from food produced in Washoe County food establishments. Reduction in the percentage of foodborne illness risk factors in food establishments has been identified as a goal in the Washoe County Health District Strategic Plan.

On-Going Program Support: These funds will be used for one-time program expenditures.

Award Amount: Total award is \$2,914 (\$2,914 direct/\$0 indirect)

Grant Period: January 1, 2018 – October 31, 2018

Funding Source: Food and Drug Administration (FDA)

Pass Through Entity: Association of Food and Drug Officials (AFDO)

CFDA Number: 93.103

Grant ID Number: G-T-1709-05309

Match Amount and Type: None

Sub-Awards and Contracts: No Sub-Awards are anticipated.

FISCAL IMPACT

The Board of County Commissioners will be requested to approve the following:

As this award was not anticipated in the FY18 budget, a budget amendment in the amount of \$2,914 is necessary to bring the Award into alignment with the direct program budget.

Should the BCC approve these budget amendments, the FY18 budget will be increased by \$2,914 in the following accounts:

<u>Account Number</u>	<u>Description</u>	<u>Amount of Increase/(Decrease)</u>
2002-IO-11467	-431100 Federal Revenue	\$2,914
	Total Revenue	\$2,914
	-710509 Seminars and Meetings	\$ 430
	-711210 Travel	\$2,484

Total Expenditures \$2,914

RECOMMENDATION

Staff recommends that the District Board of Health retroactively approve the Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through October 31, 2018 in the total amount of \$2,914 in support of the Environmental Health Services Division (EHS) Food Retail Standards Program – Western Association of Food and Drug Officials (WAFDO) Conference and FDA Pacific Region Retail Food Seminar Project, IO 11467; and if approved, authorize the District Health Officer to execute the Agreement.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to retroactively approve the Award from the Association of Food and Drug Officials (AFDO) for the period January 1, 2018 through October 31, 2018 in the total amount of \$2,914 in support of the Environmental Health Services Division (EHS) Food Retail Standards Program – Western Association of Food and Drug Officials (WAFDO) Conference and FDA Pacific Region Retail Food Seminar Project, IO 11467; and if approved, authorize the District Health Officer to execute the Agreement."

VOLUNTARY NATIONAL RETAIL FOOD
REGULATORY PROGRAM STANDARDS
(RETAIL STANDARDS) GRANT PROGRAM



December 1, 2017

Grant Number: G-T-1709-05309

Project Title: WAFDO Conference and FDA Pacific Region Retail Food Seminar

Award Value: \$2,914.00

Project Period: January 1, 2018 to October 31, 2018

Amber English
Senior Environmental Health Specialist
Washoe County Health District
1001 East 9th Street
Reno, Nevada 89512

Dear Amber English:

We have approved your application for WAFDO Conference and FDA Pacific Region Retail Food Seminar as part of the Retail Standards Grant Program, funded by the United States Food and Drug Administration (FDA). Approval is based on review of the application submitted by you on behalf of Washoe County Health District to the Association of Food and Drug Officials (AFDO).

As part of your application your agency has made an assurance that it will comply with all applicable Federal statutes and regulations in effect during the grant period, including applicable parts of 45 CFR Parts 74 and 92. Acceptance of this award and/or any funds provided by the Retail Standards Grant Program acknowledges agreement with all of the terms and conditions in this award letter.

Your award is based on the above-title project application, submitted to and approved by AFDO, and is subject to the following terms and conditions:

- **The grantee must complete the full scope of work and all tasks outlined in the approved grant application by October 31, 2018 unless a written exception is granted by the AFDO Programmatic Point of Contact for this grant award.**
- **Any changes to the scope, tasks, deliverables, or expenses of this project must be approved in advance and in writing by the AFDO Programmatic Point of Contact prior to work being modified or completed.**
- The grantee must abide by the grant guidance for the program, available as a PDF file on the Retail Standards Grant Program portal at <http://afdo.org/retailstandards>. This portal is also the site where you can find additional information/updates regarding this grant program, and where you can log in for project status and submission of required reports.
- Per United States Department of Health and Human Services Grants Policy, expenses for food or beverage are generally not allowed unless it is part of a per diem allowance provided in conjunction with allowable travel.
- A Final Project Report must be submitted through the online grants portal no more than 45 days after October 31, 2018. As part of the final report, the grantee must provide a full accounting of all expenditures made with funds from this grant award, accompanied by the documentation specified in the reporting section of the grant guidance.
- As a reminder, recipients of funding through this program are required to assure that project activities achieve greater conformance with the FDA Voluntary National Retail Food Retail Program Standards, available at: http://afdo.org/fda_vnrfrps.

The amount of \$2,914.00 represents the full amount of funds to which you are entitled. Grant awards are made with the understanding that Retail Standards Grant Program staff may require clarification of information within your application, as necessary, during the application, project, or reporting periods. These inquiries may be necessary to allow us to appropriately carry out our administrative responsibilities.

Please note, the Catalog of Federal Domestic Assistance (CFDA) number for this United States Food and Drug Administration grant, awarded to the Association of Food and Drug Officials (AFDO) on 8/11/2016, is 93.103. Your grant is considered a subaward under this AFDO grant.

If you have questions about this award, please contact your AFDO Programmatic Point of Contact. Additionally, the Retail Food Safety Specialist from your FDA Region is an integral part of your jurisdiction's successful completion of Retail Standards activities, and is available to assist with your funded project. Contact information for both individuals is listed below.

We appreciate your ongoing commitment to achieving greater conformance with the Voluntary National Retail Food Regulatory Program Standards.

Sincerely,



Joe Corby
Executive Director
Association of Food and Drug Officials
2550 Kingston Road
Suite 311
York, PA 17402

AFDO Programmatic Point of Contact:

Michael Turner
retailstandards@afdo.org
(850) 583-4593

Follow the link below to obtain contact information for the FDA Regional Food Specialist assigned to assist your jurisdiction:

<http://afdo.org/retailstandards/fdaregionalcontacts>

cc: Daniel Lukash (daniel.lukash@fda.hhs.gov)
Catherine Hosman (catherine.hosman@fda.hhs.gov)

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DHO	__ KD __
DA	__
Risk	__

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health

FROM: Nancy Kerns Cummins, Fiscal Compliance Officer
775-328-2419; nkcummins@washoecounty.us

SUBJECT: Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through September 30, 2018 in the total amount of \$50,000 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program IO# 11413; and authorize the District Health Officer to execute the Subgrant Award.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute other agreements on the Board of Health's behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

The Community and Clinical Health Services Division received a Notice of Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health on December 18, 2017 to support the HIV Prevention Program. The funding period is retroactive to January 1, 2018 through September 30, 2018. A copy of the Notice of Subgrant Award is attached.

Health District Strategic Priorities supported by this item:

Healthy Lives: Improve the health of our community by empowering individuals to live healthier lives.

Financial Stability: Enable the Health District to make long-term commitments in areas that will positively impact the community's health by growing reliable sources of income.

PREVIOUS ACTION

On May 25, 2017, the Board approved a Subgrant Award effective June 1, 2017 through September 30, 2017 in the total amount of \$59,455.00 in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program.

Subject: Approve HIV Prevention Subgrant

Date: January 25, 2018

Page 2 of 3

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: HIV / Behavioral Health Wellness & Prevention (BHWP)
Substance Abuse Prevention and Treatment Block Grant

Scope of the Project: Funding to support staffing, travel, operating to include advertising and indirect expenses

Benefit to Washoe County Residents: This component of the HIV Prevention Program will provide integrated substance use screening with HIV testing outreach to increase the awareness between substance use and HIV transmission

On-Going Program Support: The Health District will apply for continuation funding to support this program.

Award Amount: \$50,000 (includes \$4,233 indirect)

Grant Period: January 1, 2018 through September 30, 2018

Funding Source: Substance Abuse Prevention and Treatment Block Grant
Substance Abuse and Mental Health Services Administration

Pass Through Entity: State of Nevada Department of Health and Human Services,
Division of Public & Behavioral Health

CFDA Number: 93.959

Grant ID Number: 2B08TI010039-17 / HD# 16381

Match Amount and Type: No match required.

Sub-Awards and Contracts: No Sub-Awards or contracts are anticipated.

FISCAL IMPACT

The Department anticipated this award and included funding in the adopted FY18 budget in internal order #11413. As such, there is no fiscal impact to the FY18 adopted budget should the Board approve the Notice of Subgrant Award.

RECOMMENDATION

It is recommended that the District Board of Health approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through September 30, 2018 in the total amount of \$50,000 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program IO# 11413; and authorize the District Health Officer to execute the Subgrant Award.

Subject: Approve HIV Prevention Subgrant

Date: January 25, 2018

Page 3 of 3

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be: "Move to approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through September 30, 2018 in the total amount of \$50,000 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program IO# 11413; and authorize the District Health Officer to execute the Subgrant Award."

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**



State of Nevada
Department of Health and Human Services
Division of Public & Behavioral Health
(hereinafter referred to as the Division)

HD #:	16381
Budget Account:	3170
Category:	28
GL:	8516
Activity Code:	0062
Function Code:	0818
Job Number:	9395917

NOTICE OF SUBGRANT AWARD

Program Name: Behavioral Health Wellness & Prevention (BHWP) Division of Public & Behavioral Health	Subgrantee Name: Washoe County Health District Contact: Jennifer Howell, MPH						
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	Address: PO Box 11130 Reno, NV 89520-0027						
Subgrant Period: January 1, 2018 through September 30, 2018	Subgrantee's: <table border="0"> <tr> <td>EIN:</td> <td>88-600138</td> </tr> <tr> <td>Vendor #:</td> <td>T40283400Q</td> </tr> <tr> <td>Dun & Bradstreet:</td> <td>07-378-6998</td> </tr> </table>	EIN:	88-600138	Vendor #:	T40283400Q	Dun & Bradstreet:	07-378-6998
EIN:	88-600138						
Vendor #:	T40283400Q						
Dun & Bradstreet:	07-378-6998						

Purpose of Award: To increase the awareness between substance use and HIV transmission.

Region(s) to be served: Statewide Specific county or counties: Washoe County

Approved Budget Categories:	Disbursement of funds will be as follows:																								
<table border="0"> <tr> <td>1. Personnel</td> <td>\$</td> <td><u>43,289.00</u></td> </tr> <tr> <td>2. Travel</td> <td>\$</td> <td><u>278.00</u></td> </tr> <tr> <td>3. Operating</td> <td>\$</td> <td><u>200.00</u></td> </tr> <tr> <td>4. Equipment</td> <td>\$</td> <td><u>0.00</u></td> </tr> <tr> <td>5. Contractual/Consultant</td> <td>\$</td> <td><u>2,000.00</u></td> </tr> <tr> <td>6. Training</td> <td>\$</td> <td><u>0.00</u></td> </tr> <tr> <td>7. Other</td> <td>\$</td> <td><u>4,233.00</u></td> </tr> <tr> <td>Total Cost:</td> <td>\$</td> <td><u>50,000.00</u></td> </tr> </table>	1. Personnel	\$	<u>43,289.00</u>	2. Travel	\$	<u>278.00</u>	3. Operating	\$	<u>200.00</u>	4. Equipment	\$	<u>0.00</u>	5. Contractual/Consultant	\$	<u>2,000.00</u>	6. Training	\$	<u>0.00</u>	7. Other	\$	<u>4,233.00</u>	Total Cost:	\$	<u>50,000.00</u>	<p>Payment will be made upon receipt and acceptance of an invoice and supporting documentation specifically requesting reimbursement for actual expenditures <i>specific to this subgrant</i>. Total reimbursement will not exceed \$50,000.00 during the subgrant period.</p>
1. Personnel	\$	<u>43,289.00</u>																							
2. Travel	\$	<u>278.00</u>																							
3. Operating	\$	<u>200.00</u>																							
4. Equipment	\$	<u>0.00</u>																							
5. Contractual/Consultant	\$	<u>2,000.00</u>																							
6. Training	\$	<u>0.00</u>																							
7. Other	\$	<u>4,233.00</u>																							
Total Cost:	\$	<u>50,000.00</u>																							

Source of Funds:	% Funds:	CFDA:	FAIN:	Federal Grant #:
1. Substance Abuse Prevention & Treatment Block Grant	100	93.959	TI010039-17	2B08TI010039-17

Terms and Conditions:
In accepting these grant funds, it is understood that:

- Expenditures must comply with appropriate state and/or federal regulations;
- This award is subject to the availability of appropriate funds; and
- The recipient of these funds agrees to stipulations listed in the incorporated documents.

Incorporated Documents:
Section A: Assurances;
Section B: Description of Services, Scope of Work and Deliverables;
Section C: Budget and Financial Reporting Requirements;
Section D: Request for Reimbursement;
Section E: Audit Information Request; and
Section F: DPBH Business Associate Addendum
Section G: BHWP Program Requirements

Kevin Dick District Health Officer	Signature	Date
Kyle Devine Bureau Chief, BHWP		
for Amy Roukie, MBA Administrator, Division of Public & Behavioral Health		

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

Assurances

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

1. 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.
2. To submit reimbursement requests only for expenditures approved in the spending plan. Any additional expenditure beyond what is allowable based on approved categorical budget amounts, without prior written approval by the Division, may result in denial of reimbursement.
3. Approval of subgrant budget by the Division 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 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 (ASO) of the Division. Records may be destroyed by the Subgrantee five (5) calendar years after the final financial and narrative reports have been submitted to the Division.
 - 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. To disclose any existing or potential conflicts of interest relative to the performance of services resulting from this subgrant award. The Division reserves the right to disqualify any subgrantee 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. 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. To comply with the Americans with Disability Act of 1990, P.L. 101-136, 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 C.F.R. 26.101-36.999 inclusive and any relevant program-specific regulations
8. To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 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 (PHI) then the subgrantee agrees to enter into a Business Associate Agreement with the Division as required by 45 C.F.R. 164.504(e). If PHI will not be disclosed, then a Confidentiality Agreement will be entered into.
9. Subgrantee certifies, by signing this notice of subgrant award, 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. pr. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Register (pp. 19150-19211). This provision shall be required of every subgrantee receiving any payment in whole or in part from federal funds.

10. Sub-grantee agrees to comply with the requirements of the Title XII Public Law 103-227, the "PRO-KIDS Act of 1994," smoking may not be permitted in any portion of any indoor facility owned or regularly used for the provision of health, day care, education, or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans and loan guarantees, and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.
11. 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.
12. Division subgrants are subject to inspection and audit by representative of the Division, 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.
13. 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, as well as federal requirement as specified in the Office of Management and Budget (2 CFR § 200.501(a)), revised December 26, 2013, that each grantee annually expending \$750,000 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:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

This copy of the final audit must be sent to the Division within nine (9) months of the close of the subgrantee's fiscal year. **To acknowledge this requirement, Section E of this notice of subgrant award must be completed.**

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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SECTION B

Description of Services, Scope of Work and Deliverables

Washoe County Health District, hereinafter referred to as Subgrantee, agrees to provide the following services and reports according to the identified timeframes:

Scope of Work for Washoe County Health District

Purpose: To increase awareness of the connection between substance use and HIV transmission/acquisition risk through outreach and education.

Brief Description of program: Washoe County Health District (WCHD) will provide primary substance abuse prevention messaging to clients that are reached through HIV outreach, highlighting the increased risk of HIV transmission or acquisition due to substance use.

Problem Statement: Substance use increases the risk of HIV transmission and acquisition due to a stronger likelihood of engaging in high-risk behaviors of unprotected sexual contact or sharing syringe/drug equipment.

State Priority Areas Addressed: 3, 9, 10

Goal 1: Increase the number of people during HIV outreach who participate in enhanced substance use prevention education and referral through SAPTA's strategy categories of Information Dissemination, Problem Assessment/Referral, and Education.

Outcome Objective 1a: By September 30, 2018, WCHD staff will provide substance use/HIV connection education to at least 530 people at non-traditional (non-clinical) HIV outreach sites targeting LGBTQI, youth, commercial sex workers and heterosexuals at high-risk for HIV acquisition.			Percent Funding: 100%
Activities including Evidence-based Programs	CSAP Codes	Date due by	Documentation
1. Secure outreach sites, schedule dates/times by Health Educator Coordinator	STP06	Ongoing throughout funding period	<ul style="list-style-type: none"> • Program calendar • Correspondence with outreach sites
2. Promote HIV outreach for at least 5 high-risk community sites via social media, flyers, print media by Health Educator Coordinator	STN 05 STN14 STN 11	Weekly throughout the funding period	<ul style="list-style-type: none"> • Social media posts • Documentation of sites receiving flyers • Print media placement
3. HIV outreach at sites where high-risk populations are known to congregate to at least 530 high-risk clients by Public Health Nurses and Health Educator Coordinator	STP06	September 30, 2018	<ul style="list-style-type: none"> • Client paper and electronic health record chart indicating demographics, client reported risk factors, date and site of each testing session • Program calendar/staffing assignments
4. Participate in SAPTA required meetings and trainings while providing information on project to SAPTA partners by Health Educator Coordinator	N/A	Ongoing throughout funding period	<ul style="list-style-type: none"> • Program calendar • Program materials distributed during meetings or by request

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Evaluation: The following data will be collected and reported to SAPTA to assist SAPTA in providing an overview of clients being reached through primary prevention activities and the risk of clients that are reached with regard to HIV and substance use risk:

- # Media Placements
- # Media Exposures/Impressions
- # Flyers Disseminated
- # Outreach Sessions
- # Outreach Sites
- # Clients Receiving Outreach Education
- # Clients Receiving Substance Abuse Treatment Referrals
- Identified HIV risk reported by clients will also be reported in aggregate.

Data will be compiled from the electronic health record, project database (to be developed) from paper client charts that are kept secure with staff during testing outreach to ensure adherence to appropriate confidentiality regulations. Upon return from outreach sites, data will be entered into the appropriate database. Tracking of client demographics and identified risk behaviors, number of outreach sessions, number of substance use screening and referrals will be conducted with review by HIV team at weekly meetings and reported to SAPTA. If challenges in meeting the project objectives are noted, quality improvement strategies will be used and documented during team meetings to develop solutions in meeting the objectives.

The Health Educator Coordinator will coordinate outreach logistics, social marketing/media placements, and evaluation activities. In addition, the Health Educator Coordinator will provide outreach services when staffing levels require additional staff.

Public Health Nurses will provide outreach and primary prevention education on the connection between substance use and HIV transmission and acquisition risk. Staff will also collect client level data and provide the data to the Health Educator Coordinator for reporting purposes.

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SECTION C

Budget and Financial 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 State Division of Public and Behavioral Health through Grant Number 2B08TI010039-17 from the Substance Abuse and Mental Health Services Agency (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor SAMHSA."

Any activities performed under this subgrant shall acknowledge the funding was provided through the Division by Grant Number 2B08TI010039-17 from the Substance Abuse and Mental Health Services Agency (SAMHSA).

Subgrantee agrees to adhere to the following budget:

<u>Category</u>	<u>Total cost</u>	<u>Detailed cost</u>	<u>Details of expected expenses</u>
1. Personnel	\$ 43,289.00		
		\$ 8,344	Health Education Coordinator: \$83,436/12 months x 9 months x .13334 FTE = \$8,344
		20,324	Public Health Nurse: \$63,512/12 months x 9 months x .42666 FTE = \$20,324
		14,621	Fringe @ 51%: \$28,668 x .51 = \$14,621
2. Travel	\$ 278.00		
		\$ 278	Local travel: 13.3 miles/week x 39 weeks x \$0.535/mile = \$278
3. Operating	\$ 200.00		
		\$ 200	Printing costs: flyers for referral sites and prevention education materials to disseminate to public
4. Equipment	\$ 0.00		
		\$	
5. Contractual Consultant	\$ 2,000.00		
		\$ 2,000	Advertising (Contractor TBD): Provide risk-reduction messages regarding the risk of HIV transmission and acquisition with substance use.
6. Training	\$ 0.00		
		\$	
7. Other	\$ 4,233.00		
		\$ 4,233	Indirect costs 9.25%: \$45,767 x .0925 = \$4,233
Total Cost	\$ 50,000.00		

- Division of Public and Behavioral Health policy is to allow no more than 10% flexibility, within the approved Scope of Work, with prior approval.
- 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).

The 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.

- The maximum amount available through this subgrant is \$50,000.00;

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- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred;
- Quarterly program reports will be submitted by the 15th of the month following the end of the quarter; and
- 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 within 30 days of the CLOSE OF THE SUBGRANT PERIOD. Any un-obligated funds shall be returned to the Division at that time, or if not already requested, shall be deducted from the final award.

The Division agrees:

- To provide technical assistance upon request from the subgrantee;
- To share program activities and outcomes with substance abuse prevention stakeholders at the Federal, State and local levels.
- The Division 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.

Both parties agree:

Annual site visits to monitor activities and grant management may be conducted.

The Subgrantee will, in the performance of the Scope of Work specified in this subgrant, perform functions and/or activities that could involve confidential information; therefore, the Subgrantee is requested to fill out and sign Section F, which is specific to this subgrant, and will be in effect for the term of this subgrant.

All reports of expenditures and requests for reimbursement processed by the Division 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 Division, state, and/or federal funding ability to satisfy this Agreement is withdrawn, limited, or impaired.

Financial Reporting Requirements

- A Request for Reimbursement is due on a monthly 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.

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SECTION D

Request for Reimbursement

HD #: **16381**
 Budget Account: 3170
 GL: 8516
 Draw #: _____

Program Name: Behavioral Health Wellness & Prevention Division of Public & Behavioral Health	Subgrantee Name: Washoe County Health District Contact: Jennifer Howell, MPH
Address: 4126 Technology Way, Suite 200 Carson City, NV 89706	Address: PO Box 11130 Reno, NV 89520-0027
Subgrant Period: January 1, 2018 through September 30, 2018	Subgrantee's: EIN: 88-600138 Vendor #: T40283400Q

FINANCIAL REPORT AND REQUEST FOR FUNDS
(must be accompanied by expenditure report/back-up)

Month(s)	Calendar year					
	A	B	C	D	E	F
Approved Budget Category	Approved Budget	Total Prior Requests	Current Request	Year to Date Total	Budget Balance	Percent Expended
1. Personnel	\$43,289.00	\$0.00	\$0.00	\$0.00	\$43,289.00	0.0%
2. Travel	\$278.00	\$0.00	\$0.00	\$0.00	\$278.00	0.0%
3. Operating	\$200.00	\$0.00	\$0.00	\$0.00	\$200.00	0.0%
4. Equipment	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
5. Contract/ Consultant	\$2,000.00	\$0.00	\$0.00	\$0.00	\$2,000.00	0.0%
6. Training	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
7. Other	\$4,233.00	\$0.00	\$0.00	\$0.00	\$4,233.00	0.0%
Total	\$50,000.00	\$0.00	\$0.00	\$0.00	\$50,000.00	0.0%

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: _____

Scope of Work review/approval date: _____

ASO or Bureau Chief (as required): _____ Date _____

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SECTION E

Audit Information Request

1. Non-Federal entities that **expend** \$750,000.00 or more in total federal awards are required to have a single or program-specific audit conducted for that year, in accordance with 2 CFR § 200.501(a). Within nine (9) months of the close of your organization's fiscal year, you **must** submit a copy of the final audit report to:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

2. Did your organization expend \$750,000 or more in all federal awards during your organization's most recent fiscal year?

YES NO

3. When does your organization's fiscal year end?

June 30th

4. What is the official name of your organization?

Washoe County Health District

5. How often is your organization audited?

annually

6. When was your last audit performed?

August 2017

7. What time period did your last audit cover

June 30, 2017

8. Which accounting firm conducted your last audit?

Eide Bailly

Signature

Date

Administrative Health Services Officer
Title

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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SECTION F

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 agreement 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 agreement. 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 agreement 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 an agreement 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. **Agreement** shall refer to this Addendum and that particular agreement 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.

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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 statutes 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).

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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 agreement, 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 agreement 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

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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 agreement 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 agreement 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 agreement, 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.

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- 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 Agreement.** The Business Associate agrees that the Covered Entity may immediately terminate the agreement 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:

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- 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 agreement that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the agreement 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.

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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
<p>Division of Public and Behavioral Health 4150 Technology Way, Suite 300 Carson City, NV 89706</p>	<p>Washoe County Health District <hr/> Business Name</p>
<p>Phone: (775) 684-4200</p>	<p>PO Box 11130 <hr/> Business Address</p>
<p>Fax: (775) 684-4211</p>	<p>Reno, NV 89520 <hr/> Business City, State and Zip Code</p>
	<p>775.228.2400 <hr/> Business Phone Number</p>
	<p>775.328.3752 <hr/> Business Fax Number</p>
<hr/> <p>Authorized Signature</p>	<hr/> <p>Authorized Signature</p>
<p>for Amy Roukie, MBA <hr/> Print Name</p>	<p>Kevin Dick <hr/> Print Name</p>
<p>Administrator, Division of Public and Behavioral Health <hr/> Title</p>	<p>District Health Officer <hr/> Title</p>
<hr/> <p>Date</p>	<p>January 25, 2018 <hr/> Date</p>

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BUREAU OF BEHAVIORAL HEALTH WELLNESS AND PREVENTION

SECTION G

PROGRAM REQUIREMENTS

In addition to the Division of Public and Behavioral Health Subaward Grant Assurances, the subrecipient and all organizations or individuals to whom the sub-grantee passes through funding must be in compliance with all applicable rules, federal and state laws, regulations, requirements, guidelines, and policies and procedures. The terms and conditions of this State subaward flow down to the subrecipient's pass through entities unless a particular section specifically indicates otherwise.

GENERAL REQUIREMENTS

Applicability: This section is applicable to all subrecipients who receive finding from the Division of Public and Behavioral Health through the Bureau of Behavioral Health Wellness and Prevention (BBHWP). The subrecipient agrees to abide by and remain in compliance with the following:

1. 2 CFR 200 -Uniform Requirements, Cost Principles and Audit Requirements for Federal Awards
2. 45 CFR 96 - Block Grants as it applies to the subrecipient and per Division policy.
3. 42 CFR 54 and 42 CFR 54A Charitable Choice Regulations Applicable to States Receiving Substance Abuse Prevention & Treatment Block Grants and/or Projects for Assistance in Transition from Homelessness Grants
4. NRS 218G - Legislative Audits
5. NRS 458 - Abuse of Alcohol & Drugs
6. NRS 616 A through D Industrial Insurance
7. GAAP – [Generally Accepted Accounting Principles] and/or GAGAS [Generally Accepted Government Auditing Standards]
8. GSA – [General Services Administration] guidelines for travel
9. The Division of Public and Behavioral Health, BBHWP policies and guidelines.
10. State Licensure and certification
 - a. The subrecipient is required to be in compliance with all State licensure and/or certification requirements.
 - b. The subrecipient's certification must be current and fees paid prior to release of certificate in order to receive funding from the Division. Subawards cannot be issued unless certifications are current.
11. The Subgrantee shall carry and maintain commercial general liability coverage for bodily injury and property damage as provided for by NRS 41.038 and NRS 334.060. In addition, Subgrantee shall maintain coverage for its employees in accordance with NRS Chapter 616A. The parties acknowledge that Subgrantee has adopted a self-insurance program with liability coverage up to \$2,000,000 and has excess liability coverage up to \$20,000,000 for bodily injury (automobile and general liability), property damage (automobile and general liability), professional liability, and

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personal injury liability. The parties further acknowledge that Subgrantee is self-insured for workers' compensation liability. Subgrantee warrants that its participation in the plan is in full force and effect and that there have been no material modifications thereof. If, at any time, Subgrantee is no longer a participant in the self-insurance program, then Subgrantee shall immediately become a participant in a comparable self-insurance program or immediately obtain a policy of commercial insurance. The parties acknowledge that any Subgrantee liability is limited by NRS 41.0305 through NRS 41.035.

12. The subrecipient shall provide proof of workers' compensation insurance as required by Chapters 616A through 616D inclusive Nevada Revised Statutes at the time of their certification.
13. The subrecipient agrees to be a "tobacco, alcohol, and other drug free" environment in which the use of tobacco products, alcohol, and illegal drugs will not be allowed;
14. The subrecipient will report within 24 hours the occurrence of an incident, following Division policy, which may cause imminent danger to the health or safety of the clients, participants, staff of the program, or a visitor to the program, per NAC 458.153 3(e).
15. The subrecipient shall maintain a Central Repository for Nevada Records of Criminal History and FBI background checks every 3 to 5 years were conducted on all staff, volunteers, and consultants occupying clinical and supportive roles, if the subrecipient serves minors with funds awarded through this subaward.
16. Application to 2-1-1
 - o As of October 1, 2017, the Sub-grantee will be required to submit an application to register with the Nevada 2-1-1 system.
17. The subrecipient agrees to cooperate fully with all BBHWP sponsored studies including, but not limited to, utilization management reviews, program compliance monitoring, reporting requirements, complaint investigations, and evaluation studies.
18. The subrecipient must be enrolled in System Award Management (SAM) as required by the Federal Funding Accountability and Transparency Act.
19. The subrecipient acknowledges that to better address the needs of Nevada, funds identified in this subaward may be reallocated if ANY terms of the sub-grant are not met, including failure to meet the scope of work. The BBHWP may reallocate funds to other programs to ensure that gaps in service are addressed.
20. The subrecipient acknowledges that if the scope of work is NOT being met, the subrecipient will be provided an opportunity to develop an action plan on how the scope of work will be met and technical assistance will be provided by BBHWP staff or specified subcontractor. The subrecipient will have 60 days to improve the scope of work and carry out the approved action plan. If performance has not improved, BBHWP will provide written notice identifying the reduction of funds and the necessary steps.
21. The subrecipient will NOT expend BBHWP funds, including Federal Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Funds for any of the following purposes:
 - a. To purchase or improve land: purchase, construct, or permanently improve, other than minor remodeling, any building or other facility; or purchase major medical equipment.
 - b. To purchase equipment over \$1,000 without approval from the Division.
 - c. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
 - d. To provide in-patient hospital services.
 - e. To make payments to intended recipients of health services.

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- f. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstrated needle exchange program would be effective in reducing drug abuse and there is no substantial risk that the public will become infected with the etiologic agent for AIDS.
- g. To provide treatment services in penal or correctional institutions of the State.

22. Failure to meet any condition listed within the subaward award may result in withholding reimbursement payments, disqualification of future funding, and/or termination of current funding.

Audit Requirements

The following program Audit Requirements are for non-federal entities who do not meet the single audit requirement of 2 CFR Part 200, Subpart F-Audit requirements:

- 23. Subrecipients of the program who expend less than \$750,000 during the non-federal entity's fiscal year in federal and state awards are required to report all organizational fiscal activities annually in the form of a Year-End Financial Report.
- 24. Subrecipients of the program who expend \$750,000 or more during the fiscal year in federal and state awards are required to have a Limited Scope Audit conducted for that year. The Limited Scope Audit must be for the same organizational unit and fiscal year that meets the requirements of the Division Audit policy.

Year-End Financial Report

- 25. The non-federal entity must prepare financial statements that reflect its financial position, results of operations or changes in net assets, and, where appropriate, cash flows for the fiscal year.
- 26. The non-federal entity financial statements may also include departments, agencies, and other organizational units.
- 27. Year-End Financial Report must be signed by the CEO or Chairman of the Board.
- 28. The Year-End Financial Report must identify all organizational revenues and expenditures by funding source and show any balance forward onto the new fiscal year as applicable.
- 29. The Year-End Financial Report must include a schedule of expenditures of federal and State awards. At a minimum, the schedule must:
 - a. List individual federal and State programs by agency and provide the applicable federal agency name.
 - b. Include the name of the pass-through entity (State Program).
 - c. Must identify the CFDA number as applicable to the federal awards or other identifying number when the CFDA information is not available.
 - d. Include the total amount provided to the non-federal entity from each federal and State program.
- 30. The Year-End Financial Report must be submitted to the Division 90 days after fiscal year end at the following address.

Behavioral Health Wellness and Prevention
Attn: Management Oversight Team
4126 Technology Way, Second Floor
Carson City, NV 89706

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Limited Scope Audits

31. The auditor must:

- a. Perform an audit of the financial statement(s) for the federal program in accordance with GAGAS;
- b. Obtain an understanding of internal controls and perform tests of internal controls over the federal program consistent with the requirements for a federal program;
- c. Perform procedures to determine whether the auditee has complied with federal and State statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on the federal program consistent with the requirements of federal program;
- d. Follow up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with the requirements of 2 CFR Part 200, §200.511 Audit findings follow-up, and report, as a current year audit finding, when the auditor concludes that the summary schedule of prior audit findings materially misrepresents the status of any prior audit finding;
- e. And, report any audit findings consistent with the requirements of 2 CFR Part 200, §200.516 Audit findings.

32. The auditor's report(s) may be in the form of either combined or separate reports and may be organized differently from the manner presented in this section.

33. The auditor's report(s) must state that the audit was conducted in accordance with this part and include the following:

- a. An opinion as to whether the financial statement(s) of the federal program is presented fairly in all material respects in accordance with the stated accounting policies;
- b. A report on internal control related to the federal program, which must describe the scope of testing of internal control and the results of the tests;
- c. A report on compliance which includes an opinion as to whether the auditee complied with laws, regulations, and the terms and conditions of the awards which could have a direct and material effect on the program; and
- d. A schedule of findings and questioned costs for the federal program that includes a summary of the auditor's results relative to the federal program in a format consistent with 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(1), and findings and questioned costs consistent with the requirements of 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(3).

34. The Limited Scope Audit Report must be submitted to the Division within the earlier of 30 calendar days after receipt of the auditor's report(s), or nine months after the end of the audit period. If the due date falls on a Saturday, Sunday, or Federal holiday, the reporting package is due the next business day. The Audit Report must be sent to:

Behavioral Health Wellness and Prevention
Attn: Management Oversight Team
4126 Technology Way, Second Floor
Carson City, NV 89706

Amendments

35. The Division of Public and Behavioral Health policy is to allow no more than 10% flexibility within the approved Scope of Work budget line items. Notification of such modifications must be communicated in writing to the BBHWP through the assigned analyst prior to submitting any request for reimbursement for the period in which the modification affects. Notification may be made via email.

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36. For any budgetary changes that are in excess of 10 percent of the total award, an official amendment is required. Requests for such amendments must be made to BBHWP in writing.
37. Any expenses that are incurred in relation to a budgetary amendment without prior approval are unallowable.
38. Any significant changes to the scope of work over the course of the budget period will require an amendment. The assigned program analyst can provide guidance and approve all scope of work amendments.
39. The subrecipient acknowledges that requests to revise the approved subaward must be made in writing using the appropriate forms and provide sufficient narrative detail to determine justification.
40. Final changes to the approved subaward that will result in an amendment must be received 60 days prior to the end of the subaward period (no later than April 30 for State funded grants and July 31 for federal funded grants). Amendment requests received after the 60-day deadline will be denied.

Remedies for Noncompliance

41. The Division reserves the right to hold reimbursement under this subaward until any delinquent requests, forms, reports, and expenditure documentation are submitted to and approved by the Division.

SUBSTANCE USE TREATMENT SERVICES

Applicability

This section applies to all sub-grants that support direct services to persons being treated for substance use.

1. The subrecipient, as applicable, if identifying as Faith-Based Organizations must comply with 42 USC § 300x-65 and 42 CFR part 54 (42 CFR §§ 54.8(c) (4) and 54.8(b)), Charitable Choice provisions and regulations.
 - a. The subrecipient must post a notice to advise all clients and potential clients that if the client objects to the religious character of the Sub-grantee's organization as applicable.
 - b. The client has the right to be referred to another Division-funded provider that is not faith-based or that has a different religious orientation.
2. Priority Groups – The subrecipient agrees to prioritize and expedite access to appropriate treatment, except for Civil Protective Custody Services, for priority populations in the following order:
 - a. Pregnant injecting drug users;
 - b. Pregnant substance abusers;
 - c. Injection drug users;
 - d. Substance using females with dependent children and their families, including females who are attempting to regain custody of their children; and
 - e. All others.
3. The subrecipient agrees to report within 24 hours to the Bureau of Behavioral Health Wellness and Prevention when any level of service reaches 90 percent capacity or greater in accord with the Division's Wait List and Capacity Management policy.
4. A subrecipient who provides residential services agrees to report bed capacity in the HavBed system or a successor system for residential services daily in accord with the Division's Wait List and Capacity Management policy.
5. Programs will make continuing education in alcohol and other drug treatment available to all employees who provide services.

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6. The subrecipient must post a notice, where clients, visitors, and persons requesting services may easily view it, that no persons may be denied services due to inability to pay. This notice may stipulate that the organization is authorized to deny services to those who are able to pay but refuse to do so.
7. The subrecipient is required to implement the National Institute of Drug Abuse (NIDA) 13 principles of treatment.
8. The subrecipient is required to participate, if selected to be reviewed by the Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services (AADAPTS) annual peer review process.

Capacity of Treatment for Intravenous Substance Abusers

9. A subrecipient must admit an individual who requests and needs treatment for intravenous drug use to a treatment program. If unable to provide services, the subrecipient must contact the BBHWP according to the Division's Capacity Management and Wait List policy.
10. The subrecipient who treats persons who inject drugs agrees to carry out activities to encourage individuals in need of treatment for injection drug use to undergo such treatment. The subrecipient must use outreach models that are scientifically sound or an alternate outreach method that is reasonably expected to be effective and has been approved by the BBHWP. All outreach activities will be reported to the Division quarterly. The model shall require that outreach efforts include the following at a minimum:
 - a. Selecting, training and supervising outreach workers;
 - b. Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR part 2;
 - c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;
 - d. Recommend steps that can be taken to ensure that HIV transmission does not occur; and
 - e. Encouraging entry into treatment.

Treatment services for pregnant women (45 CFR § 96.131)

11. All subrecipient who treat women agree to provide immediate comprehensive treatment services to pregnant women, or if the sub-grantee is unable to do so, the sub-grantee must immediately contact the Bureau of Behavioral Health Wellness and Prevention in accord to the Divisions Capacity Management and Wait List policy.
12. Subrecipients who do not treat women and who receive a request for treatment services from a pregnant woman must provide a referral to an appropriate treatment provider within 48 hours of the request for services and must immediately notify the Bureau of Behavioral Health Wellness and Prevention of the need for such services.
13. Subrecipients who provide services to women agree to publicize the availability of services to women in priority populations and the admission priority granted to pregnant women. The publication of services for women in priority populations may be achieved by means of street outreach programs, ongoing public service announcements, regular advertisements, posters placed in target areas, and frequent notification of availability of such treatment services distributed to the network of community based organizations, health care providers, and social services agencies.

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Records

14. All subrecipients will have in effect a system to protect from inappropriate disclosure of client records, compliant with all applicable State and federal laws and regulations, including 42 CFR, Part 2.
15. The system to protect confidentiality shall include, but not be limited to, the following provisions:
 - a. Employee education about the confidentiality requirements, to be provided annually;
 - b. Informing employees of the fact that disciplinary action may occur upon inappropriate disclosure.

Reporting

16. The subrecipient is required to submit monthly Treatment Episode Data Set (TEDS) admissions files and TEDS discharges files in accordance with current block grant requirements. The subrecipient is also required to submit any other reporting as defined and requested by the BBHWP.
17. The subrecipient agrees to participate in reporting all required data and information through the authorized BBHWP data reporting system and to the evaluation team as required; or, if applicable, another qualified Electronic Health Record (EHR) reporting system.

Fee for Service requirements

18. Subrecipients that have been awarded a fee for service subaward must comply with the Division's Utilization Management policy and the following billing and eligibility rules for claims processing.
 - a. The service must be delivered at a Division certified facility.
 - b. The certifications must cover the service levels under which the qualified service was delivered.
 - c. The service must be provided by an appropriately licensed/certified staff member.
 - d. The service delivered must be a Division qualified service which is **NOT** reimbursable by Medicaid or other third party insurance carrier.
 - e. The rate of reimbursement will be based on the Division approved rates (available upon request).
 - f. The subrecipient agrees to accept the Division reimbursement rate as full payment for any program eligible services provided.
 - g. The subrecipient is responsible for ensuring that all third party liabilities are billed and collected from the third party payers and are **NOT** billed to the Division.
 - h. Division funds will **NOT** be used to fund the services for self-pay clients or clients who elect not to use their insurance coverages. This includes clients that elect not sign up for insurance under the ACA [Affordable Care Act] or clients that have existing insurance and choose not to use their insurance for treatment services. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.
 - i. Division funds will **NOT** be used to reimburse Medicare claims.
 - j. Division funds will **NOT** be used to reimburse claims for which the client is pending eligible for insurance coverage.
 - k. Division funds will **NOT** be used to reimburse for claims denied by Medicaid or other insurance carriers unless the claim was denied as "not a covered benefit".
 - a. Claims denied as "not a covered benefit" and billed to the Division must have the accompanying denial attached in order to guarantee payment.
 - l. Division funds will **NOT** be used to cover any unpaid costs that Medicaid and/or other insurance carriers may not reimburse (i.e. copayments, deductibles).
 - m. The subrecipient agrees to use Division funds as the "payer of last resort" for all services provided to clients. If an undue barrier to treatment exist, a written request to the Division may be submitted for review and some services may be covered upon written permission from the Division.

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19. The subrecipient must establish policies, procedures, and the systems for eligibility determination, billing, and collection to:
- a. Ensure that all eligible clients are insured and/or enrolled in Medicaid in accord with the ACA;
 - b. Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical assistance, any grant program, any private health insurance, or any other benefit program; and secure from client's payment for services in accordance with their ability to pay; and
 - c. Prohibits billing the Division for a service that is covered by Medicaid or any other insurance carrier. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.

Billing the Division

Fee-for-service only:

20. The subrecipient agrees to submit a monthly billing invoice, along with back-up documentation via the Secure File Transfer Protocol (SFTP) site to the Division; the Sub-grantee agrees to notify the treatment analyst once the invoice has been posted to the SFTP site.
21. Upon official written notification from the BBHWP, prior authorizations will be required for all residential and transitional housing services being billed to the Division.
22. The subrecipient agrees to include an explanation of benefits for all charges requested for services that have been denied by Medicaid or any other third-party payer due to non-coverage of that benefit.
23. The subrecipient understands that charges greater than 90 days from the date of service will be considered stale dated and may not be paid.
24. The subrecipient understands that quarterly Medicaid audits will be conducted by Division and recouping of funds may occur.
25. The subrecipient understands that they are required to produce an invoice that breaks out the total number of services provided by level of care and CPT or HCPCS code. The invoice must, at a minimum meet the following conditions.
- a. The invoice must contain, company information (Name, address, City, State and Zip), Date, unique Invoice #, vendor #, PA or HD#.
 - b. The invoice must contain contact name, phone number, e-mail and identify the invoice period.
 - c. The invoice must contain: Billed To: The Division of Public and Behavioral Health, Bureau of Behavioral Health Wellness and Prevention, 4126 Technology Way, Suite 200, Carson City, NV 89706.
 - d. The invoice must show the total number of services by CPT or HCPCS code, the rate being charged, the total amount charged to that CPT or HCPCS code line and summarize the totals by level of care.
 - e. The invoice must also show the total number of services provided, the total number of unique clients served for the invoice and the total amount charged to the invoice.
 - f. The invoice must be signed and dated by the organizations fiscal officer and include the following certification, "By submitting this invoice, we certify that all billing is correct and no Medicaid or other insurance eligible services have been charged to this invoice."

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PREVENTION SERVICES

Applicability

This section is only applicable to primary prevention coalitions and programs.

1. The subrecipient will implement the Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework Planning Process.
2. If the subrecipient is a certified prevention coalition, it will solicit representatives from local substance abuse prevention programs and treatment providers to become coalition members and assist with efforts to implement the CSAP's Strategic Prevention Framework Planning Process.
3. The subrecipient representatives are required to attend prevention training listed below as applicable to provide prevention services:
 - a. All fulltime staff must annually complete a minimum of twenty (20) hours of prevention training.
 - b. All part-time staff must annually complete a minimum for ten (10) hours of prevention training.
 - c. Participate in the implementation of evidence-based prevention programs, strategies, policies, and practices, and use the Prevention Program Operating and Access Standards as the basis for program, workforce, and agency development.

REQUESTS FOR REIMBURSEMENTS (All non-fee-for-service subawards):

1. A Request for Reimbursement is due, at a minimum, on a monthly basis, based on the terms of the sub-grant agreement, no later than the 15th of the month. If there has been no fiscal activity in a given month, a Request for Reimbursement claiming zero dollars is required to be submitted for the month.
2. Reimbursement is based on actual expenditures incurred during the period being reported.
3. Requests for advance of payment will not be considered or allowed by the Division.
4. Reimbursement must be submitted with all Division required supporting back up documentation. The Division has the authority to ask for additional supporting documentation at any time and the information must be provided to Division staff within 10 business days of the request.
5. Payment will not be processed without all programmatic reporting being current.
6. Reimbursement may only be claimed for allowable expenditures approved within the sub-grant award.
7. The subrecipient is required to submit a complete financial accounting of all expenditures to the Division within 30 days of the **CLOSE OF THE SUBAWARD PERIOD**. All remaining balances of a federally funded sub-grant revert back to the Division 30 days after the close of the subaward period.
8. The Request for Reimbursement to close the State Fiscal Year (SFY) is due at a minimum of 25 days after the close of the SFY which occurs on June 30. All remaining balances of the State funded subawards revert back to the State after the close of the SFY.
9. The subrecipient must retain copies of approved travel requests and claims, consultant invoices, payroll register indicating title, receipts for goods purchased, and any other relevant source documentation in support of reimbursement requests for a period of three years from the date of submission of the State's final financial expenditure report submitted to the governing federal agency.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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The subrecipient agrees that any failure to meet any of the conditions listed within the above Program Requirements may result in the withholding of reimbursement for payment, termination of current contract and/or the disqualification of future funding.

Signature:

District Health Officer

January 25, 2018

Authorized Subrecipient's Official Signature & Title

Date

DD__AH_	__
DHO	<u>KD</u>
DA	_____
Risk	_____

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health

FROM: Nancy Kerns Cummins, Fiscal Compliance Officer
775-328-2419; nkcummins@washoecounty.us

SUBJECT: Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through December 31, 2018 in the total amount of \$72,449 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Surveillance Program IO# 10012 and authorize the District Health Officer to execute the Subgrant Award.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute other agreements on the Board of Health's behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

The Community and Clinical Health Services Division received a Notice of Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health on December 27, 2017 to support the HIV Surveillance Program. The funding period is retroactive to January 1, 2018 and extends through December 31, 2018. A copy of the Notice of Subgrant Award is attached.

Health District Strategic Priorities supported by this item:

Healthy Lives: Improve the health of our community by empowering individuals to live healthier lives.

Financial Stability: Enable the Health District to make long-term commitments in areas that will positively impact the community's health by growing reliable sources of income.

PREVIOUS ACTION

On April 27, 2017 the Board approved a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health, retroactive to January 1 through December 31, 2017, for \$65,990 in support of the HIV Surveillance Program.

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: HIV Surveillance Program

Scope of the Project: The Subgrant scope of work includes the following: identify and report persons with HIV; conduct death ascertainment; conduct intrastate de-duplication of HIV cases; participate in routine interstate duplication review of HIV cases; conduct risk factor ascertainment; assess data quality.

The Subgrant provides funding for personnel, staff local travel and indirect expenses.

Benefit to Washoe County Residents: This Award supports the 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.

On-Going Program Support: The Health District anticipates receiving continuous funding to support the HIV Surveillance Program.

Award Amount: \$72,449 (\$65,863 direct; \$6,586 indirect)

Grant Period: January 1, 2018 – December 31, 2018

Funding Source: Centers for Disease Control and Prevention (CDC)

Pass Through Entity: State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health

CFDA Number: 93.940

Grant ID Number: 1 NU62PS924579-01 / HD#16357

Match Amount and Type: No match required.

Sub-Awards and Contracts: No Sub-Awards are anticipated.

FISCAL IMPACT

The District anticipated this award and included \$60,265 in expenditures in the adopted FY18 budget in internal order #10012. This award is slightly higher than anticipated. As such, a budget amendment in the amount of \$5,598.00 is necessary to bring the Notice of Subgrant Award into alignment with the adopted budget

Should the Board approve this Subgrant Award, the adopted FY18 budget will need to be amended as follows:

<u>Account Number</u>	<u>Description</u>	<u>Amount of Increase/(Decrease)</u>
2002-IO-10012 -431100	Federal Revenue	\$ 5,598.00
-701412	Salary Adjustment	\$ 5,395.00
-710512	Auto Expense	\$ 203.00

Subject: Approve HIV Surveillance Subgrant

Date: January 25, 2018

Page 3 of 3

RECOMMENDATION

Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through December 31, 2018 in the total amount of \$72,449 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Surveillance Program IO# 10012 and authorize the District Health Officer to execute the Subgrant Award.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "move to approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through December 31, 2018 in the total amount of \$72,449 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Surveillance Program IO# 10012 and authorize the District Health Officer to execute the Subgrant Award."



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

State of Nevada
Department of Health and Human Services

Division of Public & Behavioral Health
(hereinafter referred to as the Division)

HD #: 16357
Budget Account: 3219
Category: 18
GL: 8516
Job Number: _____

NOTICE OF SUBGRANT AWARD

Program Name: HIV/AIDS and Surveillance Program Nevada Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology	Subgrantee Name: Washoe County Health District (WCHD)
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	Address: P.O. Box 11130 Reno, NV 89520
Subgrant Period: January 1, 2018 through December 31, 2018	Subgrantee's: EIN: <u>88-6000138</u> Vendor #: <u>T40283400Q</u> Dun & Bradstreet: <u>073786998</u>

Purpose of Award: To conduct HIV/AIDS Surveillance activities in Washoe County, Nevada.

Region(s) to be served: Statewide Specific county or counties: Washoe County

Approved Budget Categories:	Disbursement of funds will be as follows:																								
<table> <tr><td>1. Personnel</td><td>\$</td><td><u>65,660</u></td></tr> <tr><td>2. Travel</td><td>\$</td><td><u>203</u></td></tr> <tr><td>3. Equipment</td><td>\$</td><td>_____</td></tr> <tr><td>4. Contractual</td><td>\$</td><td>_____</td></tr> <tr><td>5. Supplies</td><td>\$</td><td>_____</td></tr> <tr><td>6. Other</td><td>\$</td><td>_____</td></tr> <tr><td>7. Indirect/Admin</td><td>\$</td><td><u>6,586</u></td></tr> <tr><td>Total Cost:</td><td>\$</td><td><u>72,449</u></td></tr> </table>	1. Personnel	\$	<u>65,660</u>	2. Travel	\$	<u>203</u>	3. Equipment	\$	_____	4. Contractual	\$	_____	5. Supplies	\$	_____	6. Other	\$	_____	7. Indirect/Admin	\$	<u>6,586</u>	Total Cost:	\$	<u>72,449</u>	<p>Payment will be made upon receipt and acceptance of an invoice and supporting documentation specifically requesting reimbursement for actual expenditures <i>specific to this subgrant</i>. Total reimbursement will not exceed \$72,449.00 during the subgrant period.</p>
1. Personnel	\$	<u>65,660</u>																							
2. Travel	\$	<u>203</u>																							
3. Equipment	\$	_____																							
4. Contractual	\$	_____																							
5. Supplies	\$	_____																							
6. Other	\$	_____																							
7. Indirect/Admin	\$	<u>6,586</u>																							
Total Cost:	\$	<u>72,449</u>																							

Source of Funds:	% Funds:	CFDA:	FAIN:	Federal Grant #:
1. Centers for Disease Control and Prevention	100%	93.940	U62PS924579-01	1 NU62PS924579-01

Terms and Conditions:
In accepting these grant funds, it is understood that:

- Expenditures must comply with appropriate state and/or federal regulations;
- This award is subject to the availability of appropriate funds; and
- The recipient of these funds agrees to stipulations listed in the incorporated documents.

Incorporated Documents:

Section A: Assurances;
Section B: Description of Services, Scope of Work and Deliverables;
Section C: Budget and Financial Reporting Requirements;
Section D: Request for Reimbursement;
Section E: Audit Information Request; and
Section F: DPBH Business Associate Addendum

Kevin Dick, District Health Officer Washoe County Health District	Signature	Date
Julia Peek, MHA, CPM Deputy Administrator, Community Services		
for Amy Roukie, MBA Administrator, Division of Public & Behavioral Health		

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

Assurances

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

1. 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.
2. To submit reimbursement requests only for expenditures approved in the spending plan. Any additional expenditure beyond what is allowable based on approved categorical budget amounts, without prior written approval by the Division, may result in denial of reimbursement.
3. Approval of subgrant budget by the Division 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 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 (ASO) of the Division. Records may be destroyed by the Subgrantee five (5) calendar years after the final financial and narrative reports have been submitted to the Division.
 - 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. To disclose any existing or potential conflicts of interest relative to the performance of services resulting from this subgrant award. The Division reserves the right to disqualify any subgrantee 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. 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. To comply with the Americans with Disability Act of 1990, P.L. 101-136, 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 C.F.R. 26.101-36.999 inclusive and any relevant program-specific regulations
8. To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 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 (PHI) then the subgrantee agrees to enter into a Business Associate Agreement with the Division as required by 45 C.F.R. 164.504(e). If PHI will not be disclosed then a Confidentiality Agreement will be entered into.
9. Subgrantee certifies, by signing this notice of subgrant award, 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. pr. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Register (pp. 19150-19211). This provision shall be required of every subgrantee receiving any payment in whole or in part from federal funds.

10. Sub-grantee agrees to comply with the requirements of the Title XII Public Law 103-227, the "PRO-KIDS Act of 1994," smoking may not be permitted in any portion of any indoor facility owned or regularly used for the provision of health, day care, education, or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans and loan guarantees, and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.
11. 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.
12. Division subgrants are subject to inspection and audit by representative of the Division, 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.
13. 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, as well as federal requirement as specified in the Office of Management and Budget (2 CFR § 200.501(a)), revised December 26, 2013, that each grantee annually expending \$750,000 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:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

This copy of the final audit must be sent to the Division within nine (9) months of the close of the subgrantee's fiscal year. **To acknowledge this requirement, Section E of this notice of subgrant award must be completed.**

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION B

Description of Services, Scope of Work and Deliverables

Washoe County Health District (WCHD), hereinafter referred to as Subgrantee, agrees to provide the following services and reports according to the identified timeframes:

Scope of Work for Washoe County Health District

Goal 1: Conduct Case Ascertainment

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. Conduct active HIV surveillance and review 100% of reported or confirmed HIV cases; complete data entry within 90 days of report.	1.1 HIV investigation staff will complete in-person or medical record review for 100% of reported or confirmed HIV cases to obtain minimum information required. Case reports, laboratory results, and other updated case information will be entered into eHARS database, including CD4 counts, viral loads, and mode of exposure within 90 days of being reported.	December 31, 2018	Adult Case Report Forms, electronic HIV/AIDS Reporting System (eHARS) data
2. Assess and maintain contact with facilities/providers to ensure reporting, timely reporting (within 6 months of diagnosis), complete reporting of HIV cases, and promoting HIV awareness. a) ≥95% of the expected number of cases for a diagnosis year are reported. b) ≥90% of the expected number of cases for a diagnosis year are reported within six months following diagnosis.	2.1 Assess facilities/providers who reported HIV cases and evaluate timeliness (reporting within 6 months of diagnosis) and completeness of reporting. Identify providers/facilities who do not report timely and/or completely and educate on HIV reporting responsibilities, HIV education, referral and information. 2.2 Maintain contact with local hospitals and healthcare providers to ensure reporting of new cases and promoting awareness. 2.3 HIV Surveillance will ensure that providers/facilities/laboratories are reporting all cases and labs required by law and within six months of diagnosis through established routine quality and assurance activities.	December 31, 2018	eHARS data

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Goal 2: Conduct Death Ascertainment

Objective	Activities	Due Date	Documentation Needed
<p>1. Conduct matches and evaluation with local death files to update eHARS and identify unreported cases of HIV infection.</p>	<p>1.1 The local HIV surveillance programs will obtain reports at least quarterly from the local coroners to identify potential death matches, HIV/AIDS surveillance staff confirm the match, and death information (e.g., date of death and cause of death) is imported/entered into eHARS.</p> <p>1.2 If unreported cases of HIV infection are found during routine death matching, conduct appropriate follow-up and data entry into eHARS.</p>	December 31, 2018	eHARS data
<p>2. ≥85% of the deaths that occurred in 2016 have an underlying cause of death by December 31, 2018.</p>	<p>2.1 Using local death files, collect underlying cause of deaths for cases in eHARS that have a death date in 2016 and missing underlying cause of death and enter into eHARS.</p>	December 31, 2018	eHARS data

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Goal 3: Collect HIV Laboratory Reports and Case Information

Objective	Activities	Due Date	Documentation Needed
<p>1. Ensure laboratory and/or provider reporting of HIV testing, CD4 counts, viral loads, opportunistic infections, etc. and conduct data entry into eHARS. For newly diagnosed HIV infections in 2018:</p> <ul style="list-style-type: none"> a) ≥85% of cases have a CD4 test result based on a specimen collected within one month following HIV diagnosis. b) ≥85% of cases have a viral load test result based on a specimen collected within one month following HIV diagnosis. c) ≥85% of all labs are loaded in the surveillance system within two months of the specimen collection date. d) ≥60% of cases have an analyzable nucleotide sequence. e) ≥70% of cases have a known value for previous negative HIV test. f) ≥70% of cases have prior antiretroviral use history. g) ≥50% of cases with a previous negative HIV test have a valid date of documented negative test result. h) ≥90% of HIV cases are able to be geocoded to the census tract level. 	<ul style="list-style-type: none"> 1.1. Enter laboratory data into eHARS via Nevada’s Electronic Review Database (NERDS) or hand enter within 30 days of receipt of laboratory report. 1.2 HIV Surveillance Programs will use NERDS to review and process incoming electronic laboratory messages. This includes using NERDS to manage incoming labs that reflect negatives/undetectable levels to track Stage 0. 1.3 Monitor laboratory reporting to ensure HIV testing, CD4 counts, viral loads, and opportunistic infections are reported and entered into eHARS. 1.4 Enter case reports, laboratory results, and other updated case information into the eHARS database, including required information as outlined in Objective 1a-h. 1.5 Follow up with providers or labs who may not be reporting all HIV labs per Nevada law or for missing information as outlined in Objective 1a-h. 	<p>December 31, 2018</p>	<p>eHARS data/NERDS data</p>

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Goal 4: Assess Data Quality

Objective	Activities	Due Date	Documentation Needed
<p>1. ≥97% of cases that meet the surveillance case definition for HIV infection in 2018 will have no required fields missing and pass all standard data edit checks (i.e. Person View Status Flag is “A – Active” or “W – Warning”).</p>	<p>1.1 Review all newly diagnosed or reported cases at the end of each month to check for ongoing cases with Person View status of ‘E- Error’, ‘R- Required field missing’, or ‘W-Warning’ and determine the reason for errors of missing fields and correct issues.</p> <p>1.2 Review records that do not meet the HIV surveillance case definition but have at least one laboratory that is indicative of HIV at the end of each month (such records should be prioritized for epi follow-up).</p>	<p>December 31, 2018</p>	<p>eHARS data</p>

Goal 5: Conduct Risk Factor Ascertainment & Investigation

Objective	Activities	Due Date	Documentation Needed
<p>1. ≥80% of HIV cases reported will have sufficient HIV risk factor information to be classified into a known transmission category.</p>	<p>1.1 Enter investigation transmission information into eHARS for HIV cases.</p> <p>1.2 Complete risk factor analysis in eHARS to monitor epidemic trends and target prevention interventions.</p> <p>1.3 Investigate HIV/AIDS cases that present with rare or previously unidentified modes of transmission identified (e.g., transfusion and transplant related cases, healthcare or occupational exposures, HIV-2 infections, female-to female sexual contact, potentially unusual HIV strains and clinical cases with HIV infection but negative HIV tests).</p> <p>1.4 Conduct pediatric exposure and infection surveillance (e.g., collect information on maternal HIV test history, prenatal and neonatal antiretroviral therapy, etc.).</p> <p>1.5 Follow-up investigations of cases/populations of special epidemiological significance (e.g., corrections, heterosexual contact).</p>	<p>December 31, 2018</p>	<p>eHARS data</p>
<p>2. Investigate and report all Cases of Public Health Importance (COPHI).</p>	<p>2.1 Investigate cases reported with a rare or unusual risk factor for HIV infection (e.g. occupational exposure, a human bite or tattoo, blood transfusion, or transplant recipient). Should be first priority for follow-up. A “Risk Assessment Form for HIV/AIDS Cases Reported with No Identified Risk Factor” will be completed.</p> <p>2.2 After determination that the COPHI criteria have been met, the HIV/AIDS Surveillance Program will report all COPHI cases to DPBH.</p>	<p>December 31, 2018</p>	<p>eHARS data/COPHI Case Files</p>

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Goal 6: Participate in Intrastate/Interstate De-Duplication of HIV Cases

Objective	Activities	Due Date	Documentation Needed
<p>1.a ≤1% of Intrastate duplicate cases have duplicate case reports. 1.b ≤2% of Routine Interstate Duplicate Review (RIDR) pairs from Interstate duplicates remain unresolved at the end of each six month RIDR cycle.</p>	<p>1.1 Use the eHARS canned intrastate program duplicate review report and homegrown SAS, perform exact and 'fuzzy matches' monthly and resolve identified duplicates. 1.2 Conduct an interstate and intrastate duplicate review prior to entering a new case into eHARS to reduce the number of duplicates in Nevada's eHARS system. 1.3 Duplicates identified by state and local surveillance staff during routine surveillance activities will be provided to the State HIV/AIDS Surveillance Program and the cases will be merged in eHARS to resolve the duplication within 30 days of receipt. 1.4 Engage in interstate communication with amenable states using CDC's/CSTE's surveillance contact list and exchange HIV/AIDS case information, such as residency assignment and conversion status. Update health status information in the eHARS system on out-of- jurisdiction cases receiving care or testing in Nevada. 1.5 Respond to eHARS record searches from other states.</p>	December 31, 2018	eHARS data

Goal 7: Collaborate with the HIV Prevention Program

Objective	Activities	Due Date	Documentation Needed
<p>1. Data-to-Care (D2C) activities established and conducted at least annually.</p>	<p>1.1 In accordance with Nevada Law and Statutes (NRS and NAC), identify HIV-diagnosed individuals who are potentially not receiving HIV medical care (or any other prioritized groups such as persons not virally suppressed), and create list(s) of HIV-positive individuals potentially not in care for follow-up. 1.2 Determine the number of persons identified HIV-diagnosed who are potentially not receiving HIV medical care (Not In Care or NIC) in 2018.</p>	December 31, 2018	eHARS data. Qualitative descriptions of successes and challenges with conducting activities.
<p>2. HIV Surveillance data is used to assist and measure HIV prevention-surveillance activities.</p>	<p>2.1 Work with prevention partners for data matching and providing program monitoring/evaluation using HIV Surveillance data.</p>	December 31, 2018	Data or statistics as requested.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Goal 8: Develop Perinatal HIV Exposure Reporting (PHER)

Objective	Activities	Due Date	Documentation Needed
1. Conduct perinatal HIV surveillance activities. ≥85% of HIV-exposed infants for a birth year have HIV infection status determined by 18 months of age.	<p>1.1 Develop and implement standard operating procedures for identifying and conducting follow-up of perinatally HIV-exposed infants according to CDC guidance (Perinatal HIV Exposure Reporting (PHER)).</p> <p>1.2 Case surveillance completed for women with diagnosed HIV infection and their infants. Enter information into eHARS.</p> <p>1.3 Conduct matching of HIV-infected women reported with available birth registries, as applicable, and follow-up on perinatally HIV-exposed infants.</p>	December 31, 2018	eHARS data. Qualitative descriptions of successes and challenges with conducting activities.

Goal 9: Plan and Respond to HIV transmission Clusters and Outbreaks

Objective	Activities	Due Date	Documentation Needed
1. Identify and investigate HIV transmission clusters and outbreaks.	<p>1.1 Analyze HIV surveillance data at least monthly to identify HIV transmission clusters and outbreaks and submit analysis and investigation results as requested.</p> <p>1.2 Clusters are identified via surveillance (data analyzed/monitored at least monthly) and molecular data.</p> <p>1.3 Incorporate molecular cluster analysis per CDC recommendations and guidance. Clusters or outbreak investigation and analyses may be submitted to CDC if requested.</p>	December 31, 2018	eHARS data. Molecular data protocol.
2. Rapidly respond to and intervene in HIV transmission clusters and outbreaks	2.1 Develop and maintain a jurisdiction-wide cluster and outbreak detection and response plan. May incorporate elements based on the CDC national model of potential outbreak zones in the State of Nevada.	December 31, 2018	Outbreak Response Plan.

Goal 10: Ensure Data Security and Confidentiality

Objective	Activities	Due Date	Documentation Needed
1. The HIV/AIDS Surveillance Program will complete the confidentiality and security training with all surveillance staff, IT department staff that have access to computers/servers containing HIV data, and all staff located within the office where the HIV/AIDS Surveillance Program is located. Full compliance with Data Security and Confidentiality Guidelines.	<p>1.1 Provide the online HIV/AIDS confidentiality training and written guidelines to all applicable personnel and document this annual training for each employee by collecting from them and including completion certificate in his or her personnel file.</p> <p>1.2 Designate a Site Security Officer to oversee local HIV Surveillance Program and compliance measures.</p>	December 31, 2018	Documentation annual training was completed for all applicable staff and written attestation from local Site Security Officer all staff are up to date with training to DPBH.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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SECTION C

Budget and Financial 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 State Division of Public and Behavioral Health through Grant Number 1 NU62PS924579-01 from the 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 Division nor the CDC."

Any activities performed under this subgrant shall acknowledge the funding was provided through the Division by Grant Number 1 NU62PS924579-01 from the Centers for Disease Control and Prevention (CDC).

Subgrantee agrees to adhere to the following budget:

<u>Category</u>	<u>Total cost</u>	<u>Detailed cost</u>	<u>Details of expected expenses</u>
1. Personnel	\$ 65,660		
		\$ 65,660	0.67 FTE Public Health Nurse II @ \$98,000 (Includes fringe benefits)
2. Travel	\$ 203		
		\$ 203	Total mileage reimbursement for 380 miles of vehicular travel @ \$0.535/mile.
3. Equipment	\$		
4. Contractual	\$		
5. Supplies	\$		
6. Other	\$		
7. Indirect/Admin	\$ 6,586		
		\$ 6,586	10% of direct costs (\$65,863).
Total Cost	\$ 72,449		

- The 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. The Subgrantee must notify or obtain prior authorization (email notification is acceptable) for any funding adjustment(s).
- 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.
- The Subgrantee acknowledges that this subgrant and the continuation of this subgrant is contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State Legislature and/or federal sources. If funds become unavailable, the Division may restrict, reduce, or terminate funding under this award.
- 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).

The 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.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

- Reimbursement may be requested monthly or quarterly for expenses incurred in the implementation of the Scope of Work;
- Reimbursement will not exceed \$72,449 for the period of the subgrant; additionally, not more than 50% of the total funded amount will be reimbursed to the subgrantee during each six (6) month period (January 1, 2018 through June 30, 2018 (\$36,224.50) and July 1, 2018 through December 31, 2018 (\$36,224.50)). Full reimbursement is contingent on funding the CDC provides to Nevada which may not be fully realized until the final quarter of 2018, If a balance exists at the end of the first billing period DPBH will rollover the balance to the second billing period contingent upon approval from the DPBH;
- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred;
- Additional supporting documentation of invoices or receipts are needed in order to request reimbursement;
- 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 within 30 days of the CLOSE OF THE SUBGRANT PERIOD. Any un-obligated funds shall be returned to the Division at that time, or if not already requested, shall be deducted from the final award.

The Division agrees:

- Providing technical assistance, upon request from the Subgrantee;
- Providing prior approval of reports or documents to be developed;
- Coordinate with other state, federal, and international agencies;
- Tabulate and interpret required data and program evaluation;
- Seek Epidemiology Aide and other assistance from the Centers for Disease Control and Prevention (CDC) if needed to prevent or control a HIV outbreak in designated county(s);
- Forward any opportunities for education related to HIV Surveillance or program management;
- Forward any changes in the recommendations for the care of HIV cases from the CDC; and
- Serve as the authority responsible for ensuring necessary reports and documents are submitted to the CDC, per reporting deadlines;
- The Division 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.

Both parties agree:

Site-visit monitoring and/or audits may be conducted by the Division of Public and Behavioral Health or the Centers for Disease Control and Prevention or related staff of the Subgrantee's STD program in its entirety at any time. Program and fiscal audits shall occur annually or as needed.

The Subgrantee will, in the performance of the Scope of Work specified in this subgrant, perform functions and/or activities that could involve confidential information; therefore, the Subgrantee is requested to fill out and sign Section F, which is specific to this subgrant, and will be in effect for the term of this subgrant.

All reports of expenditures and requests for reimbursement processed by the Division 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 Division, state, and/or federal funding ability to satisfy this Agreement is withdrawn, limited, or impaired.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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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 30 days after the end of the reporting month or quarter. However, in order to meet fiscal year end reimbursement requirements, the June (or 2nd Quarter of calendar year) Request for Reimbursement must be submitted by no later than the 15th of July.
- 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.

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SECTION D

Request for Reimbursement

HD #: 16357
Budget Account: 3219
GL: 8516
Draw #: _____

Program Name: HIV/AIDS and Surveillance Program Nevada Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology	Subgrantee Name: Washoe County Health District (WCHD)
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	Address: P.O. Box 11130 Reno, NV 89520
Subgrant Period: January 1, 2018 through December 31, 2018	Subgrantee's: EIN: 88-6000138 Vendor #: T40283400Q

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	\$65,660.00	\$0.00	\$0.00	\$0.00	\$65,660.00	0.0%
2. Travel	\$203.00	\$0.00	\$0.00	\$0.00	\$203.00	0.0%
3. Equipment	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
4. Contractual	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
5. Supplies	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
6. Other	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
7. Indirect/Admin	\$6,586.00	\$0.00	\$0.00	\$0.00	\$6,586.00	0.0%
Total	\$72,449.00	\$0.00	\$0.00	\$0.00	\$72,449.00	0.0%

This report is true and correct to the best of my knowledge

Authorized Signature _____	Title _____	Date _____
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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: _____

Scope of Work review/approval date: _____

ASO or Bureau Chief (as required): _____ Date _____

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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SECTION E

Audit Information Request

1. Non-Federal entities that **expend** \$750,000.00 or more in total federal awards are required to have a single or program-specific audit conducted for that year, in accordance with 2 CFR § 200.501(a). Within nine (9) months of the close of your organization's fiscal year, you **must** submit a copy of the final audit report to:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

2. Did your organization expend \$750,000 or more in all federal awards during your organization's most recent fiscal year?

YES NO

3. When does your organization's fiscal year end?

June 30th

4. What is the official name of your organization?

Washoe County Health District

5. How often is your organization audited?

annually

6. When was your last audit performed?

August 2017

7. What time-period did your last audit cover?

July 2016 - June 2017

8. Which accounting firm conducted your last audit?

Eide Bailly

Signature

Date

Administrative Health Services Officer
Title

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION F

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 agreement 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 agreement. 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 agreement 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 an agreement 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. **Agreement** shall refer to this Addendum and that particular agreement 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.

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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 statutes 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).

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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 agreement, 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 agreement 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

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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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 agreement 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 agreement 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 agreement, 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.

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- 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 Agreement.** The Business Associate agrees that the Covered Entity may immediately terminate the agreement 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:

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- 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 agreement that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the agreement 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.

THIS SPACE INTENTIONALLY LEFT BLANK

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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 4150 Technology Way, Suite 300 Carson City, NV 89706	Washoe County Health District Business Name
Phone: (775) 684-4200	1001 East Ninth St. Business Address
Fax: (775) 684-4211	Reno, NV 89512 Business City, State and Zip Code
	775-328-2410 Business Phone Number
	775-328-3752 Business Fax Number
_____ Authorized Signature	_____ Authorized Signature
for Amy Roukie, MBA _____ Print Name	Kevin Dick _____ Print Name
Administrator, Division of Public and Behavioral Health _____ Title	District Health Officer Washoe County Health District _____ Title
_____ Date	1/25/2018 _____ Date

DD	AH	—
DHO		AD —
DA		—
Risk		—

Staff Report
Board Meeting Date: January 25, 2018

TO: District Board of Health

FROM: Nancy Kerns Cummins, Fiscal Compliance Officer, Washoe County Health District
775-328-2419, nkcummins@washoecounty.us

SUBJECT: Approve a Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in the total amount of \$109,099 (no required match) retroactive to January 1, 2018 through December 31, 2018 in support of the Community and Clinical Health Services Division (CCHS) Tuberculosis Prevention and Control Program, IO# 10016 and authorize the District Health Officer to execute the Notice of Subgrant Award.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute other agreements on the Board of Health's behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

The Community and Clinical Health Services Division received a Notice of Subgrant Award from the State of Nevada on December 28, 2017 to support the Tuberculosis Prevention and Control Program. The funding period is retroactive to January 1, 2018 and extends through December 31, 2018. A copy of the Notice of Subgrant award is attached.

District Health Strategic Objective supported by this item:

Healthy Lives: Improve the health of our community by empowering individuals to live healthier lives.

Financial Stability: Enable the Health District to make long-term commitments in areas that will positively impact the community's health by growing reliable sources of income.

PREVIOUS ACTION

The Board of Health approved the Notice of Subgrant Award for calendar year 2017 in the amount of \$109,098 on April 27, 2017.

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: Tuberculosis Prevention and Control Program

Scope of the Project: The Subgrant scope of work includes the following: Tuberculosis (TB) evaluation, treatment and case management activities; TB surveillance, data collection and reporting; TB outreach and education to providers, organizations and communities in Nevada; participate in evaluation and human resource development activities; conduct an annual cohort review

of confirmed TB cases; adhere to all Nevada regulatory and Centers for Disease Control and Prevention recommended policies and protocols.

The Subgrant provides funding for personnel, travel and training, lab/outpatient testing, operating expenses including housing and funding specifically for program participation via the use of incentives/enablers (including but not limited to, gift cards/gift certificates, transportation and food vouchers, educational outreach items, nutritious food and beverage, etc.) and indirect expenditures.

Benefit to Washoe County Residents: This Award supports the prevention and control of tuberculosis as stated in the Nevada Administrative Code (NAC).

On-Going Program Support: The Health District anticipates receiving continuous funding to support the Tuberculosis Program.

Award Amount: \$109,099 (includes \$13,816 indirect)

Grant Period: January 1, 2018 – December 31, 2018

Funding Source: Centers for Disease Control and Prevention (CDC)

Pass Through Entity: State of Nevada, Department of Health and Human Services
Division of Public & Behavioral Health

CFDA Number: 93.116

Grant ID Number: 5 NU52PS004681-04-00 / HD #16362

Match Amount and Type: No match required

Sub-Awards and Contracts: No Sub-Awards are anticipated.

FISCAL IMPACT

There is no additional fiscal impact should the Board approve the Notice of Subgrant Award. The FY18 budget in Internal Order# 10016 was adopted with \$95,284 in expenditure authority; therefore, no budget amendment is necessary.

RECOMMENDATION

It is recommended that the Washoe County Health District approve a Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in the total amount of \$109,099 (no required match) retroactive to January 1, 2018 through December 31, 2018 in support of the Community and Clinical Health Services Division (CCHS) Tuberculosis Prevention and Control Program, IO# 10016 and authorize the District Health Officer to execute the Notice of Subgrant Award.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be: "Move to approve a Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in the total amount of \$109,099 (no required match) retroactive to January 1, 2018 through December 31, 2018 in support of the Community and Clinical Health Services Division (CCHS) Tuberculosis Prevention and Control Program, IO# 10016 and authorize the District Health Officer to execute the Notice of Subgrant Award."



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD
 State of Nevada
 Department of Health and Human Services
Division of Public & Behavioral Health
 (hereinafter referred to as the Division)

HD #: 16362
 Budget Account: 3219
 Category: 14
 GL: 8516
 Job Number: 9311618

NOTICE OF SUBGRANT AWARD

Program Name: Tuberculosis Prevention and Control Program Office of Public Health Informatics and Epidemiology Nevada Division of Public and Behavioral Health		Subgrantee Name: Washoe County Health District (WCHD)																								
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009		Address: PO Box 11130 Reno, NV 89520																								
Subgrant Period: January 1, 2018 through December 31, 2018		Subgrantee's: EIN: <u>88-6000138</u> Vendor #: <u>T40283400Q</u> Dun & Bradstreet: <u>073786998</u>																								
Purpose of Award: To fund activities for the prevention and control of <i>M. tuberculosis</i> as stated in the Nevada Administrative Code (NAC 441A) and Nevada Revised Statutes (NRS 441A).																										
Region(s) to be served: <input type="checkbox"/> Statewide <input checked="" type="checkbox"/> Specific county or counties: <u>Washoe County</u>																										
Approved Budget Categories:		Disbursement of funds will be as follows:																								
<table style="width: 100%; border-collapse: collapse;"> <tr><td>1. Personnel</td><td style="text-align: right;">\$</td><td style="text-align: right;"><u>80,301</u></td></tr> <tr><td>2. Travel</td><td style="text-align: right;">\$</td><td style="text-align: right;"><u>4,562</u></td></tr> <tr><td>3. Operating</td><td style="text-align: right;">\$</td><td style="text-align: right;"><u>9,920</u></td></tr> <tr><td>4. Equipment</td><td style="text-align: right;">\$</td><td style="text-align: right;">_____</td></tr> <tr><td>5. Contractual/Consultant</td><td style="text-align: right;">\$</td><td style="text-align: right;">_____</td></tr> <tr><td>6. Other</td><td style="text-align: right;">\$</td><td style="text-align: right;"><u>500</u></td></tr> <tr><td>7. Indirect</td><td style="text-align: right;">\$</td><td style="text-align: right;"><u>13,816</u></td></tr> <tr><td>Total Cost:</td><td style="text-align: right;">\$</td><td style="text-align: right;"><u>109,099</u></td></tr> </table>	1. Personnel	\$	<u>80,301</u>	2. Travel	\$	<u>4,562</u>	3. Operating	\$	<u>9,920</u>	4. Equipment	\$	_____	5. Contractual/Consultant	\$	_____	6. Other	\$	<u>500</u>	7. Indirect	\$	<u>13,816</u>	Total Cost:	\$	<u>109,099</u>	Payment will be made upon receipt and acceptance of an invoice and supporting documentation specifically requesting reimbursement for actual expenditures <i>specific to this subgrant</i> . Total reimbursement will not exceed \$109,099.00 during the subgrant period.	
1. Personnel	\$	<u>80,301</u>																								
2. Travel	\$	<u>4,562</u>																								
3. Operating	\$	<u>9,920</u>																								
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Total Cost:	\$	<u>109,099</u>																								
Source of Funds:		% Funds:	CFDA:	FAIN:	Federal Grant #:																					
1. Centers for Disease Control and Prevention		100%	93.116	U52PS004681-04	5 NU52PS004681-04-00																					
Terms and Conditions: In accepting these grant funds, it is understood that:																										
<ol style="list-style-type: none"> 1. Expenditures must comply with appropriate state and/or federal regulations; 2. This award is subject to the availability of appropriate funds; and 3. The recipient of these funds agrees to stipulations listed in the incorporated documents. 																										
Incorporated Documents:																										
Section A: Assurances; Section B: Description of Services, Scope of Work and Deliverables; Section C: Budget and Financial Reporting Requirements; Section D: Request for Reimbursement; Section E: Audit Information Request; and Section F: DPBH Business Associate Addendum																										
Kevin Dick, Washoe County District Health Officer	Signature				Date																					
Julia Peek, MHA, CPM Deputy Administrator, Community Services, DPBH																										
for Amy Roukie, MBA Administrator, Division of Public & Behavioral Health																										

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION A

Assurances

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

1. 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.
2. To submit reimbursement requests only for expenditures approved in the spending plan. Any additional expenditure beyond what is allowable based on approved categorical budget amounts, without prior written approval by the Division, may result in denial of reimbursement.
3. Approval of subgrant budget by the Division 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 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 (ASO) of the Division. Records may be destroyed by the Subgrantee five (5) calendar years after the final financial and narrative reports have been submitted to the Division.
 - 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. To disclose any existing or potential conflicts of interest relative to the performance of services resulting from this subgrant award. The Division reserves the right to disqualify any subgrantee 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. 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. To comply with the Americans with Disability Act of 1990, P.L. 101-136, 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 C.F.R. 26.101-36.999 inclusive and any relevant program-specific regulations
8. To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 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 (PHI) then the subgrantee agrees to enter into a Business Associate Agreement with the Division as required by 45 C.F.R. 164.504(e). If PHI will not be disclosed then a Confidentiality Agreement will be entered into.
9. Subgrantee certifies, by signing this notice of subgrant award, 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

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Order 12549, Debarment and Suspension, 28 C.F.R. pr. 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. Sub-grantee agrees to comply with the requirements of the Title XII Public Law 103-227, the "PRO-KIDS Act of 1994," smoking may not be permitted in any portion of any indoor facility owned or regularly used for the provision of health, day care, education, or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans and loan guarantees, and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.
11. 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.
12. Division subgrants are subject to inspection and audit by representative of the Division, 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.
13. 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, as well as federal requirement as specified in the Office of Management and Budget (2 CFR § 200.501(a)), revised December 26, 2013, that each grantee annually expending \$750,000 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:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

This copy of the final audit must be sent to the Division within nine (9) months of the close of the subgrantee's fiscal year. **To acknowledge this requirement, Section E of this notice of subgrant award must be completed.**

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION B

Description of Services, Scope of Work and Deliverables

These funds will be utilized in accordance with the mission of the Nevada State Tuberculosis Prevention and Control Program, which is to promote and protect the well-being of Nevadans and visitors to our state by preventing, controlling, tracking and ultimately eliminating tuberculosis (TB) by providing services to control and eliminate tuberculosis, including rapid identification and diagnosis of the disease, timely contact investigations and completion of treatment.

Washoe County Health District (WCHD), hereinafter referred to as Subgrantee, agrees to provide the following services and reports according to the identified timeframes:

Scope of Work for Washoe County Health District

Goal 1: Provide TB Evaluation/Testing, and Case Management

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. Conduct TB evaluation/testing	<p>1. The Subgrantee will conduct TB testing/evaluation for active TB cases, suspected cases of tuberculosis and high-risk contacts including Latent Tuberculosis Infection (LTBI) cases in children under the age of five.</p> <p>a. Additional or targeted TB testing, physical evaluation and other diagnostic TB tests should be focused on individuals who are at a higher-risk of obtaining LTBI/TB disease. This may include the following populations: homeless, refugee/immigrant, corrections, pediatrics, substance abuse users. This funding source should not be used for TB testing for individuals in the general public, or employees of healthcare or correctional facilities.</p> <p>b. The Subgrantee may provide incentives or enablers with the intent that they help patients (for both TB disease and LTBI) and contacts more readily complete appropriate testing, therapy and/or adhere to treatment. The incentives and enablers are defined as, but not limited to, transportation, gasoline, food vouchers, personal items, telephone calling cards, housing and utility assistance, and patient centered behavioral reinforcement items.</p>	1a-b. Continuous/ Ongoing	1a-b. Case files and demographic, investigation, or testing data, as requested
2. Conduct case management activities	<p>2. Case management activities should occur for all LTBI, suspect/active TB disease cases as well as for all LTBI under age five cases.</p>	2. Continuous/ Ongoing	2. Case files and demographic, investigation or treatment data, as requested

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Goal 2: Provide Treatment and Case Management

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
<p>1. Conduct TB treatment and related case management, when needed</p>	<p>1. The subgrantee will coordinate case management activities for active TB cases, suspected cases of tuberculosis, high-risk contacts, and LTBI in children under the age of five, by regular reporting; investigating; assurance of patient adherence to medication regimen; legal referral for non-adherence; and home visits for assessment, provision of Direct Observed Therapy (DOT), and the monitoring of treatment regimes.</p> <p>a. The Subgrantee may provide incentives or enablers with the intent that they help patients (for both TB disease and LTBI) and contacts more readily complete appropriate testing, therapy and/or adhere to treatment. The incentives and enablers are defined as, but not limited to, transportation, gasoline, food vouchers, personal items, telephone calling cards, housing and utility assistance, and patient centered behavioral reinforcement items.</p> <p>b. This funding source should not be used for TB testing for individuals in the general public, or employees of healthcare or correctional facilities.</p>	<p>1a-b. Continuous/ Ongoing</p>	<p>1a-b. Case files and demographic, investigation or treatment data, as requested</p>

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Goal 3: Conduct TB Surveillance

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
<p>1. Conduct TB surveillance which includes the regular monitoring of, maintaining case files and records, and conducting contact/source-case investigations for suspect, active and LTBI cases, as needed.</p>	<p>1. The Subgrantee will conduct TB Surveillance by performing the following activities:</p> <ul style="list-style-type: none"> a. Will conduct TB surveillance for epidemiological trends. b. Will maintain case files, contact/source-case investigation and other records that are necessary for the planning, implementation and evaluation of the program; upon request allow the Nevada Division of Public and Behavioral Health (DPBH) TB Program personnel to observe clinics, to communicate directly with the staff and, to have access to all information, data and records pertinent to the Tuberculosis Prevention and Control Program. c. Will notify Nevada's Division of Public and Behavioral Health TB Program within 24 hours of large-scale contact investigations and confirmed TB outbreaks occurring within Nevada. During a declared outbreak of TB, Subgrantee will provide case and contact records on demand and will provide written status reports every thirty (30) days to the Nevada DPBH TB Program personnel, until such personnel declare the outbreak to have ceased. In the event the Subgrantee is unable to provide an electronic version, a hardcopy version may be accepted with prior verbal authorization. 	<p>1a-1b. Continuous/Ongoing</p> <p>1c. Within 30 days of confirmed outbreak</p>	<p>1a-1b. Case files and demographic, investigation or treatment data, as requested. Electronic Disease Notification (EDN) and National Electronic Disease Surveillance System (NEDSS) Base System (NBS) reports</p> <p>1c. Outbreak Reports</p>

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

<p>2. Conduct TB surveillance which includes the regular monitoring of the Center for Disease Control and Prevention's (CDC) EDN (Electronic Disease Notification) system and performing timely and complete data entry activities in the National Base Systems (NBS) for all reportable TB and LTBI cases</p>	<p>2. The Subgrantee will conduct TB Surveillance by performing the following activities:</p> <p>a. Will initiate timely checking and response to EDN alerts regarding immigrants and refugees (Class A/B cases).</p> <ul style="list-style-type: none"> • Staff will have taken an EDN training and/or reviewed the CDC's EDN Manual. • Subgrantee will follow CDC's guidance and the Nevada DPBH TB Program guidance on EDN TB Follow-up Worksheet completion activities; including the continuous updating of cases until TB Follow-up Worksheet is able to be submitted. • Subgrantee will review/update EDN cases based on quarterly EDN report sent to Subgrantee by the Nevada DPBH TB Program. <p>b. Will use the NBS case management fields for all reportable cases (active, suspect and LTBI under five), laboratory report fields and contact investigation fields.</p> <ul style="list-style-type: none"> • Staff will be trained on these databases by participating in at least one annual training, webinar/call with the Nevada DPBH TB Program and/or will have reviewed the Report of Verified Case of Tuberculosis (RVCT) and NBS Manuals. • Laboratory reports in NBS will be reviewed by Subgrantee within 1 business day and will be linked to appropriate case. • Contact Investigation fields will be completed on an ongoing basis; but at a minimum of by the end of each quarter. Subgrantees not using NBS for their contact investigation data will supply it to the Nevada DPBH TB Program via excel or a similar software, at least, quarterly. 	<p>2a: Continuous/ Ongoing</p> <p>2b: Continuous/ Ongoing</p>	<p>2a. EDN Manual, TB Follow-up Guide, and EDN Reports</p> <p>2b. NBS Reports</p>
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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Goal 4: Data Collection and Reporting

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
<p>1. Prepare and submit reports, as required.</p>	<p>1. The TB Clinic and/or surveillance/investigation program, or designated individual responsible for reporting on behalf of both programs, will prepare and submit the following:</p> <ul style="list-style-type: none"> a. A RVCT will be submitted for all Mycobacterium Tuberculosis confirmed cases identified in the county(s) designated in this notice. The RVCT form must be submitted via NBS. b. An Aggregate Report for Tuberculosis Program Evaluation (ARPE) will be submitted no later than August 1st. The ARPE is to be submitted electronically to smcelhany@health.nv.gov or other designated e-mail. The ARPE will be completed using the template provided by the Nevada DPBH TB Program. c. Annual Performance Reports will be submitted no later than August 1st. Annual Performance Reports are to be submitted electronically to smcelhany@health.nv.gov or other designated e-mail. The Annual Performance Reports will be completed using the template provided by the Nevada DPBH TB Program. • Annual Performance Reports must include the current year's Workplan along with a Workplan for the activities, goals and objectives of the following year, (template will be provided). 	<p>1a. Within 45 days of diagnosis</p> <p>1b. 08/01/2018</p> <p>1c. 08/01/2018</p>	<p>1a. RVCT</p> <p>1b. ARPE</p> <p>1c. Annual Performance Reports</p>

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Goal 5: Provide Outreach and Education

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
<p>1. To provide TB outreach and education to healthcare providers/facilities, residents of healthcare facilities, organizations and the general public or communities in Nevada.</p>	<p>1. The Subgrantee will provide TB outreach and education to the community and health care providers, as requested.</p> <p>a. These outreach and education activities could include (but are not limited to), the following populations/organizations and should focus on trainings to strengthen screening processes and staffs' recognition of symptoms of TB: detention centers, clinics and hospitals, homeless shelters, group homes, correctional facilities and immigrant/refugee programs.</p> <p>b. The Subgrantee may also be asked to assist with TB evaluation in treatment and residential care centers and offer technical assistance consultation.</p> <p>c. The Subgrantee will conduct at least one (1) TB outreach and/or education activity per quarter (3 month period) specifically for high-risk populations in Nevada which includes immigrants/refugees, corrections inmates and/or pediatrics.</p> <p>d. All outreach and education activities will be reported to the Nevada TB Controller using the Annual Performance Report due on August 1st of each year.</p>	<p>1a-1b. Continuous/Ongoing</p> <p>1c. 03/31/2018 06/30/2018 09/30/2018 12/31/2018</p> <p>1d. 08/01/2018</p>	<p>1a-1d. Annual Performance Report</p>

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Goal 6: Participate Human Resource Development Activities

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. To participate in the TB Program Evaluation and Human Resource Development activities as outlined by the Nevada DPBH TB Program.	<ol style="list-style-type: none"> 1. The Subgrantee will participate on the Nevada DPBH TB Program's Call-in Meetings. 2. The Subgrantee will track attendance and participation of staff at any Human Resource Development or training activity. The Subgrantee will report to Nevada TB Controller using the Annual Performance Report. 3. The Subgrantee will send staff to appropriate trainings/webinars in or out of Nevada (depending on Subgrantee's policies). Human Resource Development funds must be used for this purpose only and will be specified on Section C of this Subgrant. Furthermore, Human Resource Development funds cannot be redirected without the Nevada DPBH TB Program's written approval. 	<ol style="list-style-type: none"> 1. 6/30/2018, 12/31/2018 2. Quarterly 3. 08/01/2018 	<ol style="list-style-type: none"> 1. Role call by DPBH TB/Program/Annual Performance Report 2. Call Minutes and Agendas 3. Annual Performance Report

Goal 7: Conduct a Cohort Review of TB cases on an Annual Basis

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. To conduct an annual Cohort Review that will include all confirmed active TB cases in Subgrantee's geographical area from the previous year.	<ol style="list-style-type: none"> 1. The Subgrantee will participate in, at least, one annual Cohort Review that will include all cases of confirmed active TB and LTBI for children under the age of five in Subgrantee's geographical area from the previous/current year. <ol style="list-style-type: none"> a. The Subgrantee must follow the Nevada DPBH TB Program's policy on Cohort Reviews. b. The Subgrantee is responsible for reviewing the CDC's "TB Cohort Review Process: Instruction Guide (2006)," as well as provide any applicable materials and logistics needed for the event. 	1a-1b. 12/31/2018	1a-1b. PowerPoint and other materials, as needed, created by Subgrantee including the Nevada DPBH TB Program's Cohort Review Policy, and the CDC's TB Cohort Review Process: Instruction Guide (2006).

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Goal 8: Participate in Program Evaluation Activities

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. To participate in the TB Program Evaluation activities as outlined by the DPBH's TB and SAPTA Programs.	1. The Subgrantee will participate in a regularly scheduled site visit that will occur at least one (1) time per year, and will evaluate the TB activities and data collection/reporting conducted by this Subgrantee.	1. 12/31/2018	1. Annual Performance Report and the Tuberculosis Checklist.

Goal 9: Adhere to all Nevada Regulatory and Centers for Disease Control and Prevention Recommended Policies and Protocols

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. To adhere to procedures and protocols for TB care and investigation, infection control and the Occupational Safety and Health Administration (OSHA) requirements by following Nevada regulations, the CDC's recommendations, AND/OR request clarification or guidance on these policies from Nevada's TB Controller.	<ol style="list-style-type: none"> 1. The Subgrantee will follow and adhere to all Nevada health regulations within NAC 441A, and the NAC and NRS as referenced in NAC 441A. 2. The Subgrantee will follow guidance provided by Nevada TB Controller. 3. The Subgrantee will follow guidance and recommendations provided by the CDC. 	1-3. Continuous/Ongoing	Documentation may include e-mails, meeting notes, Curry Center Summary Reports.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD
SECTION C**

Budget and Financial 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 State Division of Public and Behavioral Health through Grant Number NU52PS004681 from Tuberculosis Prevention and Laboratory Grant funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor the Centers for Disease Control and Prevention".

Any activities performed under this subgrant shall acknowledge the funding was provided through the Division by Grant Number NU52PS004681 from the Tuberculosis Prevention and Laboratory Grant funded by the Centers for Disease Control and Prevention.

Subgrantee agrees to adhere to the following budget:

<u>Category</u>	<u>Total cost</u>	<u>Detailed cost</u>	<u>Details of expected expenses</u>
1. Personnel	\$ 80,301		
		\$ 48,633	TB Program Coordinator at \$88,423 x 55% FTE
		\$ 22,901	Fringe Benefits at 47.09% of \$48,633
		\$ 8,642	Intermittent hourly PHN with hourly rate of \$29.00 x 298 hours
		\$ 125	Medicare at 1.45% of \$8,642
2. Travel	\$ 4,562		
		\$ 1,319	Out-of-State Travel: 1 staff to Palm Springs, CA, for NTCA Conference, 5 days, 4 nights.
		\$ 1,559	Out-of-State Travel: 1 staff to Oakland, CA, for "TB Case Management Training" at Curry Center, 5 days, 4 nights.
		\$ 1,684	In-State Travel: 2 staff to Las Vegas for trainings/conferences, 3 days, 2 nights.
3. Operating	\$ 9,920		
		\$ 2,160	Patient housing support at \$180/month x 3 months x 4 patients
		\$ 1,880	Incentives and Enablers at \$10 each x 150 and \$20 each x 19
		\$ 5,880	IGRA/QFT (TB blood test) at \$49/test x 120 tests
4. Equipment	\$		
		\$	
5. Contractual/ Consultant	\$		
		\$	
6. Other	\$ 500		
		\$	NTCA Conference Fee of \$500 for 1 staff (\$500)
7. Indirect	\$ 13,816		
		\$ 13,816	Administrative Fee of 14.5% of costs above (\$95,283)
Total Cost	109,099		

- The 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. The Subgrantee must notify or obtain prior authorization (email notification is acceptable) for any funding adjustment(s).
- 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.
- The Subgrantee acknowledges that this subgrant and the continuation of this subgrant is contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State Legislature and/or

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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federal sources. If funds become unavailable, the Division may restrict, reduce, or terminate funding under this award.

- 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).

The 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.

- Reimbursement may be requested monthly or quarterly for expenses incurred in the implementation of the Scope of Work;
- Reimbursement will not exceed **\$109,099** for the period of the subgrant; additionally, not more than 50% of the total funded amount will be reimbursed to the subgrantee during each six (6) month period (January 1, 2018 through June 30, 2018 (\$54,549.50) and July 1, 2018 through December 31, 2018 (\$54,549.50). Full reimbursement is contingent on funding the CDC provides to Nevada which may not be fully realized until the final quarter of 2018, If a balance exists at the end of the first billing period DPBH will rollover the balance to the second billing period contingent upon approval from the DPBH;
- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred;
- Additional supporting documentation of invoices or receipts are needed in order to request reimbursement;
- 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 within 30 days of the CLOSE OF THE SUBGRANT PERIOD. Any un-obligated funds shall be returned to the Division at that time, or if not already requested, shall be deducted from the final award.

The Division agrees:

- Responsibilities of Nevada Tuberculosis Prevention and Control Program:
 - Provide technical assistance, upon request from the Subgrantee;
 - Provide assistance for the implementation of program activities;
 - Coordinate with other state, federal, and international agencies;
 - Collect and interpret required data;
 - Conduct program evaluation and disseminate findings to the Subgrantee;
 - Forward any opportunities for education related to TB disease or LTBI;
 - Forward any changes in the recommendations in the testing or care of TB cases or Latent TB Infection from the CDC;
 - Serve as the authority responsible for ensuring necessary reports and documents are submitted to the proper state agency and the CDC, per reporting deadlines
 - Forward reports to appropriate facility, e.g. CDC, interstate agencies, Dept. of Quarantine, etc.
- The Division 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.

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Both parties agree:

Site-visit monitoring and/or audits will occur as needed, but at least one (1) time per year, and will be conducted by the State Tuberculosis Program and/or the CDC with related staff of the Subgrantee TB Program to evaluate progress and compliance with the activities outlined in the Scope of Work.

The Subgrantee will, in the performance of the Scope of Work specified in this subgrant, perform functions and/or activities that could involve confidential information; therefore, the Subgrantee is requested to fill out and sign Section F, which is specific to this subgrant, and will be in effect for the term of this subgrant.

All reports of expenditures and requests for reimbursement processed by the Division 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 Division, state, and/or federal funding ability to satisfy this Agreement is withdrawn, limited, or impaired.

Financial Reporting Requirements

- Reimbursement may be requested monthly or quarterly for expenses incurred in the implementation of the Scope of Work, but may not be requested later than 30 days after the end of the reporting month or quarter. However, in order to meet fiscal year end reimbursement requirements, the June (or 2nd Quarter of calendar year). Request for Reimbursement must be submitted by no later than the 15th of July.
- Reimbursement is based on actual expenditures incurred during the period being reported.
- Payment will not be processed without all reporting being current.
- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred.
- Additional supporting documentation of invoices or receipts may be needed in order to request reimbursement.
- Additional expenditure detail will be provided upon request from the Division.
- Reimbursement may only be claimed for expenditures approved within the Notice of Subgrant Award.

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SECTION D

HD #: 16362
Budget Account: 3219
GL: 8516
Draw #: _____

Request for Reimbursement

Program Name: Tuberculosis Prevention and Control Program Office of Public Health Informatics and Epidemiology Nevada Division of Public and Behavioral Health	Subgrantee Name: Washoe County Health District (WCHD)
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	Address: PO Box 11130 Reno, NV 89520
Subgrant Period: January 1, 2018 through December 31, 2018	Subgrantee's: EIN: 88-6000138 Vendor #: T40283400Q

FINANCIAL REPORT AND REQUEST FOR FUNDS
(must be accompanied by expenditure report/back-up)

	Month(s)	Calendar year				2018	
1. Personnel	\$80,301.00	\$0.00	\$0.00	\$0.00	\$80,301.00	0.0%	
2. Travel	\$4,562.00	\$0.00	\$0.00	\$0.00	\$4,562.00	0.0%	
3. Operating	\$9,920.00	\$0.00	\$0.00	\$0.00	\$9,920.00	0.0%	
4. Equipment	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-	
5. Contractual/Consultant	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-	
6. Other	\$500.00	\$0.00	\$0.00	\$0.00	\$500.00	0.0%	
7. Training	\$13,816.00	\$0.00	\$0.00	\$0.00	\$13,816.00	0.0%	
Total	\$109,099.00	\$0.00	\$0.00	\$0.00	\$109,099.00	0.0%	

This report is true and correct to the best of my knowledge

Authorized Signature _____	Title _____	Date _____
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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: _____

Scope of Work review/approval date: _____

ASO or Bureau Chief (as required): _____

Date

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SECTION E

Audit Information Request

1. Non-Federal entities that **expend** \$750,000.00 or more in total federal awards are required to have a single or program-specific audit conducted for that year, in accordance with 2 CFR § 200.501(a). Within nine (9) months of the close of your organization's fiscal year, you **must** submit a copy of the final audit report to:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

2. Did your organization expend \$750,000 or more in all federal awards during your organization's most recent fiscal year?

YES NO

3. When does your organization's fiscal year end?

June 30th

4. What is the official name of your organization?

Washoe County Health District

5. How often is your organization audited?

annually

6. When was your last audit performed?

August 2017

7. What time-period did your last audit cover?

July 2016 - June 2017

8. Which accounting firm conducted your last audit?

Eide Bailly

Signature

Date

Administrative Health Services Officer

Title

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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SECTION F

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 agreement 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 agreement. 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 agreement 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 an agreement 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. **Agreement** shall refer to this Addendum and that particular agreement 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.

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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 statutes 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).

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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 agreement, 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 agreement 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

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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 agreement 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 agreement 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 agreement, 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.

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- 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 Agreement.** The Business Associate agrees that the Covered Entity may immediately terminate the agreement 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:

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- 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 agreement that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the agreement 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.

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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 4150 Technology Way, Suite 300 Carson City, NV 89706	Washoe County Health District Business Name
Phone: (775) 684-4200	1001 E. Ninth Street, Building B Business Address
Fax: (775) 684-4211	Reno, NV 89512 Business City, State and Zip Code
	(775) 328-2400 Business Phone Number
	(775) 328-3752 Business Fax Number
_____ Authorized Signature	_____ Authorized Signature
for Amy Roukie, MBA _____ Print Name	Kevin Dick _____ Print Name
Administrator, Division of Public and Behavioral Health _____ Title	Washoe County District Health Officer _____ Title
_____ Date	1/25/2018 _____ Date

DD	AH	—
DHO	_____	_____
DA	_____	_____
Risk	_____	_____

Staff Report
Board Meeting Date: January 25, 2018

TO: District Board of Health

FROM: Nancy Kerns Cummins, Fiscal Compliance Officer, Washoe County Health District
775-328-2419, nkcummins@washoecounty.us

SUBJECT: Approve a Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in the total amount of \$129,630 (no required match) retroactive to January 1, 2018 through December 31, 2018 in support of the Community and Clinical Health Services Division (CCHS) Sexually Transmitted Disease Prevention and Control Program IO# 10014 and authorize the District Health Officer to execute the Notice of Subgrant Award.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute other agreements on the Board of Health's behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

The Community and Clinical Health Services Division received a Notice of Subgrant Award from the State of Nevada on December 26th to support the Sexually Transmitted Disease (STD) Prevention and Control Program. The funding period is retroactive to January 1, 2018 and extends through December 31, 2018. A copy of the Notice of Subgrant award is attached.

District Health Strategic Objective supported by this item:

Healthy Lives: Improve the health of our community by empowering individuals to live healthier lives.

Financial Stability: Enable the Health District to make long-term commitments in areas that will positively impact the community's health by growing reliable sources of income.

PREVIOUS ACTION

The Board of Health approved the Notice of Subgrant Award for calendar year 2017 in the amount of \$129,629 on April 27, 2017.

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: Sexually Transmitted Disease Prevention and Control Program

Scope of the Project: The Subgrant scope of work includes conducting the following: STD testing, case identification and partner services; STD surveillance which includes the regular

monitoring of STD surveillance database, maintaining case files and records, and conducting investigations; prepare and submit reports as required, respond to STD outbreaks; provide STD outreach and education to residents, organizations and communities; confidentiality and security training of all surveillance staff, IT department staff that have access to computers/servers containing HIV data, and all staff where the STD program is located.

The Subgrant provides funding for personnel, lab testing, and indirect expenditures.

Benefit to Washoe County Residents: This Award supports identification through examination and testing, treatment and control of sexually transmitted diseases in Washoe County.

On-Going Program Support: The Health District anticipates receiving continuous funding to support the STD Program.

Award Amount: \$129,630

Grant Period: January 1, 2018 – December 31, 2018

Funding Source: Centers for Disease Control and Prevention (CDC)

Pass Through Entity: State of Nevada, Department of Health and Human Services
Division of Public & Behavioral Health

CFDA Number: 93.977

Grant ID Number: 5 NH25PS004376-05-00 / HD #16355

Match Amount and Type: No match required

Sub-Awards and Contracts: No Sub-Awards are anticipated.

FISCAL IMPACT

The District anticipated this award and included funding in the adopted FY18 budget in internal order #10014. As such, there is no fiscal impact to the FY18 adopted budget should the Board approve the Notice of Subgrant Award.

RECOMMENDATION

It is recommended that the Washoe County Health District approve a Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in the total amount of \$129,630 (no required match) retroactive to January 1, 2018 through December 31, 2018 in support of the Community and Clinical Health Services Division (CCHS) Sexually Transmitted Disease Prevention and Control Program IO# 10014 and authorize the District Health Officer to execute the Notice of Subgrant Award.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "move to approve a Notice of Subgrant Award from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in the total amount of \$129,630 (no required match) retroactive to January 1, 2018 through December 31, 2018 in support of the Community and Clinical Health Services Division (CCHS) Sexually Transmitted Disease Prevention and Control Program IO# 10014 and authorize the District Health Officer to execute the Notice of Subgrant Award."



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

State of Nevada

Department of Health and Human Services

Division of Public & Behavioral Health

(hereinafter referred to as the Division)

HD #: 16355
 Budget Account: 3219
 Category: 09
 GL: 8516
 Job Number: 9397718

NOTICE OF SUBGRANT AWARD

Program Name: STD Prevention and Control Program Nevada Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology		Subgrantee Name: Washoe County Health District (WCHD)			
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009		Address: PO Box 11130 Reno, NV 89520			
Subgrant Period: January 1, 2018 through December 31, 2018		Subgrantee's: EIN: <u>88-6000138</u> Vendor #: <u>T40283400Q</u> Dun & Bradstreet: <u>07-378-6998</u>			
Purpose of Award: To identify, treat and control Sexually Transmitted Diseases (STD) in Washoe County.					
Region(s) to be served: <input type="checkbox"/> Statewide <input checked="" type="checkbox"/> Specific county or counties: Washoe County					
Approved Budget Categories: 1. Personnel \$ <u>101,384</u> 2. Travel \$ _____ 3. Operating \$ <u>17,000</u> 4. Equipment \$ _____ 5. Contractual/Consultant \$ _____ 6. Training \$ _____ 7. Other \$ <u>11,246</u> Total Cost: \$ <u>129,630</u>		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 <i>specific to this subgrant</i> . Total reimbursement will not exceed \$129,630.00 during the subgrant period.			
Source of Funds: 1. Centers for Disease Control and Prevention (CDC)		% Funds: 100%	CFDA: 93.977	FAIN: H25PS004376-05	Federal Grant #: 5 NH25PS004376-05-00
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; and 3. The recipient of these funds agrees to stipulations listed in the incorporated documents.					
Incorporated Documents: Section A: Assurances; Section B: Description of Services, Scope of Work and Deliverables; Section C: Budget and Financial Reporting Requirements; Section D: Request for Reimbursement; Section E: Audit Information Request; and Section F: Business Associate Addendum (based on PHI usage)					
Kevin Dick, District Health Officer Washoe County Health District	_____ Signature			_____ Date	
Elizabeth Kessler STD & Hepatitis Program Manager					
Brian Parrish, OPHIE Health Program Specialist II					
for Amy Roukie, MBA Administrator, Division of Public & Behavioral Health					

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

Assurances

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

1. 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.
2. To submit reimbursement requests only for expenditures approved in the spending plan. Any additional expenditure beyond what is allowable based on approved categorical budget amounts, without prior written approval by the Division, may result in denial of reimbursement.
3. Approval of subgrant budget by the Division 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 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 (ASO) of the Division. Records may be destroyed by the Subgrantee five (5) calendar years after the final financial and narrative reports have been submitted to the Division.
 - 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. To disclose any existing or potential conflicts of interest relative to the performance of services resulting from this subgrant award. The Division reserves the right to disqualify any subgrantee 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. 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. To comply with the Americans with Disability Act of 1990, P.L. 101-136, 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 C.F.R. 26.101-36.999 inclusive and any relevant program-specific regulations
8. To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 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 (PHI) then the subgrantee agrees to enter into a Business Associate Agreement with the Division as required by 45 C.F.R. 164.504(e). If PHI will not be disclosed, then a Confidentiality Agreement will be entered into.
9. Subgrantee certifies, by signing this notice of subgrant award, 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. pr. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Register (pp. 19150-19211). This provision shall be required of every subgrantee receiving any payment in whole or in part from federal funds.

10. Sub-grantee agrees to comply with the requirements of the Title XII Public Law 103-227, the "PRO-KIDS Act of 1994," smoking may not be permitted in any portion of any indoor facility owned or regularly used for the provision of health, day care, education, or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans and loan guarantees, and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.
11. 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.
12. Division subgrants are subject to inspection and audit by representative of the Division, 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.
13. 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, as well as federal requirement as specified in the Office of Management and Budget (2 CFR § 200.501(a)), revised December 26, 2013, that each grantee annually expending \$750,000 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:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

This copy of the final audit must be sent to the Division within nine (9) months of the close of the subgrantee's fiscal year. **To acknowledge this requirement, Section E of this notice of subgrant award must be completed.**

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION B

Description of Services, Scope of Work and Deliverables

Washoe County Health District (WCHD), hereinafter referred to as Subgrantee, agrees to provide the following services and reports according to the identified timeframes:

Scope of Work for Washoe County Health District

Goal 1: Identify and Report Persons with STD (Chlamydia, Gonorrhea, and Syphilis).

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. Conduct STD testing, case identification, and partner services in Nevada.	<p>1.1 Provide testing and clinical services to all patients, contacts, and suspects referred to or volunteering for examination, treatment, or counseling for sexually transmitted diseases (STDs) as specified in the budget, during the subgrant period. The services will be provided at STD clinics, Family Planning Clinics, and non-traditional sites where services are provided by County-Level Community Outreach.</p> <p>1.2 Provide and supervise Communicable Disease Investigators, Public Health Nurses, Laboratory and Administrative Staff, and other staff necessary for the successful provision of testing and clinical services to patients, contacts, and suspects for STDs during the subgrant period.</p> <p>1.3 Provide interview and investigative services including pre and post-test evaluations of STD patients seeking STD evaluations per STD epidemiology performance standards approved by the Centers for Disease Control and Prevention (CDC) throughout the subgrant period.</p>	12/31/2018	1. Surveillance data
2. Conduct Syphilis testing, case identification, and partner services in Nevada.	2.1 Conduct testing and partner services for all Primary, Secondary, and congenital syphilis cases in Nevada based on CDC guidelines and ensure treatment bases on 2018 STD treatment guidelines.	12/31/2018	2. Surveillance data

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Goal 2: Improve STD Surveillance in Nevada.

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. Conduct STD surveillance which includes the regular monitoring of STD surveillance database [Sexually Transmitted Disease*Management Information System (STD*MIS), National Electronic Disease Surveillance (NEDS) Base System (NBS), or equivalent system]), maintaining case files and records, and conducting investigations.	1.1 Minimum information required will be obtained through active surveillance and entered into STD*MIS, NBS, or compatible system for all reported and confirmed STD cases within 90 days of receiving report. 1.2 Complete and maintain an STD file system that adequately and timely documents all STD program activity conducted during the subgrant period. 1.3 STD Program will ensure that providers/facilities as well as laboratories are reporting all cases and labs required by law through established routine quality and assurance.	12/31/2018	1. Case files or demographic information, as requested.
2. Prepare and submit reports, as required.	2.1 Submit electronically to the Division of Public and Behavioral Health (DPBH) STD*MIS or Compatible System Reports to DPBH-OPHIE.	12/31/2018	2. File compatible to be sent to CDC.
3. Respond to STD outbreaks in Nevada.	3.1 Develop and maintain an outbreak response plan for STDs in given jurisdiction using current data and epidemiological methods or direction from the DPBH. Notify DPBH of outbreaks according to the policy.	12/31/2018	3. Outbreak response plan.

Goal 3: Provide Outreach and Education

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. To provide STD outreach and education to residents, organizations and communities in Nevada.	1.1 The Subgrantee will provide STD outreach and education to the community and health care providers, to identified high risk populations in Nevada. a. These outreach and education activities could include (but not limited to) the following populations/ organizations and should focus on trainings to strengthen screening processes and staffs' recognition of symptoms of STD.	6/30/2018 and 12/31/2018	1. Summary of activity for interim and annual reports as requested by DPBH.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Goal 4: Develop Reports for Annual and Interim Progress Reports for CDC.

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. Prepare and submit reports, as required.	1.1 The STD Clinic and/or surveillance/investigation program, or designated individual responsible for reporting on behalf of both programs, will prepare and submit the following: a. <u>Annual and Interim Progress Reports</u> are required within thirty (30) days after they are requested. These reports must follow the template provided by the Nevada Division of Public and Behavioral Health.	Within 30 days of Request.	1. Report as requested by DPBH.

Goal 5: Implement and Adhere to Security and Confidentiality Procedures.

<u>Objective</u>	<u>Activities</u>	<u>Due Date</u>	<u>Documentation Needed</u>
1. The STD Program will complete a confidentiality and security training with all surveillance staff, IT department staff that have access to computers/servers containing HIV data, and all staff located within the office where the STD Program is located.	1.1 Provide STD confidentiality training and document this training requirement for each employee in their personnel file.	12/31/2018	1. Documentation training was completed

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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SECTION C

Budget and Financial 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 State Division of Public and Behavioral Health through Grant Number 5NH25PS004376 from the 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 Division nor the CDC."

Any activities performed under this subgrant shall acknowledge the funding was provided through the Division by Grant Number 5NH25PS004376 from the Centers for Disease Control and Prevention (CDC).

Subgrantee agrees to adhere to the following budget:

Category	Total cost	Detailed cost	Details of expected expenses
1. Personnel	\$ 101,384		
		\$ 101,384	60% of 1.0 FTE Public Health Nurse II at \$62,00 (\$37,200) 50% of 1.0 FTE Public Health Nurse I at \$63,500 (\$31,750) Fringe benefits (47.04% x total salary/wages) (\$32,434)
2. Travel	\$		
		\$	
3. Operating	\$ 17,000		
		\$ 17,000	1,700 Aptima nucleic acid amplification tests (NAAT) x \$10.00 per test
4. Equipment	\$		
		\$	
5. Contractual Consultant	\$		
		\$	
6. Training	\$		
		\$	
7. Other	\$ 11,246		
		\$ 11,246	Administrative Costs 9.5% of total direct costs (118,384 x .095)
Total Cost	\$ 129,630		

- The 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. The Subgrantee must notify or obtain prior authorization (email notification is acceptable) for any funding adjustment(s).
- The Subgrantee acknowledges that this subgrant and the continuation of this subgrant is contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State Legislature and/or federal sources. If funds become unavailable, the Division may restrict, reduce, or terminate funding under this award
- 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).

The 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.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

- Reimbursement may be requested monthly or quarterly for expenses incurred in the implementation of the Scope of Work;
- Reimbursement will not exceed \$129,630 for the period of the subgrant; additionally, not more than 50% of the total funded amount (\$64,815) will be reimbursed to the subgrantee during each six (6) month period (January 1, 2018 through June 30, 2018 and July 1, 2018 through December 31, 2018). Full reimbursement is contingent on funding the CDC provides to Nevada which may not be fully realized until the final quarter of 2018. If a balance exists at the end of the first billing period DPBH will rollover the balance to the second billing period contingent upon approval from the DPBH;
- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred;
- Additional supporting documentation of invoices or receipts are needed in order to request reimbursement; and
- 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 within 30 days of the CLOSE OF THE SUBGRANT PERIOD. Any un-obligated funds shall be returned to the Division at that time, or if not already requested, shall be deducted from the final award.

The Division agrees:

- The STD Prevention and Control Program will provide or accomplish the following items to ensure successful completion of this project, such as:
 - Provide reimbursement of activities related to this subgrant, not to exceed **\$129,630** during the subgrant period, given receipt of appropriate documentation;
 - Providing technical assistance, upon request from the Subgrantee;
 - Providing prior approval of reports or documents to be developed; and
 - Forwarding a report to CDC.
- The Division 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.

Both parties agree:

Site-visit monitoring and/or audits may be conducted by the Division of Public and Behavioral Health or the Centers for Disease Control and Prevention or related staff of the Subgrantee's STD program in its entirety at any time. Program and fiscal audits shall occur annually or as needed.

The Subgrantee will, in the performance of the Scope of Work specified in this subgrant, perform functions and/or activities that could involve confidential information; therefore, the Subgrantee is requested to fill out and sign Section F, which is specific to this subgrant, and will be in effect for the term of this subgrant.

All reports of expenditures and requests for reimbursement processed by the Division 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 Division, state, and/or federal funding ability to satisfy this Agreement is withdrawn, limited, or impaired.

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 30 days after the end of the reporting month or quarter. However, in order to meet fiscal year end reimbursement requirements, the June (or 2nd Quarter of calendar year) Request for Reimbursement must be submitted by no later than the 15th of July.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

- 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 Awarded within the Notice of Subgrant Award.

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION D

Request for Reimbursement

HD #: 16355
Budget Account: 3219
GL: 8516
Draw #: _____

Program Name: STD Prevention and Control Program Nevada Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology	Subgrantee Name: Washoe County Health District (WCHD)
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	Address: PO Box 11130 Reno, NV 89520
Subgrant Period: January 1, 2018 to December 31, 2018	Subgrantee's: EIN: 88-6000138 Vendor #: T40283400Q

FINANCIAL REPORT AND REQUEST FOR FUNDS
(must be accompanied by expenditure report/back-up)

Month(s)	Calendar year					
1. Personnel	\$101,384.00	\$0.00	\$0.00	\$0.00	\$101,384.00	0.0%
2. Travel	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
3. Operating	\$17,000.00	\$0.00	\$0.00	\$0.00	\$17,000.00	0.0%
4. Equipment	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
5. Contractual/Consultant	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
6. Training	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
7. Other	\$11,246.00	\$0.00	\$0.00	\$0.00	\$11,246.00	0.0%
Total	\$129,630.00	\$0.00	\$0.00	\$0.00	\$129,630.00	0.0%

This report is true and correct to the best of my knowledge

Authorized Signature	Title	Date
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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: _____

Scope of Work review/approval date: _____

ASO or Bureau Chief (as required): _____

Date

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION E

Audit Information Request

1. Non-Federal entities that **expend** \$750,000.00 or more in total federal awards are required to have a single or program-specific audit conducted for that year, in accordance with 2 CFR § 200.501(a). Within nine (9) months of the close of your organization's fiscal year, you **must** submit a copy of the final audit report to:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

2. Did your organization expend \$750,000 or more in all federal awards during your organization's most recent fiscal year?

YES NO

3. When does your organization's fiscal year end?

June 30th

4. What is the official name of your organization?

Washoe County Health District

5. How often is your organization audited?

annually

6. When was your last audit performed?

August 2017

7. What time-period did your last audit cover?

July 2016 - June 2017

8. Which accounting firm conducted your last audit?

Eide Bailly

Signature

Date

Administrative Health Services Officer
Title

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION F

Business Associate Addendum

BETWEEN

Nevada Division of Public and Behavioral Health

Hereinafter referred to as the "Covered Entity"

and

Washoe County Health District (WCHD)

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 agreement 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 agreement. 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 agreement 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 an agreement 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. **Agreement** shall refer to this Addendum and that particular agreement 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.

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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 statutes 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).

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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 agreement, 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 agreement 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

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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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 agreement 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 agreement 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 agreement, 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.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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- 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 Agreement.** The Business Associate agrees that the Covered Entity may immediately terminate the agreement 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:

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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- 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 agreement that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the agreement 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.

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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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 4150 Technology Way, Suite 300 Carson City, NV 89706	Washoe County Health District (WCHD)
Phone: (775) 684-4200	Business Name
Fax: (775) 684-4211	PO Box 11130
	Business Address
	Reno, NV 89520
	Business City, State and Zip Code
	775-328-2410
	Business Phone Number
	775-328-3752
	Business Fax Number
_____	_____
Authorized Signature	Authorized Signature
for Amy Roukie, MBA	Kevin Dick
_____	_____
Print Name	Print Name
Administrator,	District Health Officer
Division of Public and Behavioral Health	_____
_____	_____
Title	Title
_____	1/25/2018
_____	_____
Date	Date

DD	AH
DHO	KD
DA	
Risk	

Staff Report
Board Meeting Date: January 25, 2018

TO: District Board of Health

FROM: Nancy Kerns Cummins, Fiscal Compliance Officer
775-328-2419, nkcummins@washoecounty.us

SUBJECT: Accept Subgrant Amendment #1 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, retroactive to March 29, 2017 through March 28, 2018 for an additional amount of \$12,346 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Tobacco Prevention and Control Program IO# 11238; and if approved, authorize the District Health Officer to execute the Subgrant Amendment.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute other agreements on the Board of Health's behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

The Community and Clinical Health Services Division received a Notice of Subgrant Amendment #1 from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health to support the Tobacco Prevention and Control Program. The funding period is retroactive to March 29, 2017 and extends through March 28, 2018. A copy of the Notice of Subgrant Amendment is attached.

District Health Strategic Priority supported by this item: Improve the health of our community by empowering individuals to live healthier lives.

PREVIOUS ACTION

There has been no previous action taken by the Board this fiscal year.

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: Tobacco Prevention and Control Program

Scope of the Project: This supplemental funding is being awarded so that Nevada Cancer Coalition can be contracted with to secure a facilitator to assist with the planning of a five-year strategic plan in Nevada addressing tobacco use and exposure. The funding also supports indirect costs.

Benefit to Washoe County Residents: Development of a strategic plan will help guide programs to prevent tobacco use with the goal of maximizing the health of residents.

On-Going Program Support: The Health District anticipates receiving continuous funding to support the Program.

Award Amount: \$12,346.00
Grant Period: March 29, 2017 – March 28, 2018
Funding Source: Centers for Disease Control and Prevention (CDC)
Pass Through Entity: State of Nevada Department of Health and Human Services,
Division of Public & Behavioral Health
CFDA Number: 93.305
Grant ID Number: HD#15903 / 1U58DP006009
Match Amount and Type: No match required.

Sub-Awards and Contracts: A sole source agreement with Nevada Cancer Coalition is specifically required in the award.

FISCAL IMPACT

The FY18 budget was adopted with \$107,623.00 in expenditures. The supplemental award amount is \$12,346.00 (\$12,000.00 direct and \$346.00 indirect). A budget amendment in the amount of \$12,000 is necessary to bring the Subgrant Amendment into alignment with the adopted budget.

Should the Board approve this Subgrant Amendment, the adopted FY18 budget will need to be amended as follows:

<u>Account Number</u>	<u>Description</u>	<u>Amount of Increase/(Decrease)</u>
2002-IO-11238 -431100	Federal Revenue	\$ 12,000.00
2002-IO-11238 -710400	Pmts to Other Agencies	\$ 12,000.00

RECOMMENDATION

It is recommended that the Washoe County District Board of Health accept Subgrant Amendment #1 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, retroactive to March 29, 2017 through March 28, 2018 for an additional amount of \$12,346 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Tobacco Prevention and Control Program IO# 11238; and if approved, authorize the District Health Officer to execute the Subgrant Amendment.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be: "Move to accept Subgrant Amendment #1 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, retroactive to March 29, 2017 through March 28, 2018 for an additional amount of \$12,346 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Tobacco Prevention and Control Program IO# 11238; and if approved, authorize the District Health Officer to execute the Subgrant Amendment."



State of Nevada
 Department of Health and Human Services
Division of Public & Behavioral Health

Original HD #: **15903**
 Budget Account: 3220
 Category: 10
 GL: 8516
 Job Number: 9330517

SUBGRANT AMENDMENT #1

Program Name: Tobacco Prevention and Control Chronic Disease Prevention and Health Promotion (CDPHP) Bureau of Child, Family and Community Wellness (CFCW)	Subgrantee Name: Washoe County Health District (WCHD)		
Address: 4150 Technology Way, Suite #210 Carson City, NV 89706-2009	Address: PO Box 11130 Reno, NV 89520		
Subgrant Period: March 29, 2017 through March 28, 2018	Amendment Effective Date: Upon approval by all parties		
This amendment reflects a change to: <input checked="" type="checkbox"/> Scope of Work <input type="checkbox"/> Term <input checked="" type="checkbox"/> Budget			
Reason for Amendment: CDPHP needs a vendor to draft a five-year strategic plan which can be accomplished by adding activities 6.1.4, 6.1.5, and 6.1.6 to WCHD's existing scope of work. The most cost-effective and time-efficient option is to fund WCHD to secure the same facilitator who is drafting the annual strategic plan for the Nevada Tobacco Prevention Coalition.			
Required Changes: Current Language: Total reimbursement will not exceed \$110,000 during the subgrant period. See Sections B & C of the original subgrant. Amended Language: Total reimbursement will not exceed \$122,346 during the subgrant period. See Sections B & C of the original subgrant and Exhibits A & B of Amendment #1.			
Budget Categories	Current Budget	Amended Adjustments	Revised Budget
1. Personnel	\$ 106,913.00	\$ 0.00	\$ 106,913.00
2. Travel	\$ 0.00	\$ 0.00	\$ 0.00
3. Operating	\$ 0.00	\$ 0.00	\$ 0.00
4. Equipment	\$ 0.00	\$ 0.00	\$ 0.00
5. Contractual/Consultant	\$ 0.00	\$ 12,000.00	\$ 12,000.00
6. Indirect	\$ 3,087.00	\$ 346.00	\$ 3,433.00
Total	\$ 110,000.00	\$ 12,346.00	\$ 122,346.00
Incorporated Documents: Exhibit A: Amended Scope of Work Exhibit B: Amended Budget Detail Exhibit C: Original Notice of Subgrant Award and all previous amendments			

By signing this Amendment, the Authorized Subgrantee Official or their designee, Program Manager, Bureau Chief, and Division of Public and Behavioral Health 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.

Kevin Dick District Health Officer, WCHD	Signature	Date
Jenni Bonk, MS CDPHP Section Manager, CFCW		
Beth Handler, MPH Bureau Chief, CFCW		
for Amy Roukie, MBA Administrator, Division of Public & Behavioral Health		

Exhibit A: Amendment to HD #15903 Scope of Work

Washoe County Health District – Tobacco Prevention

Section 6: Infrastructure, Administration, and Management						
Strategy 1: Develop and maintain responsive planning						
<i>Objective</i>	<i>Activities</i>	<i>Outputs</i>	<i>Timeline Begin/Completion</i>	<i>Target Population</i>	<i>Evaluation Measure (indicator)</i>	<i>Evaluation Tool</i>
6.1 By March 2018, contribute to and facilitate activities to produce one (1) state strategic plan to prevent tobacco use to maximize the health of Nevadans.	6.1.4 Secure a facilitator to conduct at least two (2) strategic planning meetings with statewide partners.	Facilitator Contract Meeting Agendas and Notes	Q3-Q4	Tobacco Control Stakeholders	# of contracts # of strategic planning meetings	Quarterly progress report Contract
	6.1.5 Ensure community input is received from at least five (5) partner regions in Nevada and compiled into a data document to guide strategic planning efforts.	Data Document	Q3-Q4		# of regions reached # of data documents	Quarterly progress report
	6.1.6 Draft a five-year strategic plan for Nevada Tobacco Prevention Coalition (NTPC) and other stakeholders to review and develop into a final version in the next grant year.	Strategic Plan Draft	Q4		# of Strategic Plans	Quarterly progress report Strategic Plan Draft

Exhibit B: Amendment HD #15903 Budget Detail

Washoe County Health District – Tobacco Prevention

CONTRACTUAL

Name of Contractor: Nevada Cancer Coalition (NCC)
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Period of Performance: Upon Approval – March 28, 2018

Scope of Work: NCC will secure a facilitator to assist with the planning of a five-year strategic plan in Nevada addressing tobacco use and exposure. NCC will survey key stakeholders in six (6) county/communities across Nevada – Carson, Clark, Elko, Fernley, Fallon, and Washoe – on the topic of tobacco prevention and control priorities. NCC will communicate with tobacco prevention advocates across Nevada regarding the strategic planning process and survey results.

Method of Accountability: For five-year strategic planning activities, with support from the NTPC Board of Directors, the Health Educator Coordinator will monitor progress to ensure all components of the agreed-upon scope of work are completed.

Itemized Budget:

Facilitator	\$4,000
Survey Piece	\$6,000
Communication Aspect	\$2,000

Sub-Total:	\$12,000
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Justification: The current scope of work requires strategic planning which necessitates additional activities for the objective to be met. By selecting NCC as the vendor, their experience in developing the Nevada Cancer Control Plan and existing relationships can be leveraged to provide resources to best accomplish this objective. They are also knowledgeable on the topic of tobacco control and are currently providing strategic planning services, aligning with these efforts for the Nevada Tobacco Prevention Coalition. It would be advantageous for all tobacco control strategic planning efforts to be as consistent as possible by using the same facilitator.

TOTAL CONTRACTUAL:	\$12,000
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INDIRECT COSTS:

Reduced Indirect Cost rate applied due to funding cap. 2.8874% of total direct costs

TOTAL INDIRECT COSTS:	\$346
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TOTAL DIRECT COSTS:	\$12,000
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TOTAL BUDGET:	\$12,346
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DD	AH
DHO	KD
DA	
Risk	

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health

FROM: Nancy Kerns Cummins, Fiscal Compliance Officer
775-328-2419; nkcummins@washoecounty.us

SUBJECT: Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through December 31, 2018 in the total amount of \$287,496 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program IO# 10013 and authorize the District Health Officer to execute the Subgrant Award.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute other agreements on the Board of Health's behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

The Community and Clinical Health Services Division received a Notice of Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health on December 21, 2017 to support the HIV Prevention Program. The funding period is retroactive to January 1, 2018 and extends through December 31, 2018. A copy of the Notice of Subgrant Award is attached.

Health District Strategic Priorities supported by this item:

Healthy Lives: Improve the health of our community by empowering individuals to live healthier lives.

Financial Stability: Enable the Health District to make long-term commitments in areas that will positively impact the community's health by growing reliable sources of income.

PREVIOUS ACTION

On February 23, 2017, the Board approved a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health, retroactive to January 1 through December 31, 2017, for \$290,182 in support of the HIV Prevention Program.



BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: HIV Prevention Program

Scope of the Project: The Subgrant scope of work includes the following: conduct HIV testing, conduct comprehensive prevention activities with HIV-positive individuals, distribute condoms, and perform prevention planning, reporting and evaluation activities.

The Subgrant provides funding for personnel, travel and training, operating supplies, professional services, educational supplies, advertising, lab/outpatient, and other expenses, including funding specifically for community outreach, planning meetings and program participation via the use of incentives/enablers (including but not limited to, gift cards/gift certificates, transportation and food vouchers, educational outreach items, nutritious food and beverage, behavioral reinforcers, etc.)

Benefit to Washoe County Residents: This Award supports the 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.

On-Going Program Support: The Health District anticipates receiving continuous funding to support the HIV Prevention Program.

Award Amount: \$287,496.00

Grant Period: January 1, 2018 – December 31, 2018

Funding Source: Centers for Disease Control and Prevention (CDC)

Pass Through Entity: State of Nevada Department of Health and Human Services,
Division of Public & Behavioral Health

CFDA Number: 93.940

Grant ID Number: 1 NU62PS924579-01-00 / HD#16348

Match Amount and Type: No match required.

Sub-Awards and Contracts: No Sub-Awards are anticipated.

FISCAL IMPACT

The District anticipated this award and included funding in the adopted FY18 budget in internal order #10013. As such, there is no fiscal impact to the FY18 adopted budget should the Board approve the Notice of Subgrant Award.

Subject: Approve HIV Prevention Subgrant

Date: January 25, 2018

Page 3 of 3

RECOMMENDATION

It is recommended that the Washoe County Health District approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through December 31, 2018 in the total amount of \$287,496 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program IO# 10013 and authorize the District Health Officer to execute the Subgrant Award.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "move to approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health retroactive to January 1, 2018 through December 31, 2018 in the total amount of \$287,496 (no required match) in support of the Community and Clinical Health Services Division (CCHS) HIV Prevention Program IO# 10013 and authorize the District Health Officer to execute the Subgrant Award."



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

State of Nevada
Department of Health and Human Services
Division of Public & Behavioral Health
(hereinafter referred to as the Division)

HD #: **16348**
Budget Account: 3215
Category: 15
GL: 8516
Job Number: 9394018

NOTICE OF SUBGRANT AWARD

Program Name: HIV Prevention Program Bureau of Behavioral Health, Wellness, and Prevention	Subgrantee Name: Washoe County Health District Attn: Anna Heenan, Administrative Health Services Officer
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	Address: P. O. Box 11130 Reno, NV 89520-00207
Subgrant Period: January 1, 2018 through December 31, 2018	Subgrantee's: EIN: 88-60000138 Vendor #: T40283400Q Dun & Bradstreet: 073786998

Purpose of Award: To conduct HIV Prevention Services in Northern Nevada

Region(s) to be served: Statewide Specific county or counties: Washoe County

<p>Approved Budget Categories:</p> <table> <tr><td>1. Personnel</td><td>\$</td><td>196,024</td></tr> <tr><td>2. Travel</td><td>\$</td><td>9,522</td></tr> <tr><td>3. Operating</td><td>\$</td><td>4,224</td></tr> <tr><td>4. Supplies</td><td>\$</td><td>7,480</td></tr> <tr><td>5. Contractual/Consultant</td><td>\$</td><td>0</td></tr> <tr><td>6. Other</td><td>\$</td><td>41,689</td></tr> <tr><td>7. Indirect</td><td>\$</td><td>28,557</td></tr> <tr><td>Total Cost:</td><td>\$</td><td>287,496</td></tr> </table>	1. Personnel	\$	196,024	2. Travel	\$	9,522	3. Operating	\$	4,224	4. Supplies	\$	7,480	5. Contractual/Consultant	\$	0	6. Other	\$	41,689	7. Indirect	\$	28,557	Total Cost:	\$	287,496	<p>Disbursement of funds will be as follows:</p> <p>Payment will be made upon receipt and acceptance of an invoice and supporting documentation specifically requesting reimbursement for actual expenditures <i>specific to this subgrant</i>. Total reimbursement will not exceed \$287,496.00 during the subgrant period.</p>
1. Personnel	\$	196,024																							
2. Travel	\$	9,522																							
3. Operating	\$	4,224																							
4. Supplies	\$	7,480																							
5. Contractual/Consultant	\$	0																							
6. Other	\$	41,689																							
7. Indirect	\$	28,557																							
Total Cost:	\$	287,496																							

Source of Funds:	% Funds:	CFDA:	FAIN:	Federal Grant #:
1. Centers for Disease Control and Prevention (CDC)	100%	93.940	NU62PS9245 79	1 NU62PS924579-01- 00

Terms and Conditions:
In accepting these grant funds, it is understood that:

- Expenditures must comply with appropriate state and/or federal regulations;
- This award is subject to the availability of appropriate funds; and
- The recipient of these funds agrees to stipulations listed in the incorporated documents.

Incorporated Documents:

Section A: Assurances;
Section B: Description of Services, Scope of Work and Deliverables;
Section C: Budget and Financial Reporting Requirements;
Section D: Request for Reimbursement;
Section E: Audit Information Request; and
Section F: DPBH Business Associate Addendum.

	Signature	Date
Kevin Dick District Health Officer		
Lyell Collins, MBA HIV Prevention Program Manager		
Kyle Devine, MSW Bureau Chief		
for Amy Roukie, MBA Administrator, Division of Public & Behavioral Health		

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION A

Assurances

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

1. 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.
2. To submit reimbursement requests only for expenditures approved in the spending plan. Any additional expenditure beyond what is allowable based on approved categorical budget amounts, without prior written approval by the Division, may result in denial of reimbursement.
3. Approval of subgrant budget by the Division 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 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 (ASO) of the Division. Records may be destroyed by the Subgrantee five (5) calendar years after the final financial and narrative reports have been submitted to the Division.
 - 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. To disclose any existing or potential conflicts of interest relative to the performance of services resulting from this subgrant award. The Division reserves the right to disqualify any subgrantee 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. 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. To comply with the Americans with Disability Act of 1990, P.L. 101-136, 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 C.F.R. 26.101-36.999 inclusive and any relevant program-specific regulations
8. To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 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 (PHI) then the subgrantee agrees to enter into a Business Associate Agreement with the Division as required by 45 C.F.R. 164.504(e). If PHI will not be disclosed then a Confidentiality Agreement will be entered into.
9. Subgrantee certifies, by signing this notice of subgrant award, 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

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Order 12549, Debarment and Suspension, 28 C.F.R. pr. 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. Sub-grantee agrees to comply with the requirements of the Title XII Public Law 103-227, the "PRO-KIDS Act of 1994," smoking may not be permitted in any portion of any indoor facility owned or regularly used for the provision of health, day care, education, or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans and loan guarantees, and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.
11. 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.
12. Division subgrants are subject to inspection and audit by representative of the Division, 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.
13. 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, as well as federal requirement as specified in the Office of Management and Budget (2 CFR § 200.501(a)), revised December 26, 2013, that each grantee annually expending \$750,000 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:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

This copy of the final audit must be sent to the Division within nine (9) months of the close of the subgrantee's fiscal year. **To acknowledge this requirement, Section E of this notice of subgrant award must be completed.**

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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD

SECTION B

Description of Services, Scope of Work and Deliverables

Washoe County Health District, hereinafter referred to as Subgrantee, agrees to provide the following services and reports according to the identified timeframes:

Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response

HIV prevention program monitoring and evaluation

A: During the reporting the Subgrantee will collect and input data into EvaluationWeb and PartnerServicesWeb. Data will be used to monitor HIV testing activities and key performance indicators. Data must be entered in the required CDC format and by CDC required deadlines.

B: The Subgrantee will meet with the State HIV Prevention Program (HPP) at least semi-annually or upon request to discuss performance measures and program progress.

Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV

HIV Testing

A: During the reporting period the Subgrantee will complete 2,000 HIV tests (of which no more than 500 may be conventional testing) targeted to high-risk individuals and target populations identified in the Nevada Integrated HIV Prevention and Care Plan.

B: During the reporting period, the Subgrantee will conduct one (1) provider education presentations to educate hospital and medical staff on the benefits of routine HIV testing.

C: During the reporting period, the Subgrantee will conduct one (1) provider education presentations to educate hospital and medical staff on the requirement to test pregnant women who present themselves at hospitals but with no evidence of previous prenatal care.

D: The Subgrantee will utilize the social networks strategies to target high-risk networks for HIV testing.

HIV Partner Services

A: The Subgrantee will utilize STD and HIV Prevention data to identify HIV positive individuals, their contacts and disease clusters for Partner Services and other interventions.

B: All Disease Intervention Specialist will receive the CDC supported Passport to Partner Services training.

C: During the reporting period, the Subgrantee will provided data and technical assistance to medical and community providers upon request.

Data to Care

A: During the reporting period, the Subgrantee will work with HPP to provide missing or updated data to HIV Surveillance for review, entry into eHARS, and quality assurance.

Strategy 3: Develop, maintain, and implement plan to respond to HIV transmission clusters and outbreaks

Rapidly respond to and intervene in HIV transmission clusters and outbreaks

A: During the reporting period, the Subgrantee will work with the HPP to develop and maintain a jurisdictional and CDC identified rural counties outbreak and detection response plan.

B: Partners of transmission cluster will be referred to HIV testing and provided retesting within 6 months.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Strategy 4: Provide for comprehensive HIV- related prevention services for people living with diagnosed HIV infection

Provide linkage to, re-engagement in, and retention in HIV medical care services using Data-to-Care activities and other strategies

A: During the reporting period, the Subgrantee will perform data-to-care activities to identify HIV positive individuals who have not linked to care or have fallen out of care.

B: During the reporting period, the Subgrantee will identify newly diagnosed positive individuals and ensure they are linked into care and monitored until they attend their first appointment.

C: During the reporting period, the Subgrantee will work with the HPP to identify social determinants of health that are impacting a client's ability to successfully link and be retained into HIV care.

Promote early ART initiation and support medication adherence

A: During the reporting period, the Subgrantee will educate primary care physicians on the importance of early ART initiation.

B: During the reporting period, the Subgrantee will continue to offer the ARTAS intervention and wrap around services to ensure clients access and retain in medical care.

Promote and monitor HIV viral suppression & Monitor HIV drug resistance

A: During the reporting period, the Subgrantee will use peer navigators to engage and support clients' access and retention into medical care and treatment adherence.

B: The Subgrantee must use client-centered counseling during HIV testing and condom distribution as Health Reduction and Health Education strategies.

Conduct risk reduction interventions for PLWH

A: During the reporting period, the Subgrantee will ensure client-centered counseling is performed during the HIV testing process. Once identified as positive, the Subgrantee's DIS must provide health education to reduce high-risk behaviors and future transmissions.

Refer PLWH to other essential support services

A: During the reporting period, the Subgrantee will upon initial identification of newly diagnosed positive individuals will referred to care and support services, such as screenings and active referrals for healthcare benefits, behavioral health, and other medical and social services. Clients will continue to be monitored through the first medical appointment by local DIS.

Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection.

Periodic HIV testing and risk screening HIV Testing

A: During the reporting period, the Subgrantee will work with HPP and community partners to introduce legislation to require physicians to offer an HIV test annually as part of routine medical care for ages 13 – 64.

Increase awareness of and expand access to PrEP and medication adherence to PrEP/ Screening for PrEP eligibility

A: During the reporting period, the Subgrantee will provide community education for PrEP and PEP awareness through social media strategies.

Linkage to and support for PrEP

A: During the reporting period, the Subgrantee will clients in accessing PrEP and PEP services and navigating insurance, Medicaid, and patient assistance programs.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Risk reduction interventions for HIV-negative persons at risk for HIV infection

A: During the reporting period, the Subgrantee will offer Personalized Cognitive Counseling, RESPECT, Motivational Interviewing, and other intervention as identified to HIV-negative persons at risk for HIV infection.

Refer HIV-negative persons at risk for HIV infection to other essential support services

A: During the reporting period, the Subgrantee will work with HIV-negative persons to identify essential support services that the client needs to improve their health outcomes, such as: transportation, substance abuse treatment, mental health services, housing, etc.

Strategy 6: Conduct perinatal HIV prevention and surveillance activities.

Universal prenatal HIV testing

A: During the reporting period, the Subgrantee will re-educate providers on the Nevada Revised Statutes pertaining to HIV testing for pregnant women, i.e., to test pregnant women who present themselves at hospitals but with no evidence of previous prenatal care.

B: During the reporting period, the Subgrantee will utilize new online tools that assist medical providers with educating expecting mothers and provide the necessary mandatory reporting forms.

Perinatal HIV exposure reporting

A: During the reporting period, the Subgrantee will conduct Fetal Infant Mortality Review (FIMR) activities and address HIV related case review as appropriate.

B: During the reporting period, the Subgrantee will develop and implement standard operating procedures for identifying and conducting follow-up of perinatally HIV-exposed infants according to CDC guidance.

Perinatal HIV service coordination (e.g., fetal and infant mortality review)

A: During the reporting period, the Subgrantee will review the FIMR and will discuss with clinic personal and local medical providers to ensure patients are receiving newest treatment protocols.

Strategy 7: Conduct community-level HIV prevention activities

Social marketing campaigns and social media strategies

A: Should the Subgrantee choose to develop a media campaign, the Subgrantee must use a CDC approved media campaign, such as the Act Against AIDS initiative.

Community mobilization

A: During the reporting period, the Subgrantee will involve the HIV Prevention Planning Groups (HPPG) and community partners to promote marketing and outreach plans that provide stigma and discrimination free messaging.

Condom distribution programs

A: During the reporting period, the Subgrantee will distribute condoms to high risk HIV negative and positive individuals; 52,254 by 12/31/18, 54,811 by 12/31/19, 57,611 by 12/31/20, 60,492 by 12/31/21, and 63,516 by 12/31/22.

B: During the reporting period, the Subgrantee will use vending machines and mail order to provide STD testing self-collection kits; specimen collection kits will be packaged with condoms for distribution.

Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Maintain HIV Planning Group

A: During the reporting period, the Subgrantee will manage, oversee, and provide logistical coordination of the Northern Nevada HIV Prevention Planning Council and meet at least quarterly throughout the year to discuss and monitor the progress of the State's HIV Prevention grant. The Subgrantee is also responsible for providing nutrition and hydration at all HPPG meetings.

Develop HIV prevention and care networks

A: During the reporting period, the Subgrantee will continue working with community partners, other local health authorities, and the University Nevada Reno- Center for Program Evaluation to identify new stakeholders and engage them in the Integrated HIV Prevention and Care Plan process to evaluate and monitor the Plan.

Strategy 9: Implement structural strategies to support and facilitate HIV surveillance and prevention

Ensure data security, confidentiality, and sharing

A: During the reporting period, the Subgrantee will ensure that all staff is trained and in compliance with the CDC's Data Security and Confidentiality Guidelines.

Strengthen laws, regulations, and policies

A: During the reporting period, the Subgrantee will work with the HPP and other advocacy groups to support legislation or policy changes that will benefit HIV prevention, care, and surveillance in Nevada.

Strengthen health information systems infrastructure

A: During the reporting period, the Subgrantee will maintain and/or enhance integrated information systems and workforces between HIV Prevention and Surveillance.

B: During the reporting period, the Subgrantee will support CDC approved software and hardware equipment necessary to strengthen health information systems infrastructure, such as eHARS, SAS licenses, and the organization's EMR systems. The Subgrantee will ensure that all CDC provided software releases and upgrades are installed within required time frames.

Strategy 10: Conduct data- driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities

Monitor the Integrated HIV Prevention and Care Plan

A: During the reporting period, the Subgrantee will continue working with community partners, other local health authorities, and the University Nevada Reno- Center for Program Evaluation to evaluate and monitor the Integrated HIV Prevention and Care Plan.

Monitor HIV within the jurisdiction for program planning, resource allocation, and monitoring and evaluation purposes

A: During the reporting period, the Subgrantee will use epidemiological data to assist with monitoring HIV in the state. This data will be used in the community planning process to identify priority populations and resource allocation.

Strategy 11: Build capacity for conducting effective HIV program activities, epidemiological science, and geocoding

Assess capacity building and technical assistance needs

A: During the reporting period, the Subgrantee will participate in an annual statewide survey to assess capacity building and technical assistance needs.

B: During the reporting period, the Subgrantee will comply with the HPP's annual site visit, provide all supporting documentation, and provide programmatic feedback.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

Develop and implement capacity building assistance plan, including technical assistance

A: During the reporting period, the Subgrantee will participate in all CDC identified trainings.

B: During the reporting period, the Subgrantee will adequately train new hires in current CDC prevention interventions.

C: During the reporting period, the Subgrantee will ensure the development and implementation of standard operating procedures are in place or in process.

Programmatic Reporting

A: During the reporting period, the Subgrantee will submit to the HPP narrative and statistical reports in a format established by the HPP and the CDC. By July 31 each year, the Subgrantee will report on the first six (6) months of the grant year. By January 31 each year, the Subgrantee will report on the entire twelve (12) months of the grant year.

B: During the reporting period, the Subgrantee will measure all performance indicators and objectives identified in the Evaluation and Monitoring Plan using the program template provided, monthly. The report is due by the fifteenth (15) of each month, reporting on the previous month.

C: During the reporting period, the Subgrantee will be responsible for HIV counseling, testing, Partner Services, and referral data collection and timely entry into respective databases.

*Important Notice: Any unspent funding may result in having the next year's grant reduced by that amount.

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

SECTION C

Budget and Financial 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 State Division of Public and Behavioral Health through Grant Number 1 NU62PS924579-01-00 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor the Centers for Disease Control and Prevention."

Any activities performed under this subgrant shall acknowledge the funding was provided through the Division by Grant Number 1 NU62PS924579-01-00 from the Centers for Disease Control and Prevention.

Subgrantee agrees to adhere to the following budget:

<u>Category</u>	<u>Total cost</u>	<u>Detailed cost</u>	<u>Details of expected expenses</u>
1. Personnel	\$ 196,024		(Includes Fringe)
Salary		\$ In Kind	Public Health Nursing Supervisor .30 FTE – (\$97,236 per year x .30 FTE)
		53,897	Health Educator Coordinator .65 FTE – (\$82,918 per year x .65 FTE)
		19,232	Public Health Nurse I/II/DIS .31FTE -- (\$62,040 per year x .31 FTE)
		17,051	Public Health Nurse I/II/DIS .27 FTE – (\$63,150 per year x .27 FTE)
		3,458	Office Assistant II .07 FTE – (\$49,395 per year x .07 FTE)
		3,458	Office Assistant II .07 FTE – (\$49,395 per year x .07 FTE)
Fringe		45,887	Fringe Benefits (47.259% of \$97,096)
		30,576	RN – Intermittent Hourly Pooled (\$28.98/hr. x 20 hrs. per week x 52 wks. per year + Medicare @ 1.45%) (Amount does not include fringe benefits.)
		22,465	Health Educator – Intermittent Hourly Pooled (\$28.39/hr. x 15 hrs. per week x 52 wks. per year + Medicare @ 1.45% (Amount does not include fringe benefits.)
2. Travel	\$ 9,522		
		\$ 2,874	<u>In-State Travel</u> Travel to Las Vegas for 1 night x 2 trips x 2 staff to attend trainings or meetings. Mileage (local): \$.535 per mile x 530 miles – Day-to-day travel to provide HIV testing, education, attend local meetings. Registrations for 5 staff @ \$150 ea. to attend AIDS Education and Training Center (AETC) Autumn Update
		6,648	<u>Out-of-State Travel</u> Travel and conference registration for HIV Health Educator Coordinator, and one staff or appropriate community member to attend two (2) development conferences, such as the U. S. Conference on AIDS (USCA) in Orlando, FL and other HIV prevention-related conference (2 staff x 2 trips x 3 nights)

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD**

3. Operating	\$	4,224		
			\$	300 Postage and Freight: \$25 per mo. x 12 mos. = \$300 700 Copy Machine: \$58.33 per mo. x 12 mos. = \$700 500 Printing: \$41.66 per mo. x 12 mos. = \$500 600 Licenses & Certifications: \$600 500 Security Service for off-site & after-hours HIV testing 900 Telephone: \$75 per mo. x 12 mos. = \$900 624 Cell Phone: \$52 per mo. x 12 mos. = \$624 100 Books and Subscriptions
4. Supplies	\$	7,480		
			\$	1,280 Educational Materials = \$1,280 5,200 Medical Supplies = \$5,000 1,000 Office Supplies: \$83.33 per mo. x 12 mos. = \$1,000
5. Contractual Consultant	\$	<0>		
			\$	<0>
6. Other	\$	41,689		
			\$	100 Professional Services: Marketing development & materials = \$100 8,987 Advertising: Targeted HIV testing efforts, including social network strategies: \$748.91/mo. x 12 mos. = \$8,987 1,000 Program Incentives: Implementing the social network strategy intervention & Partner Services participation: \$83.33/mo. x 12 mos. = \$1,000 250 Hydration at testing events: \$250 200 Meeting Room Rental: Meeting spaces, storage space for HIV materials and audio/visual equipment = \$200 29,652 Lab/Outpatient Services: Costs associated with HIV testing, including test kits and controls = \$29,652 <u>Northern Nevada HIV Prevention Planning Group (NNHPPG)</u> 900 Hydration/Nutrition for NNHPPG Meetings: \$7.50 x 20 attendees x 6 meetings per year = \$ 900 500 Community Engagement meetings: \$250 per mtg. x 2 mtgs. = \$500 100 Supplies for PPG meetings: \$16.66 per mtg. x 6 mtgs. = \$100
7. Indirect	\$	28,557		
			\$	28,557 11.026% of Direct Costs, (including Personnel) \$258,939 x 11.0286% = \$28,557
Total Cost	\$	287,496		

- The subgrantee may reallocate up to 10% of the total grant award (\$28,749) within existing categories, if it does not alter the Scope of Work, but must receive prior written approval (letter or email request) from the HIV Prevention Program Manager to do so.
- 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

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the rates established by the US General Services Administration, with some exceptions (State Administrative Manual 0200.0 and 0320.0).

The 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.

- Reimbursement Requests may be made monthly, but at least quarterly;
- The maximum available through this subgrant shall not exceed \$287,496 per grant year;
- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred;
- Other supporting documentation shall include payroll documentation to support salary reimbursement, and receipts for Travel and Operating expenses;
- 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 within 30 days of the CLOSE OF THE SUBGRANT PERIOD. Any un-obligated funds shall be returned to the Division at that time, or if not already requested, shall be deducted from the final award.

The Division agrees:

- Provide technical assistance, upon request and when feasible;
- Provide prior approval of all reports or documents to be developed by Subgrantee;
- Will be responsible for forwarding all documents, or required reports, to the Centers for Disease and Prevention (CDC) or other entity, as required under this grant;
- The Division 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.

Both parties agree:

- The Division's HIV Prevention Program will conduct at least annually, one (1) programmatic and fiscal review of the subgrantee. The Division of Public and Behavioral Health has the option to conduct site visits more often should they be necessary.
- The Subgrantee will, in the performance of the Scope of Work specified in this subgrant, perform functions and/or activities that could involve confidential information; therefore, the Subgrantee is requested to fill out and sign Section F, which is specific to this subgrant, and will be in effect for the term of this subgrant.

All reports of expenditures and requests for reimbursement processed by the Division 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 Division, state, and/or federal funding ability to satisfy this Agreement is withdrawn, limited, or impaired.

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.

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SECTION D

Request for Reimbursement

HD #: **16348**

Budget Account: 3215

GL: 8516

Draw #: _____

Program Name: HIV Prevention Program Bureau of Behavioral Health, Wellness, and Prevention	Subgrantee Name: Washoe County Health District Attn: Anna Heenan
Address: 4126 Technology Way, Suite #200 Carson City, NV 89706-2009	Address: P. O. Box 11130 Reno, NV 89520-00207
Subgrant Period: January 1, 2018 through December 31, 2018	Subgrantee's: EIN: 88-60000138 Vendor #: T40283400Q

FINANCIAL REPORT AND REQUEST FOR FUNDS
(must be accompanied by expenditure report/back-up)

	Month(s)		Calendar year			
1. Personnel	\$196,024.00	\$0.00	\$0.00	\$0.00	\$196,024.00	0.0%
2. Travel	\$9,522.00	\$0.00	\$0.00	\$0.00	\$9,522.00	0.0%
3. Operating	\$4,224.00	\$0.00	\$0.00	\$0.00	\$4,224.00	0.0%
4. Supplies	\$7,480.00	\$0.00	\$0.00	\$0.00	\$7,480.00	0.0%
5. Contractual/Consultant	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
6. Other	\$41,689.00	\$0.00	\$0.00	\$0.00	\$41,689.00	0.0%
7. Indirect	\$28,557.00	\$0.00	\$0.00	\$0.00	\$28,557.00	0.0%
Total	\$287,496.00	\$0.00	\$0.00	\$0.00	\$287,496.00	0.0%

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/back-up. 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: _____

Scope of Work review/approval date: _____

ASO or Bureau Chief (as required): _____

Date

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SECTION E

Audit Information Request

1. Non-Federal entities that **expend** \$750,000.00 or more in total federal awards are required to have a single or program-specific audit conducted for that year, in accordance with 2 CFR § 200.501(a). Within nine (9) months of the close of your organization's fiscal year, you **must** submit a copy of the final audit report to:

***Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009***

2. Did your organization expend \$750,000 or more in all federal awards during your organization's most recent fiscal year?

YES NO

3. When does your organization's fiscal year end?

June 30th

4. What is the official name of your organization?

Washoe County Health District

5. How often is your organization audited?

annually

6. When was your last audit performed?

August 2017

7. What time period did your last audit cover

July 1, 2016 - June 30, 2017

8. Which accounting firm conducted your last audit?

Eide Bailly

Signature

Date

Administrative Health Services Officer
Title

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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SECTION F

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 agreement 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 agreement. 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 agreement 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 an agreement 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. **Agreement** shall refer to this Addendum and that particular agreement 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.

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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 statutes 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).

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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 agreement, 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 agreement 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

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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 agreement 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 agreement 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 agreement, 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.

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- 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 Agreement.** The Business Associate agrees that the Covered Entity may immediately terminate the agreement 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:

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- 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 agreement that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the agreement 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.

THIS SPACE INTENTIONALLY LEFT BLANK

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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 4150 Technology Way, Suite 300 Carson City, NV 89706	Washoe County Health District Business Name
Phone: (775) 684-4200	1001 E. 9 th Street, Building B Business Address
Fax: (775) 684-4211	Reno, NV 89512 Business City, State and Zip Code
	(775) 328-2400 Business Phone Number
	(775) 328-3752 Business Fax Number
_____ Authorized Signature	_____ Authorized Signature
for Amy Roukie, MBA _____ Print Name	Kevin Dick _____ Print Name
Administrator, Division of Public and Behavioral Health _____ Title	District Health Officer _____ Title
_____ Date	1/25/2018 _____ Date

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health

FROM: Steve Kutz, RN, MPH, Director, Community and Clinical Health Services
775-328-6159; skutz@washoecounty.us

Nancy Kerns Cummins, Fiscal Compliance Officer
775-328-2419; nkcummins@washoecounty.us

SUBJECT: Approve the modification of the Community and Clinical Health Services Fee Schedule to add Human Papillomavirus (HPV) Genotype (16 18 45) Testing.

SUMMARY

The Washoe County District Board of Health must approve changes to the adopted fee schedule.

Community and Clinical Health Services (CCHS) is requesting approval to modify the fee schedule to add HPV Genotype (16 18 45) testing.

Health District Strategic Priorities supported by this item:

Healthy Lives: Improve the health of our community by empowering individuals to live healthier lives.

Financial Stability: Enable the Health District to make long-term commitments in areas that will positively impact the community's health by growing reliable sources of income.

PREVIOUS ACTION

On December 14, 2017, the Board approved modifying the fee schedule to add Lidocaine with Epinephrine, Naproxen and Herpes Simplex 1 and 2 testing.

On October 26, 2017, the Board approved modifying the fee schedule to add the Vasectomy Procedure.

On August 24, 2017, the Board approved modifying the laboratory fee schedule to add ThinPrep Pap test, associated Pathologist review and HPV high risk testing.

On January 26, 2017, the Board approved modifying the fee schedule to change the immunization administration fee to \$21.34.

On August 25, 2016, the Board approved modifying the fee structure for prescription and non-prescription drugs, specifically codes J8499 and A9150.

COMMUNITY AND CLINICAL HEALTH SERVICES

1001 East Ninth Street | P.O. Box 11130 | Reno, Nevada 89520
CCHS Phone: 775-328-2441 | Fax: 775-328-3750 | washoecounty.us/health
Serving Reno, Sparks and all of Washoe County, Nevada. Washoe County is an Equal Opportunity Employer.



Subject: Modify the CCHS Fee Schedule

Date: January 25, 2018

Page 2 of 2

On March 24, 2016, the Board approved modifying the fee schedule to add Gentamycin, Bexsero MenB and Admin of Depo.

On October 22, 2015, the Board approved revisions to the fee schedule for the CCHS Division and authorized yearly increases using the Consumer Price Index for the Western Region.

BACKGROUND

The Family Planning Program is requesting approval to add HPV Genotype (16 18 45) testing, a second test to determine if women who test positive for high-risk HPV have one of three types of the virus that are associated with the highest mortality from cervical cancer: 16, 18 and 45. The recently added ThinPrep Pap test can identify abnormal cells but cannot detect HPV directly.

FISCAL IMPACT

Should the Board approve this proposed revision to the CCHS Fee Schedule, the following will be added:

HPV Genotype (16 18 45) testing	\$ 126.30
---------------------------------	-----------

The actual fiscal impact cannot be determined as the application the schedule of discounts and the client's ability to pay varies. It is CCHS' policy to maximize collections from clients and third party payers.

RECOMMENDATION

Approve the modification of the Community and Clinical Health Services Fee Schedule to add Human Papillomavirus (HPV) Genotype (16 18 45) testing.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "move to approve the modification of the Community and Clinical Health Services Fee Schedule to add Human Papillomavirus (HPV) Genotype (16 18 45) testing."

DD_CW	__
DHO	__ KD __
DA	_____
Risk	_____

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health

FROM: Jim English, Environmental Health Specialist Supervisor
775-328-2610, jenglish@washoecounty.us

SUBJECT: Approve Agreement between the Washoe County Health District and Keep Truckee Meadows Beautiful in the amount of \$100,000 for the period January 25, 2018 through December 31, 2018 in support of the Recycling and Solid Waste Management Plan program activities; Approve FY18 Purchase Requisition #3000034667 issued to Keep Truckee Meadows Beautiful in the amount of \$100,000 on behalf of the Environmental Health Services Division of the Washoe County Health District; and if approved, authorize the Chair to execute the Agreement.

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements. The District Health Officer is authorized to execute agreements on the Board of Health's behalf not to exceed a cumulative amount of \$50,000 per contractor; over \$50,000 up to \$100,000 would require the approval of the Chair or the Board designee.

District Health Strategic Priority supported by this item:

1. **Healthy Environment:** Create a healthier environment that allows people to safely enjoy everything Washoe County has to offer.

PREVIOUS ACTION

There has been no previous action taken by the board.

BACKGROUND

The Washoe County Health District proposes to partner with Keep Truckee Meadows Beautiful (KTMB) a 501 (c)(3) organization that specializes in waste reduction, illegal dumping, open space clean ups and public outreach. They have conducted these activities in Washoe County since 1989 as the only organization dedicated solely to helping keep our community clean and free of garbage, trash and litter while promoting recycling and proper waste management practices.

In October 2017, KTMB received \$50,000 to complete a project that consisted of public outreach regarding illegal dumping activities and recycling efforts and outlets within Washoe County. They used this funding for actual tools and dumpsters to facilitate cleanups within Washoe County and the Health District utilizing KTMB's network of over 3,000 local volunteers.

The purchase requisition that is being approved today will support the attached scope of work.

Subject: FY18 Keep Truckee Meadows Beautiful Partnership Agreement – Recycling and Solid Waste Management Plan

Date: January 25, 2018

Page 2 of 2

Should the District Board of Health approve Purchase Requisition #300034667, staff will proceed with obtaining approval of the Purchase Order from the Board of County Commissioners.

FISCAL IMPACT

There will be no additional fiscal impact for the Solid Waste Program should the Board approve the Agreement and FY18 Purchase Requisition #3000034667 as this expenditure amount was anticipated and included in the FY18 Solid Waste Program budget (Internal Order 20269) in General Ledger account 710100 (Professional Services).

RECOMMENDATION

Staff recommends that the District Board of Health approve the Agreement between the Washoe County Health District and Keep Truckee Meadows Beautiful in the amount of \$100,000 for the period January 25, 2018 through December 31, 2018 in support of the Recycling and Solid Waste Management Plan program activities; Approve FY18 Purchase Requisition #3000034667 issued to Keep Truckee Meadows Beautiful in the amount of \$100,000 on behalf of the Environmental Health Services Division of the Washoe County Health District; and if approved, authorize the Chair to execute the Agreement.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to approve the Agreement between the Washoe County Health District and Keep Truckee Meadows Beautiful in the amount of \$100,000 for the period January 25, 2018 through December 31, 2018 in support of the Recycling and Solid Waste Management Plan program activities; Approve FY18 Purchase Requisition #3000034667 issued to Keep Truckee Meadows Beautiful in the amount of \$100,000 on behalf of the Environmental Health Services Division of the Washoe County Health District; and if approved, authorize the Chair to execute the Agreement."

**Washoe County Health District
Independent Contractor Agreement for Litter Control
Calendar Year 2018**

**Keep Truckee Meadows Beautiful
\$100,000**

Work is as outlined in the Solid Waste Management Plan and will be completed to support the Solid Waste Management Program of the Environmental Health Services Division:

1. Provide year round dumpsters, equipment and passes to support solid waste cleanup
 - a. KTMB will be responsible for the procurement, removal and tracking of dumpsters
2. Document historical illegal dump sites and conduct annual Litter Survey to evaluate and refine cleanup efforts
 - a. Expand Adopt-An-Open-Space to engage more volunteer groups at habitual dump locations
 - b. Manage and monitor Adopt-A-Spot litter removal
3. Increase awareness about the Illegal Dumping Hotline and WCSO Mobile App
 - a. Conduct public outreach to support solid waste cleanup and raise awareness about alternatives to dumping and reporting abilities to deter dumping activity
 - b. Continue coordination of the Illegal Dumping Task Force to support ongoing efforts to reduce and eliminate illegal dumping activity
4. Promote KTMB's Recycling Guide to increase public's awareness of local diversion outlets
 - a. Provide year round reduce, reuse and recycle youth and adult education through KTMB's Waste Warrior's education program
5. Coordinate regional waste minimization efforts of Sustainability Partners in Northern Nevada (SPINN)
 - a. Support and recognize local citizens and businesses that have adopted green initiatives or been involved in increasing diversion rates

6. Work in partnership with the Environmental Health Services Division to review results and design a plan for future waste minimization activities based on the results of the current waste study being conducted by the WCHD
 - a. Working in partnership with the WCHD and SPINN coordinate local efforts to implement plan to reduce waste based on the results of the waste study

Washoe County Health District will be prominently featured as the funder on all of KTMB's materials, literature and media pieces related to these programs using the language "funded by the Washoe County Health District." KTMB will provide regular updates to the Washoe County Health District Board.

Keep Truckee Meadows Beautiful is a 501C3 tax exempt organization 88-0254957 dedicated since 1989 to creating a cleaner, more beautiful region through education and active community involvement. For 15 years KTMB's Executive Director has been Christi Cakiroglu, a Keep America Beautiful Certified Community Environmental Professional which is the highest professional distinction offered through KAB. www.ktmb.org

Keep Truckee Meadows Beautiful
P.O. Box 7412
Reno, NV 89510
(775) 851-5185

DD	AH	
DHO		KD
DA		
Risk		

Staff Report
Board Meeting Date: January 25, 2018

TO: District Board of Health

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

SUBJECT: Approve donation of five (5) Dell Latitude E6520 laptops with a current market value estimated at \$-0- to Amateur Radio Emergency Service (ARES).

SUMMARY

The Washoe County District Board of Health must approve the donation of equipment/supplies to ensure there is a benefit to the citizens of Washoe County.

District Health Strategic Objective supported by this item: Healthy Environment: Create a healthier environment that allows people to safely enjoy everything Washoe County has to offer.

PREVIOUS ACTION

There has been no previous action taken this fiscal year.

BACKGROUND

The Washoe County Health District has five Dell Latitude E6520 laptops that were purchased in June 2011 with 2009 Centers for Disease Control and Prevention Public Health Preparedness Extension funds. These laptops are obsolete and have difficulty meeting the current encryption performance standards. They have been “wiped” by Technology Services and have been identified as inactive on the Washoe County Health District Asset Inventory.

The Washoe County Health District would like to donate these laptops to ARES. Amateur Radio has a long and honored tradition of providing communications during special events and in times of emergency. The Washoe County Amateur Radio Emergency Service exists to provide emergency communications via Amateur Radio, when regular communication systems are overloaded or fail.

The primary mission is to link Served Agencies to the Washoe County Regional Emergency Operations Center (REOC), and to provide links between critical facilities, including hospitals, other emergency management and support agencies, and various field locations. The Washoe County Amateur Radio Emergency Service also provides communications links out of Washoe County, including links to the Nevada State Emergency Operations Center in Carson City.

In the event of a disaster, Washoe County Amateur Radio Emergency Service members perform a number of tasks, including:

- **Emergency and Supplemental Communications:** During emergencies, such as earthquakes or extended power-outages, cellular telephone, Internet and fax systems can fail and public service radio channels can rapidly become saturated. Washoe County Amateur Radio Emergency Service members are capable of providing back-up radio communications, with many additional channels, and using radio, instead of phone lines, to transmit email-like messages and other computer data.
- **Inter-Agency Communications:** Washoe County Amateur Radio Emergency Service members can be assigned to "shadow" key agency personnel to provide inter-agency communications when normal channels are not available. Because of the special frequency and power-output privileges Radio Amateurs have, direct links can be established with locations out of range of normal agency radios, such as the State Emergency Operations Center or FEMA in Washington, D.C.
- **Health and Welfare Information:** Washoe County Amateur Radio Emergency Service members can collect and transmit Health and Welfare messages to the American Red Cross (ARC) and to out-of-area family members on behalf of emergency workers and people in the community, freeing emergency personnel and disaster workers to concentrate on priority matters.
- **Simulated Emergency Tests:** To maintain operator skill and to develop working relationships with our Served Agencies, Washoe County Amateur Radio Emergency Service members participate in various disaster drills, exercises, and other related activities.

During emergencies it is increasingly important to be able to send complex messages that include lists of equipment, supplies, personnel, directions, and other similar types of information. Transmission of such information by voice can and often does lead to errors. Therefore, the use of computers in conjunction with radios provides a way to minimize mistakes and assure that accurate information is sent. The outdated computer equipment in question is perfect for this application.

FISCAL IMPACT

Should the Board approve this donation, there will be no additional fiscal impact to the adopted FY18 budget.

RECOMMENDATION

Staff recommends the District Board of Health approve donation of five (5) Dell Latitude E6520 laptops with a current market value estimated at \$-0- to Amateur Radio Emergency Service (ARES).

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to approve donation of five (5) Dell Latitude E6520 laptops with a current market value estimated at \$-0- to Amateur Radio Emergency Service (ARES)."

DD	CA	—
DHO		—
DA		—
Risk		—

Staff Report
Board Meeting Date: January 25, 2018

TO: District Board of Health
FROM: Charlene Albee, Director, Air Quality Management Division
(775) 784-7211, calbee@washoecounty.us
SUBJECT: Recommendation for the Board to Uphold Notice of Violation Citation No. 5994 Issued to Sandra Nimmo, Case No. 1199, for a violation of the District Board of Health Regulations Governing Air Quality Management with a \$3400.00 Negotiated Fine.

SUMMARY

Washoe County Air Quality Management Division Staff recommends Citation No. 5994 be **upheld** and a fine of **\$3400.00** be levied against Sandra Nimmo for the removal of regulated asbestos containing materials without submitting a National Emission Standards for Hazardous Air Pollutants (NESHAP) Notification, failing to conduct an asbestos survey prior to renovation activities, and failing to follow asbestos control work practices in an EPA regulated facility. Failure to submit a NESHAP Notification, failure to conduct an asbestos survey, and failure to follow proper asbestos control work practices are **major violations** of the District Board of Health Regulations Governing Air Quality Management, specifically Section 030.105(B)(10) National Emission Standards for Hazardous Air Pollutants Subpart M, which is implemented through Section 030.107 Hazardous Air Pollutants, (A) Asbestos Sampling and Notification and (B) Asbestos Control Work Practice.

District Health Strategic Objective supported by this item: Healthy Environment – Create a healthier environment that allows people to safely enjoy everything Washoe County has to offer.

PREVIOUS ACTION

No previous actions.

BACKGROUND

On November 9, 2017, the Washoe County Health District Air Quality Management Division (AQMD) received an anonymous complaint about a possible asbestos disturbance in Unit 23N at Arlington Tower located at 100 N. Arlington in Reno, Nevada. The complainant stated work involving the removal of asbestos containing materials had been performed at this address without obtaining the required permits. A preliminary records search of AQMD's database did not produce any permits or notifications for the noted address. Senior Air Quality Specialist (AQS) Joshua Restori was dispatched to the site to conduct an investigation.

On the same date, Senior AQS Restori met with Sandra Nimmo, the property owner of Unit 23N and observed the work completed in the condominium and immediately noticed the majority of the spray acoustic ceiling texture had been removed. Ms. Nimmo stated that none of the materials in the condominium were tested for asbestos prior to the start of the renovation activities and that she had hired a company, Drywall Dragon, remove the spray acoustic ceiling texture. Senior AQS Restori

AIR QUALITY MANAGEMENT

1001 East Ninth Street | P.O. Box 11130 | Reno, Nevada 89520
AQM Office: 775-784-7200 | Fax: 775-784-7225 | washoecounty.us/health
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inspected the apartment and with Ms. Nimmo's permission, took photographs of the remaining spray acoustic ceiling texture in the corners between the walls and the ceilings. Senior AQS Restori placed a Stop Work Order on the condominium until the remaining ceiling materials and any other suspect asbestos containing materials that were part of the renovation activity were tested for asbestos and properly abated and cleared, if necessary.

Senior AQS Restori inquired with Ms. Nimmo about the location of the spray acoustic ceiling texture waste and determined the material was in a roll-away garbage can in the basement of Arlington Tower. Ms. Nimmo stated that Drywall Dragon used a garden hose to wet the spray acoustic ceiling texture prior to removal and lined the floors of the condominium with plastic to collect the material as it was removed. When the removal was completed, the plastic, with the water saturated spray acoustic ceiling texture, was wrapped up and placed in a roll-away garbage can and taken to the basement of Arlington Tower. No containments or negative air enclosures were utilized during the removal. Senior AQS Restori was led to the garbage cans in the basement and placed a Stop Work Order on each of the cans until the material inside was tested for asbestos and properly abated and cleared, if necessary.

On November 13, 2017, Senior AQS Restori was informed that the spray acoustic texture in Unit 23N contained 4% chrysotile asbestos fibers. The spray acoustic ceiling texture waste in the roll-away garbage cans in the basement of Arlington Tower also contained 4% chrysotile asbestos fibers. Subsequently, a NESHAP Notification was submitted identifying All Eagle, LLC as the abatement company performing the completion of the abatement activities and required clean-up. After numerous failed attempts to contact Dragon Drywall, a referral was made to the State Contractors Board regarding the asbestos abatement work performed without the appropriate licensing.

On December 1, 2017, Senior AQS Restori and Branch Chief Michael Wolf met with Sandra Nimmo and Lyle Nimmo at the AQMD offices to discuss the air quality violations that occurred at Unit 23N. During the meeting, Notice of Violation No. 5594 was issued to Sandra Nimmo for failure to submit a NESHAP Notification for the removal of more than 160 square feet of regulated asbestos containing material, failure to conduct an asbestos survey prior to renovation activities, and failure to use asbestos control practices during the removal of the spray acoustic ceiling texture, each being a major violation of Section 030.107 (A) and (B) of Washoe County District Board of Health Regulations Governing Air Quality Management. Ms. Nimmo understood the violations cited and signed Notice of Violation No. 5594.

On the same date, Branch Chief Wolf conducted a negotiated settlement meeting attended by Senior AQS Restori, Sandra Nimmo and Lyle Nimmo. After careful consideration of all the facts in the case, Branch Chief Wolf recommended that Citation No. 5594 be upheld with a fine of \$3400.00 for the major violations of the Washoe County District Board of Health Regulations Governing Air Quality Management. Ms. Nimmo agreed to the terms of the settlement agreement. A Memorandum of Understanding was signed on this date by all parties present.

FISCAL IMPACT

There are no fiscal impacts resulting from the Board upholding the issuance of the Notice of Violation Citation and associated fine. All fine money collected is forwarded to the Washoe County School District to be used for environmentally focused projects for the benefit of the students.

RECOMMENDATION

Staff recommends the District Board of Health **uphold** Notice of Violation Citation No. 5594, Case No. 1199, and levy a fine in the amount of **\$3400.00** as a negotiated settlement for a **major violation**.

ALTERNATIVE

An alternative to upholding the Staff recommendation as presented would include:

1. The Board may determine no violation of the regulations has occurred and dismiss Citation No. 5594.

Or

2. The Board may determine to uphold Citation No. 5594 and levy any fine in the range of \$0 to \$10,000 per day for the major violation.

POSSIBLE MOTION(s)

Should the Board agree with Staff's recommendation or the alternatives, a possible motion would be:

1. "Move to grant the uphold Citation No. 5594, Case No. 1199, as recommended by Staff."

Or

2. "Move to uphold Citation No. 5594, Case No. 1199, and levy a fine in the amount of (*range of \$0 to \$10,000*) per day for each major violation, with the matter being continued to the next meeting to allow for Sandra Nimmo to be properly noticed."



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



NOTICE OF VIOLATION

NOV 5594

DATE ISSUED: 12-1-2017

ISSUED TO: Sandra Nimmo PHONE #: (209) 993-3010
 MAILING ADDRESS: 416 2nd Street CITY/ST: Galt, CA ZIP: 95632
 NAME/OPERATOR: Sandra Nimmo PHONE #: (209) 993-3010
 COMPLAINT NO. WCMP17-00905 Viol # WV10-AQM17-0015

YOU ARE HEREBY OFFICIALLY NOTIFIED THAT ON 12-1-2017 (DATE) AT 11:25 p.m. (TIME), YOU ARE IN VIOLATION OF THE FOLLOWING SECTION(S) OF THE WASHOE COUNTY DISTRICT BOARD OF HEALTH REGULATIONS GOVERNING AIR QUALITY MANAGEMENT:

- | | |
|--|---|
| <input type="checkbox"/> MINOR VIOLATION OF SECTION: | <input type="checkbox"/> MAJOR VIOLATION OF SECTION: |
| <input type="checkbox"/> 040.030 __ DUST CONTROL | <input type="checkbox"/> 030.000 OPERATING W/O PERMIT |
| <input type="checkbox"/> 040.055 __ ODOR/NUISANCE | <input type="checkbox"/> 030.2175 VIOLATION OF PERMIT CONDITION |
| <input type="checkbox"/> 040.200 __ DIESEL IDLING | <input checked="" type="checkbox"/> 030.105 ASBESTOS/NESHAP |
| <input type="checkbox"/> OTHER _____ | <input checked="" type="checkbox"/> OTHER <u>030.107 (A)(B)</u> |

VIOLATION DESCRIPTION: 030.107 (A)(B) for failure to submit EPA NESHAP Notification per 030.105 for removal of RACM >160 ft², failure to conduct an asbestos survey prior to renovation and failure to use asbestos control work practices.

LOCATION OF VIOLATION: 100 N. Arlington Unit 23N Reno, Nevada 89501

POINT OF OBSERVATION: At Unit 23N and basement of Arlington Tower

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

Emissions Observed: Visual emissions of asbestos per NESHAP standards
 (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 12-1-17 (date) you are in violation of the section(s) cited above. You are hereby ordered to abate the above violation within 48 hours 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: [Signature] Date: 12/1/17

Issued by: Joshua C. Restori Title: Sr. AQS

PETITION FOR APPEAL FORM PROVIDED

**WASHOE COUNTY
HEALTH DISTRICT**

ENHANCING QUALITY OF LIFE

MEMORANDUM OF UNDERSTANDING

**WASHOE COUNTY DISTRICT HEALTH DEPARTMENT
AIR QUALITY MANAGEMENT DIVISION**

Date: December 1, 2017

Company Name: Sandra Nimmo

Address: 416 2nd Street Gault, CA 95632

Notice of Violation # 5594 Case # 1199

The staff of the Air Quality Management Division of the Washoe County Health District issued the above referenced citation for the violation of Regulation: 030.107 (A) Asbestos Sampling and Notification of Abatement/Disturbance and 030.107 (B) Asbestos Control Work Practices. Complete an EPA NESHAP Notification of Demolition and Renovation within 2 weeks of the date of this MOU.

A settlement of this matter has been negotiated between the undersigned parties resulting in a penalty amount of \$ \$3400.00. This settlement will be submitted to the District Board of Health for review at the regularly scheduled meeting on January 25, 2018

The undersigned agrees to waive an appeal to the Air Pollution Control Hearing Board so this matter may be submitted directly to the District Board of Health for consideration.



Signature of Company Representative

Sandra Nimmo

Print Name

Responsible Party

Title

Witness



Signature of District Representative

Michael Wolf

Print Name

Branch Chief

Title



Witness



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

Company Name Sandra Nimmo
Contact Name Sandra Nimmo

Case 1199 NOV 5994 WVIO-AQM 17-0015

I. Violation of Section 030.107 (A) Asbestos Sampling and Notification

I. **Recommended/Negotiated Fine** = \$ 1800

II. Violation of Section 030.107 (B) Asbestos Control Work Practices

II. **Recommended/Negotiated Fine** = \$ 1600

III. Violation of Section 0

III. **Recommended/Negotiated Fine** = \$ 0

IV. Violation of Section 0

IV. **Recommended/Negotiated Fine** = \$ 0

V. Violation of Section 0

V. **Recommended/Negotiated Fine** = \$ 0

Total Recommended/Negotiated Fine = \$ 3400



Air Quality Specialist

12-01-2017

Date



Senior AQ Specialist/Supervisor

12/1/17

Date

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

Company Name Sandra Nimmo
Contact Name Sandra Nimmo

Case 1199 NOV 5994 WVIO-AQM 17-0015

Violation of Section 030.107 (A) Asbestos Sampling and Notification

I. Base Penalty as specified in the Penalty Table = \$ 2,000.00

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

Comment: Violation of 030.107 (A) constitutes a major violation per 020.040.A

2. Toxicity of Release

Criteria Pollutant – 1x
Hazardous Air Pollutant – 2x **Adjustment Factor** 2.0

Comment: Asbestos is a hazardous air pollutant per the Clean Air Act

3. Environmental/Public Health Risk (Proximity to sensitive environment or group)

Negligible – 1x Moderate – 1.5x Significant – 2x **Adjustment Factor** 1.0

Comment: The disturbed asbestos material remains inside the unit and building

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

B. Adjusted Base Penalty

Base Penalty \$ 2000 x Adjustment Factor 2 = \$ 4000

C. Multiple Days or Units in Violation

Adjusted Penalty \$ 4000 x Number of Days or Units 1 = \$ 4000

Comment: Citation reflects one day of violation

D. Economic Benefit

Avoided Costs \$ \$500.00 + Delayed Costs \$ 0 = \$ 500

Comment: Asbestos Sampling (\$500)

Penalty Subtotal

Adjusted Base Penalty \$ 4000 + Economic Benefit \$ 500 = \$ 4500

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

III. Penalty Adjustment Consideration

A. Degree of Cooperation (0 – 25%)	-	<u>25%</u>
B. Mitigating Factors (0 – 25%)	-	<u>25%</u>
1. Negotiated Settlement		
2. Ability to Pay		
3. Other (explain)		
Comment <u>Willing to negotiate settlement</u>		
C. Compliance History		
No Previous Violations (0 – 10%)	-	<u>10%</u>
Comment <u>No prior violations</u>		
Similar Violation in Past 12 months (25 - 50%)	+	<u> </u>
Comment: <u>NA</u>		
Similar Violation within past 3 year (10 - 25%)	+	<u> </u>
Comment: <u>NA</u>		
Previous Unrelated Violation (5 – 25%)	+	<u> </u>
Comment: <u>NA</u>		
Total Penalty Adjustment Factors – sum of A, B, & C		<u>-60%</u>

IV. Recommended/Negotiated Fine

Penalty Adjustment:								
\$ <u>4500</u>	x	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; text-align: center;"><u>-60%</u></td> <td style="width: 5%; text-align: center;">=</td> <td style="width: 65%; text-align: right;"><u>-2700</u></td> </tr> <tr> <td style="text-align: center;">Total Adjustment Factors (From Section III)</td> <td></td> <td style="text-align: right;">Total Adjustment Value</td> </tr> </table>	<u>-60%</u>	=	<u>-2700</u>	Total Adjustment Factors (From Section III)		Total Adjustment Value
<u>-60%</u>	=	<u>-2700</u>						
Total Adjustment Factors (From Section III)		Total Adjustment Value						
Penalty Subtotal (From Section II)								

Additional Credit for Environmental Investment/Training - \$

Comment: NA

Adjusted Penalty:


\$ <u>4500</u>	+/-	\$ <u>-2700</u>	=	\$ <u>1800</u>
Penalty Subtotal (From Section II)		Total Adjustment Value (From Section III + Credit)		Recommended/Negotiated Fine



Air Quality Specialist

12-1-2017

Date



Senior AQ Specialist/Supervisor

12/1/17

Date

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

Company Name Sandra Nimmo
Contact Name Sandra Nimmo

Case 1199 NOV 5994 WVIO-AQM 17-0015

Violation of Section 030.107 (B) Asbestos Control Work Practices

I. Base Penalty as specified in the Penalty Table = \$ 2000

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

Comment: Violation of 030.107 (B) constitutes a major violation per 020.040.A

2. Toxicity of Release

Criteria Pollutant – 1x
Hazardous Air Pollutant – 2x **Adjustment Factor** 2

Comment: Asbestos is a hazardous air pollutant per the Clean Air Act

3. Environmental/Public Health Risk (Proximity to sensitive environment or group)

Negligible – 1x Moderate – 1.5x Significant – 2x **Adjustment Factor** 1

Comment: The disturbed asbestos material remains inside the unit and building

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

B. Adjusted Base Penalty

Base Penalty \$ 2000 x Adjustment Factor 2 = \$ 4000

C. Multiple Days or Units in Violation

Adjusted Penalty \$ 4000 x Number of Days or Units 1 = \$ 4000

Comment: Citation reflects one day of violation

D. Economic Benefit

Avoided Costs \$ 0 + Delayed Costs \$ 0 = \$ 0

Comment: Clean-up of disturbed asbestos paid for by the property owner

Penalty Subtotal

Adjusted Base Penalty \$ 4000 + Economic Benefit \$ 0 = \$ 4000

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

III. Penalty Adjustment Consideration

A. Degree of Cooperation (0 – 25%)	-	<u>25%</u>
B. Mitigating Factors (0 – 25%)	-	<u>25%</u>
1. Negotiated Settlement		
2. Ability to Pay		
3. Other (explain)		
Comment <u>Willing to negotiate settlement</u>		
C. Compliance History		
No Previous Violations (0 – 10%)	-	<u>10%</u>
Comment <u>No prior violations</u>		
Similar Violation in Past 12 months (25 - 50%)	+	<u>0%</u>
Comment: <u>NA</u>		
Similar Violation within past 3 year (10 - 25%)	+	<u>0%</u>
Comment: <u>NA</u>		
Previous Unrelated Violation (5 – 25%)	+	<u>0%</u>
Comment: <u>NA</u>		
Total Penalty Adjustment Factors – sum of A, B, & C		<u>-60%</u>

IV. Recommended/Negotiated Fine

Penalty Adjustment:								
\$ <u>4000</u>	x	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; text-align: center;"><u>-60%</u></td> <td style="width: 5%; text-align: center;">=</td> <td style="width: 65%; text-align: right;"><u>-2400</u></td> </tr> <tr> <td style="text-align: center;">Total Adjustment Factors (From Section III)</td> <td></td> <td style="text-align: right;">Total Adjustment Value</td> </tr> </table>	<u>-60%</u>	=	<u>-2400</u>	Total Adjustment Factors (From Section III)		Total Adjustment Value
<u>-60%</u>	=	<u>-2400</u>						
Total Adjustment Factors (From Section III)		Total Adjustment Value						
Penalty Subtotal (From Section II)								

Additional Credit for Environmental Investment/Training - \$ 0

Comment: NA

Adjusted Penalty:

\$ <u>4000</u>	+/-	\$ <u>-2400</u>	=	\$ <u>1600</u>
Penalty Subtotal (From Section II)		Total Adjustment Value (From Section III + Credit)		Recommended/Negotiated Fine


Air Quality Specialist

12-01-17
Date


Senior AQ Specialist/Supervisor

12/1/17
Date

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health
FROM: James English, EHS Supervisor
775-328-2610, jenglish@washoecounty.us

SUBJECT: Request to provide a 60 day continuance from January 25, 2018 to March 25, 2018, to the temporary program in which septic repair fees are not collected on single family homes affected by Swan Lake (and the immediate vicinity) flooding in Lemmon Valley, in the instance where verification is provided in writing by the insurance carrier that permit cost for repairs is not covered by the applicable insurance policy as approved on May 25, 2017. This action applies to the owner of record as of February 1, 2017, on the following Assessor Parcel Numbers, with a building permit application deadline of July 1, 2020 or Washoe County Health District (WCHD) permit application deadline of March 25, 2018: (APN 086-303-18, 086-303-19, 086-303-22, 086-305-02). All associated costs will be covered through the Health Fund Account.

SUMMARY

The Environmental Health Services Division (EHS) is requesting the District Board of Health (Board) consider the a 60 day continuance from January 25, 2018 to March 25, 2018 of the temporary program of not collecting septic repair permit fees and any applicable plan review fees for residential onsite-sewage disposal system (OSDS) repairs in the areas affected by flooding with the North Valleys Flood Incident as part of a federally declared disaster as originally approved on May 25, 2017. The intent of this program was to provide assistance to property owners for single family homes affected by lake flooding in Lemmon Valley where verification is provide in writing by the insurance carrier that the permit costs for repairs are covered by the applicable insurance policy. The continuation for the program would apply to the owners of record as of February 1, 2017, on the following Accessor Parcel Numbers, (APN 086-303-18, 086-303-19, 086-303-22, 086-305-02). All associated costs will be covered through the Health Fund Account.

District Health Strategic Objective supported by this item:

1. **Healthy Environment:** Create a healthier environment that allows people to safely enjoy everything Washoe County has to offer.

PREVIOUS ACTION

At the April 27, 2017 Board meeting, an item was heard to request a temporary program in which fees are not collected for residents affected by North Valley flooding who voluntarily connect to the Truckee Meadows Water Authority (TMWA). Direction was provided to consistently follow the eight bullet points the BCC provided the Director of Washoe County Community Services Department (CSD) regarding the not collecting of fees associated with red and yellow tagged properties as a result of flooding in Lemmon Valley and as part of the area receiving a federal disaster declaration.

At the May 25, 2017 Board meeting, the temporary program was approved by the Board with an expiration date of WCHD permit applications being September 30, 2017.

BACKGROUND

Pursuant to NRS 439.350 and NRS 439.410, the District Board of Health oversees all sanitary conditions of Washoe County and has jurisdiction over public health matters except those emergency medical services matters listed in NRS 450B. The WCHD through NRS 439.410 has the authority to adopt regulations regulating sanitation and sanitary practices in the interest of public health, to provide for the sanitary protection of water and food supplies and to protect and promote the public health generally in the geographical area subject to its jurisdiction.

The Board has the discretion to adopt a schedule of reasonable fees to be collected for issuing or renewing any health permit or license required to be obtained from the Board. The fees are for the sole purpose of defraying the costs and expenses of the procedures for issuing licenses and permits, and investigations related thereto. Based on the public health implications, staff is recommending that the Board continue the temporary program of not collecting fees from owners of single family homes affected by lake flooding in Lemmon Valley, limited to the following Accessor Parcel Numbers, with a WCHD permit application of March 25, 2018: (APN 086-303-18, 086-303-19, 086-303-22, 086-305-02).

The primary basis for the limited continuation of this program is the above referenced single family homes were still impacted by flood waters on September 30, 2017. Therefore, meaning the property owners could not take part in the program as their properties were inaccessible and therefore unable to be properly evaluated for damage. Since September 30, 2017 Washoe County has successfully built additional flood berms and temporary wall barriers around these homes which have allowed the property owners to gain access to their properties with the intent of making necessary repairs and moving back in to their properties.

FISCAL IMPACT

Should the Board approve this item, the FY 18 adopted budget would be negatively impacted with a potential reduction in revenue in the total maximum amount of \$6,320.00. However, based on the evaluation of these homes, it is reasonable to expect a reduction in revenue in the approximate amount of \$1,580.00. The fees effective July 1, 2017 are septic repair = \$1,580.00 and onsite abandonment permit/connect to sewer = \$484.00. EHS will continue to look for ways to reduce expenditures in FY18 to help offset the reduction in budgeted revenue.

RECOMMENDATION

Staff recommends: The Washoe County Board of Health provide a 60 day continuance from January 25, 2018 to March 25, 2018, to the temporary program in which septic repair fees are not collected from single family homes affected by Swan Lake (and the immediate vicinity) flooding in Lemmon Valley, in the instance where verification is provided in writing by the insurance carrier that permit cost for repairs is not covered by the applicable insurance policy as approved on May 25, 2017. This action applies to the owner of record as of February 1, 2017, on the following Accessor Parcel Numbers, with building permit application deadline of July 1, 2020 or Washoe County Health District (WCHD) permit application deadline of March 25, 2018: (APN 086-303-18, 086-303-19, 086-303-22, 086-305-02).

Subject: Septic Repair Permit Fee
Date: January 25, 2017
Page 3 of 3

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to approve a 60 day continuance from January 25, 2018 to March 25, 2018, the temporary program in which septic repair fees are not collected from single family homes affected by Swan Lake (and the immediate vicinity) flooding in Lemmon Valley, in the instance where verification is provided in writing by the insurance carrier that permit cost for repairs is not covered by the applicable insurance policy as approved on May 25, 2017. This action applies to the owner of record as of February 1, 2017, on the following Assessor Parcel Numbers, with building permit application deadline of July 1, 2020 or Washoe County Health District (WCHD) permit application deadline of March 25, 2018: (APN 086-303-18, 086-303-19, 086-303-22, 086-305-02).

DD	NA	___
DHO		___
DA	NA	___
Risk	NA	___

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health
FROM: Anna Heenan, Administrative Health Services Officer
 328-2417, aheenan@washoecounty.us
SUBJECT: Acknowledge receipt of the Health Fund Financial Review for December, Fiscal Year 2018

SUMMARY

The six months of fiscal year 2018, (FY18) ended with a cash balance of \$4,227,316. Total revenues of \$11,135,535 were 49.2% of budget and an increase of \$1,707,583 over FY17. The expenditures totaled \$11,158,791 or 47.6% of budget and up \$711,100 compared to FY17 mainly due to the increased costs for chemicals required for additional mosquito abatement treatments.

District Health Strategic Objective supported by this item: Financial Stability: Enable the Health District to make long-term commitments in areas that will positively impact the community’s health by growing reliable sources of income.

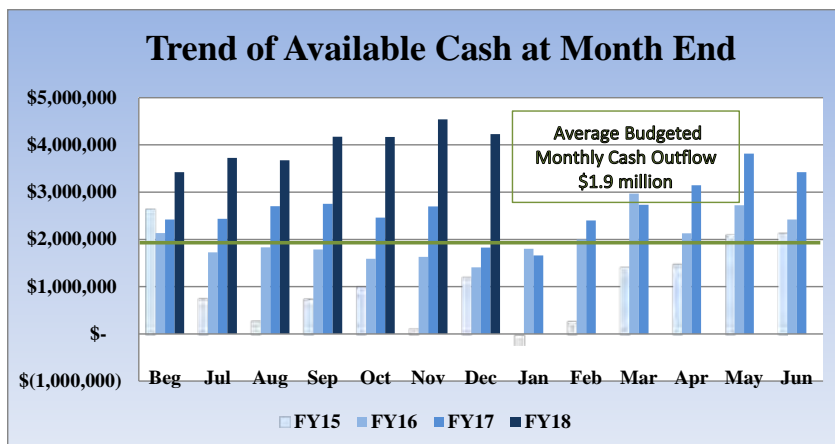
PREVIOUS ACTION

Fiscal Year 2018 Budget was adopted May 23, 2017.

BACKGROUND

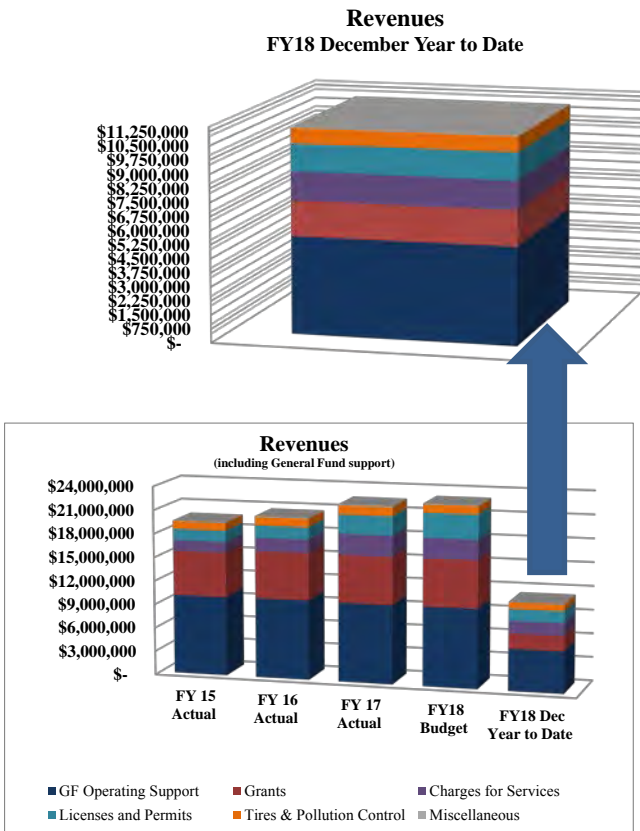
Review of Cash

The available cash at the end of December, FY18, was \$4,227,316 up 131.7% or \$2,402,472 compared to the same time in FY17. The encumbrances and other liability portion of the cash balance totals \$1.0 million; the portion of cash restricted as to use is approximately \$1.5 million (e.g. Air Quality and the Solid Waste Management programs restricted cash); leaving a balance of approximately \$1.7 million.



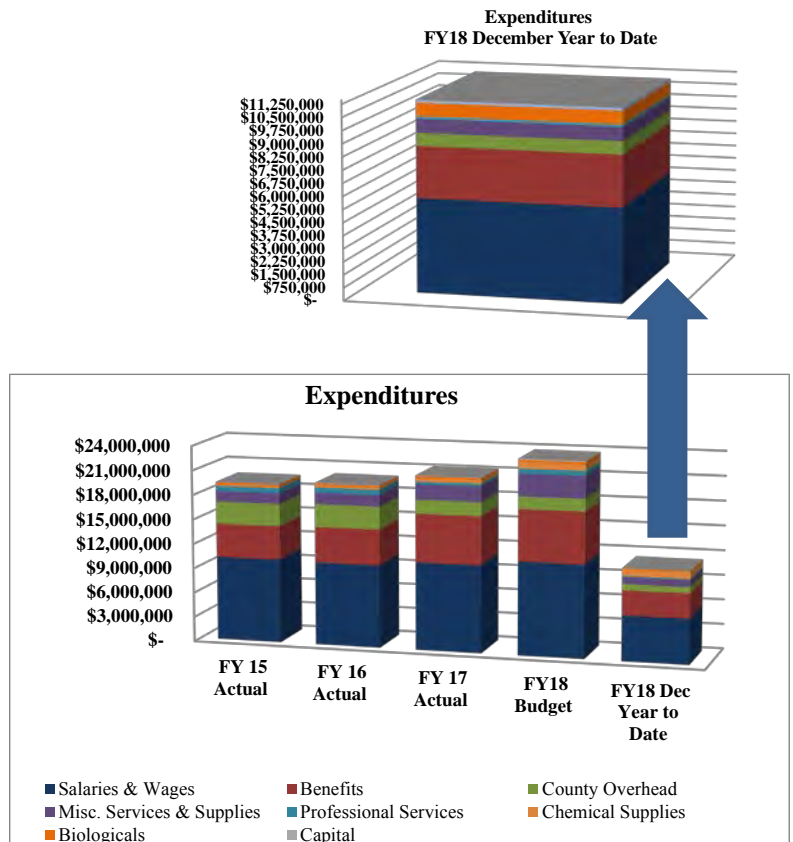
Note: January FY15 negative cash is due to no County General Fund support transferred to the Health Fund leading to a negative cash situation.

Review of Revenues (including transfers from General Fund) and Expenditures by category



Total year to date **revenues** of \$11,135,535 were up \$1,707,583 compared to December FY17; of that increase, \$534,835 was due to the County General Fund transfer for the additional mosquito abatement required this fiscal year and \$388,875 of Air Pollution Control funds not received until the 4th quarter last fiscal year. The revenue categories up over last fiscal year are as follows: licenses and permits of \$1,485,703 were up \$422,647 or 39.8% mainly due to fee increases and an increase in work load; charges for services of \$1,570,330 up \$479,486 or 44.0%; tire and pollution control revenues of \$835,055 up \$552,097 or 195.1% due to timing of receiving the air pollution control funds; and, the County General Fund transfer of \$5,293,263 up \$394,835 or 8.1% due to the contingency transfer for mosquito abatement. The revenue categories down compared to FY17 included: federal and state grant reimbursements of \$1,929,588 down \$139,134 or 6.7%; and, miscellaneous revenues of \$21,597 down \$2,346.

The total year to date **expenditures** of \$11,158,791 increased by \$711,100 or 6.8% compared to the same period in FY17 mainly due to the \$534,816 additional chemical supplies purchased for Mosquito abatement. Salaries and benefits expenditures for the fiscal year were \$8,511,785 up \$226,938 or 2.7% over the prior year. The total services and supplies of \$2,632,203 were up \$504,699 due to the increase in chemical costs. The major expenditures included in the services and supplies are: the professional services which totaled \$137,194 and were up \$73,907 or 116.8% over the prior year; chemical supplies of \$766,309 were up 226.1% or \$531,334 over last year; the biologicals of \$150,424 were down \$14,113 10.4%; and, County overhead charges of \$760,311 were down 10.6% or \$90,087. There has been \$14,802 in capital expenditures down \$20,539 or 58.1% compared to FY17.



Review of Revenues and Expenditures by Division

ODHO has received grant funding of \$3,365 for workforce development initiatives and spent \$473,465 up \$111,772 over FY17 mainly due to the cost associated with the Community Health Needs Assessment and the hiring of Public Service Interns. **AHS** has spent \$569,495 up \$2,598 compared to FY17. **AQM** revenues were \$1,637,374 up \$634,984 compared to FY17 due to a lag in FY17 receipts of the Air Pollution Control Funds from the DMV and spent \$1,375,139 down \$86,670 over last fiscal year due to costs for advertisement campaigns and support for the Reno-Tahoe Clean Cities Coalition in FY17 not spent in FY18. **CCHS** revenue was \$1,572,951 up \$229,876 over FY17 mainly due to Medicaid and insurance reimbursements and spent \$3,702,135 or \$113,986 more than FY17 due to an increase in salaries and benefits costs for FY18. **EHS** revenue was \$1,974,564 up \$599,766 over FY17 mainly due to increased permitting revenue and spent \$3,813,590 that was an increase of \$583,923 over last year due to the increased chemical cost for the Vector program. **EPHP** revenue was \$654,017 down \$150,099 over last year mainly due to loss of grant funding for the Public Health Preparedness program and expenditures were \$1,224,968 down \$14,508 over FY17.

Washoe County Health District Summary of Revenues and Expenditures Fiscal Year 2013/2014 through December Year to Date Fiscal Year 2017/2018 (FY18)									
	Actual Fiscal Year			Fiscal Year 2016/2017		Fiscal Year 2017/2018			
	2013/2014	2014/2015	2015/2016	Actual Year End (audited)	December Year to Date	Adjusted Budget	December Year to Date	Percent of Budget	FY18 Increase over FY17
Revenues (all sources of funds)									
ODHO	-	-	15,000	51,228	5,145	6,639	3,365	50.7%	-34.6%
AHS	87,930	151	-	-	-	-	-	-	-
AQM	2,491,036	2,427,471	2,520,452	2,979,720	1,002,390	3,195,239	1,637,374	51.2%	63.3%
CCHS	3,388,099	3,520,945	3,506,968	3,872,898	1,343,075	3,777,268	1,572,951	41.6%	17.1%
EHS	1,890,192	2,008,299	2,209,259	3,436,951	1,374,798	3,789,441	1,974,564	52.1%	43.6%
EPHP	1,805,986	1,555,508	2,141,334	2,027,242	804,116	1,818,890	654,017	36.0%	-18.7%
GF support	8,603,891	10,000,192	10,076,856	10,002,381	4,898,428	10,051,691	5,293,263	52.7%	8.1%
Total Revenues	\$18,267,134	\$19,512,566	20,469,870	\$22,370,420	\$ 9,427,952	\$22,639,168	\$ 11,135,535	49.2%	18.1%
Expenditures (all uses of funds)									
ODHO	-	481,886	594,672	904,268	361,693	1,079,245	473,465	43.9%	30.9%
AHS	1,336,740	1,096,568	996,021	1,119,366	566,897	1,156,241	569,495	49.3%	0.5%
AQM	2,524,702	2,587,196	2,670,636	2,856,957	1,461,809	3,437,526	1,375,139	40.0%	-5.9%
CCHS	6,949,068	6,967,501	6,880,583	7,294,144	3,588,149	7,669,327	3,702,135	48.3%	3.2%
EHS	5,737,872	5,954,567	5,939,960	6,366,220	3,229,667	7,515,458	3,813,590	50.7%	18.1%
EPHP	2,374,417	2,312,142	2,688,659	2,616,411	1,239,476	2,563,833	1,224,968	47.8%	-1.2%
Total Expenditures	\$18,922,800	\$19,399,859	19,770,532	\$21,157,367	\$10,447,691	\$23,421,631	\$ 11,158,791	47.6%	6.8%
Revenues (sources of funds) less Expenditures (uses of funds):									
ODHO	-	(481,886)	(579,672)	(853,040)	(356,548)	(1,072,606)	(470,100)		
AHS	(1,248,810)	(1,096,417)	(996,021)	(1,119,366)	(566,897)	(1,156,241)	(569,495)		
AQM	(33,666)	(159,725)	(150,184)	122,763	(459,419)	(242,287)	262,235		
CCHS	(3,560,969)	(3,446,556)	(3,373,615)	(3,421,246)	(2,245,074)	(3,892,059)	(2,129,184)		
EHS	(3,847,680)	(3,946,268)	(3,730,701)	(2,929,270)	(1,854,869)	(3,726,017)	(1,839,025)		
EPHP	(568,431)	(756,634)	(547,325)	(589,168)	(435,361)	(744,943)	(570,951)		
GF Operating	8,603,891	10,000,192	10,076,856	10,002,381	4,898,428	10,051,691	5,293,263		
Surplus (deficit)	\$ (655,666)	\$ 112,707	699,338	\$ 1,213,053	\$ (1,019,740)	\$ (782,463)	\$ (23,256)		
Fund Balance (FB)	\$ 2,155,799	\$ 2,268,506	\$ 2,967,844	\$ 4,180,897		\$ 3,398,434			
FB as a % of Expenditures	11%	12%	15%	20%		15%			

Note: ODHO=Office of the District Health Officer, AHS=Administrative Health Services, AQM=Air Quality Management, CCHS=Community and Clinical Health Services, EHS=Environmental Health Services, EPHP=Epidemiology and Public Health Preparedness, GF=County General Fund

FISCAL IMPACT

No fiscal impact associated with the acknowledgement of this staff report.

RECOMMENDATION

Staff recommends that the District Board of Health acknowledge receipt of the Health Fund Financial Review for December, Fiscal Year 2018.

POSSIBLE MOTION

Move to acknowledge receipt of the Health Fund Financial Review for December, Fiscal Year 2018.

Attachment:
Health District Fund financial system summary report

Period: 1 thru 6 2018
 Accounts: GO-P-L P&L Accounts
 Business Area: *

Fund: 202 Health Fund
 Fund Center: 000 Default Washoe County
 Functional Area: 000 Standard Functional Area Hiera

Accounts	2018 Plan	2018 Actuals	Balance	Act%	2017 Plan	2017 Actual	Balance	Act%
705230 Medicare April 1986	147,351	75,616	71,735	51	143,403	73,114	70,289	51
705240 Insur Budgeted Incr	48,610		48,610					
705320 Workmens Comp	97,239	48,978	48,261	50	93,193	48,853	44,340	52
705330 Unemploy Comp	10,224	1,495	8,729	15	13,751	1,764	11,987	13
705360 Benefit Adjustment	28,461		28,461		21,529		21,529	
* Employee Benefits	6,317,860	3,013,886	3,303,974	48	6,117,014	2,958,692	3,158,322	48
710100 Professional Services	463,912	78,000	385,912	17	655,630	33,288	622,342	5
710101 Lab Testing Services								
710105 Medical Services	9,971	2,083	7,888	21	9,971	1,626	8,345	16
710108 MD Consultants	58,936	20,173	38,763	34	61,210	21,948	39,263	36
710110 Contracted/Temp Services	53,610	36,940	16,670	69	39,600	6,425	33,175	16
710119 Subcontracted Payments								
710155 Lobbying Services								
710200 Service Contract	63,129	70,278	7,149-	111	91,731	45,725	46,006	50
710201 Laundry Services		911	911-					
710205 Repairs and Maintenance	13,545	8,970	4,575	66	14,843	7,197	7,646	48
710210 Software Maintenance	3,000	3,059	59-	102	12,319	2,942	9,378	24
710300 Operating Supplies	145,399	50,760	94,640	35	178,449	77,786	100,663	44
710302 Small Tools & Allow	1,435	36	1,399	2	1,435	1,266	169	88
710308 Animal Supplies	1,600	780	820	49	1,600	1,049	551	66
710312 Special Dept Expense		480	480-					
710319 Chemical Supplies	767,535	766,309	1,226	100	438,225	234,975	203,250	54
710325 Signs and Markers								
710334 Copy Machine Expense	26,237	9,276	16,960	35	35,875	9,793	26,082	27
710335 Copy Machine-Copy Charges	4,794	3,316	1,478	69	2,001	2,887	886-	144
710350 Office Supplies	38,016	16,771	21,245	44	42,667	21,398	21,269	50
710355 Books and Subscriptions	4,953	2,558	2,394	52	15,690	4,417	11,273	28
710360 Postage	20,105	7,682	12,423	38	21,774	7,923	13,851	36
710361 Express and Courier	100	13	87	13	370	7	363	2
710391 Fuel & Lube	125		125		125		125	
710400 Payments to Other Agencies	140,650	93,061	47,589	66	31,500	20,538	10,962	65
710412 Do Not Use								
710500 Other Expense	28,430	3,088	25,342	11	105,780	5,812	99,968	5
710502 Printing	29,093	4,183	24,910	14	26,573	3,676	22,897	14
710503 Licenses & Permits	8,845	3,023	5,822	34	9,245	3,620	5,625	39
710504 Registration		1,400	1,400-			504	504-	
710505 Rental Equipment		1,812	1,812-		1,800	1,800		100
710506 Dept Insurance Deductible		150	150-			284	284-	
710507 Network and Data Lines	7,550	3,280	4,270	43	9,662	4,262	5,400	44
710508 Telephone Land Lines	36,397	17,567	18,830	48	36,606	17,220	19,386	47
710509 Seminars and Meetings	43,103	15,115	27,989	35	47,577	11,679	35,898	25
710512 Auto Expense	10,017	3,059	6,959	31	13,109	3,776	9,333	29
710514 Regulatory Assessments	20,000	9,923	10,077	50	20,000	6,836	13,164	34

Period: 1 thru 6 2018
 Accounts: GO-P-L P&L Accounts
 Business Area: *

Fund: 202 Health Fund
 Fund Center: 000 Default Washoe County
 Functional Area: 000 Standard Functional Area Hiera

Accounts	2018 Plan	2018 Actuals	Balance	Act%	2017 Plan	2017 Actual	Balance	Act%
710519 Cellular Phone	14,641	5,431	9,210	37	14,833	6,935	7,898	47
710529 Dues	32,654	30,403	2,251	93	8,362	31,381	23,019-	375
710535 Credit Card Fees	51,157	27,818	23,339	54	52,157	12,995	39,162	25
710546 Advertising	166,247	28,975	137,272	17	149,712	85,294	64,417	57
710551 Cash Discounts Lost		6				9	9-	
710563 Recruitment		771	771-					
710571 Safety Expense	57,891	17,709	40,182	31	55,000	2,030	52,970	4
710577 Uniforms & Special Clothing	5,200	2,197	3,003	42	5,657	1,618	4,039	29
710585 Undesignated Budget	794,954		794,954		450,000		450,000	
710594 Insurance Premium	5,815		5,815		5,815		5,815	
710600 IT Lease-Office Space	76,607	38,303	38,303	50	76,607	34,731	41,876	45
710620 IT Lease-Equipment								
710703 Biologicals	277,212	150,424	126,789	54	302,681	136,311	166,371	45
710714 Referral Services	6,780	1,808	4,972	27	6,780		6,780	
710721 Outpatient	114,985	41,922	73,063	36	108,555	43,061	65,494	40
710872 Food Purchases	2,744	669	2,075	24	2,994	676	2,319	23
711008 Combined Utilities	90,800	45,400	45,400	50	90,800	45,400	45,400	50
711010 Utilities								
711100 ESD Asset Management	40,091	21,168	18,923	53	47,382	23,475	23,907	50
711113 Equip Srv Replace	55,159	24,052	31,107	44	44,876	19,800	25,076	44
711114 Equip Srv O & M	64,486	39,015	25,472	61	66,315	32,328	33,987	49
711115 Equip Srv Motor Pool	5,000		5,000		5,000		5,000	
711116 ESD Vehicle Lease								
711117 ESD Fuel Charge	27,852	16,000	11,853	57	34,167	14,325	19,842	42
711119 Prop & Liab Billings	82,007	41,004	41,004	50	82,007	39,354	42,653	48
711210 Travel	164,774	40,830	123,944	25	183,341	36,400	146,941	20
711213 Travel-Non Cnty Pers		1,944	1,944-			2,148	2,148-	
711300 Cash Over Short		0-	0			0	0-	
711399 ProCard in Process						41	41-	
711400 Overhead - General Fund	1,520,621	760,311	760,310	50	1,700,797	850,398	850,399	50
711504 Equipment nonCapital	83,270	55,279	27,991	66	75,392	76,200	808-	101
711508 Computers nonCapital	20,000	1,944	18,056	10				
711509 Comp Sftw nonCap	2,631	4,770	2,139-	181				
* Services and Supplies	5,764,065	2,632,203	3,131,861	46	5,494,596	13,856	13,856-	38
781004 Equipment Capital	100,000		100,000		40,472	35,340	5,132	87
781007 Vehicles Capital								
781009 Computer Software Capital								
** Capital Outlay	25,000	14,802	10,199	59	25,000		25,000	
** Expenses	125,000	14,802	110,199	12	65,472	35,340	30,132	54
621001 Transfer From General	23,537,198	11,158,791	12,378,407	47	22,794,942	10,389,610	12,405,332	46
* Transfers In	10,051,691-	5,293,263-	4,758,428-	53	10,002,381-	4,898,428-	5,103,953-	49
812230 To Reg Permits-230	10,051,691-	5,293,263-	4,758,428-	53	10,002,381-	4,898,428-	5,103,953-	49
814430 To Reg Permits Capit	100,271		100,271		58,081	58,081		100

Period: 1 thru 6 2018 P&L Accounts
 Accounts: GO-P-L
 Business Area: *

Fund: 202 Health Fund
 Fund Center: 000 Default Washoe County
 Functional Area: 000 Standard Functional Area Hiera

Accounts	2018 Plan	2018 Actuals	Balance	Act%	2017 Plan	2017 Actual	Balance	Act%
* Transfers Out	100,271		100,271		58,081	58,081		100
** Other Financing Src/Use	9,951,420-	5,293,263-	4,658,157-	53	9,944,300-	4,840,347-	5,103,953-	49
*** Total	782,463	23,256	759,207	3	1,227,669	1,019,740	207,929	83

DD	CA	-
DHO		10
DA		

Staff Report
Board Meeting Date: January 25, 2018

TO: District Board of Health

FROM: Charlene Albee, Director, Air Quality Management Division
(775) 784-7211, calbee@washoecounty.us

SUBJECT: Review, discussion and possible adoption of the Business Impact Statement regarding Proposed Revisions to the District Board of Health Regulations Governing Air Quality Management, Section 040.080 (Gasoline Transfer And Dispensing Facilities) with a finding that the revised regulations do not impose a direct and significant economic burden on a business; nor do the revised regulations directly restrict the formation, operation or expansion of a business; and set a public hearing for possible adoption of the proposed revisions to the Regulations for February 22, 2018 at 1:00 pm.

SUMMARY

The Washoe County District Board of Health must adopt any changes to the District Board of Health Regulations Governing Air Quality Management (Regulations). Per NRS 237, Business Impact Statements “must be considered by the governing body at its regular meeting next preceding any regular meeting held to adopt” the proposed revisions.

District Health Strategic Objective supported by this item: #2 - Healthy Environment: Create a healthier environment that allows people to safely enjoy everything Washoe County has to offer.

PREVIOUS ACTION

February 23, 2017. The District Board of Health adopted proposed regulations to remove Phase II vapor recovery requirements. Per Regulation 020.015 (Adopting, Amending Regulations), proposed rule revisions are required to be published in the local newspaper once a week for three (3) weeks. Unfortunately, the Notice of Proposed Action for the proposed revision to Section 040.080 was only published twice (2). This staff report documents the correct publication of the Notice of Proposed Action.

December 20, 2012. A revision to Section 040.080, Subsection C – Standards, provided for an exemption from the Phase II vapor recovery requirements for facilities that could demonstrate at least 95% of the fleet vehicles being fueled were equipped with on-road vapor recovery systems.

August 7, 2012. EPA issued a memorandum allowing air districts to remove Phase II vapor recovery requirements.

April 22, 2005. A revision to Section 040.080 brought the Regulations into compliance with the then current U.S. Environmental Protection Agency (EPA) guidelines on Phase I and Phase II vapor recovery.

BACKGROUND

Gasoline dispensing pump vapor control devices, commonly referred to as Phase II vapor recovery, are systems that control volatile organic compounds (VOCs) released during the refueling of motor vehicles. This process takes the vapors normally emitted directly into the atmosphere when pumping gas and recycles them back into the fuel storage tanks, preventing them from polluting the air. The Phase II system controls the release of VOCs, benzene and other toxics emitted from gasoline.

Since the early 2000s, new passenger cars, light-duty trucks, and most heavy-duty gasoline powered vehicles are required to be equipped with onboard refueling vapor recovery (ORVR) systems. ORVR systems are carbon canisters installed directly on automobiles to capture the fuel vapors evacuated from the gasoline tank before they reach the nozzle of a gas pump. The fuel vapors captured in the carbon canisters are then combusted in the engine when the automobile is in operation.

The phase-in of ORVR controls has essentially eliminated the need for Phase II vapor recovery systems. As such, EPA has been working with local agencies as they strive to address State legislation and/or revise State regulations aimed at phasing-out Phase II vapor recovery programs. Phase II vapor recovery was always intended by EPA as an intermediary step until most of the nationwide vehicle fleet could be equipped with ORVR.

Washoe County AQMD implemented the requirement for gasoline dispensing facilities (GDF) to install and maintain Phase II in 1997. This measure was adopted to aid in the control of the formation of ozone within the jurisdiction. The support documentation for the August 7, 2012, EPA letter references that in 2012 the national fleet is 75% ORVR compliant. In Washoe County the fleet reached 75% in 2016. Since the Washoe County fleet has had a slower rate of ORVR conversion, the WCAQMD delayed the Phase II decommissioning until the target ORVR fleet rate was achieved.

Public notice for the revisions to these Regulations was published in the Reno Gazette-Journal on December 1, 12, and 29, 2017. The proposed revisions were also made available in the "Current Topics" section of the AQMD website (www.OurCleanAir.com). All GDFs in Washoe County will potentially be affected by this rule change. Each of the affected businesses was contacted and provided with a copy of the notification and a solicitation for comments. Public workshops were scheduled on January 12 at noon and at 6 pm, to address any questions or concerns, no GDF representatives or members of the public attended either workshop. Due to the large number of affected businesses, the published notification included instructions that an additional public workshop would be scheduled upon receipt of a written request. No request for an additional workshop or any comments were received from any of the affected businesses or the general public by the January 8, 2018 deadline.

FISCAL IMPACT

There are no fiscal impacts resulting from the Board adopting the revisions to the regulations as the revisions will not require any modifications to the existing administrative duties associated with the implementation of the program.

RECOMMENDATION

Staff recommends the District Board of Health approve and adopt the Business Impact Statement for the proposed revisions to the District Board of Health Regulations Governing Air Quality Management, Section 040.080, Gasoline Transfer And Dispensing Facilities, and set a public hearing for possible adoption of said revisions for February 22, 2018 at 1:00 pm.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be:

“Move to approve and adopt the Business Impact Statement for the proposed revisions to the District Board of Health Regulations Governing Air Quality Management, Section 040.080 Gasoline Transfer and Dispensing Facilities, specific to the removal of the requirement for Phase II vapor recovery systems, with a finding that the proposed regulations will not impose a direct and significant economic burden on a business; or does the proposed regulations directly restrict the formation, operation or expansion of a business. Further move to set a public hearing for possible adoption of the proposed regulations for February 22, 2018 at 1:00 pm.”

The following business impact statement was prepared pursuant to NRS 237.090 to address the proposed impact of the revision to the DBOH Regulations Governing Air Quality Management, Section 040.080 (Gasoline Transfer and Dispensing Facilities).

1. The following constitutes a description of the manner in which comment was solicited from affected businesses, a summary of their response and an explanation of the manner in which other interested persons may obtain a copy of the summary. (*List all trade association or owners and officers of businesses likely to be affected by the proposed rule that have been consulted*).

Notification of the public hearing to address the proposed regulation changes were published on December 30, 2016, and January 9, 2017, in the Reno Gazette Journal. Two public workshops were held on January 12, 2017, at noon and at 6pm. The notification also included a request to submit comments to the Air Quality Management Division by January 27, 2017. No one attended either workshop nor was any comments received by the deadline.

Additional publication of the Notice of Proposed Action was published in the Reno Gazette Journal on December 1, 12, and 29, 2017. Due to the large number of affected facilities, the published notification included instructions that an additional public workshop would be scheduled upon receipt of a written request. No request for an additional workshop or any comments were received from any of the affected facilities or the general public by the January 8, 2018, posted deadline.

2. The estimated economic effect of the proposed rule on businesses, including, without limitation, both adverse and beneficial effects, and both direct and indirect effects:

Adverse effects: None.

Beneficial effects: The regulation has been modified to remove the requirement for gasoline dispensing facilities to install and maintain Phase II vapor recovery. The affected facilities will save money on vapor recovery equipment and associated testing. This regulation change is in compliance with a memorandum dated August 7, 2012, from Stephen Page, director of the Office of Air Quality and Planning Standards for USEPA.

Direct effects: Time saved from purchasing, maintaining and testing Phase II vapor recovery equipment.

Indirect effects: Cost savings for Washoe County motorists due to decreased overhead for facilities.

3. The following constitutes a description of the methods the local government considered to reduce the impact of the proposed rule on businesses and a statement regarding whether any, and if so, which of these methods were used: (*Include whether the following was considered: simplifying the proposed rule; establishing different standards of compliance for a business; and if applicable, modifying a fee or fine set forth in the rule so that business could pay a lower fee or fine*).

There should be a financial benefit to business owners.

4. The governing body estimates the annual cost to the local government for enforcement of the proposed rule is: There is no increase in anticipated annual cost as the work is already being conducted.
5. The proposed rule provides for a new fee or increases and existing fee and the total annual amount expected to be collected is: N/A.
6. The money generated by the new fee or increase in existing fee will be used by the local government to: N/A.
7. The proposed rule includes provisions that duplicate or are more stringent than federal, state or local standards regulating the same activity. The following explains when such duplicative or more stringent provisions are necessary:

The proposed change is not duplicative, nor more stringent than existing federal, state or local standards.

8. The following constitutes an explanation of the reasons for the conclusions regarding the impact of the proposed rule on businesses: The proposed rule will have positive impacts on businesses.

To the best of my knowledge or belief, the information contained in this statement is prepared properly and is accurate.

Kevin Dick, District Health Officer

January 12, 2018
Date



REMSA

**FRANCHISE COMPLIANCE
REPORT**

DECEMBER 2017



**REMSA Accounts Receivable Summary
Fiscal 2018**

Month	#Patients	Total Billed	Average Bill	YTD Average	Average Collected
July	3986	\$4,530,081.40	\$1,136.50	\$1,136.50	\$409.14
August	4101	\$4,669,433.60	\$1,138.61	\$1,137.57	\$409.52
September	4059	\$4,631,774.80	\$1,141.11	\$1,138.75	\$409.95
October	3812	\$4,346,731.00	\$1,140.28	\$1,139.12	\$410.08
November	4026	\$4,580,696.00	\$1,137.78	\$1,138.85	\$409.98
Totals	19984	\$22,758,717	\$1,138.85		

Allowed ground average
bill:
Monthly average collection
rate:

\$1,161.23

36%

Fiscal Year 2017-2018

Compliance			
Month	Priority 1 System - Wide Avg. Response Time	Priority 1 Zone A	Priority 1 Zones B,C,D
Jul-17	5 Minutes 43 Seconds	93%	91%
Aug-17	5 Minutes 38 Seconds	93%	93%
Sep-17	5 Minutes 43 Seconds	92%	97%
Oct-17	5 Minutes 45 Seconds	92%	92%
Nov-17	5 Minutes 38 Seconds	92%	96%
Dec-17	5 Minutes 52 Seconds	91%	93%

Year to Date: July 2017 through December 2017

Priority 1 Zone A	Priority 1 Zones B,C,D
92%	94%



Year to Date: July 2017 through December 2017

Average Response Times by Entity				
Month/Year	Priority	Reno	Sparks	Washoe County
Jul-17	P-1	4:56	5:49	7:48
	P-2	5:06	6:08	8:23
Aug-17	P-1	4:55	5:48	8:09
	P-2	5:03	6:03	7:59
Sep-17	P-1	5:01	5:45	8:06
	P-2	5:21	6:25	6:06
Oct-17	P-1	5:09	5:53	8:05
	P-2	5:22	6:14	8:01
Nov-17	P-1	5:09	5:39	7:34
	P-2	5:13	6:49	8:05
Dec-17	P-1	5:02	6:01	8:30
	P-2	5:23	6:02	8:38

Year to Date: July 2017 through December 2017

Priority	Reno	Sparks	Washoe County
P-1	5:04	5:49	8:02
P2	5:14	5:15	8:20



**REMSA OCU INCIDENT DETAIL REPORT
PERIOD: 12/01/17 THRU 12/31/17**

Corrections Requested					
Zone	Clock Start	Clock Stop	Unit	Response Time Original	Response Time Correct
Zone A	12/31/2017 19:32	12/31/2017 19:36	1C22	04:36	04:36
Zone A	12/31/2017 19:27	12/31/2017 19:27	1C33	-00:00:03	00:25
Zone A	12/30/2017 19:33	12/30/2017 19:36	1C25	-00:01:22	02:54
Zone A	12/26/2017 6:00	12/26/2017 6:03	1C41	-00:00:09	02:54
Zone A	12/20/2017 18:24	12/20/2017 18:29	1C41	05:03	05:03
Zone A	12/19/2017 4:02	12/19/2017 4:09	1C14	07:16	07:16
Zone A	12/17/2017 8:12	12/17/2017 8:21	1C44	09:14	09:14
Zone A	12/15/2017 15:24	12/15/2017 15:29	1C12	05:18	05:18
Zone B	12/13/2017 20:10	12/13/2017 20:20	1C19	10:39	10:39
Zone A	12/9/2017 16:32	12/9/2017 16:37	1C41	39:37	05:02
Zone A	12/8/2017 11:08	12/8/2017 11:15	1N02	06:59	06:59
Zone A	12/3/2017 8:49	12/3/2017 8:57	2I12	07:52	07:12
Zone A	12/3/2017 8:49	12/3/2017 8:57	3S72	04:36	07:12
Zone A	12/1/2017 18:47	12/1/2017 18:47	1C15	-00:00:05	00:21
Zone A	12/1/2017 9:26	12/1/2017 9:27	1C31	01:39	01:39



Upgrade Requested						
Response Area	Zone	Clock Start	Clock Stop	Unit	Threshold	Response Time.
None						

Exemptions Requested					
Incident Date	Approval	Exemption Reason	Zone	Response Time	Overage
12/20/17	Exemption Approved	Weather	Zone A	12:44	03:45
12/20/17	Exemption Approved	Weather	Zone A	11:22	02:23
12/20/17	Exemption Approved	Weather	Zone A	14:43	05:44
12/20/17	Exemption Approved	Weather	Zone A	11:32	02:33
12/20/17	Exemption Approved	Weather	Zone A	18:02	09:03
12/20/17	Exemption Approved	Weather	Zone A	14:02	05:03
12/20/17	Exemption Approved	Weather	Zone A	28:44	19:45
12/20/17	Exemption Approved	Weather	Zone A	15:15	06:16
12/20/17	Exemption Approved	Weather	Zone A	12:57	03:58
12/20/17	Exemption Approved	Weather	Zone A	09:53	00:54
12/20/17	Exemption Approved	Overload	Zone A	09:53	00:54
12/20/17	Exemption Approved	Overload	Zone A	13:41	04:42
12/20/17	Exemption Approved	Overload	Zone A	15:02	06:03
12/20/17	Exemption Approved	Overload	Zone A	14:49	05:50
12/20/17	Exemption Approved	Overload	Zone A	09:04	00:05
12/20/17	Exemption Approved	Overload	Zone A	09:04	00:05
12/20/17	Exemption Approved	Overload	Zone A	09:34	00:35
12/20/17	Exemption Approved	Overload	Zone C	21:56	00:57
12/20/17	Exemption Approved	Overload	Zone A	10:01	01:02
12/20/17	Exemption Approved	Overload	Zone A	09:52	00:53
12/20/17	Exemption Approved	Overload	Zone A	12:34	03:35
12/20/17	Exemption Approved	Overload	Zone A	12:10	03:11
12/20/17	Exemption Approved	Overload	Zone A	14:45	05:46



GROUND AMBULANCE OPERATIONS REPORT DECEMBER 2017

1. Overall Statics

- a) Total number of system responses: 6949
- b) Total number of responses in which no transports resulted: 2482
- c) Total number of System Transports (including transports to out of county): 4467

2. Call Classification

- a) Cardiopulmonary Arrests: 1.4%
- b) Medical: 53.5%
- c) Obstetrics (OB): 0.4%
- d) Psychiatric/Behavioral: 7.4%
- e) Transfers: 9.2%
- f) Trauma – MVA: 7.0%
- g) Trauma – Non MVA: 18.2%
- h) Unknown: 2.9%

3. Medical Director's Report

- a) The Clinical Director or designee reviewed:
 - 100% of cardiopulmonary arrests
 - 100% of pediatric patients (transport and non-transport)
 - 100% of advanced airways (excluding cardio pulmonary arrests)
 - 100% of STEMI alerts or STEMI rhythms
 - 100% of deliveries and neonatal resuscitation
 - 100% Advanced Airway Success rates for nasal/oral intubation and King Airway placement for adult and pediatric patients.

Total number of ALS Calls: 2075

Total number of above calls receiving QA Reviews: 387

Percentage of charts reviewed from the above transports: 18.65%



**REMSA Education
Monthly Course and Student Report
Month: December 2017**

Discipline	Total Classes	Total Students	REMSA Classes	REMSA Students	Site Classes	Site Students
ACLS	5	39	3	35	2	4
ACLS EP	0	0	0	0	0	0
ACLS EP I	0	0	0	0	0	0
ACLS I	0	0	0	0	0	0
ACLS P	1	2	1	2	0	0
ACLS R	11	49	3	32	8	17
ACLS S	2	8	1	1	1	7
AEMT	0	0	0	0		
-	-	-	-	-		
B-CON	1	6	1	6	0	0
BLS	68	313	19	89	49	224
BLS I	2	31	1	18	1	13
BLS R	24	100	16	79	8	21
BLS S	17	35	0	0	17	35
CE	1	2	1	2	0	0
EMAPCT	0	0	0	0	0	0
EMPACT I	0	0	0	0	0	0
EMR	0	0	0	0		
EMR R	0	0	0	0		
EMS I	0	0	0	0		
EMT	0	0	0	0		
EMT R	3	6	3	6		
FF CPR	4	45	2	10	2	35
FF CPR FA	0	0	0	0	0	0
FF FA	0	0	0	0	0	0
HS BBP	2	6	2	6	0	0
HS CPR	30	191	2	15	28	176
HS CPR FA	47	322	6	31	41	291
HS CPR FA S	0	0	0	0	0	0
HS CPR PFA	3	14	1	10	2	4
HS PFA S	0	0	0	0	0	0
HS CPR S	0	0	0	0	0	0
HS FA	5	19	1	1	4	18
HS FA S	0	0	0	0	0	0
HS PFA	0	0	0	0	0	0
ITLS	0	0	0	0	0	0
ITLS A	0	0	0	0	0	0
ITLS I	0	0	0	0	0	0
ITLS P	0	0	0	0	0	0
ITLS R	1	14	1	14	0	0
ITLS S	0	0	0	0	0	0
PALS	3	19	2	12	1	7
PALS I	0	0	0	0	0	0
PALS R	7	30	2	11	5	19
PALS S	3	12	1	1	2	11
PEARS	4	26	0	0	4	26
PM	1	13	1	13		
PM R	0	0	0	0		
HS Spanish RCP y DEA	0	0	0	0	0	0
Legend						
Classes		CPR		REMSA CPR		REMSA CPR
w/ CPR		Students		Classes		Students
199		1077		47		252



COMMUNITY OUTREACH DECEMBER 2017	
Point of Impact	
Date	Outreach
12/01/17	Eight office installation appointments; Nine (9) cars and Nine (9) seats inspected.
Cribs for Kids/Community	
Date	Outreach
12/01/17	C4K attended Washoe County Child Death Review.
12/05/17	Health Plan of Northern Nevada Baby Show at Northern Nevada Hopes. Ten (10) mother attended.
12/14 - 12/15 & 12/17	C4K taught "Train-the-Trainer" had 13 participates attend class at East Valley Family Services in Las Vegas.
12/14/17	EDU Manager attended Pedestrian Safety Task Force for Coordinator and will be part of the outreach/Education sub-committee.
12/18/17	C4K taught "Train-the-Trainer" had 8 participates attend the class at REMSA.
12/27/17	Pedestrian Safety Interview with KTVN Channel 2 news.



REMSA

Reno, NV
Client 7299



1515 Center Street
Lansing, Mi 48096
1 (877) 583-3100
service@EMSSurveyTeam.com
www.EMSSurveyTeam.com

EMS System Report

December 1, 2017 to December 31, 2017

Your Score

96.02

Number of Your Patients in this Report

150

Number of Patients in this Report

6,096

Number of Transport Services in All EMS DB

143





Executive Summary

This report contains data from **150 REMSA** patients who returned a questionnaire between **12/01/2017** and **12/31/2017**.

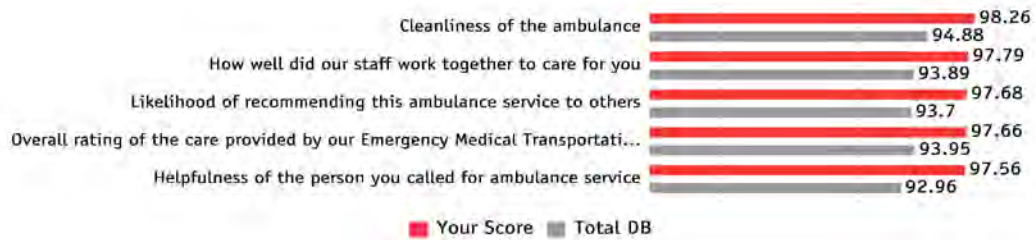
The overall mean score for the standard questions was **96.02**; this is a difference of **2.96** points from the overall EMS database score of **93.06**.

The current score of **96.02** is a change of **1.83** points from last period's score of **94.19**. This was the **16th** highest overall score for all companies in the database.

You are ranked **2nd** for comparably sized companies in the system.

90.50% of responses to standard questions had a rating of Very Good, the highest rating. **98.25%** of all responses were positive.

5 Highest Scores



5 Lowest Scores

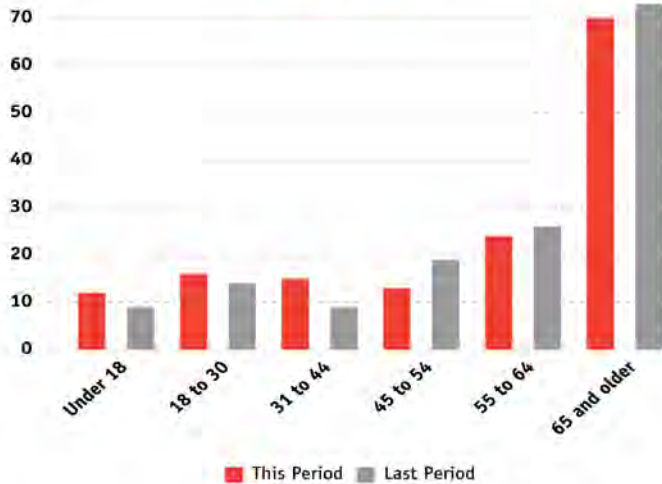




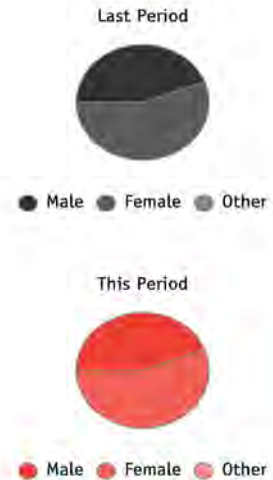
Demographics — This section provides demographic information about the patients who responded to the survey for the current and the previous periods. The information comes from the data you submitted. Compare this demographic data to your eligible population. Generally, the demographic profile will approximate your service population.

	Last Period				This Period			
	Total	Male	Female	Other	Total	Male	Female	Other
Under 18	9	6	3	0	12	5	7	0
18 to 30	14	6	8	0	16	8	8	0
31 to 44	9	4	5	0	15	7	8	0
45 to 54	19	8	11	0	13	9	4	0
55 to 64	26	9	17	0	24	6	18	0
65 and older	73	33	40	0	70	31	39	0
Total	150	66	84	0	150	66	84	0

Age Ranges



Gender





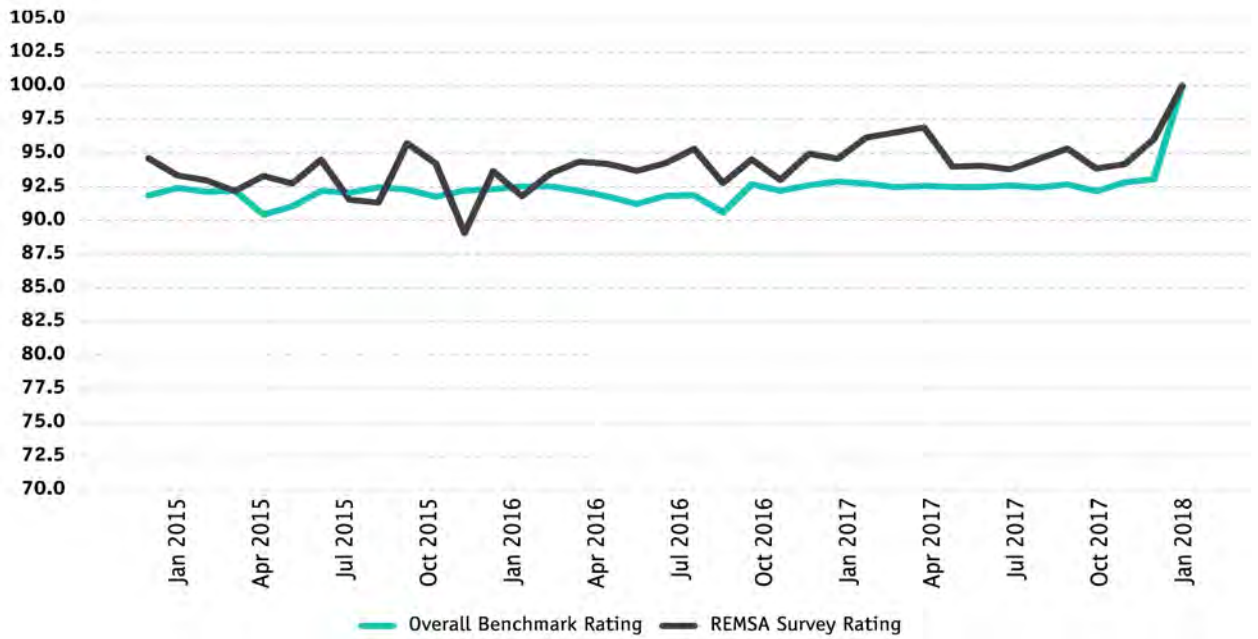
Monthly Breakdown

Below are the monthly responses that have been received for your service. It details the individual score for each question as well as the overall company score for that month.

	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Helpfulness of the person you called for ambulance service	93.48	97.50	96.25	94.32	95.45	96.59	91.69	95.21	95.21	93.13	90.58	93.13	97.56
Extent to which you were told what to do until the ambulance	91.88	97.92	95.14	89.53	94.26	94.77	92.10	91.48	96.02	89.89	92.33	94.59	95.65
Extent to which the ambulance arrived in a timely manner	95.79	95.01	96.28	94.12	95.39	92.40	93.40	92.01	95.01	95.44	92.37	92.87	95.84
Cleanliness of the ambulance	97.79	96.18	97.37	96.12	98.13	95.17	97.11	96.04	96.57	99.09	96.82	96.12	98.26
Skill of the person driving the ambulance	96.34	95.88	97.14	97.24	96.23	96.01	95.42	95.49	96.40	96.44	96.82	95.26	96.96
Care shown by the medics who arrived with the ambulance	96.23	96.23	96.83	97.55	98.08	94.47	94.74	95.12	93.90	96.19	93.68	95.49	95.45
Degree to which the medics took your problem seriously	94.37	95.62	97.16	97.45	98.19	93.99	95.88	94.73	94.70	95.90	93.59	95.21	95.93
Degree to which the medics listened to you and/or your family	94.51	95.64	96.43	97.48	97.78	94.31	93.63	93.77	94.52	96.88	94.22	94.75	96.11
Extent to which the medics kept you informed about your	94.76	92.67	95.83	96.92	95.45	91.96	92.92	91.76	92.33	92.75	92.56	93.81	94.98
Extent to which medics included you in the treatment decisions	94.44	88.94	94.29	96.52	95.36	93.77	92.86	92.01	93.16	91.71	93.93	91.47	96.68
Degree to which the medics relieved your pain or discomfort	93.16	89.18	92.86	92.60	94.74	87.89	87.94	87.43	92.54	90.17	86.22	92.90	91.13
Medics' concern for your privacy	94.53	94.41	97.23	97.39	97.44	94.31	95.39	97.16	96.00	96.73	94.72	93.45	95.85
Extent to which medics cared for you as a person	95.65	94.92	98.11	97.83	98.18	94.29	95.74	95.40	95.20	96.95	94.54	94.51	96.41
Professionalism of the staff in our ambulance service billing	90.10	89.76	100.00	100.00	92.86	90.00	95.00	81.25	93.18	96.43	100.00	87.50	97.22
Willingness of the staff in our billing office to address your	90.10	88.35	100.00	100.00	96.43	90.00	87.50	84.50	87.50	100.00	98.08	87.50	96.88
How well did our staff work together to care for you	96.08	96.28	96.51	98.20	98.54	94.99	96.22	96.25	95.72	96.68	95.92	95.98	97.79
Extent to which the services received were worth the fees	86.39	82.19	87.20	94.91	92.29	90.72	78.61	87.92	88.24	83.63	85.47	89.39	91.20
Overall rating of the care provided by our Emergency Medical	95.27	96.58	96.66	97.45	98.20	95.52	94.78	94.94	94.54	95.94	94.97	94.82	97.66
Likelihood of recommending this ambulance service to others	96.24	96.97	97.38	97.40	97.60	95.79	94.93	93.55	96.46	97.34	96.87	95.29	97.68
Your Master Score	94.96	94.58	96.16	96.52	96.91	94.00	94.07	93.80	94.57	95.33	93.86	94.19	96.02
Your Total Responses	165	150	150	150	150	150	150	144	150	150	150	150	150



Monthly tracking of Overall Survey Score





GROUND AMBULANCE DECEMBER CUSTOMER REPORT

GROUND AMBULANCE DECEMBER CUSTOMER REPORT

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results After Follow Up
1	11/08/17	"Everyone did a really good job."	"The fees seem to be too expensive."			
2	11/08/17	"They guys were really awesome!"	"inside of ambulance was very cold and bumpy."			
3	11/09/17		"No."			
4	11/09/17	"The medics were really awesome. They helped come me down and talked to me, made me feel safe "				
5	11/09/17	"The medics had a lot of compassion for me "	"I was in so much pain, I wish they would've been there a little faster."			
6	11/08/17	"No."				
7	11/09/17	"The medics took really good care of me, they were awesome!"	"Nothing."			
8	11/09/17		"Medics need to be more compassionate, understanding about patients needs and believe them. Medics should research patients history before treating patient as if they don't know what they are talking about "	"It took some time for medics to take me serious. After they looked at my history they believed my story."	Assigned 1.3.17 #5157	Refer to #8 Results after Follow-Up
9	11/09/17		"I am sure there is, I just can't think of it."			
10	11/09/17	"Everything was top notch."				
11	11/10/17	"They were all really good."	"No."			
12	11/10/17	"It was a wonderful experience."				
13	11/10/17	"They were patient with me and compassionate. I was scared and alone but they took awesome care of me."				
14	11/10/17	"The medics were all really great "				
15	11/09/17		"Yes, hire medics who are sympathetic. The experience I had with the male medic, seemed as if he didn't care. I felt that the male medic acted as if I was over exaggerated how I felt."		Assigned 1.3.17 #5158	Refer to #15 Results After the Follow Up
16	11/09/17	"The medics have always been so good with my mom."	"You can't get much better than REMSA."			
17	11/12/17	"The medics were awesome"		"They were great"		
18	11/12/17	"It was a good experience overall"				
19	11/11/17	"The medics were so great. They couldn't have done a better job"	"They couldn't have done a better job"			
20	11/15/17	"it was good service they got here in time."				



GROUND AMBULANCE DECEMBER CUSTOMER REPORT

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results After Follow Up
21	11/15/17	"The medics were awesome and super nice."	"It was a car accident and medic piled five of us in the back of the ambulance. The medics were overwhelmed by how many ppl were there and kept forgetting to write the vitals down. I think the competency could've been better."			
22	11/15/17	"no"	"I can't think of anything."			
23	11/15/17	"Medics were fabulous!"				
24	11/16/17		"Keep doing a good job."			
25	11/16/17	"The medics were terrific and fabulous!"	"Nothing I can think of."			
26	11/16/17	"I was really amazed with the service. They were great."	"I don't see how they could."			
27	11/16/17		"Yes, arrive in a timely manner. By the time the medics arrived I was fully recovered from my seizure."	"1/2 hour took."		Call received: 14:27 Dispatched 14:28 Enroute: 14:28 On scene 14:31 At PT:14:36
28	11/16/17	"Everything went very well."				
29	11/16/17		"Not that I can think of."			
30	11/16/17	"They all did very good."	"I can't think of anything."			
31	11/16/17		"I don't know if there is anything to improve."			
32	11/16/17	"Everything was almost a five."	"Don't circle the apartment complex bc you don't know which building it is, know your directions."			
33	11/17/17		"We have lived in your home for almost two year and we are the 74th house built. I would think by now that GPS would track for emergencies in better ways than that night REMSA was called."	"Ambulance got lost." "I don't blame anyone but bc the ambulance couldn't find my home, you lost about four minutes of care to my wife who was in need."		
34	11/17/17	"They were very helpful."				
35	11/17/17	"they were really nice"				
36	11/17/17	"their attitudes they were very kind to me"	"if in pain i'd like pain medication"			
37	11/17/17	"i couldn't have asked for anything better"				
38	11/17/17	"they were phenomenal!"				
39	11/17/17	"they eased my fear"				
40	11/17/17	"they did everything exceptionally well"				
41	11/17/17	"they treated my cuts perfect and made sure I was ok"				
42	11/17/17	"During the whole experience, I felt comforted by the medics."				



GROUND AMBULANCE DECEMBER CUSTOMER REPORT

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results After Follow Up
43	11/17/17		"No."	"Upon Arrival three female medics, one was at trainee the fire department was there. One female started flirting with fireman. Not appropriate for the condition I was in. Medics parked on street, I was put on gurney sat in ambulance for 20/30 min. Couldn't get IV, tried other hand. It hurt"	assigned 1.4.17 #5164	Refer to #43 Results After Follow Up
44	11/18/17	"They did just everything perfect."	"No."			
45	11/18/17	"Over kill with ambulance and fire department."				
46	11/18/17	"No."	"Ask about pain and show concern for patient. Ask and treat patient with respect."	"Medics didn't check me over or treat me. They threw me in the ambulance. They just knew I couldn't breathe. One medic grabbed my legs, it hurt. They were retaining water and my legs swollen and it hurt."	Assigned 1.4.17 # 5161	1/4/18 1645, left a message for the pt 1/6/18 1400, left message for PT. Chart is very well documented on pts complaints and how pt was treated with oxygen, IV, 12 lead. Pts condition improved with the oxygen enroute. Closing this ticket until I hear back from the pt.
47	11/18/17	"Medics came in with a smile, made me laugh and comforted me. They didn't make me feel like an old lady who had been drinking haha."	"No."			
48	11/18/17	"They did great."	"No."			
49	11/19/17	"Their professional manner. They knew what they were doing and did it effectively"				
50	11/19/17			"They were great"		
51	11/19/17		"Act like a human. I'm a BSN at the hospital that they took me to. I had an epileptic seizure"	"They yelled that they thought I was drunk. No drinking no drugs, no nothing. It was degrading. I felt worse than a dog. Not the first time they've done that" "They were both assholes"	Assigned 1.4.17 # 5162	1/4/18 1808, left a message for the pt
52	11/19/17	"They were nice guys, very courteous. They were gentle, to a point. They were great with my kids"	"Better shocks on the ambulances"	"I have some bruising from the IV"		
53	11/19/17			"They are the best in the world"		
54	11/20/17	"Great customer service. Very helpful"				



GROUND AMBULANCE DECEMBER CUSTOMER REPORT

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results After Follow Up
55	11/19/17	"Got me there. Calmed me from the start. Took some time to explain A fib to me."		"Great peace of mind" "Nice communication" "Always quite professional and on top of it"		
56	11/20/17	"Got me there in a timely fashion and moved from the plane to the hospital in a timely fashion"		"Didn't have any pain" "Roads are bad"		
57	11/21/17	"They took really good care of me and transported me. I was very happy"				
58	11/21/17	"The transportation"				
59	11/22/17	"treated me very very well and they were"	"It was a surprise to have such amazing service. Thank you!"			
60	11/22/17	"I have a hard time finding a vein due to chemo, but they found it"				
61	11/22/17			"Very good as always"		
62	11/22/17	"I fell in the backyard and broke my hand and arm. They were so kind and good"		"They were excellent" "Coordinated. Took good care of us. Didn't leave me until I was taken care of. Polite and nice, well trained, fast"		
63	11/22/17	"Overall care and concern"				
64	11/22/17	"Everything to my knowledge"				
65	11/22/17			"They were pretty fast"		
66	11/24/17	"They did everything they could to make me comfortable. I got good care"		"They were excellent"		
67	11/24/17	"I was scared and eased the tension"	"Be a little quicker. It seemed like I was waiting in the hospital for a long time"	"They joked with me" "They were busy, so it took a long time. Didn't pay attention to cleanliness"		
68	11/24/17	"They were really careful with me"				
69	11/23/17	"They were fast and efficient as far as I know (was in and out of consciousness)"	"I don't think they started any breathing treatment when I was going out which seemed weird. I was pretty far gone the last time I passed out so it seems strange. Can't complain because they saved my life"	"Don't recall them talking about my treatment"		
70	11/23/17	"The care, the concern, how fast they got here. Just making me feel comfortable and explaining everything that they were doing. They were great and I have no complaints"	"They were perfect"			



GROUND AMBULANCE DECEMBER CUSTOMER REPORT

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results After Follow Up
71	11/24/17	"They knew what was wrong and that I was a diabetic. They didn't ignore anything and figured out what was going on. They did their jobs. They asked me what kind of music I liked, then played it!"		"Probably saved my life" "They excelled all the way around"		
72	11/24/17			"I was out"		
73	11/23/17		"Some medics are unprofessional and some medics are really mean. I would say that improvement on attitude needs to be dealt with."			
74	11/25/17			"My veins are tiny and they roll. Medics were unable to get my IV in."		
75	11/25/17	"Happy and healthy new year."				
76	11/25/17	"They had me put into the ambulance for privacy instead of doing the EKG in front of my family."				
77	11/25/17	"The medic were very friendly."	"my mother had a difficult time in getting through to 911 for the ambulance."	"my mother had a difficult time in getting through to 911 for the ambulance."	Assigned 1.4.17 #5163	Call was answered by REMSA in 3.7 seconds. Unknown duration between when PT dialed 911 and Sparks Dispatch picked up. Once transferred over, it took 3.7 seconds for REMSA to initiate EMD.
78	11/26/17	"The medics were wonderful! I really appreciate them coming and taking great care of me."				
79	11/26/17	"I didn't have no negative thought. They were all very professional."				
80	11/26/17	"I had fallen and the medic took really good care of me."				
81	11/26/17	"Medics were very professional and I felt comfortable."				
82	11/26/17	"The medics ""did real well""."				
83	11/26/17	"Very happy with the service."				
84	11/26/17	"Excellent service"				
85	11/26/17	"Very caring and fast."				
86	11/26/17		"Have a Spanish speaker available."			
87	11/27/17	"They calmed me down and kept me calm."				



GROUND AMBULANCE DECEMBER CUSTOMER REPORT

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results After Follow Up
88	11/27/17	"no comment"				
89	11/27/17	"no comment"				
90	11/27/17	"They calmed her daughter down and transported her from the school to the hospital. Great job with a child."				
91	11/27/17	"They took good care of me."				
92	11/27/17	"Put in an IV"				
93	11/28/17	"They started an IV, did an EKG, explained what was going on with my heart and the fact that I was having a stroke. Calmed me down and kept me focused on my condition instead of what was going on around me"		"Excellent"		
94	11/28/17	"They showed up on time. There was also a fire truck that came. They took it seriously. Worked hard and did their jobs"				
95	11/28/17	"It was what was expected. They were here before the firemen were. They did what they had to do and got him hooked up to vitals and oxygen. Got my baby breathing again"	"My two younger ones when we had to call 911 on them each got a Bobby Bear, but my 15 year old didn't get one."	"We had a 5 minute ride to the hospital and she gave him 3 breathing treatments. They turned the lights and sirens off before entering the apartment complex because it was so early in the morning"		
96	11/28/17		"Make the blood pressure cuff not so tight"			
97	11/28/17	"I was very satisfied!"				
98	11/28/17		"I felt that I was treated fairly. I think one thing I would like to see differently is that medics would be able to administer drugs to treat the flu."			
99	11/29/17	"He was taken good care of. he received very good care. I appreciate REMSA"				
100	11/29/17	"Everything except that needle. That hurt bad"	"Only complaint is that they couldn't find on a vein on the top of my hand"	"Had a hard time finding a vein. Wasn't in pain"		
101	11/29/17	"It was good"				
102	11/29/17			"I'm 6 foot 5 and my feet were flat against the back doors on the gurney in the ambulance"		
103	11/29/17	"Everything. They were professional, friendly, good natured. They treated me like a friend and like they cared"	"I don't know what that would be"			



GROUND AMBULANCE DECEMBER CUSTOMER REPORT

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results After Follow Up
104	11/29/17	"Compassionate and understood my daughter's needs. Great human beings. That's not just their job"	"Drop some of the fees. I know how much ambulance bills are"	"They were super good. They came in the hospital room and got to know my paralyzed 9 year old and got her feeling comfortable. The same medics rode with her on the airplane"		
105	11/29/17	"Sat him down to calm him down and talk to him before they took him out"		"I have no complaints" "They were excellent"		
106	11/30/17		"the guy in the back very nice man- he had no idea where the great lakes were- makes me nervous"			
107	11/30/17	"I am very grateful for your service."				
108	11/30/17	"They did what they needed to do."	"Nothing from my end."			
109	11/30/17		"I was hit my a car. Medic were on their game and I say they are top notch. They were very attentive to me and kept me calm "			
110	09/17/17			"couple guys kept putting each down, I had to stop it. I don't need to hear that while I am not feeling well. Overall they good a good job."	Assigned 12/8/17 #5014	
Results After Follow-Up						
8	1/6/18 1342,	I spoke with the pt, he was very nice but concerned he was not taken seriously about his history of DVT's and the pain he was in. When he arrived at RPMC they looked up his history and he was given pain meds. I apologized to PT and told him I would be following up with the crew and a report would be filed. PT thanked me for taking the time to call him. I will have the crew complete occurrence reports ASAP.				
15		I spoke with the patient on the phone today regarding her complaint. She states that she didn't have any complaints, but just felt like the male crew member was a little stand off-ish and not as empathetic as he could have been. She reported that the crew was helpful and got her to the hospital and treated her fine. I apologized and thanked her for the feedback. She thanked me and did not want any follow up. After review of the chart the patient was treated clinically appropriate and she reports that she was treated fine and just had a bad feeling about the paramedic. No further follow up required.				
43		Spoke with the patient over the phone. She remembers the call and just thought that it took a little too long to start the IV. She reports that it was two attempts, but the PCR only reflects one attempt. She understands that people need to learn and practice IVs. She does report that she felt that the female EMT was a little too friendly with the fire department. She states the EMT said "Oh hey how are you, how's it going? Did you go to the party last weekend?". She does state that she is 78 years old and does understand that young people today flirt. She was also adamant that there were three females on the crew. The crew was one female and one male according to the chart. She does not want to cause any problems and was in good spirits about the call in general. I thanked her for the feed back and see no issues after reviewing the chart. The IV was appropriate and the interaction between crew and fire was within normal interactions on scene. She thanked me for the follow-up and states she has used our service several times without incident.				
110	12/8/17 1218,	I spoke to the pt, she was very nice, I asked her happened and she told me the two guys were just trying to "up each other". PT asked me not to say anything to them as she did not want to get them in trouble, she said something on scene and they stopped. PT said she could do that because she is old and people listen to her, we both had a good laugh. I apologized to PT and thanked her for her time. Crew member no longer employed by REMSA and other is a female. No further action.				



December 2017 Public Relations + Social Media Highlights Report

District Board of Health

MEDIA / EVENTS

Drones/Flirtey

Coverage continued from the initial announcement about the REMSA/Flirtey partnership. The Reno Gazette-Journal ran a few follow-up stories, and Forbes BrandVoice and AOPA also covered the story.



Taking Flight In The U.S.

Zipline is not the only company using unmanned autonomous vehicles to ferry medical supplies to hospitals and health centers. Drones now seem poised to take off in the U.S., too, with a growing number of humanitarian drone networks delivering domestic supplies.

In October 2017, Nevada-based automated logistics startup, Flirtey, partnered with Regional Emergency Medical Services Authority (REMSA) to launch its defibrillator drone delivery service, bringing people in rural Nevada immediate access to critical medical supplies. The company plans to dispatch a drone to deliver an Automated External Defibrillator (AED)—a portable electronic device that delivers a shock to restore normal heart rhythm—whenever a 911 caller in the area reports symptoms of cardiac arrest.





December 2017 Public Relations + Social Media Highlights Report

District Board of Health

MEDIA / EVENTS

Opioids

Coverage also continued on the topic of opioids, as REMSA is now seen as an expert resource. Adam Heinz did an interview with KTVN on opioid use as it relates to the Rand story.



Santa Crawl

REMSA's public safety role in the Santa Crawl received great coverage this season. KRXI, KOLO and KTVN interviewed Adam Heinz about special event coverage preparations for the event.



Tips:

- Keep in mind alcohol doesn't actually warm you up, it speeds up hypothermia
- Wear warm clothing
- If you decide not to wear much clothing -- limit your time outside
- Travel in groups
- Be aware of your surroundings and be vigilant
- Carry identification at all time in the case that you get injured and need to be identified.





December 2017 Public Relations + Social Media Highlights Report

District Board of Health

MEDIA / EVENTS

REMSA and Care Flight Organize Food and Cash Donations to Benefit the Food Bank of Northern Nevada

Care Flight and REMSA Ground were featured on KTVN's coverage of its Share Your Christmas Food Drive benefiting the Food Bank of Northern Nevada.

Care Flight arrived early in the day at the Carson Valley Inn with Santa Claus.

Plus, the Business Office organized a crew of volunteers to staff the event to receive donations from community members at 6 a.m.

Care Flight delivered 1,400 pounds of food via the helicopter and the CCT ground ambulance at the Grand Sierra Resort. During that part of the event, JW Hodge, COO provided an extended interview and presented the reporter with a \$1,000 check and the food donations from ground.

Congratulations to to the Care Flight top donors: in first place, Bill Landon, Flight Paramedic and Safety Officer who donated 137.5 lbs; Kaitlyn Brown, Flight Nurse and Pete Lindley, Flight Nurse who donated 125.3 lbs each; and Sam Blesse, Supervisor for Plumas Ground Operations and Ashley Blesse, CQI Coordinator in for Plumas Ground Operations who each donated 99.5 lbs.





December 2017 Public Relations + Social Media Highlights Report

District Board of Health

MEDIA / EVENTS

Nurse Helpline

TV personality Dr. Oz featured Nurse Helplines across the country including REMSA's, including how to contact the 24-hour helplines.

Dr. Oz Talks to Nurses About Why They Love Their Jobs
Nurses talk to Dr. Oz and Kelley Johnson about why they're proud to be ...

Dr. Oz Talks to Nurses About Why They Love Their Jobs (2:20)

The Nurses On-Call helpline is a service available under most insurance plans, including Aetna, Blue Cross Blue Shield, Cigna, Novant Health, Remsa, and United. It is a health advice and physician referral service line provided by the HCA Midwest Health Research Medical Center

Community Health

EMSAAC highlighted REMSA in an article, Report On REMSA's Innovative Approaches To Community Health.

EMSAAC - EMERGENCY MEDICAL SERVICES ADMINISTRATORS' ASSOCIATION OF CALIFORNIA
12/16/2017 News Release - Distributed by Public on 12/16/2017 2:23PM

Report On REMSA's Innovative Approaches To Community Health

In 2012, Regional EMS Authority (based in Reno, NV) launched a system of community health programs to improve access to the appropriate level of healthcare throughout Washoe County, Nevada. Funded through a \$9.1 million Health Care Innovation Award from the Center for Medicare & Medicaid Innovation, part of the U.S. Department of Health and Human Services, the program consisted of three interventions:

Nurse Health Line: a non-emergency phone number that provides 24/7 access to nurse navigators who could assess, triage and refer Northern Nevada residents to health care and community services.

December 2017 Public Relations + Social Media Highlights Report

District Board of Health

MEDIA / EVENTS

Ski and Snowboarding Tips

The Reno Dads Blog published REMSA's Community Advisor on ski and snowboarding tips for parents and kids. Community Advisors are health information tips distributed frequently by REMSA/Care Flight to assist the public and to generate media interest in the topics.



Falling on Ice

Nevada Business posted the Community Advisor, Falling on Ice. KTVN also incorporated it into their segment, REMSA Offers Tips on How to Stay Safe on Ice.



REMSA Offers Tips on How to Stay Safe on Ice

Posted Dec 20, 2017 10:04 AM PST
Updated Dec 20, 2017 10:30 AM PST



With wet, snowy and cold weather conditions, REMSA is reminding people of a few tips to avoid falling on the ice.

- Seven quick tips to avoid falling on ice:**
1. Wear boots or overshoes with good treads. Slick leather or plastic soles on shoes may increase the risk of slipping.
 2. Don't walk with your hands in your pockets. This reduces the ability to use your arms for balance if you do slip.
 3. Take short shuffling steps in very icy areas.
 4. Don't carry or swing heavy loads, such as large boxes, cases or purses that may cause you to become off balance when you are walking.
 5. When walking, curl your toes under and walk as flat-footed as possible.
 6. Don't step on uneven surfaces. Avoid curbs with ice on them.
 7. Place your full attention on walking. Digging in your pocketbook or backpack while walking on ice is dangerous.

Other tips to be aware of when walking in a potentially icy area:

- If the sidewalks and walkways are mossy and you have to walk in the street, walk against traffic and as close to the curb as you can.
- Proper gear is a must, but wearing dark winter colors can make it hard for motorists to see you, especially if they aren't expecting you. Consider wearing a brightly-colored scarf or hat, or reflective gear, especially if you have to walk in the street. And don't forget gloves, and shoes or boots with treaded soles.
- Snow that has accumulated into drifts can muffle the sounds of approaching motor vehicles. Wearing hats and scarves that cover your ears can also distort or even eliminate these sounds. Keep warm, but make sure you can hear what's going on around you.
- If you can't shop before the storm hit if you have to shop and carry your purchases by hand, don't buy more than you can easily carry. Remember—the streets may be slippery and carrying heavy packages can impair your balance.

December 2017 Public Relations + Social Media Highlights Report

District Board of Health

MEDIA / EVENTS

Car Seat Safety in Winter

The Reno Dads Blog also posted Car Seat Safety in Winter tips on its Facebook page.



Pedestrian Safety

Francisco Ceballos interviewed with KTVN on pedestrian safety and the grant received by REMSA to educate the public.



December 2017 Public Relations + Social Media Highlights Report

District Board of Health

SOCIAL MEDIA HIGHLIGHTS

Top 3 Facebook Posts By Engagement

Communication Specialist Job posting

12/20/17

- 3,099 people reached
- 185 post clicks

Santa Crawl / Hypothermia

12/6/17

- 1,227 people reached
- 217 post clicks

Regional Emergency Medical Services Authority - REMSA December 20 at 8:30am · 🌐

We are hiring a Communications Specialist to join our team! As part of our Communications team, you will help dispatch ground ambulances and respond to requests for our critical care air transport using leading technology and reliable data. REMSA's medical 911 center has national recognition and certifications for excellence. Learn more and apply here:



Communications - REMSA

Communications Specialists provide over-the-phone emergency care in our internationally accredited communications center. This team dispatches ground ambulances and responds to requests for our critical care air transport using...

REMSAHEALTH.COM

Regional Emergency Medical Services Authority - REMSA December 6 at 10:00am · 🌐

Did you know alcohol doesn't actually warm you up, it speeds up hypothermia? Adam Heinz joined KRXI FOX 11 News, Reno this morning to share information on staying safe during the Santa Crawl this weekend. Watch the video below for more.



REMSA offers safety tips for annual Santa Pub Crawl

The annual Reno Santa Pub Crawl will take over the streets of downtown on Saturday, December 9 starting at 7:30 p.m. REMSA Director of Communications Adam Heinz joined us in studio to discuss tips to keep Santa and Mrs. Claus...

FOXRENO.COM

December 2017 Public Relations + Social Media Highlights Report

District Board of Health

SOCIAL MEDIA HIGHLIGHTS

Common Snow Injuries

12/1/17

- ◆ 1,057 people reached
- ◆ 121 post clicks





REMSA 2017-18 PENALTY FUND RECONCILIATION AS NOVEMBER 30, 2017

2017-18 Penalty Fund dollars accrued by month

<u>Month</u>	<u>Amount</u>
July 2017	\$6,510.60
August 2017	6,275.80
September 2017	9,269.04
October 2017	7,060.72
November 2017	6,271.88
December 2017	
January 2018	
February 2018	
March 2018	
April 2018	
May 2018	
June 2018	
Total accrued as of 11/30/2017	<u>\$35,388.04</u>

2017-18 Penalty Fund dollars encumbered by month

<u>Program</u>	<u>Amount</u>	<u>Description</u>	<u>Submitted</u>
Total encumbered as of 11/30/2017	<u>\$0.00</u>		
Penalty Fund Balance at 11/30/2017	<u>\$35,388.04</u>		



REMSA INQUIRIES

DECEMBER 2017

No inquiries for December 2017

DD	RT	—
DHO	_____	—
DA	_____	—
Risk	_____	—

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health
FROM: Brittany Dayton, EMS Coordinator
775-326-6043, bdayton@washoecounty.us
THROUGH: Kevin Dick, District Health Officer
SUBJECT: Presentation, discussion and possible approval of the Regional Emergency Medical Services Authority (REMSA) Franchise Compliance Report for the period of 7/1/2016 through 6/30/2017.

SUMMARY

On an annual basis the District Board of Health (DBOH) is given a staff presentation and recommendation for possible action on the REMSA Franchise Compliance Report for the previous Fiscal Year (FY). This report is an assessment of REMSA's adherence to the various requirements outlined in the Amended and Restated Franchise Agreement for Ambulance Service (Franchise).

Attached to the staff report are the FY 16/17 Compliance Checklist and Compliance Report. REMSA was found compliant with all auditable Franchise articles.

District Health Strategic Priority:

4. Impactful Partnerships: Extend our impact by leveraging partnerships to make meaningful progress on health issues.

PREVIOUS ACTION

Since the establishment of the REMSA Franchise, the DBOH has been presented with a REMSA Franchise Compliance Report annually. Subsequently, since 1986, the DBOH annually receives reports and recommendations regarding compliance of REMSA under the terms of the Franchise.

On January 26, 2017 the DBOH was presented with the REMSA Franchise Compliance Report for FY 15/16 and found REMSA in compliance with the terms of the Franchise. It was noted for fiscal year 15/16 REMSA met all requirements except Article 8.1: average patient bill. The District Health Officer enacted Article 8.3 of the Franchise Agreement to address the billing overage, but compliance with Article 8.3 could not be determined until the next reporting period.

BACKGROUND

The REMSA Franchise Compliance Report is based on documentation and analysis of data from REMSA personnel, the District Health Officer, the Nevada Division of Public and Behavioral Health (DPBH) and EMS Oversight Program staff. Documentation is available to the DBOH upon request.

All articles of the Franchise were reviewed as part of the annual REMSA Franchise Compliance Report; however some are not auditable in terms of compliance. EMS Program staff used the Franchise (approved by the DBOH in May 2014, effective July 1, 2014) and Compliance Checklist (approved by the DBOH on May 26, 2016) to determine compliance.

EMS Oversight Program staff found REMSA to be in full compliance with the terms of the Franchise and the required documentation of the Compliance Checklist. This includes compliance with the DHO's enactment of Article 8.3 to address the average bill overage during the previous fiscal year.

Staff met with REMSA personnel on December 1, 2017 to review the findings of the FY 16/17 REMSA Compliance Report.

FISCAL IMPACT

There is no additional fiscal impact to the budget should the Board approve the FY 16/17 REMSA Franchise Compliance Report.

RECOMMENDATION

Staff recommends the DBOH find REMSA in compliance with the terms of the Franchise agreement for FY 16/17.

POSSIBLE MOTION

Should the DBOH agree with staff's recommendation, a possible motion would be:

“Move to approve the REMSA Franchise Compliance Report as presented and find REMSA in compliance with the Franchise agreement for the period of 7/1/2016 through 6/30/2017.”

REMSA Franchise Compliance Report
Fiscal Year 2016-2017

ARTICLE 1 - DEFINITIONS

1.1. Definitions

→ *Definitions are stated in the Franchise, but are not part of compliance determination.*

ARTICLE 2 - GRANTING OF EXCLUSIVE FRANCHISE

2.1. Exclusive Market Rights

→ **REMSA met the requirement.**

2.1 a) As demonstration of exclusive market rights, the signed Franchise agreement is included as part of the compliance report.

2.1 b) The Regional Emergency Medical Services Authority (REMSA) provided nine (9) mutual aid agreements with regional partners. These agreements are used if REMSA needs to request additional resources during day-to-day operations, or during a time of disaster. There are two new mutual aid agreements with Pyramid Lake Fire Rescue and Reno Fire Department.

2.2. Franchise Service Area

→ **REMSA met the requirement.**

2.2 a) The Franchise agreement specifies REMSA's service area includes Washoe County with the exception of the Gerlach Volunteer Fire Department service area and the North Lake Tahoe Fire Protection District. The REMSA response map indicates the Franchise service area and associated response time requirements.

2.3. Level of Care

→ **REMSA met the requirement.**

2.3 a) According to the Franchise agreement, all ambulances responding to emergency 911 calls and ILS transfers and transports must be staffed according to NAC 450B regulations. REMSA supplied a copy of their State of Nevada permit for Advanced Life Support (ALS) and community paramedicine services which expires on June 30, 2018.

2.3 b) In June 2016, October 2016 and April 2017 REMSA provided staffing graphs that depict the number of ambulances responding to 911 calls per day and per hour of the day.

2.4. Term

→ *The Franchise term is stated in the Franchise, but is not part of compliance determination until 2024.*

2.5. Periodic Review

→ ***Requirement of periodic review is stated in the Franchise, but is not part of compliance determination until 2024.***

2.6. Oversight Fee

→ **REMSA met the requirement.**

2.6 a) The Franchise agreement stipulates REMSA pays an oversight fee of 12.5% of the total costs per year for the Washoe County Health District (WCHD) EMS Oversight Program. The FY 16/17 Compliance Report includes the WCHD letters and invoices issued to REMSA and copies of the checks cashed on a quarterly basis. Table 1 below demonstrates the quarterly amounts paid by REMSA.

Table 1: Quarterly Oversight Fee

Quarterly Reimbursement Billing	Oversight Fee Paid
July 2016 – September 2016	\$12,462.92
October 2016 – December 2016	\$12,375.97
January 2017 – March 2017	\$15,497.65
April 2017 – June 2017	\$13,844.03

2.7. Supply Exchange and Reimbursement

→ **REMSA met the requirement.**

2.7 a) REMSA developed Medical Resupply Agreements with the three regional fire agencies within the Franchise service area. Reno Fire Department and Sparks Fire Department signed the agreement in March 2014 and Truckee Meadows Fire Protection District revised and signed their agreement in October 2015. REMSA provided copies of the signed agreements with each agency.

2.7 b) The EMS Coordinator requested written confirmation from the three fire agencies that REMSA reimbursed based on their supply/exchange reimbursement agreements. All jurisdictions confirmed reimbursement for FY 16/17 by November 30, 2017.

2.8. No Obligation for Subsidy

→ **REMSA met the requirement.**

2.8 a) In the audited REMSA Consolidated Financial Statements prepared by Cupit, Milligan, Ogden & Williams the major payer sources are detailed in Note 1. The major payer sources included commercial insurance carriers, Medicare/Medicaid, and health care facility contracts. REMSA's revenue for the fiscal year exceeded expenses by \$202,389.

2.8 b) REMSA originally filed Articles of Incorporation with the Office of the Secretary of State of the State of Nevada in 1981. Since then, REMSA submitted certificates of amendment in 1986, 1987, 1994, 1996 and 2008. A copy of the 2008 Articles of

Incorporation are on file at the WCHD. Additionally, a copy of REMSA's business information is available on the Secretary of State's website.

2.8 c) REMSA did not receive any grant funding for Franchise ground ambulance services for the fiscal year.

ARTICLE 3 - GOVERNING BODY

3.1. REMSA Board of Directors

→ **REMSA met the requirement.**

3.1 a) REMSA provided the following list of Board Members for FY 16/17:

James Begbie, Chairman
Timothy Nelson
Erik Olson
Tiffany Coury
Helen Lidholm
Louis Test
Krys Bart
Kevin Dick, Ex Officio

3.1 b) REMSA's legal counsel, Michael Pagni, Esq. of McDonald, Carano and Wilson LLP, verified in a letter to the District Health Officer (DHO) dated October 19, 2017 that, "all contractual relationships involving a member of the REMSA Board entered between July 1, 2016 through June 30, 2017 were approved by a majority of the disinterested members of the REMSA Board."

3.2. Board Member Separation

→ **REMSA met the requirement.**

3.2 a) To demonstrate Board separation, REMSA provided signed copies of the "Affirmation of Compliance to REMSA's Conflict of Interest Policy" form. Members of the Board mentioned in section 3.1a signed the form acknowledging that they have received a copy of the policy, read and understand the policy and will comply with the policy. In addition, members confirmed that they are not an employee of either REMSA or its contractor.

3.3. Meetings

→ **REMSA met the requirement.**

3.3 a) REMSA provided a list of board meetings held in the fiscal year, which met the required minimum of six meetings indicated in the Franchise agreement. The REMSA Board meetings are typically scheduled on the third Friday of each month, excluding holidays.

3.3 b) As confirmation of the information above, the DHO also submitted a letter that included the REMSA board meetings for the fiscal year. The DHO attested that the REMSA Board met on eleven (11) occasions throughout the fiscal year.

ARTICLE 4 - AMBULANCE SERVICE CONTRACTS, COMPETITIVE BIDDING AND MARKET SURVEY

4.1 Market Survey and Competitive Bidding

→ *A market survey or competitive bid is stated in the Franchise, but is not part of compliance determination until 2021.*

ARTICLE 5 – COMMUNICATIONS

5.1. Radios

→ **REMSA met the requirement.**

5.1 a) REMSA provided a copy of the letter of agreement signed on January 23, 2015 between Washoe County and REMSA. This letter provides REMSA with sponsorship from Washoe County to participate in the Washoe County Regional 800 MHz Communications System (WCRCS).

5.1 b) In spring 2015 REMSA installed and maintains hardware in their dispatch center that allows two-way communication between primary Public Safety Answer Points (PSAPs) and REMSA dispatch. Call information is transmitted on REMSA1 on the 800 MHz system to communicate with fire units about calls.

Additionally, REMSA provided the 800 MHz Joint Operating Committee and User Committee Meetings attended during the fiscal year:

- | 800 MHz Joint Operating Committee: | 800 MHz User Committee Meetings: |
|---|---|
| • 07/15/2016 | • 07/21/2016 |
| • 10/21/2016 | • 09/15/2016 |
| • 01/27/2017 | • 11/17/2016 - cancelled |
| • 02/24/2017 - special meeting | • 12/12/2016 |
| • 04/07/2017 - cancelled | • 01/19/2017 - cancelled |
| • 04/28/2017 | • 03/16/2017 |
| | • 07/20/2017 - no quorum |
| | • 09/21/2017 - no quorum |

REMSA does not have a vote in the meetings since they are a sponsored agency (by Washoe County). REMSA's attendance is observation only. Several meetings discussed what users can do to provide better interoperability of the 800 MHz system and Nevada Dispatch Interconnect Project (NDIP). The above meetings also discussed current use and

the possibility to expand use of the existing 800 MHz system. Unfortunately Washoe County and the State do not have many available Logical ID Codes (LIDs) needed to operate the radios on the 800 MHz system so REMSA cannot add radios at this time. The reported outcomes of the meetings included:

- 1) Continue with the current communications configuration - REMSA1 talkgroup patch through the NDIP switch and REMSA radio consoles to Med 09, which allows fire to request updates and listen to the response.
- 2) Approval for budget costs to expand the NDIP switch, which is scheduled for the third quarter of fiscal year 17/18 to be purchased and installed.

REMSA also participated in the WCHD HD SUP 800 MHz radio checks on a regular basis.

5.2. Dispatch

→REMSA met the requirement.

5.2 a) As required in the Franchise agreement, REMSA must maintain a secondary emergency communication system and conduct a drill on the backup system annually. During FY 16/17, REMSA conducted two tests to ensure the back-up dispatch system equipment is maintained and in good working order.

5.2 b) REMSA completed a system check on May 23, 2017 and an operational drill was conducted on April 6, 2017 with REMSA dispatch, operations and IT personnel.

5.2 c) During the May Emergency Back-Up Communications Center (EBUCC) checks/drills all systems worked as anticipated; staff transferred calls and performed outbound calls. The after action report indicated the need to add additional personnel on the call lists. Staff confirmed that REMSA did add the identified personnel to the call lists.

5.2 d) The EMS Oversight Program began coordinating meetings with regional partners concerning Computer-Aided Dispatch (CAD)-to-CAD at the start of 2016, but those efforts transitioned to the City of Reno (Reno) during the fiscal year. Through the fiscal year Reno's Assistant Director of Information Technology (DoIT) provided updates to the EMS Advisory Board on the process with the CAD-to-CAD interface. Those updates were also provided quarterly to the District Board of Health (DBOH). The last update stated Reno DoIT, has established a testing server, which Tiburon is configuring now with their middleware and software for the CAD-to-CAD. DoIT, along with City Attorney's office, is reviewing a Memorandum of Understanding/Business Associate Agreement with REMSA to ensure an understanding in regards to operations of the CAD-to-CAD programming. The region is still on schedule to begin testing by March 2018.

5.2 e/f) During the fiscal year, several meetings were held to discuss the implementation process of CAD-to-CAD and Automatic Vehicle Location (AVL). These planning meetings

were designed to ensure agreements and contracts are moving forward for the Reno Communications Center servers and REMSA. In the current fiscal year, Reno and REMSA established weekly meetings and the agencies are scheduled for implementation in early 2018.

5.2 g) REMSA provided the following documentation related to CAD-to-CAD:

1. Proposal Sales/Scope of Work Document
2. REMSA's signed and paid agreement with TriTech
3. CAD-to-CAD Developer's Guide

5.2 h) As stated above, AVL will be included in the CAD-to-CAD project and is outlined in the CAD-to-CAD Developer's Guide. REMSA has utilized AVL for several years as part of its current CAD system and is an active participant in the CAD-to-CAD project with Reno and intends to allow for sharing of information, including AVL.

5.3. Change of Priority

→ **REMSA met the requirement.**

5.3 a) During the FY 16/17 REMSA upgraded 5 calls. All of the calls were requests by on-scene first responders. REMSA began including change of priority information in their monthly Operations Reports to the DBOH in January 2015.

ARTICLE 6 - DATA AND RECORDS MANAGEMENT

6.1. Data and Records

→ **REMSA met the requirement.**

6.1 a/b) Same as 5.2 d, e, f, and g.

6.1 c) In accordance with Article 6.1 of the Franchise agreement, REMSA provided additional response data and records to support the WCHD's oversight role. During FY 16/17, the EMS Oversight Program conducted one investigation related to a possible delay in response.

6.1 d) Due to the map revision, there were no time study reports for this fiscal year.

6.1 e) During FY 16/17 the DHO/EMS Oversight Program made two requests for data and/or records from REMSA: one concerning Omega determinants and the other for CAD data. In addition to the requests, the EMS Oversight Program provided recommendations to REMSA based on analyses conducted during the fiscal year.

ARTICLE 7 - RESPONSE COMPLIANCE AND PENALTIES

7.1. Response Zones

→ **REMSA met the requirement.**

7.1 a) The Franchise response map was recreated through a nearly yearlong data-driven process with regional contributions. The map went into effect on July 1, 2016. Shortly after implementation there was a question concerning the northern boundary of the Franchise; staff presented to the DBOH on July 28, 2016, who determined the Franchise northern boundary would follow along the rural fire boundary. The Franchise response map is divided into five (5) response zones with varying response requirements. Table 2 exhibits the response times required for priority 1 calls in each of the zones (A-E).

Table 2: Priority 1 Response Time Requirements, by Zone

	ZONE A	ZONE B	ZONE C	ZONE D	ZONE E
Priority 1	8:59	15:59	20:59	30:59	Wilderness/ Frontier

7.1 b) No changes went into effect during the fiscal year for the REMSA Franchise response map since it was newly created and then implemented at the start of the fiscal year.

7.1 c/d) EMS Oversight Program staff used the Franchise response requirements for all life-threatening calls (priority 1) to determine compliance for the fiscal year on a monthly basis. The Franchise agreement states that REMSA shall ensure that 90% of life-threatening calls (priority 1) have a response time as indicated by the respective zone.

Table 3 below specifies REMSA's percentage of response compliance for Zone A and Zones B, C, and D. Please note that the Franchise compliance calculations collectively analyze responses to life-threatening (priority 1) calls in Zones B, C, and D.

Table 3: Percentage of Compliant P1 Response, by Month

Month	Zone A	Zones B,C and D
July 2016	94%	94%
August 2016	93%	92%
September 2016	95%	93%
October 2016	93%	92%
November 2016	93%	94%
December 2016	92%	91%
January 2017	92%	90%
February 2017	91%	93%
March 2017	92%	96%
April 2017	93%	93%
May 2017	94%	93%
June 2017	94%	96%
YTD	93%	93%

7.1 e) Zone E, the wilderness/frontier regions of REMSA’s franchise area, is the only zone that does not have a specified response time requirement. For FY 16/17, REMSA had a total 754 calls for service in Zone E; however 242 of those calls were cancelled enroute.

There were 348 priority 1 calls, but 106 of those calls were cancelled enroute. For priority 1 calls in Zone E, REMSA had an average response time of 23 minutes and 57 seconds.

7.2. Response Determinants

→ **REMSA met the requirement.**

7.2 a/b) REMSA’s Medical Director and the Medical Directors for Fire agencies met on June 26, 2017 and jointly reviewed the EMD determinants and set priorities for the system. REMSA also provided a packet of information regarding the EMD review, which included information on the Medical Priority Dispatch System (MPDS) Version 13.0 and expected changes/improvements with the system.

7.3. Zone Map

→ **REMSA met the requirement.**

7.3 a/b) Same as 7.1b.

7.3 c) The Franchise response map is located in the offices of the EMS Oversight Program Manager and EMS Coordinator. An online version of the response map is also located on Washoe County’s GIS quick map tool as a map layer.

7.4. Response Time Reporting

→ **REMSA met the requirement.**

7.4 a) REMSA provided EMS Oversight Program staff with log-ins to the FirstWatch Online Compliance Utility (OCU) in July 2014. With this access, EMS Oversight Program staff independently pulls the call/response data from the FirstWatch database on a monthly basis.

7.4 b) During the fiscal year, REMSA had a total of 68,484 calls (priorities 1-3 and 9) for service in their FirstWatch database. Table 4 below shows the number of life-threatening calls (priority 1) for service per zone.

Table 4: Number of Priority 1 Calls for Service, by Zone

Zone	Number of P1 Calls
A	26,230
B	671
C	311
D	56
E	348

7.4 c) In an effort to review compliance on a monthly basis, the EMS Coordinator calculates the percentage of compliant responses and the 90th percentile response time for each month. This information is reported in the Epidemiology and Public Health Preparedness (EPHP) Division staff report provided to the DBOH at each meeting.

7.5 Penalties

→ **REMSA met the requirement.**

7.5 a) On October 24, 2017 REMSA submitted a penalty fund reconciliation packet to the DHO. The DHO approved penalty fund amount was based on an estimate of \$76,000. The actual penalty dollars for the FY 16/17 totaled \$73,827.59 and REMSA spent the entire balance of the fund, as outlined in Article 7.7 of the Franchise agreement.

7.5 b) The WCHD issued a letter on April 25, 2016 notifying REMSA that the annual review of the Consumer Price Index (CPI) had been completed. For fiscal year 2016-2017, REMSA's maximum average ground bill was \$1,129.48, an increase of 2.91% from the previous year.

The CPI letter also set the penalty amount for late responses to life-threatening calls (priority 1) at \$18.71 per minute, a \$0.53 increase from the previous year.

7.5 c) According to the Franchise agreement, penalties are assessed only on a call resulting in a patient transport, up to a maximum of \$150.00 per call. Table 5 depicts the number of priority 1 calls that incurred penalties, as well as the total amount added to the penalty fund each month.

Table 5: Penalty Fund, by Month

Month	Number of Calls	Penalty Amount
July	150	\$5,258.15
August	154	\$5,652.02
September	110	\$3,911.03
October	160	\$5,856.87
November	127	\$5,184.27
December	174	\$6,044.93
January	190	\$7,578.83
February	179	\$7,822.06
March	185	\$7,803.35
April	167	\$6,681.71
May	155	\$6,457.83
June	139	\$5,576.54
Total	1,890	\$73,827.59

7.5 d/e) Cupit, Milligan, Ogden & Williams completed an independent accountant’s report entitled “Agreed-Upon Procedures Related to Priority 1 Penalty Fund” as part of REMSA’s annual audit. This report reviewed and identified the agreed-upon procedures between REMSA and the WCHD as well as the penalty fund expenditures. The report concluded that there is no carry-over to fiscal year 2017-2018 for the penalty fund account.

7.6. Exemptions

→ **REMSA met the requirement.**

7.6 a) During FY 16/17 REMSA had 124 approved exemptions, with the majority of exemptions being blanket weather related exemptions. EMS Oversight Program staff continue to have monthly meetings with REMSA to review and discuss all calls that received an exempt status through REMSA’s internal process. Table 6 indicates the types of exemptions and number of calls approved for each category.

Table 6: Exemptions, by Type

Exemption Type	Number of Exemptions
Incorrect address	3
Other	2
Weather	119

7.6 b) REMSA submitted a document that explains their internal process for reviewing and requesting late run exemptions. Below is the description:

Late Run Exemption Process

Response Performance is measured through First Watch and their Online Compliance Utility (OCU). Late responses are identified by the Communications Supervisor using the OCU. The Communications Supervisor will investigate the response and identify a reason for the delay. Calls that are not identified as a correction or exemption are marked "Late After Review" and calculated as a late response to be calculated into the fractal compliance.

Corrections and exemptions identified by the Communications Supervisor will be marked as "Manager Review" with details explaining the delayed reason. The call is then processed in the OCU by the Communication Manager or Senior Systems Analyst for validity of the correction or exemption reason with additional information as needed. The Communication Manager or Senior Systems Analyst will update a status correction and exemptions as Correction Requested or Exemption Requested.

Correction and exemption requests are processed by the Authority through the OCU. Each response is reviewed and either approved for exemption, denied for exemption or request for further information. Approved and denied exemptions are identified in the OCU and calculated into the fractal compliance.

7.6 c) There were no disputes this fiscal year.

7.6 d) On May 26, 2016 the DHO issued a letter that detailed the exemption guidelines for REMSA and what is considered an allowable exemption. The letter identifies eight (8) types of possible exemptions. According to the letter, REMSA can internally review two (2) types of exemptions with the WCHD, while all others exemptions require REMSA to submit documentation to the WCHD for review and possible approval.

7.6 e) Same as 7.6a.

7.7 Penalty Fund

→**REMSA met the requirement.**

7.7 a) The CFO of REMSA wrote a letter to the DHO confirming that the penalty funds are recorded monthly in a separate restricted account.

7.7 b) As indicated in 7.5c Table 5, REMSA incurred \$73,827.59 in penalties for the fiscal year.

7.7 c) REMSA supplied the FY 16/17 penalty fund reconciliation documents along with copies of invoices, purchase orders and checks used for purchases with penalty fund monies.

7.7 d) In the Agreed-Upon Procedures Related to the Penalty Fund issued by the external auditor, the report reconciled total penalties of \$73,827.59 and confirmed the ending balance of the fund on June 30, 2017 was zero dollars.

7.8. Health Officer Approval

→ **REMSA met the requirement.**

7.8 a) In a letter dated November 14, 2016 REMSA estimated that the penalty fund would reach approximately \$62,000 for the year. REMSA's President/CEO requested using the penalty fund dollars for programs supporting the health and safety of our community. This included the following:

- Child Safety
- Field Crew Ballistic Vests
- Community AEDs
- Washoe County Health District BLS/CPR Recertification

On June 27, 2017 the WCHD DHO received an update penalty fund expenditure letter that stated the penalty fund was estimated to reach \$76,000 for the fiscal year. The letter stated there was additional fund based on the number of late calls, but REMSA would use the monies for the previously approved items.

7.8 b) The DHO responded to the penalty fund expenditure request in a letter dated November 15, 2016 and approved all requests. The DHO sent a second approval for the June penalty fund letter which increased the penalty fund approval to \$76,000.

ARTICLE 8 - PATIENT BILLING

8.1. Average Patient Bill

→ **REMSA met the requirement.**

8.1 a) As stated in Article 7.5, the WCHD issued a letter on April 25, 2016 notifying REMSA that the annual review of the CPI had been completed. For fiscal year 2016-2017, REMSA's maximum average ground bill was \$1,129.48, an increase of 2.91% from the previous year.

8.1 b) On June 1, 2016 the WCHD received a letter for REMSA concerning a change to their schedule of rates go into effect July 1, 2017. REMSA increased the emergency base rate from \$1,097.55 to \$1,129.48. REMSA submitted an additional schedule of rates on July 20, 2016 that changed their emergency base rate to \$1,044.00.

8.1 c) REMSA submitted the follow explanation for their average bill calculations:

After a billing month has concluded, the total gross sales dollar amount billed for the month is divided by the number of patients transported in the same month. The sum of this calculation is then compared to the Average Bill approved by the DBOH. If necessary, the average bill is then adjusted for the new month to insure the Average Bill remains consistent. Table 7 depicts a summary of the average bill calculations that were reported to the DBOH on a monthly basis.

Table 7: Average Bill Calculations Reported, by Month

Month	# Patients	Avg. Bill
July 2016	4106	\$1,092.43
Aug.	4156	\$1,105.54
Sept.	4000	\$1,107.04
Oct.	4023	\$1,109.36
Nov.	3718	\$1,109.70
Dec.	4281	\$1,109.74
Jan. 2017	4413	\$1,115.51
Feb.	3913	\$1,109.91
Mar.	4192	\$1,111.69
Apr.	3978	\$1,110.34
May	4086	\$1,112.00
June	3885	\$1,110.35
Total	48751	\$1,108.63

8.2. Increase beyond CPI

→ *Only applicable if REMSA requested an increase beyond the annual CPI adjustment. REMSA did not request such an adjustment during FY 16/17.*

8.3. Overage in Bill Amount

→ **REMSA met the requirement.**

8.3 a) REMSA exceeded the average patient bill during FY 15/16 by \$0.04. Therefore, the maximum average patient bill for ground ambulance transport was reduced by \$.04 for the remainder of FY 16/17. This was dictated in a letter written by the DHO on December 13, 2016. When staff presented the FY 15/16 Franchise Compliance Report it was relayed to the DBOH that compliance with this item could not be audited until the FY 16/17 Compliance Report. REMSA adjusted its billing to account for the \$.04 overage and decreased the average patient bill amount based on documentation submitted for 8.1.

8.4. Third Party Reimbursement

→ **REMSA met the requirement.**

8.4 a) According to the Franchise agreement REMSA shall utilize its best efforts to maximize third party reimbursements and minimize patients' out-of-pocket expenses. This is accomplished through billing insurance and governmental reimbursement and maintaining a voluntary prepaid ambulance membership program.

8.5. Prepaid Subscription Program
→ **REMSA met the requirement.**

8.5 a/b) The Silver Saver program is designed to cover the co-insurance or deductible costs for ambulance service for individual households. The annual membership costs \$69 and there were 931 members enrolled as of June 30, 2017.

8.6. Billing
→ **REMSA met the requirement.**

8.6 a) The Franchise agreement states REMSA is responsible for all billing services, or may allow a contractor to do so. REMSA elects to conduct its own billing of patients and third-party billers. The billing department is under the purview of REMSA's Chief Operating Officer. The billing department is structured with a VP of Business Services, a Billing Services Supervisor and Billers and Coders.

8.7. Accounting Practices
→ **REMSA met the requirement.**

8.7 a) The external auditor used for REMSA's annual audit, Cupit, Milligan, Ogden & Williams, does adhere to GAAP and GAAS standards. According to the Nevada State Board of Accountancy website the agency license is current through December 31, 2017.

8.8. Audit
→ **REMSA met the requirement.**

8.8 a) The Consolidated Financial Statements prepared by the external auditor were submitted on November 22, 2017. The fourteen (14) page document includes the independent auditor's report and the financial statements for FY 16/17.

8.8 b) The Form 990 is an annual reporting return that REMSA must file with the IRS. It provides information on the filing organization's mission, programs, and finances. REMSA's Form 990 for FY 15/16 was submitted on November 22, 2017.

8.8 c) The Agreed-Upon Procedures Related to Franchise Average Bill prepared by the external auditor were submitted on November 22, 2017. The five (5) page document includes the independent auditor's report and Schedule A, B and C for FY 16/17.

ARTICLE 9 - PERSONNEL AND EQUIPMENT

9.1. Dispatch Personnel Training
→ **REMSA met the requirement.**

9.1 a/b) REMSA submitted a list of personnel that work in the communications center. A total of twenty-seven (27) employees were included and had current EMD certifications for FY 16/17, which was confirmed by the Nevada Division of Public and Behavioral

Health (DPBH) office of Emergency Medical Systems. Additionally, three (3) REMSA communications personnel were hired during the fiscal year and received EMD training within 6 months.

9.2. Dispatch Accreditation

→ **REMSA met the requirement.**

9.2 a) REMSA submitted a copy of their ACE accreditation certification, which is issued for through April 30, 2018.

9.2 b) EMS Oversight Program staff obtained the standards of accreditation and the ACE application from the IAED website. EMS Oversight Program staff also located a list of ACE accredited dispatch centers, which listed REMSA as one of three dispatch centers in Nevada that have received this designation.

9.3. Personnel Licensing and Certification

→ **REMSA met the requirement.**

9.3 a) REMSA submitted lists of their certified personnel to include Paramedics, AEMTs and EMTs. Table 8 demonstrates the number of staff per each certified position.

Table 8: REMSA Certified Personnel

Certified Position	Number of Staff
Paramedics	122
EMT-Is	84
EMT-Basic	11

9.3 b) The Nevada Department of Health and Human Services, DPBH office of Emergency Medical Systems confirmed in a letter/email received by the WCHD on October 26, 2017 that REMSA was in compliance in regards to NRS 450B and NAC 450B requirements pertaining to permits, inspections, staffing, equipment, operations and protocols for FY 16/17.

9.4. ICS Training

→ **REMSA met the requirement.**

9.4 a) REMSA submitted documentation that 236 personnel have been trained in the Washoe County Multi-Casualty Incident Plan (MCIP) as of October 4, 2017.

9.4 b) REMSA submitted documentation that 252 personnel have been trained in Incident Command System (ICS) 100 as of September 15, 2017.

9.4 c) REMSA submitted documentation that 245 personnel have been trained in ICS 200 as of September 15, 2017.

9.4 d) REMSA submitted documentation that 18 personnel have been trained in ICS 300 as of September 15, 2017.

9.4 e) REMSA submitted documentation that 6 personnel have been trained in ICS 400 as of September 15, 2017.

9.4 f) REMSA submitted documentation that 243 personnel have been trained in ICS 700 as of September 15, 2017.

9.4 g) REMSA provided a list of operational field management personnel that included an EMS director, 3 managers, 5 full-time supervisors, 2 administrative supervisors and 3 part-time supervisors.

9.4 h) REMSA provided a list of 6 REOC qualified personnel based on their REMSA position and ICS courses completed.

9.5. Ambulance Markings

→**REMSA met the requirement.**

9.5 a) The Franchise agreement states that all ambulance units shall be marked with REMSA emblems rather than the individual identity of any ambulance service contractor. EMS Oversight Program staff completed quarterly spot checks to ensure that units had the REMSA logo. The spot checks found REMSA in compliance and occurred on the following dates:

- July 7, 2016
- November 14, 2016
- February 13, 2017
- April 26, 2017

9.6. Ambulance Permits and Equipment

→**REMSA met the requirement.**

9.6 a/b) REMSA provided EMS Oversight Program staff a detailed inventory list of all organizational capital equipment, such as monitors, power cots, stair chairs, etc. REMSA also submitted a list of vehicles to include model, type and VIN numbers.

9.6 c) Same as 9.3b.

9.7. Field Supervisor Staffing

→**REMSA met the requirement.**

9.7 a/b) REMSA submitted a week of supervisor shift schedules as a sample to demonstrate that a field supervisor is on each shift. In the shift schedule provided, there are 2-3 supervisors

on shift per 24-hours, depending on day and time of the week. REMSA also provided the job description for EMS supervisor that was last revised in January 2016.

9.8. Medical Director

→**REMSA met the requirement.**

9.8 a/b) The Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Emergency Medical Systems Program confirmed in a letter/email received by the WCHD on October 26, 2017 that REMSA was in compliance in regards to their Medical Director appointment. According to State EMS, Dr. Bradford Lee, meets the requirements as a Medical Director for a permitted service in Nevada in accordance with NAC 450B and NRS 450B. Additionally, Dr. Lee is in good standing with the State of Nevada Board of Medical Examiners. The WCHD also has a copy of Dr. Lee's CV on file.

ARTICLE 10 - QUALITY ASSURANCE

10.1. Personnel

→**REMSA met the requirement.**

10.1 a) REMSA provided written documentation of the individuals designated to conduct the oversight and maintenance of the continuous quality improvement program for ground ALS services. The members of the CQI department include the Medical Director, Manager of Clinical Development and CQI, two (2) Clinical Development and CQI Coordinators, Director of EMS Operations and Director of Communications.

10.2. Review

→ **REMSA met the requirement.**

10.2 a) In the monthly Operation Reports presented to the DBOH, REMSA includes the Medical Director's Report. This report includes a breakdown of the patient charts reviewed during the previous month. All monthly reviews during FY 16/17 met or exceeded the requirement of 5% of ALS calls.

10.2 b) With the following types of calls, REMSA CQI department personnel conduct manual reviews of all patient care reports (PCRs) for accurate and complete documentation as well as appropriate use of protocols:

- 100% of cardiopulmonary arrests (adult and pediatric)
- 100% of advanced airways (outside cardiac arrests-adult and pediatric)
- 100% of Deliveries and Neonatal Resuscitation
- 100% of Pediatric patients receiving the following medications
 - Versed
 - Epinephrine
 - Narcan

- 100% of Pediatric patients with a GCS of ≤ 14
- 100% of STEMI Alert or STEMI rhythms
- 100% Adult Patients who receive critical medications outside cardiac arrest resuscitation.
- 100% Advanced Airway Success Rates for nasal/oral-endotracheal intubation and King Airway placement (first and second attempt) for adult and pediatric patients

All PCR's that are reviewed are returned to the provider via Zoll Reroute System with an accompanying email for the Clinical Development/CQI Coordinator for any negative finding. The provider will have the opportunity to review the comments and the PCR and reply if desired. The Clinical Development/CQI Coordinator will monitor via Zoll Reroute system report the opening of messages by providers. If not checked in 30 days the message is rerouted to the provider's direct supervisor.

Any call attended by an EMT-Intermediate outside scope will be routed to the paramedic partner with notification of ALS requirements.

ARTICLE 11 - COMMUNITY RELATIONS AND PUBLIC EDUCATION

11.1. CPR Courses

→ **REMSA met the requirement.**

11.1 a) In the monthly Operation Report presented to the DBOH, REMSA provided a list of the CPR courses that were offered throughout the previous month. In January 2015 REMSA reformatted the style of this report to differentiate between the courses that are REMSA classes and site classes.

11.2. Community Health Education

→ **REMSA met the requirement.**

11.2 a) In the monthly Operation Report presented to the DBOH, REMSA included the public relations report that outlines the multimedia activities completed during the previous month.

11.3. Clinical Skills

→ **REMSA met the requirement.**

11.3a) According to the Education Manager, REMSA did not have the need to utilize hospital partners this past year (2016-2017) for the remediation of employees in clinical skills. REMSA maintains a close and valuable relationship with the clinical departments of all participating hospitals and utilize them for continuing education of our REMSA employees. REMSA had numerous continuing education courses this year to include physicians from Saint Mary's and Renown Regional Medical Center. Some of the topics this year have been:

- September 6, 2016: “Acute Heart Failure”, Presented by Thomas-Duythuc To, MD, Cardiovascular Disease Physician at RRMCC. 2.0 CEs
- September 7, 2016 & September 8, 2016: “Capnography in the Prehospital Setting”, Presented by Covidien and Medtronic representatives. 3.0 CEs
- September 29, 2016 & October 19, 2016. “Advanced STEMI and STEMI Mimics”, Presented by Jason Hatfield, NRP, CCEMT-P, CQI Coordinator for REMSA. 2.0 CEs
- September 29, 2016:” aVR, The Unforgotten Lead”, Presented by Jason Hatfield, NRP, CCEMT-P, CQI Coordinator for REMSA. 1.0 CEs
- October 21, 2016 & October 22, 2016: “Surviving a Zombie Apocalypse”, Presented by Rob Harper, NRP, CCEMT-P, Education Coordinator for REMSA. 1.0 CEs
- December 8, 2016 & April 17, 2017 & July 10, 2017: “Challenges in Pediatric Trauma”, Presented by Kristina Deeter MD, Medical Director of the PICU at Renown Regional Medical Center. 2.0 CEs
- April 8, 2017 & April 24, 2017 & April 26, 2017: “When Good Drugs Go Bad”, Presented by Rob Harper, NRP, CCEMT-P, Education Coordinator for REMSA. 2.0 CEs
- May 02, 2017: “Deficits and Disability in Acute Ischemic Stroke”, Presented by Christie Casper, MSN, ANP, CNRN, from St. Anthony Hospital, Denver CO. 2.0 CEs (sponsored by Genentech)
- May 22, 2017: “Addiction in Healthcare and EMS”, Presented by Kristin Knowles, RN. 2.0 CEs
- May 26, 2017: “Spectrum of Stroke Care: Neuro Case Review”, Presented by Jennifer Wilson, MD, Medical Director of Saint Mary’s Emergency Department. 2.0 CEs
- June 5, 2017 & June 6, 2017: “Critical Care Capnography”, Presented by Kyle Henson, Representative from Covidien. 2.0 CEs
- Saint Mary’s Regional Medical Center provides a 4 hour educational observation opportunity for REMSA employees in their cardiac cath lab coordinated through their Cardiac Services with CE certification provided by REMSA Education.

In addition, the REMSA Clinical Development and CQI Coordinator is a member of each hospital’s STEMI and Stroke Committees and has the opportunity to review and discuss all STEMI and Stroke patients transported by REMSA to each hospital. The hospitals send follow-up information to the REMSA Clinical Development Coordinator on STEMI Alert patient times to cath labs and outcomes. In turn, any false STEMI Alert called by the REMSA paramedic is reported to REMSA CQI and individual follow-up and education is completed with the employee.

11.4. Fire EMS Training

→ **REMSA met the requirement.**

11.4 a) REMSA provides CEU opportunities that are available to all first responders. In each quarter of the fiscal year REMSA also offered specialty training on diverse topics to regional EMS agencies. Through the Franchise agreement the EMS Advisory Board has the ability to make recommendations for Fire EMS trainings to the DBOH. EMS Oversight Program staff periodically observe the trainings.

ARTICLE 12 – REPORTING

12.1. Monthly Reports

→ **REMSA met the requirement.**

12.1 a) During the fiscal year REMSA submitted twelve (12) Operational Reports to the DBOH. These reports typically include documentation about response compliance, average response times, average bill, community CPR class, patient feedback and multimedia campaign activities.

12.2. Annual Reports

→ **REMSA met the requirement.**

12.2 a) The WCHD received all compliance documentation on or before November 30, 2017.

12.2 b) During the fiscal year EMS Oversight Program staff conducted monthly compliance calculations based on data pulled from the FirstWatch OCU, held exemption meetings, observed the Fire EMS trainings and held compliance meetings throughout the fiscal year.

ARTICLE 13 - FAILURE TO COMPLY/REMEDIES

13.1. Failure to Comply with Agreement

→ *Failure to comply is stated in the Franchise, but is not part of compliance determination, unless REMSA does not comply with the terms of the Franchise.*

13.2. Notice of Noncompliance

→ *Notice of noncompliance is stated in the Franchise, but is not part of compliance determination, unless REMSA does not comply with the terms of the Franchise.*

13.3. Failure to Correct/ Rescission of Agreement

→ *Failure to correct/rescission is stated in the Franchise, but is not part of compliance determination, unless REMSA does not comply with the terms of the Franchise.*

13.4. Alternate to Rescinding Agreement

→ *Alternate to rescinding is stated in the Franchise, but is not part of compliance determination, unless REMSA does not comply with the terms of the Franchise.*

ARTICLE 14 - DISPUTE RESOLUTION

14.1 Agreement to Mediate Disputes

→ *Agreement to mediate disputes is stated in the Franchise, but is not part of compliance determination, unless a dispute occurs.*

ARTICLE 15 - FINANCIAL ASSURANCE/CONTINUITY OF OPERATIONS

15.1. Financial Assurance/Continuity of Operations

→ **REMSA met the requirement.**

15.1 a) The Consolidated Financial Statements prepared by the auditor indicate REMSA's net assets of \$24,422,016. Additionally, according to a letter written by the REMSA CFO, REMSA has a reserve amount of \$3 million in the equity statements as a Board designated reserve.

ARTICLE 16 - INSURANCE AND INDEMNIFICATION

16.1. Insurance

→ **REMSA met the requirement.**

16.1 a/b) REMSA provided a copy of their certificate of liability insurance that included general liability, automobile, workers compensation and employer's insurance policies. Additionally, "Washoe County" is listed as the certificate holder.

16.2. Indemnification

→ **REMSA met the requirement.**

16.2 a) The Franchise agreement includes an indemnification statement that the parties of the Franchise agree to hold harmless, indemnify and defend the other party. This statement became binding when the parties signed the Franchise agreement. Therefore, a signed copy of the Franchise agreement is included as part of the compliance report documentation.

16.3. Limitation of Liability

→ **REMSA met the requirement.**

16.3 a/b) The Franchise agreement states the WCHD will not waive and intends to assert any available remedy and liability limitation set forth in NRS Chapter 41 and applicable case law. Therefore the compliance documentation collected for the fiscal year includes a copy of NRS Chapter 41 and the signed Franchise.

ARTICLE 17 – MISCELLANEOUS

17.1. REMSA Contracts with Other Entities

→**REMSA met the requirement.**

17.1 a) REMSA submitted nine (9) mutual aid agreements that are REMSA's current agreements with other political entities or Fire/EMS agencies.

17.2. Governing Law; Jurisdiction

→ *Governing law; jurisdictions are stated in the Franchise, but are not part of compliance determination.*

17.3. Assignment

→ *Assignment is stated in the Franchise, but is not part of compliance determination.*

17.4. Severability

→ *Severability is stated in the Franchise, but is not part of compliance determination.*

17.5. Entire Agreement/Modification

→ *Entire agreement/modification is stated in the Franchise, but is not part of compliance determination.*

17.6. Benefits

→ *Benefits are stated in the Franchise, but are not part of compliance determination.*

17.7. Notice

→ *Notice is stated in the Franchise, but is not part of compliance determination.*

REMSA Franchise Compliance Checklist

Franchise Article	Title	Compliance Documentation	Responsible Party	Date Received	Reviewer's Notes
1	Definitions	1.1 Definitions - Definitions are stated in the franchise, but are not part of compliance determination			
2	Granting of Exclusive Franchise	2.1 Exclusive Market Rights a) <input checked="" type="checkbox"/> The franchise agreement signed by DBOH and REMSA in May 2014, which gives REMSA the exclusive market rights within the franchise service area b) <input checked="" type="checkbox"/> All disaster agreements and/or mutual aid agreements 2.2 Franchise Service Area a) <input checked="" type="checkbox"/> Map of the REMSA franchise area 2.3 Level of Care a) <input checked="" type="checkbox"/> A copy of state certification for ALS services b) <input checked="" type="checkbox"/> Documentation that demonstrates the staffing model for 9-1-1 units and interfacility transfer units 2.4 Term - The franchise term is stated in the franchise, but is not part of compliance determination until 2024 2.5 Periodic Review - Requirement of periodic review is stated in the franchise, but is not part of compliance determination until 2024 2.6 Oversight Fee a) <input checked="" type="checkbox"/> Copies of quarterly invoices paid to the EMS Program	WCHD REMSA WCHD REMSA REMSA	5/2014 10/19/17 7/1/16 & 8/12/16 9/5/17 4/14/17	Full Compliance
			WCHD	7/13/17	

2	Granting of Exclusive Franchise <i>(continued)</i>	<p>2.7 Supply Exchange and Reimbursement</p> <p>a) <input checked="" type="checkbox"/> The current signed supply exchange/reimbursement agreements with each fire agency</p> <p>b) <input checked="" type="checkbox"/> Confirmation that jurisdictions were reimbursed</p> <p>2.8 No Obligation for Subsidy</p> <p>a) <input checked="" type="checkbox"/> A statement from the external auditor that REMSA does not receive any funding/monetary subsidy from the Cities of Reno and Sparks and Washoe County</p> <p>b) <input checked="" type="checkbox"/> 501C3 articles of incorporation</p> <p>c) <input checked="" type="checkbox"/> Disclosure of grant funding for franchise ground ambulance services, if any</p>	REMSA	9/5/17	
3	Governing Body	<p>3.1 Board of Directors</p> <p>a) <input checked="" type="checkbox"/> List of Board members</p> <p>b) <input checked="" type="checkbox"/> Legal confirmation that all contractual relationships involving a member of the REMSA Board have been approved by a majority of the disinterested members</p> <p>3.2 Board Member Separation</p> <p>a) <input checked="" type="checkbox"/> A signed statement by each Board member that declares any contracts/conflicts of interest, and states the Board member is not an employee of REMSA or the contractor</p> <p>3.3 Meetings</p> <p>a) <input checked="" type="checkbox"/> List of six Board meetings held during the fiscal year</p> <p>b) <input checked="" type="checkbox"/> Statement from the DHO that REMSA held six Board meetings with a quorum of its members</p>	REMSA	9/5/17	Full Compliance
4	Contract, Competitive Bidding and Market Survey	<p>4.1 Market Survey and Competitive Bidding</p> <p>- A market survey or competitive bid is stated in the franchise, but is not part of compliance determination until 2021</p>			

5	Communications	5.1 Radio			Full Compliance
		a) <input checked="" type="checkbox"/> Current 800 MHz MOU	REMSA	10/9/17	
		b) <input checked="" type="checkbox"/> A checklist and timeline that demonstrates outcomes/progress made concerning compatible communications with the Washoe County Regional Communications System (WCRCS)	REMSA	10/9/17	
		5.2 Dispatch			
		a) <input checked="" type="checkbox"/> Documentation of at least one check/drill conducted on the backup system during the year	REMSA	10/2/17	
		b) <input checked="" type="checkbox"/> Documentation of one operational drill on the backup system, including dates and names of the individuals who participated	REMSA	10/2/17	
		c) <input checked="" type="checkbox"/> A brief summary of the drill and an AAR-IP	REMSA	10/12/17	
		d) <input checked="" type="checkbox"/> Documentation of CAD to CAD meetings	WCHD	10/6/16	
		e) <input checked="" type="checkbox"/> A timeline of meetings/discussions that demonstrate REMSA's progress toward the establishment of the CAD to CAD interface	REMSA	10/2/17	
		f) <input checked="" type="checkbox"/> A timeline of meetings/discussions that demonstrate REMSA's progress towards AVL connections between agencies	REMSA	10/12/17	
g) <input checked="" type="checkbox"/> Documentation of completed efforts that demonstrates REMSA's progress toward the establishment of the CAD to CAD interface	REMSA	10/2/17			
h) <input checked="" type="checkbox"/> Documentation of completed efforts that demonstrates REMSA's progress toward AVL connections between agencies (including current capabilities)	REMSA	10/12/17			
5.3 Change of Priority					
a) <input checked="" type="checkbox"/> Number of calls that were upgraded and downgraded	REMSA	10/6/17			

		and why this action occurred (<i>included in monthly report</i>)			
6	Data and Records Management	<p>6.1 Data and Records</p> <p>a) <input checked="" type="checkbox"/> A timeline of meetings/discussions that demonstrate REMSA’s progress toward the establishment of the CAD to CAD interface</p> <p>b) <input checked="" type="checkbox"/> A checklist of completed efforts that demonstrates REMSA’s progress toward the establishment of the CAD to CAD interface</p> <p>c) <input checked="" type="checkbox"/> List of investigations made by the DHO, or designee during the fiscal year</p> <p>d) <input checked="" type="checkbox"/> Response time compliance report/study zone reports</p> <p>e) <input checked="" type="checkbox"/> List of DHO requests for data/records during the fiscal year (identifies outcomes of requests- i.e., data provided or reasonable justification why request was not adhered to)</p>	From 5.2	10/2/17	Full Compliance
			From 5.2	10/2/17	
			WCHD	10/11/17	
			REMSA	-----	
			WCHD	10/11/17	
7	Response Compliance and Penalties	<p>7.1 Response Zones</p> <p>a) <input checked="" type="checkbox"/> REMSA Franchise map (Zones A – E)</p> <p>b) <input checked="" type="checkbox"/> Date(s) of meeting(s) of the annual map review</p> <p>c) <input checked="" type="checkbox"/> Zone A report – 90% of all P1 calls have a response time of 8:59 or less</p> <p>d) <input checked="" type="checkbox"/> Zones B, C and D report – 90% of all P1 calls have a collective response time of 15:59, 20:59 and 30:59</p> <p>e) <input checked="" type="checkbox"/> Zone E report – total number of calls</p> <p>7.2 Response Determinants</p> <p>a) <input checked="" type="checkbox"/> Meeting date(s) of the EMD determinants jointly reviewed by the REMSA MD and fire agency MDs</p> <p>b) <input checked="" type="checkbox"/> A summary of all pertinent outcomes/decisions -</p>	WCHD	2.2a	Full Compliance
			WCHD	9/7/17	
			WCHD	6/7/17	
			WCHD	6/7/17	
			WCHD	6/7/17	
			REMSA	8/30/17	
			REMSA	10/3/17	

7	Response Compliance and Penalties (continued)	including updates/changes to determinants, if any			
		7.3 Zone Map			
		a) <input checked="" type="checkbox"/> Date(s) of meeting(s) of the annual map review	From 7.1b	9/7/17	
		b) <input checked="" type="checkbox"/> List of changes to the map, if applicable	WCHD	-----	
		c) <input checked="" type="checkbox"/> List of locations of the REMSA franchise map	WCHD	6/30/17	
		7.4 Response Time Reporting			
		a) <input checked="" type="checkbox"/> Monthly call/response data with address and zone information (<i>collected from the OCU</i>)	WCHD	8/7/17	
		b) <input checked="" type="checkbox"/> Total number of responses in the fiscal year (<i>collected from the OCU</i>)	WCHD	8/7/17	
		c) <input checked="" type="checkbox"/> EMS staff monthly review documentation	WCHD	8/7/17	
		7.5 Penalties			
		a) <input checked="" type="checkbox"/> Penalty fund dollars verification letter from REMSA and all penalty fund reconciliation documents for the fiscal year	REMSA	10/4/17	
		b) <input checked="" type="checkbox"/> CPI calculation	WCHD	5/25/16	
		c) <input checked="" type="checkbox"/> Documentation of all penalties – all calls that incurred penalties and number of minutes per month	REMSA	10/5/17	
		d) <input checked="" type="checkbox"/> Priority 1 penalty fund analysis for the fiscal year (<i>submitted by independent accounting firm</i>)	REMSA	11/22/17	
e) <input checked="" type="checkbox"/> Agreed-upon procedures related to Priority 1 Penalty Fund (<i>submitted by independent accounting firm</i>)	REMSA	10/25/17			
7.6 Exemptions					
a) <input checked="" type="checkbox"/> Exemption reports (<i>collected from the OCU</i>)	REMSA /WCHD	6/12/17			
b) <input checked="" type="checkbox"/> Description of REMSA's internal exemption approval	REMSA	9/5/17			

7	Response Compliance and Penalties <i>(continued)</i>	process			
		c) <input checked="" type="checkbox"/> Any exemption disputes between REMSA and its contractor reviewed by the DHO, if any	WCHD	-----	
		d) <input checked="" type="checkbox"/> Letter detailing approved exemptions by the DHO	WCHD	5/26/16	
		e) <input checked="" type="checkbox"/> Exemption request(s) and any approvals by the DHO, or designee, during the fiscal year, if applicable	REMSA	6/12/17	
		7.7 Penalty Fund			
		a) <input checked="" type="checkbox"/> Letter from REMSA confirming penalty funds are recorded monthly in a separate restricted account	REMSA	11/22/17	
		b) <input checked="" type="checkbox"/> Documentation of all penalties – all calls that incurred penalties and number of minutes per month	REMSA	10/12/17	
		c) <input checked="" type="checkbox"/> Documentation of penalty fund usage to include dates received, services rendered, purpose, recipients, etc. <i>(included in the monthly Operations Report, as appropriate)</i>	REMSA	10/2/17	
		d) <input checked="" type="checkbox"/> Documentation from the external auditor that the penalty fund is in a separate restricted account	REMSA	11/22/17	
		7.8 Health Officer Approval			
a) <input checked="" type="checkbox"/> Letter to the DHO requesting use of penalty fund dollars	REMSA	10/14/16			
b) <input checked="" type="checkbox"/> Letter of approval from the DHO	WCHD	11/15/16			

8	Patient Billing	8.1 Average Patient Bill a) <input checked="" type="checkbox"/> CPI calculation b) <input checked="" type="checkbox"/> Letter(s) from REMSA on schedule of rates, changes and fees as they occur throughout the fiscal year c) <input checked="" type="checkbox"/> Explanation of the average bill calculations that are reported monthly to DBOH	From 7.5	5/25/16	Full Compliance		
			REMSA	6/1//16 & 7/22/16			
			REMSA	10/2/17			
				8.2 Increase Beyond CPI - Only applicable if REMSA requests an increase beyond the annual CPI adjustment			
				8.3 Overage in Bill Amount <input checked="" type="checkbox"/> Only applicable if REMSA exceeds the maximum average patient bill	WCHD	12/13/16	
				8.4 Third Party Reimbursement a) <input checked="" type="checkbox"/> Explanation of billing policies/procedures related to billing third parties and mitigating out of pocket expenses	REMSA	10/2/17	
				8.5 Prepaid Subscription Program a) <input checked="" type="checkbox"/> Silver Saver brochure b) <input checked="" type="checkbox"/> Number of enrolled members as of June 30	REMSA	9/5/17	
		8.6 Billing a) <input checked="" type="checkbox"/> REMSA organizational chart showing placement of billing department	REMSA	9/5/17			
		8.7 Accounting Practices a) <input checked="" type="checkbox"/> Documentation that the independent auditor adheres to GAAP and GAAS	WCHD	9/14/17			

8	Patient Billing <i>(Continued)</i>	8.8 Audit a) <input checked="" type="checkbox"/> Current fiscal year financial audit from independent auditor b) <input checked="" type="checkbox"/> Form 990 from the previous fiscal year c) <input checked="" type="checkbox"/> Agreed-upon procedures on the average bill <i>(submitted by an independent auditing firm)</i>	REMSA	11/22/17	
9	Personnel and Equipment	9.1 Dispatch Personnel Training a) <input checked="" type="checkbox"/> List of dispatch personnel that dispatch 911 and routine transfer calls that includes EMD certification, EMT/Paramedic certification number and expiration date b) <input checked="" type="checkbox"/> List of new dispatch personnel that dispatch 911 and routine transfer calls and training completed within their first 6-months of employment 9.2 Dispatch Accreditation a) <input checked="" type="checkbox"/> A copy of the certification of the National Academy of Emergency Medical Dispatchers accreditation of the Accredited Center of Excellence (ACE) b) <input checked="" type="checkbox"/> List of ACE standards/requirements 9.3 Personnel Licensing and Certification a) <input checked="" type="checkbox"/> Lists of attendants, EMTs, Paramedics, and EMD certified personnel that includes certification number and expiration date b) <input checked="" type="checkbox"/> Letter from State EMS confirming adherence to Chapter 450B 9.4 ICS Training a) <input checked="" type="checkbox"/> List of individuals who completed MCIP training	REMSA	8/25/17	Full Compliance

9	Personnel and Equipment (continued)	b) <input checked="" type="checkbox"/> List of individuals trained in ICS 100 (certificates of completion on file at REMSA)	REMSA	9/15/17	
		c) <input checked="" type="checkbox"/> List of individuals trained in ICS 200 (certificates of completion on file at REMSA)	REMSA	9/15/17	
		d) <input checked="" type="checkbox"/> List of individuals trained in ICS 300 (certificates of completion on file at REMSA)	REMSA	9/15/17	
		e) <input checked="" type="checkbox"/> List of individuals trained in ICS 400 (certificates of completion on file at REMSA)	REMSA	9/15/17	
		f) <input checked="" type="checkbox"/> List of individuals trained in ICS 700 (certificates of completion on file at REMSA)	REMSA	9/15/17	
		g) <input checked="" type="checkbox"/> List of field operational management personnel (both part-time and full-time)	REMSA	9/15/17	
		h) <input checked="" type="checkbox"/> List of REMSA REOC representatives	REMSA	9/15/17	
		9.5 Ambulance Markings			
		a) <input checked="" type="checkbox"/> Dates of quarterly EMS program “spot checks”	WCHD	5/22/17	
		9.6 Ambulance Permits and Equipment			
		a) <input checked="" type="checkbox"/> List of all REMSA ambulances	REMSA	9/5/17	
		b) <input checked="" type="checkbox"/> List of all ambulance capital equipment: monitors, power cots, stair chairs, etc.	REMSA	9/5/17	
		c) <input checked="" type="checkbox"/> Letter from State EMS office confirming adherence to Chapter 450B (NAC/NRS)	From 9.3	10/26/17	
		9.7 Field Supervisor Staffing			
a) <input checked="" type="checkbox"/> Example of a week’s supervisor shift schedule	REMSA	9/15/17			
b) <input checked="" type="checkbox"/> Supervisor job description	REMSA	9/5/17			

9	Personnel and Equipment <i>(continued)</i>	9.8 Medical Director a) <input checked="" type="checkbox"/> Medical Director's CV (from State EMS) b) <input checked="" type="checkbox"/> Documentation that MD meets NAC 450B. 505 state requirements (coordination with State EMS)	WCHD	10/25/17	
		9.8 Medical Director a) <input checked="" type="checkbox"/> Medical Director's CV (from State EMS) b) <input checked="" type="checkbox"/> Documentation that MD meets NAC 450B. 505 state requirements (coordination with State EMS)	WCHD	10/25/17	
10	Quality Assurance	10.1 Personnel a) <input checked="" type="checkbox"/> Written identification of the individual(s) responsible for the internal coordination of medical quality assurance issues 10.2 Review a) <input checked="" type="checkbox"/> Quality assurance reviews of ambulance runs for at least 5% of the previous month's ALS calls (<i>included in the monthly Operations Report</i>) b) <input checked="" type="checkbox"/> Summary of the quality assurance review activities conducted throughout the fiscal year	REMSA	10/2/17	Full Compliance
		10.2 Review a) <input checked="" type="checkbox"/> Quality assurance reviews of ambulance runs for at least 5% of the previous month's ALS calls (<i>included in the monthly Operations Report</i>) b) <input checked="" type="checkbox"/> Summary of the quality assurance review activities conducted throughout the fiscal year	REMSA	7/27/17	
		b) <input checked="" type="checkbox"/> Summary of the quality assurance review activities conducted throughout the fiscal year	REMSA	10/18/17	
11	Community Relations and Public Education	11.1 CPR Courses a) <input checked="" type="checkbox"/> List of all CPR public courses offered during the fiscal year – separated into REMSA employee conducted training and REMSA affiliated trainings (<i>included in the monthly Operations Report</i>) 11.2 Community Health Education a) <input checked="" type="checkbox"/> Multimedia campaign(s) about a current need within the community (<i>included in the monthly Operations Report</i>) 11.3 Clinical Skills a) <input checked="" type="checkbox"/> List of clinical skill experience(s) offered for specific prehospital care personnel through participating hospitals and the number of attendees, if necessary	REMSA	7/27/17	Full Compliance
		11.2 Community Health Education a) <input checked="" type="checkbox"/> Multimedia campaign(s) about a current need within the community (<i>included in the monthly Operations Report</i>)	REMSA	7/27/17	
		11.3 Clinical Skills a) <input checked="" type="checkbox"/> List of clinical skill experience(s) offered for specific prehospital care personnel through participating hospitals and the number of attendees, if necessary	REMSA	9/25/17	

11	Community Relations and Public Edu. <i>(continued)</i>	11.4 Fire EMS Training a) <input checked="" type="checkbox"/> List of quarterly Fire EMS trainings and dates	REMSA	9/14/17	
12	Reporting	12.1 Monthly Reports a) <input checked="" type="checkbox"/> Monthly Operations Reports presented to the DBOH 12.2 Annual Reports a) <input checked="" type="checkbox"/> All documentation for the Compliance Report should be submitted to the WCHD no later than December 31 b) <input checked="" type="checkbox"/> Documentation of compliance monitoring	REMSA	7/27/17	Full Compliance
			REMSA	11/30/17	
			WCHD	9/15/17	
13	Failure to Comply/ Remedies	13.1 Failure to Comply with Agreement - Failure to comply is stated in the franchise, but is not part of compliance determination unless REMSA does not comply with the terms of the Franchise 13.2 Notice of Noncompliance - Notice of noncompliance is stated in the franchise, but is not part of compliance determination unless REMSA does not comply with the terms of the Franchise 13.3 Failure to Correct/Rescission of Agreement - Failure to correct/rescission is stated in the franchise, but is not part of compliance determination unless REMSA does not comply with the terms of the Franchise 13.4 Alternate to Rescinding Agreement - Alternate to rescinding is stated in the franchise, but is not part of compliance determination unless REMSA does not comply with the terms of the Franchise			
14	Dispute Resolution	14.1 Agreement to Mediate Disputes - Agreement to mediate disputes is stated in the franchise, but is not part of compliance determination unless a dispute occurs			

15	Financial Assurance/Continuity of Operations	15.1 Financial Assurance/Continuity of Operations a) <input checked="" type="checkbox"/> Documentation of the performance security in the amount of 3 million dollars - demonstrating that it is a reserve amount in the equity statement of the REMSA financials (<i>included in the financial audit</i>)	REMSA	11/22/17	Full Compliance
16	Insurance and Indemnification	16.1 Insurance a) <input checked="" type="checkbox"/> REMSA’s insurance certificates for general liability insurance, automobile liability, workers compensation and employer’s liability b) <input checked="" type="checkbox"/> Documentation that the WCHD is listed as an additional insured 16.2 Indemnification a) <input checked="" type="checkbox"/> Signed franchise agreement 16.3 Limitation of Liability a) <input checked="" type="checkbox"/> NRS Chapter 41 b) <input checked="" type="checkbox"/> Signed franchise agreement	REMSA	9/5/17	Full Compliance
		b) <input checked="" type="checkbox"/> Documentation that the WCHD is listed as an additional insured	REMSA	10/2/17	
		a) <input checked="" type="checkbox"/> Signed franchise agreement	WCHD	5/2014	
		a) <input checked="" type="checkbox"/> NRS Chapter 41	WCHD	9/14/17	
		b) <input checked="" type="checkbox"/> Signed franchise agreement	WCHD	5/2014	
17	Miscellaneous	17.1 REMSA Contract with Other Entities a) <input checked="" type="checkbox"/> All current contracts, service agreements MAAs and MOUs with other political entities	REMSA	10/19/17	Full Compliance

17	Miscellaneous (continued)	<p>17.2 Governing Law; Jurisdictions</p> <ul style="list-style-type: none"> - Governing law; jurisdictions are stated in the franchise, but are not part of compliance determination <p>17.3 Assignment</p> <ul style="list-style-type: none"> - Assignment is stated in the franchise, but is not part of compliance determination <p>17.4 Severability</p> <ul style="list-style-type: none"> - Severability is stated in the franchise, but is not part of compliance determination <p>17.5 Entire Agreement/Modification</p> <ul style="list-style-type: none"> - Entire agreement/modification is stated in the franchise, but is not part of compliance determination <p>17.6 Benefits</p> <ul style="list-style-type: none"> - Benefits are stated in the franchise, but are not part of compliance determination <p>17.7 Notice</p> <ul style="list-style-type: none"> - Notice is stated in the franchise, but is not part of compliance determination 			
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The Reviewer’s Notes column shall be used to indicate REMSA’s compliance with each checklist item. Compliance will be indicated as follows:

- Full Compliance - Documentation was provided and fulfilled the checklist requirement(s).
- Substantial Compliance - Documentation was provided, but did not entirely fulfill the checklist requirement(s).
- Non- Compliance - No documentation was provided, or documentation provided did not fulfill the checklist requirement(s).

DD	RT	
DHO		KD
DA		
Risk		

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health
FROM: Christina Conti, Preparedness & EMS Program Manager
775-326-6042, cconti@washoecounty.us
Subject: Regional Emergency Medical Services Advisory Board January Meeting Summary

The Regional EMS Advisory Board (Board) held its quarterly meeting on January 4, 2018. Below is a summary of items discussed.

Updates to the EMSAB: The Board heard updates on several projects the EMS Oversight Program (Program) is working on, which included highlighting a regional project focused on creating an alternative response model for 911 calls to the downtown corridor, the progress of the low acuity Priority 3 subcommittee and recommendations for service levels, the completion of a first draft of the MCI Alpha Plan, and the development of the Regional Emergency Operations Center handbook for the medical unit leader position.

CAD-to-CAD Interface Update:

REMSA and City of Reno Department of Information Technology continue to work collaboratively towards the goal of testing in the 1st quarter of 2018. Weekly, except during holidays and conflicting meetings/commitments, the REMSA and Reno team have been briefly touching base via conference call to provide updates and share experiences.

- REMSA has successfully updated to the latest version of the TriTech Inform CAD without issue.
- The map update project is completed and has been pushed out to the production CAD and is live.
- A site-to-site VPN test occurred this past week between REMSA & Reno and was apparently successful.
- REMSA IT is working with TriTech on the data table translation

Data Reports - EMS Oversight Special Areas of Interest: The Board had previously requested two special data analyses to be conducted by the Program. The first related to Duck Hill and the second was a special event held in Northern Washoe County. Both were reviewed and accepted by the Board. Those reports are attached.

EMS Mutual Aid Agreements: The Board received a review of the mutual aid agreements for the EMS agencies within Washoe County. This is an annual item of the strategic plan. It was also noted that a partner agency notified the Program that the Division of Emergency Management (DEM) also does an annual review. Staff will reach out to DEM to ensure there is not a duplication of efforts.

Five-Year Strategic Plan: The Board was provided an update on projects ongoing with the strategic plan. Listed below are the highlighted items:

- Staff requested and received direction on the evaluation of the Omega processes. WCHD will now work with partners to validate the exclusion of determinants from traditional response.
- The regional protocols are now on the website as well as live on the application for field response. The download of the application and access to the protocols is being made available at no-cost to the regional EMS providers.
- Staff completed an AVL survey that was provided to the Board. (attached)
- Staff provided the Board with a copy of the AVL Project document previously sent to Truckee Meadows Fire Protection District and Sparks Fire Department for review. The EMSAB approved the project and directed staff to begin working on the proposed analysis, with discussion to exclude the calls. (attached)
- Staff completed a survey of determining the electronic patient record platform being used by the regional agencies. The information will be used to help achieve the objective of improving patient flow of information from the scene to the hospital. (attached)

Duck Hill Data Request Results

Location of Duck Hill

Duck Hill is located in Washoe County at the south end of Washoe Valley, bordering the east side of highway 580 [image below], just north of Carson City. There are 13 total addresses located within the defined area of interest. Duck Hill homes are within an 8-minute drive to the nearest hospital, Carson Tahoe Regional Medical Center. In the event of a medical emergency, phone towers connect a 911 call from that location to the Washoe County Sherriff's Office dispatch center where the call would be answered by the dispatchers for Truckee Meadows Fire Protection District (TMFPD).

BLACK BOX: Area of interest, Duck Hill within Washoe County, NV.

RED LINE: County boundary

HOSPITAL: Carson Tahoe Regional Medical Center, Carson City, NV



Drive time analysis

There were five posts or stations identified as the closest locations with emergency response units to be dispatched for response to an EMS call for service in the Duck Hill area. The five posts or stations likely to be dispatched are as follows:

1. TMFPD Station 30, Co Rd 330, New Washoe City, NV 89704
2. TMFPD Station 16, 1240 Eastlake Blvd, New Washoe City, NV 89704

3. CCFD: Station 52, 2400 East College Parkway, Carson City, NV 89706
4. CCFD: Station 51, 777 South Stewart Street, Carson City, NV 89701
5. REMSA: Closest static posting location @ corner of Wedge Parkway and Mt Rose HWY

The attached series of images created by Washoe County GIS illustrate how much time it takes for a unit from each the five locations to reach the houses in the Duck Hill area. The software utilized to create the drive time analyses are generated using predictive modeling, which takes into account distances, speed limits, turn restrictions and other road characteristics. A descriptive summary of the predicted drive times are provided below.

1. Within 5 minutes:
 - CCFD Station 52 would be closest and nearing the off ramp to access the Duck Hill addresses of interest.
2. Within 7:30 minutes:
 - TMFPD Station 30 would be nearing the off ramp.
 - CCFD Station 52 responders could potentially arrive at 12 of the 13 addresses within the defined area of interest.
3. Within 10 minutes:
 - CCFD Station 51 would be nearing the off ramp to access the Duck Hill area.
 - TMFPD Station 30 could potentially arrive at 12 of the 13 addresses.
 - CCFD Station 52 responders would potentially have arrived at all of the 13 addresses within the defined area of interest.
4. Within 15 minutes:
 - REMSA unit dispatched from the closest posting station would potentially have arrived at 5 of the 13 addresses.
 - First-tier responders from TMFPD Station 16, CCFD Station 51, TMFPD Station 30 and CCFD Station 52 would have arrived at all of the 13 addresses within the defined area of interest.

Historic Call Data

The following table provides a summary of the number of calls each agency has responded to each year and the median response time for all completed calls. For Carson City Fire Department, only 5 responses to the Duck Hill area were identified, 3 were EMS the other 2 were smoke investigations. Only EMS calls were included in the table below.

Location	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	Total calls for service	Total calls arrived
CCFD Station 52	0	0	0	0	0	0	0	1	0	0	2	3	3
TMFPD Station 30	~	~	~	~	~	~	0	0	0	1	0	1	1
TMFPD Station 16	~	~	~	~	~	~	2	0	0	1	2	5	5
REMSA	~	~	~	1	2	0	2	2	1	1	1	10	6

*Too few calls to conduct statistically meaningful review of mean, median or 90th percentile response times

Call Volume

CCFD Station 52 reported 4,254 calls during calendar year 2016, this equates to 11.6 calls per day on average. CCFD Station 52 also created 2,460 electronic Patient Contact Reports¹ for 2016, this equates to 6.7 treatments per day. CCFD is also a transport agency for Carson City and Station 52 conducted 1,921 patient transports during 2016, during transports, the units are not available for dispatch until patient care is transferred.

In contrast, TMFPD Station 30 responded to .5 calls per day during calendar year 2016 while TMFPD Station 16 responded to slightly fewer than 1 call per day during calendar year 2016. Furthermore, TMFPD is not a transport agency so the crews could be available more often for dispatch as the transfer of patient care occurs on scene rather than at a hospital.

Mutual Aid Agreements

A summary of mutual aid agreements which impact the area of interest are as follows:

- Request for CCFD response will originate from REMSA dispatch. CCFD may provide EMS response to Priority 1 incidents within the REMSA franchise area along South Washoe Valley, south of the Bellevue Bridge area. Likewise, if CCFD dispatch is notified of a Priority 1 incident in this area the EMS response information will be immediately referred to REMSA dispatch.
- TMFPD must contact Carson City dispatch if they need a rescue or engine response from CCFD.

Summary Brief

Duck Hill is located at the southern border of Washoe County and was identified as an area of interest due to Duck Hill resident's concerns related to EMS response to the neighborhood. There are four fire stations and a REMSA ambulance posting considered for the analyses; the closest Truckee Meadows Fire Protection District (TMFPD) station, Station 30, the second closest TMFPD station, Station 16, the closest Carson City Fire Department (CCFD) station, Station 52, the second closest CCFD station, Station 51, and the closest REMSA ambulance posting location. There were 13 addresses included in the area of interest. According to a drive time analysis, response units from CCFD Station 52 and TMFPD

¹ This number does not necessarily reflect non-EMS responses, nor does it account for calls that another unit is initially dispatched to that Station 52 then is dispatched to and completes.

Station 30 would be able to be on scene to all 13 addresses within 10 minutes. All four fire stations would be able to be on scene within 15 minutes, while the second due-tier responders, REMSA, would be able to be on scene to five of the 13 addresses.

While drive time analyses indicate CCFD responders may be able to reach more addresses within shorter drive times, the CCFD stations respond to approximately 11.6 incidents per day, while the closest TMFPD station responds to an average of .5 calls per day. Additionally CCFD transports patients, while TMFPD typically does not. Therefore, CCFD response units are not available to respond to additional calls until patient care from the previous call is transferred to a hospital. This illustrates that when a 911 EMS call for service originates in the Duck Hill area, a TMFPD response unit from Station 30 or Station 16 would be more likely to be available for response and is the appropriate EMS response agency to dispatch first.

DRAFT

Impacts of the Special Event of Interest

The annual event of interest occurs over seven days starting in late August ending early September, taking place in the Black Rock Desert. While the actual event is located just east of the Washoe County border in Pershing County, upwards of 60,000 attendees travel to the remote location on Washoe County roadways to attend the event. The impacts to Washoe County EMS first responders include a statistically significant ($p < 0.01$) increase in the number of 911 EMS calls during the event as well as the month leading up to the event through the week after the event. There is also a large increase in the number of EMS air transports from the event to the Reno Tahoe International Airport, where REMSA then transports those patients to area hospitals. EMS Program staff recommends continuation of efforts aimed at preventing both traffic-related injuries and fatalities en route to the event, as well as injuries resulting from the event itself.

Areas of Interest

The areas of interest included roadways and highways extending from the northern border of Washoe County to the event entrance up to Pershing County and highways from the metropolitan region of Reno-Sparks. See attached map for visual representation of the areas of interest and call locations.

Time Periods of Interest

A total of 142 calls occurred over FY17 (July 2016-June 2017) within the areas of interest. An additional 70 calls occurred during August and September of 2017, also within the area of interest. Combined, all 212 calls were considered for analyses.

Due to the unique nature of the event, the initial timeframe for analyses included the full month before the event through the week after the event. This timeframe is referred to as the Time Period of Interest, or TPOI. Both the 2016 and the 2017 events were included in the following analyses as well as four “control” time periods. The control time periods were selected as comparisons as they are equivalent in length of time and occur within FY17 during each of the four seasons. No major special events took place during the control periods.

Table 1: Shows the month prior to the event of interest, the event of interest, and the week after the event combined for both 2016 and again in 2017 with four control periods of equal length for comparison.

Time Periods	Description	Start Date	End date	Total days	Total calls
TPOI CY2016	First time period of interest, month before the event to the week after the event	8/1/2016	9/12/2016	42	38
CTP4	Fall comparison time period	10/1/2016	11/12/2016	42	14
CTP1	Winter comparison time period	1/1/2017	2/12/2017	42	10
CTP2	Spring comparison time period	3/1/2017	4/12/2017	42	17
CTP3	Early summer comparison time period	5/1/2017	6/12/2017	42	16
TPOI CY2017	Second time period of interest, month before the event to the week after the event	8/1/2017	9/11/2017	42	54

The duration of the event, one week, was considered as a secondary timeframe, embedded within the initial TPOs. Control periods equivalent to the event duration were also selected [CE] and results are provided in Table 2.

Table 2: Shows the week of the event itself, the 2017 event opened a day earlier to allow for ingress of traffic. Four control time periods equivalent in duration were selected for comparison.

Time Periods	Description	Start Date	End date	Total days	Total calls
2016 Event	First event of interest	8/29/2016	9/5/2016	7	17
CE4	Fall comparison event duration	10/29/2016	11/5/2016	7	1
CE1	Winter comparison event duration	1/29/2017	2/5/2017	7	3
CE2	Spring comparison event duration	3/29/2017	4/5/2017	7	1
CE3	Early summer comparison event duration	5/29/2017	6/5/2017	7	2
2017 Event	Second event of interest, event opened a day earlier than previous years to allow for ingress of traffic	8/27/2017	9/4/2017	8	29

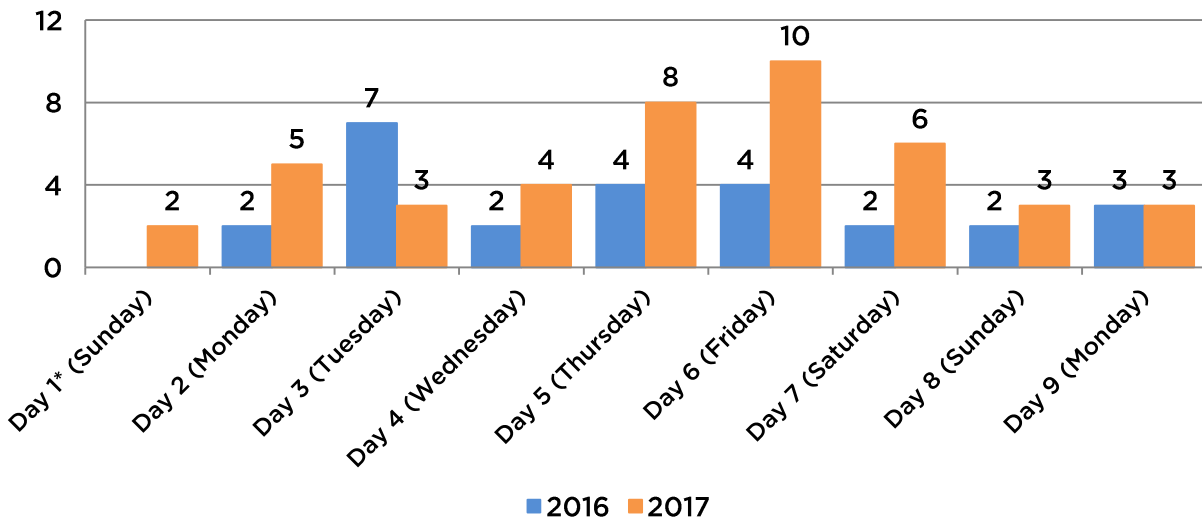
During the event, anyone requiring transport to a hospital are typically flown into Reno-Tahoe International Airport, where REMSA meets the aircraft and transports the patient to a local hospital. These are illustrated in Table 3.

Table 3: Shows the number of airport rendezvous REMSA ran during the week of the event in 2016 and again in 2017, with four week-long control periods for comparison.

Time Periods	Description	Total Airport Rendezvous	Event Related	% Related
Event 2016	First event of interest	48	26	54%
CE4	Fall comparison event duration	32	~	~
CE1	Winter comparison event duration	14	~	~
CE2	Spring comparison event duration	20	~	~
CE3	Early summer comparison event duration	11	~	~
Event 2017	Second event of interest	69	44	64%

The following figure illustrates the number of REMSA calls for service during each day of the event.

Number of Calls per Day, Event of Interest, 2016 & 2017



*2017 event began a day earlier.

Regional EMS Mutual Aid Agreements (MAA)
2017 Review

REMSA MAAs			
Agreement	Date Signed	EMS Oversight Reviewed	Recommendation
Carson City Fire	9/24/2007	10/19/2017	Needs update
North Lake Tahoe Fire Protection District	6/6/2008	10/19/2017	Needs update
North Lyon County Fire Protection District	10/13/2010	10/19/2017	Needs update
Pyramid Lake Fire Rescue	7/7/2017	10/19/2017	New/no changes
Reno Fire Department	10/26/2016	10/19/2017	New/no changes
Sierra Emergency Medical Services Alliance	4/1/2007	10/19/2017	Needs update
Storey County Fire Department	2/4/2011	10/19/2017	Needs update
Truckee Fire Protection District	3/15/1999	10/19/2017	Needs update
Truckee Meadows Fire Protection District	6/21/2016	10/19/2017	New/no changes

Sparks Fire Department MAAs			
Agreement	Date Signed	EMS Oversight Reviewed	Recommendation
Truckee Meadows Fire Protection District	8/8/2016	10/24/2017	New/no changes
Reno Fire Department	8/22/2016	10/24/2017	New/no changes
Storey County	7/11/2016	10/24/2017	New/no changes

TMFPD MAAs			
Agreement	Date Signed	EMS Oversight Reviewed	Recommendation
Sierra County	7/1/2016	10/30/2017	Currently being revised

Gerlach MAAs/MOUs			
Agreement	Date Signed	EMS Oversight Reviewed	Recommendation
Cederville	6/28/2016	10/19/2017	New/no changes
Eagleville	6/28/2016	10/19/2017	New/no changes
Fort Bidwell	6/28/2016	10/19/2017	New/no changes
Pyramid Lake Fire Rescue	7/15/2016	10/19/2017	New/no changes
Surprise Valley	6/28/2016	10/19/2017	New/no changes
Lovelock	7/25/2017	10/19/2017	New/no changes

North Lake Tahoe Fire Protection District			
Agreement	Date Signed	EMS Oversight Reviewed	Recommendation
LTRFCA Mutual Aid Agreement/Operational Plan	2011/2012	12/11/2017	Needs update

	All response vehicles have AVL installed?	AVL log lat/long for onscene time?	AVL viewable by dispatch center?	Dispatched using AVL?	Monitored using AVL?
Gerlach	No	n/a	n/a	n/a	n/a
NLTFPD	No	n/a	n/a	n/a	n/a
REMSA	Yes	Yes	Yes	Yes	Yes
RFD	Yes	Yes/No - does not relate back for onscene time	Yes	No	Yes
RTAFD	No	n/a	n/a	n/a	n/a
SFD	Yes	Unknown	Yes	No	No
TMFPD	Yes	Unknown	Yes	No	Unknown

Automatic Vehicle Locator Project

Background

The EMS Oversight Program was created through an Inter Local Agreement (ILA) signed by the City of Reno (RENO), City of Sparks (SPARKS), Washoe County (WASHOE), Truckee Meadows Fire Protection District (TMFPD), and the Washoe County Health District. Within the ILA there are eight duties specifically outlined for the EMS Oversight Program, one of them being the creation and maintenance of a Five-Year Strategic Plan.

The purpose of the strategic plan, as written, is to ensure the continuous improvement of Emergency Medical Services in the area of standardized equipment, procedures, technology training, and capital investments to ensure that proper future operations continue to perform including Dispatching Systems, Automated Vehicle Locations Systems, Records Management Systems, Statistical Analysis, Regional Medical Supply and Equipment, and other matters related to strategic and ongoing Emergency Medical Services and approved by RENO, SPARKS, WASHOE and TMFPD.

On August 31, 2015 the EMS Advisory Board (EMSAB) conducted a SWOT (strengths, weaknesses, opportunities and threat) analysis. The region, comprised of diverse stakeholders, participated in the SWOT analysis as a way to provide a current summarized view of EMS in the region. After the SWOT analysis, a workgroup was formed and eleven months later a strategic plan was presented to the EMS Advisory Board. The Board approved the strategic plan on October 6, 2016. Additionally, the District Board of Health approved the plan on October 27, 2016.

Contained within the approved strategic plan are two objectives that directly relate to regional usage of automatic vehicle locators (AVL) for EMS agencies.

- Objective 3.3: Establish a two-way interface to provide visualization of AVL for all EMS vehicles for the primary PSAPs and REMSA dispatch center.
- Objective 2.1: Implement regional usage of AVL technology to dispatch closest available unit.

The EMS Oversight Program took initial steps to address these objectives by conducting an EMS survey to assess and understand the current AVL technology used in the region. The survey results will be presented to the EMSAB on January 4, 2018. The next strategy outlined within the strategic plan to achieve the objectives is developing of a regional process to utilize AVL within the dispatch centers.

A CAD-to-CAD interface is currently being developed, which will link REMSA dispatch and the RENO PSAP. Per the REMSA contract the EMS Oversight Program has reviewed, AVL is an included component of the interface.

Another component of the strategic plan is to obtain approval from the individual Councils/Boards to utilize AVL to dispatch the closest available unit to EMS calls. While this is not yet a region-wide effort, TMFPD and SPARKS have begun to implement an enhanced automatic aid agreement to dispatch based on proximity of the stations to the call for service. With enhanced auto-aid, only a single unit would be dispatched (predicated on the type of call, which station is closest to the call, and whether or not that station has a unit available to respond).

The EMS Oversight Program would like to offer support for TMFPD and SPARKS for this project. Support activities may include, not limited to, data, analytics, and mapping.

Proposed GIS Data Analysis

This project requires Council/Board approval including discussion on jurisdictional boundaries and response to EMS calls. Therefore, the EMS Oversight Program would like to employ the same philosophy utilized for SB 185 during the 2015 Legislative Session and partnering with GIS. GIS could utilize software to create a drive time analyses using predictive modeling, which takes into account distances, speed limits, turn restrictions and other road characteristics. The EMS Oversight Program is proposing ~~to send all fire EMS Priority 1 and Priority 2 calls for service for a specified period of time~~ work with GIS to complete this project. GIS would ~~then~~ produce maps showing fire stations and response times within 4 minutes, 6 minutes and 8 minutes. This would allow the partners and subsequently the Councils/Boards to visually see the overlap of response areas as well as the possible areas within the region that have longer response times due to station locations.

The analysis would be presented to the EMSAB for input and recommendation regarding presentation to other Councils/Board for discussion. This analysis would not be intended to provide a recommendation, but provide the data for each jurisdiction to utilize while continuing discussions and planning for AVL dispatching.

Barriers to AVL

The identified barriers to the use of AVL within the region include the political components of a boundary drop. The concept of a boundary drop is that the jurisdictional boundaries do not apply; it instead recognizes that the closest unit to the call is dispatched. This could include a unit that is driving through town for training or patient transport being the closest unit.

Financial barriers could include technological needs including software or upgrades to ensure cross-jurisdictional compatibility. Based on a survey conducted by the EMS Oversight Program, all regional partner agencies have AVL capabilities on their response vehicles. However, the technology to dispatch the unit, as opposed to a static station has not been employed in our region. Additionally, SPARKS PSAP is not co-located with WASHOE or RENO. While the CAD system is the same, SPARKS operates as the regional back-up PSAP and may have a different server which might have additional costs affiliated.

Assessment Area	RFD	SFD	TMFPD	REMSA	RTAA	Gerlach	Pyramid	NLTFPD
Currently use ePCR [YES]	Yes	Dec-17	Nov-17	YES			YES	YES
Software vendor	Zoll	Zoll	Zoll	Zoll RescueNet ePCR locally-based, not web-based			Image Trend	Zoll
Vendor version	UNKN/Most current version	6.2.2.3	6.2	6.3			UNKN	6.2.2.49
Automatic updates	NO	NO	NO	YES			YES	NO
Why not automatically updated	Consideration of potential impacts to RMS and the cost	Potential compatibility issues; updates done at IT discretion	State has to be able to receive ePCR through Intermedix					Cost, bugs, configuration issues, and most updates are for NEMSIS versions that are required reporting for each state
Currently use ePCR [NO]						X		
Plans to begin						YES		
When						When TMFPD begins		
Vendor version						Zoll		

DISASTER PREPAREDNESS IN WASHOE COUNTY

Christina Conti
Preparedness
& EMS
Oversight
Program
Manager

PRESENTATION OBJECTIVE

The objective of the presentation is to provide the District Board of Health an overview of emergency response plans within the region.

- Dr. Novak request
 - Mass casualty and emergency surge plans
- Dr. Hess request
 - Healthcare coalition response plan

EMERGENCY PLANNING

- Washoe County Department of Emergency Management & Homeland Security
 - Emergency Manager
 - Regional Emergency Operations Center

- Regional Emergency Managers
 - City of Reno
 - City of Sparks
 - Tribes
 - School District
 - Private agencies

REGIONAL PLANNING EFFORTS

Regional partners work together to integrate planning.

- **Regional Emergency Operations Plan (REOP)**
 - Foundation for regional planning and emergency activation
- **Annexes of REOP**
 - Hazard Mitigation
 - Hazardous Materials
 - Continuity of Operations
- **Mass Fatality Response Plan**
 - Family Assistance Center Annex

HEALTH DISTRICT EMERGENCY RESPONSE ANNEXES

- Pandemic Influenza Plan
- Point of Dispensing Operations Manual
- Medical Counter Measure Distribution and Dispensing Plan
- Mass Illness/Isolation and Quarantine Plan
- Public Information Communications Plan
- Volunteer Management Plans
- Access & Functional Needs Plan

BOARD OF HEALTH PLANS

- **Multi-Casualty Incident Plan (MCIP)**
 - Mutual Aid Evacuation Annex (MAEA)
 - Family Service Center Annex (FSC)
- **In draft form – MCI Alpha Plan – for large scale and/or multi-location incidents in Washoe County.**

MULTI-CASUALTY INCIDENT PLAN

Outlines Emergency Medical Services (EMS) response to a multiple casualty incident:

- 10 or more patients, or other factors warrant activation
- Notifications
- Triage procedures
- Hospital baseline numbers
- Communication plan (ICS 205)
- Documentation

TRIAGE TAG SYSTEM



INITIAL TRIAGED PATIENT COUNT			
Location of Triaged Patients: School Bus		Count Relayed to Triage Unit Leader	
ADULTS		PEDIATRICS	
1		Total	2
2		Total	4
3		Total	6
0		Total	0

TriageTags.com
©2015-05/15

TRANSPORTATION RECEIPT Tag Number: 4869

Destination: _____ Via: _____ Time: _____

TRIAS TAG E10004869

Age: _____ Sex: _____

First: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Wristband EMTA

AMBULANCE RECEIPT

TRANSPORTATION RECEIPT For Use by Transportation Recorder Only

Age: _____ Sex: _____

First: _____ Last: _____

Tourniquet Applied: _____ Airway Management: _____

GCS Tx In: E: _____ M: _____ V: _____ Time: _____

GCS Tx Out: E: _____ M: _____ V: _____ Time: _____

Known Allergies: _____

Treatment Administered/Comments: _____

Time: _____ Drug Solution: _____ Dose: _____

START triage system

MINOR Move the Walking Wounded

IMMEDIATE Perfusion - Cap, Radial Over 2 sec. or Radial Pulse Absent

IMMEDIATE Mental Status - Unable to Follow Simple Commands

DELAYED All Others

MORGUE No Respiration After Head Tilt

RE-TRIAGED E10004869

MORGUE E10004869

IMMEDIATE E10004869

DELAYED E10004869

MINOR E10004869

CONTAMINATED E10004869

RE-TRIAGED E10004869

MORGUE E10004869

IMMEDIATE E10004869

DELAYED E10004869

MINOR E10004869

CONTAMINATED E10004869

HOSPITAL BASELINE NUMBERS

Facility	Red	Yellow	Green
Incline Village Community Hospital	0	2	8
Northern Nevada Medical Center	3	7	10
Renown Regional Medical Center	10	20	50
Renown South Meadows	3	4	10
Saint Mary's Regional Medical Center	6	10	20
VA Sierra NV Health Care System	3	7	10

Total baseline numbers: 25 reds, 50 yellows and 108 greens

FAMILY SERVICE CENTER ANNEX

A FSC is a center that would be set up to deliver compassionate care to the family member(s) of the missing, injured or deceased.

- *Private secure place for families to gather and to receive information about the response and recovery of the incident.*
- *Facilitate information sharing with hospitals to support family reunification with the injured.*
- *Centralize and coordinate missing person inquiries.*

Objective of the plan is to provide responding agencies with the management framework to establish, operate and close a FSC.

MUTUAL AID EVACUATION ANNEX

Objective is to coordinate transportation and care of patients who are being evacuated from healthcare facilities in Washoe County.

- The MAEA coordinates transportation and care of patients who have been evacuated from a Washoe County healthcare facility in a qualified disaster.
 - Designed for minimal disruption to acute emergency care to the community.
 - The plan now includes Skilled Nursing/Long Term Care/Mental Health facilities.

EVACUATION TAG SYSTEM

Tag Key Features

The diagram illustrates the Evacuation Tag System, a multi-page form used for patient evacuation. The main tag is divided into several sections:

- Top Section:** Includes instructions for "Floor in Hall" and "Rooming your in patient".
- Left Side:** Contains "DNR and ISO indicators" (Yes/No/Other/Unknown/Expected), "Triage assessments" (Acuity, Priority, etc.), "Facility identifier", "Destination receipt", and "Transport receipt".
- Center:** Features the large vertical word "EVACUEE" and a "TRiage CATEGORY" section with color-coded indicators.
- Right Side:** Includes "Bilingual and symbolic" instructions, "Patient mobility indicators" (wheelchair, walker, bed, etc.), and "SBAR documentation".
- Bottom Section:** Contains a "Room evacuation receipt" and a "SBAR" form.

Additional components shown include:

- Evac 1-2-3™ Instructional Flip Chart for Hospital/Care Facility Patient Evacuation:** A flip chart with three pages (1, 2, 3) and a cover.
- Evac 1-2-3™ Instructional Flip-chart:** A smaller version of the flip chart.
- Room Evacuation Personnel:** A tag with instructions for personnel to "Team-Off & Retain This Receipt as Patient is Evacuated from Room".
- SBAR Form:** A form for documentation, including sections for "SBAR" and "SBAR" (Situation, Background, Assessment, Recommendation).

Evac 1-2-3™ instructional flip-chart. DMS-05879

REGIONAL MEDICAL PLANS

- **Inter-Hospital Coordinating Council Response Guidelines**
 - Outlines the guidelines for the Coalition response during an emergency.
 - Each healthcare facility has an internal emergency response plan.
- **Statewide Medical Surge Plan**
 - **West Region Response Annexes**
 - Washoe, Carson, Storey, Douglas, Churchill, Humboldt, Lyon, Mineral, and Pershing Counties.

QUESTIONS?

“What we did was perfect – would we try different things next time, yes. But, what we did was perfect.”

-Mental Health Volunteer 2011 Air Race Incident

DHO_	<u> KD </u>	_____
DDA	_____	_____
Risk	_____	_____

STAFF REPORT
BOARD MEETING DATE: January 25, 2018

TO: District Board of Health
FROM: Catrina Peters MS RD, Director of Programs and Projects
775-328-2401, cpeters@washoecounty.us
SUBJECT: Review and possible approval of 2018-2020 Community Health Needs Assessment

SUMMARY

District Health Strategic Priorities supported by this item:

1. **Healthy Lives:** Improve the health of our community by empowering individuals to live healthier lives.
2. **Healthy Environment:** Create a healthier environment that allows people to safely enjoy everything Washoe County has to offer.
3. **Local Culture of Health:** Lead a transformation in our community's awareness, understanding, and appreciation of health resulting in direct action.
4. **Impactful Partnerships:** Extend our impact by leveraging partnerships to make meaningful progress on health issues.

PREVIOUS ACTION

- The previous CHNA (2015-2017) was presented to the board on January 22, 2015.
- A summary of the preliminary 2018-2020 CHNA was presented at the DBOH Strategic Plan retreat on November 2, 2017.
- The CHNA is mentioned in the revised Strategic Plan under Outcome 3.3.3.

BACKGROUND

The CHNA provides ranked health need topics, which utilized primary and secondary data sources and applied a methodology to evaluate criteria such as the severity of need and the community's perception of health needs. This document serves as the reference document for the development of both the Community Health Improvement Plan, to be developed through Truckee Meadows Healthy Communities and Renown's Community Benefits Plan.

Subject: 2018-2020 Community Health Needs Assessment

Date: January 9, 2018

Page 2 of 2

FISCAL IMPACT

- *Should the Board approve the CHNA, there will be no fiscal impact to the adopted FY18 budget as staff time to develop this document was included in the budget.*

RECOMMENDATION

Staff recommends the DBOH accept the 2018-2020 Community Health Needs Assessment as presented.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to accept the 2018-2020 Community Health Needs Assessment as presented."

2018-2020 Washoe County Community Health Needs Assessment Highlights & Results

January 25, 2018
Heather Kerwin, MPH, CPH
CHNA Coordinator

Reminder of the Purpose of Community Health Needs Assessments (CHNA)

- Purpose and outcomes
 - Identified health needs of a geographically defined area
 - Identified assets within a community
 - Informs community decision makers and leaders
 - Framework for Washoe County Community Health Improvement Plan (CHIP)

What does our CHNA contain?

- Section 1
 - Secondary data: 250+ health indicators (statistics)
 - Primary data: Community survey
- Section 2
 - Community strengths, assets, and opportunities for improvement
- Section 3
 - Ranked and prioritized health needs/topics

Highlights: Areas of Improvement

- Increased enrollment of health insurance coverage*
- Increase in percentage of infants that are breastfed
- Increased immunization rates among children
- Increase in screening rates for diabetes* and colorectal cancer
- Decrease in new cases and deaths due to cervical, colorectal, and lung cancer
- Decrease in poverty*, unemployment*, food insecurity, and percentage of children living in single-parent homes*
- Decrease in adult cigarette use*
- Decrease in teen pregnancy rates*
- Decrease in infant mortality rates

*indicator used for Robert Wood Johnson Foundation County Health Rankings

Highlights: Areas of Concern

- Lack of improvement in nutrition or physical activity*
- Increase in obesity among adults*
- Increase in perceived poor and fair health among adults*
- Increase in binge and heavy drinking among adults*
- Increase in alcohol-related, prescription drug and illicit drug-related deaths
- Increase in unintentional fatality rates*, due to increase in poisonings, falls, and alcohol-related motor vehicle fatalities*
- Increase in poor mental health days* and lack of improvement in suicide deaths
- Increase in violent crime rates* and deaths due to homicides and assault

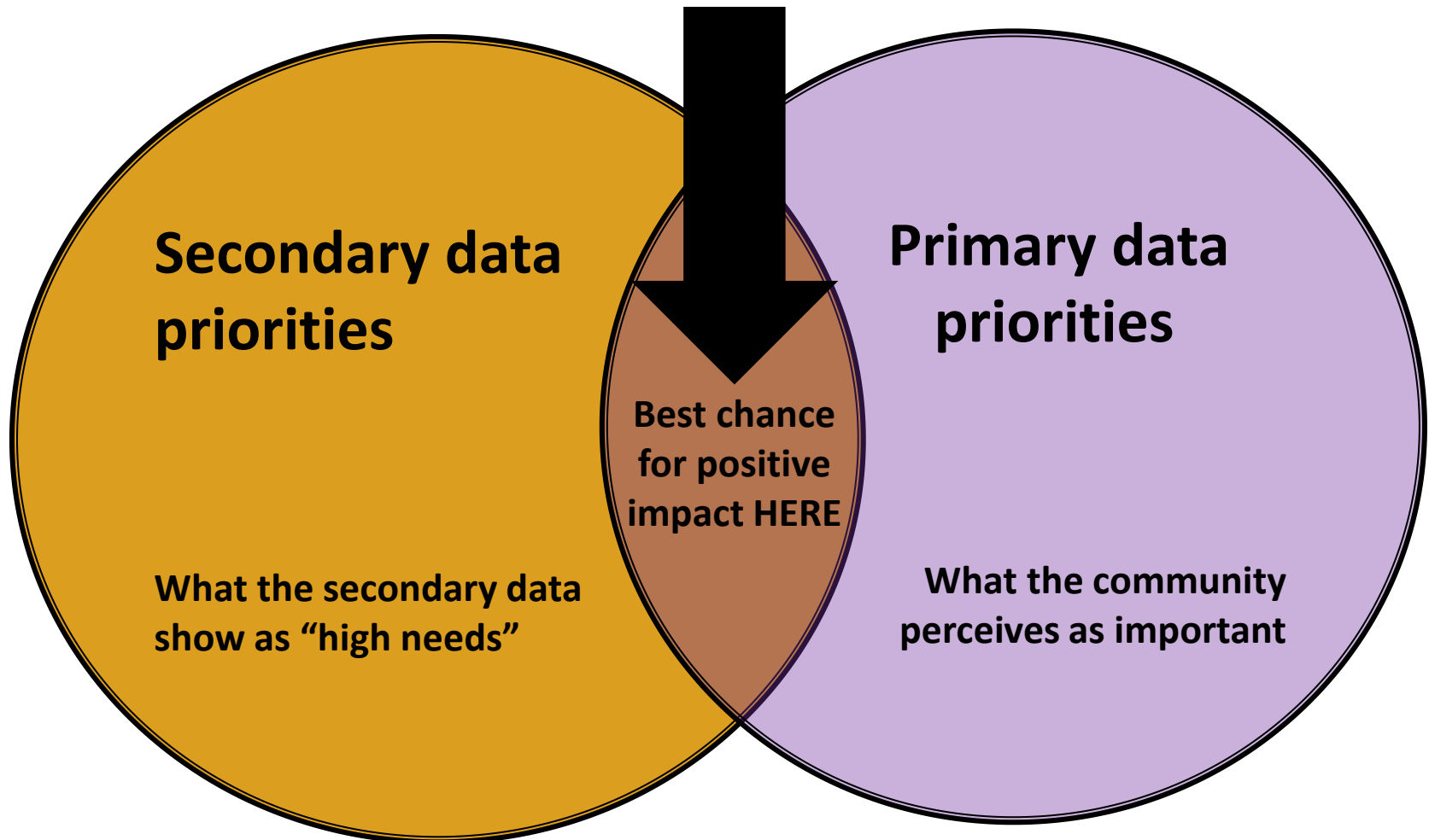
Highlights: Areas of Concern Continued

- Decrease in rate of mothers who seek prenatal care in 1st trimester
- Increase in child (ages 1-14 years) mortality rates
- Decrease in cervical, breast*, and prostate cancer screening rates and increased rates of new cases of breast and prostate cancer
- Increase in the prevalence of arthritis, asthma, diabetes, heart attacks, and strokes as well as increased prevalence of high cholesterol and high blood pressure among adults
- Increased overall mortality rates*

Why Identify & Rank Health Needs

- How to know where to focus?
- Cannot actively improve everything
- Guides priorities for Community Health Improvement Plan
- Provides an objective overview of health needs for all community partners

Systematic Ranking of Health Issues

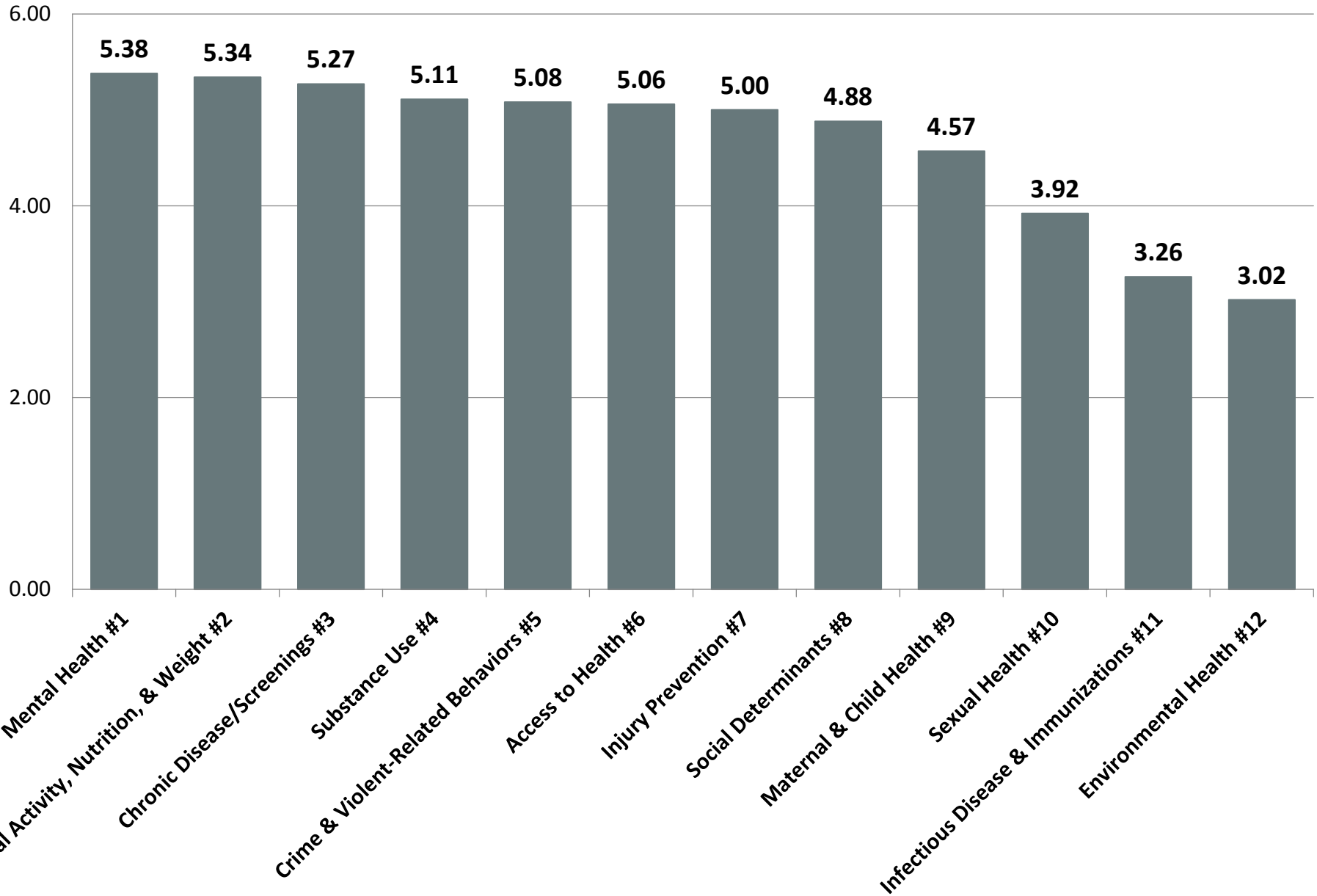


Systematic Ranking of Health Issues

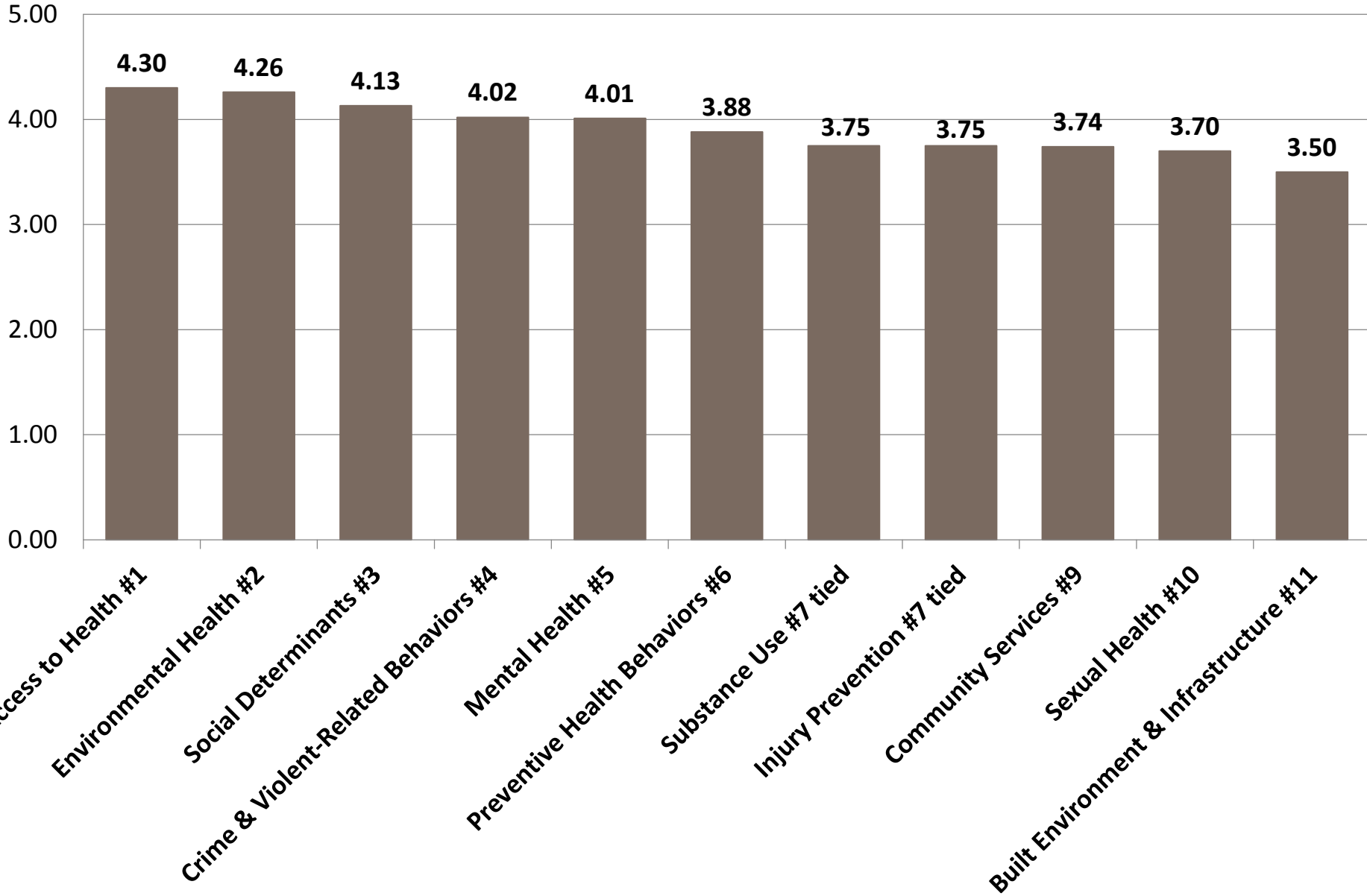
Scored the 250 indicators based on the following criteria

1. **Magnitude:** percent, rate or number of measured population impacted
2. **Severity:** the level of impact the indicator has on a person long term/chronic impacts versus short term/acute impacts
3. **Trend:** improvement, worsening, or no improvement over time
4. **Benchmark:** Washoe County ranks relative to Nevada, the United States, or Healthy People 2020 objective
5. **Community perception:** survey ranked score, aligns with major health topic areas

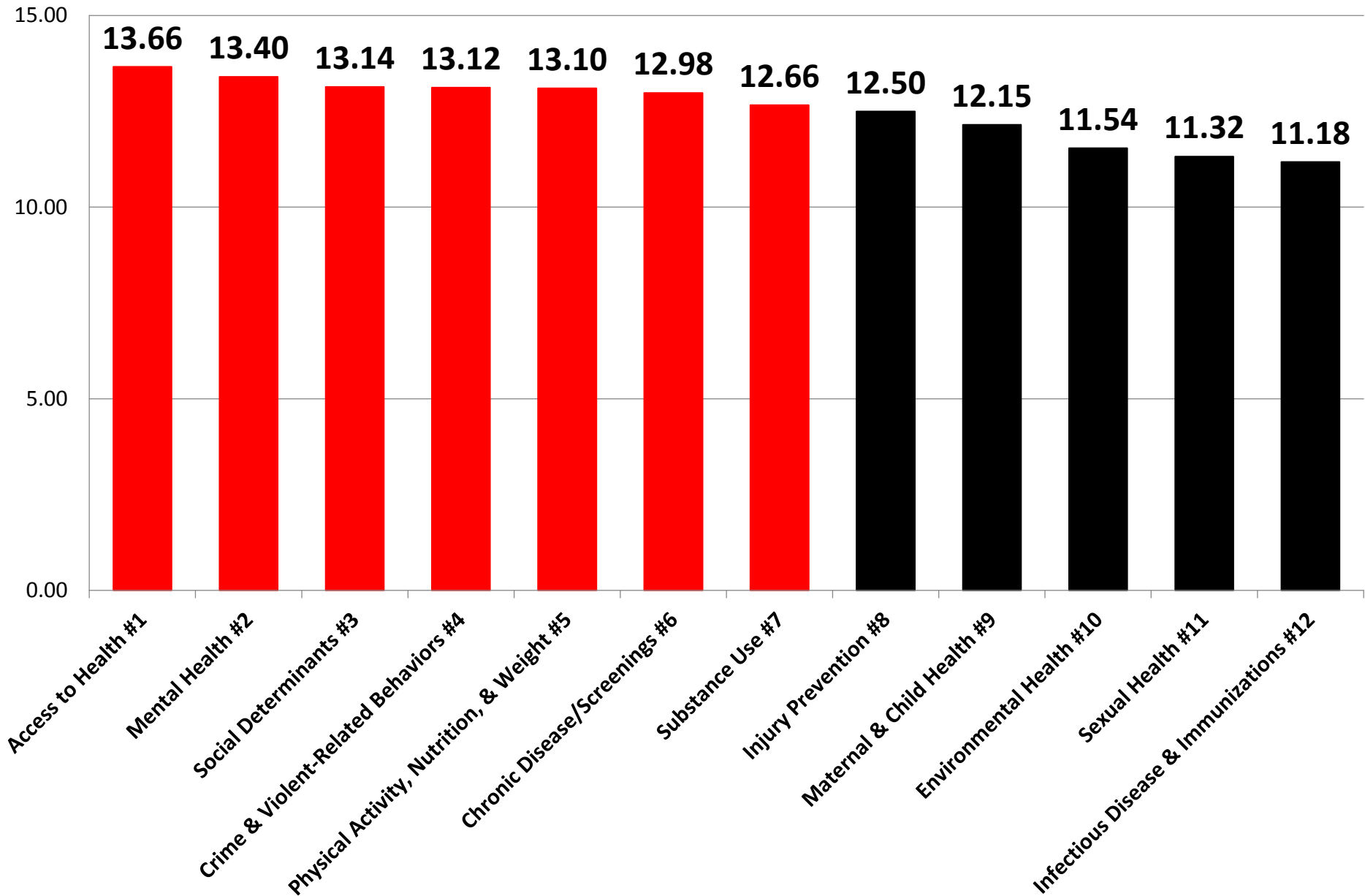
Secondary Data Score & Rank



Community Survey Score & Rank



Overall Health Topic Score & Rank



Keep in Mind

- Simply because a health need is not in the “Top 3”, does NOT mean there is no need or low need.
- There are multiple indicators that cross over from one health topic to the next.
- Health behaviors and health outcomes are impacted by a complex and dynamic system of influencing factors.



2018-2020
Washoe County
Community Health
Needs Assessment

The 2018-2020 Washoe County Community Health Needs Assessment was sponsored in full by the Washoe County Health District and Renown Health in collaboration with Truckee Meadows Healthy Communities.

**WASHOE COUNTY
HEALTH DISTRICT**
ENHANCING QUALITY OF LIFE

Renown[®]
HEALTH



Published January 2018

2018-2020 Washoe County Community Health Needs Assessment

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ACKNOWLEDGMENTS

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The following agencies for disseminating the online community survey or allowing for hardcopy survey distribution

Access to Healthcare Network	Join Together Northern Nevada
ACTIONN	Medical Reserve Corps
Bristlecone Family Resources	Northern Nevada HOPES
Catholic Charities of Northern Nevada	Northern Nevada Literacy Council
Children's Advocacy Alliance	REMSA
Children's Cabinet	Reno-Sparks Chamber of Commerce
Citizen Corps	Renown Health
City of Reno	Project MANA
City of Sparks	Truckee Meadows Healthy Communities
Communities in Schools	Two Chicks Restaurant
Community Health Alliance	United Way
Community Services Agency	UNR Adjunct Faculty
ENGAGE, Inc	Washoe County
EDAWN	Washoe County Chronic Disease Coalition
Food Bank of Northern Nevada	Washoe County Food Policy Council
Get Healthy Washoe County	Washoe County Health District
Girls on the Run	Washoe County Library System
Human Services Network	Washoe County School District
Immunize Nevada	Washoe County Senior Services

Introduction

The 2018-2020 Washoe County Community Health Needs Assessment (CHNA) is a comprehensive health overview informing the development of two action plans; the Community Health Improvement Plan and Renown Health's Community Benefit Plan. Additionally, the CHNA serves as a resource for organizations working in social and human services capacities to address health in Washoe County. The 2018-2020 CHNA utilizes validated and reliable secondary data sources, results from an online community survey, input from subject matter experts, as well as contributions from participants in a Community Workshop. Each source of information provided additional insight into the health needs of Washoe County's residents and the social circumstances that impact health in the region.

The Patient Protection and Affordable Care Act (Public Law 111-148), passed March 2010, added Section 501(r)(3) to the Internal Revenue Code, which requires non-profit hospitals to conduct a community health needs assessment every three years and adopt an implementation strategy (Community Benefit Plan) to meet health needs identified through the CHNA.¹ While Renown Health serves a broad area, including nearly 80,000 square miles across northern Nevada, the majority of patients come from Washoe County and adjacent surrounding rural communities. For clarity and focus of this report, the health needs were narrowed in scope to the geopolitical boundary of Washoe County. Similarly, state, tribal, local, and territorial health departments conduct CHNAs in accordance with the Public Health Accreditation Board (PHAB) standards for accreditation. Additionally, a Fundamental Review of the Washoe County Health District by the Public Health Foundation, recommended a community health needs assessment be conducted and the District Board of Health provide direction to implement that recommendation.²

The two entities determined there was an opportunity to collaborate to produce one singular document on the health needs and service gaps in Washoe County. The first collaborative assessment was created in 2014 and released in coordination with the 2015 Truckee Meadows Healthy Communities Conference held at the University of Nevada, Reno on January 8, 2015. This document, the 2018-2020 Community Health Needs Assessment, is the second collaborative assessment and was produced through funding provided by Renown Health and Washoe County Health District.

¹ The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat 119 (2010). Accessed <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>.

² Public Health Foundation. (2014). Washoe County Public Health: A Fundamental Review. PHF Assessment Team, Washington, D.C.

Contents, Methodology, & Community Survey Demographics

There are 20 main sections within the assessment; including, 18 sections specific to health topics containing secondary data for over 250 health indicators, one section detailing sociodemographic indicators of high needs ZIP codes, a description of community strengths and challenges, and a section of the final prioritized health needs.

Secondary Data

Secondary data are health indicators systematically gathered for other purposes or surveys. Major secondary data sources used throughout the assessment include the Youth Risk Behavioral Survey (YRBS), the Behavioral Risk Factor Surveillance Survey (BRFSS), and the American Community Survey (ACS) data. These surveys collect data through a variety of means and descriptions of the methodology for major sources of data can be found in the Technical Notes. Secondary data for several of the indicators were provided by the local and state health departments. State and some local health data were provided by the Nevada Office of Public Health Informatics and Epidemiology (OPHIE), a department within the Nevada Department of Health and Human Services, Division of Public and Behavioral Health. Other local health data were provided by several Divisions within the Washoe County Health District. State and local health data include standardized and reportable health-related statistics, which are tracked on an ongoing basis. Only high quality, reliable sources of data were utilized, so secondary data estimates provided are generalizable to Washoe County's overall population. Secondary data sources for each of the tables and figures are located at the end of each corresponding section.

Selection of Secondary Data Indicators

The initial set of secondary data indicators was developed based on the Nevada Core Health Indicators list. The Nevada Core Health Indicators were developed by a statewide taskforce in 2013 and defines a minimum set of data to be included in local and state health assessments conducted in Nevada. The list of secondary data health indicators were presented to the Washoe County CHNA workgroup and workgroup members were provided the opportunity to add or make changes to the list. The revised indicators were then grouped into 18 topic areas and sent to the respective subject matter experts (SMEs) for each of the 18 topic areas. The SMEs were asked to provide input on the indicators to be included and made revisions, substitutions, or additions to any of the indicators within their corresponding topic(s).

Presentation of Secondary Data

A snapshot of the secondary data indicators, trends, most recent year of data for Washoe County, and any associated Healthy People 2020 target objectives are shown at the beginning of each

section. When identical data were available, the health indicator includes percentages or rates at the local (Washoe County), state (Nevada), and national (United States) levels for comparison purposes. If a Healthy People 2020 objective aligned with an indicator, those were also illustrated in the figure. When available, trend data were provided to understand changes over a five to ten year period.

Primary Data

Primary data are data or input collected directly from a population of interest. Primary data can be obtained through a variety of means including public forums, focus groups, surveys, interviews and/or panel discussions. For the 2018-2020 Washoe County Community Health Needs Assessment, primary data were obtained via an online community survey.

2018-2020 Online Community Survey Development

Community survey questions were designed to gather additional information not widely available at the county level in order to understand the factors that influence health behaviors. For example, secondary data show the proportion of adults that consume fruits and vegetables or the proportion of high school students that engage in physical activity. The community survey questions were developed to better understand what about Washoe County makes it challenging to eat more healthy foods or which barriers could be addressed to increase physical activity levels. Additionally the survey asked respondents to rank major health topics, providing residents an opportunity to “vote” on what they perceive as important. The survey questions were initially drafted by the CHNA author using a combination of standardized questions, brought to the Washoe County CHNA workgroup for revisions and input, and then piloted with a variety of individuals to test for clarity, length, and overall content. The online survey instrument was translated and back-translated into Spanish and adapted for distribution as a hardcopy as well.

The 44 question survey assessed respondents’ perceived barriers to engaging in physical activity, eating healthy foods more often, accessing healthcare in Washoe County, and asked respondents what would help to reduce those barriers. Other questions included food insecurity, perceived stress, housing and financial challenges, as well as enrollment in government supportive services. A key question asked survey respondents to rate health topics, these ratings were used as a criteria metric to score, ranked and identify the health priorities in Washoe County.

2018-2020 Online Community Survey Dissemination

Information regarding the survey’s purpose and a link to the surveys (English and Spanish versions) were provided via email to over 30 community partner agencies. These agencies disseminated the survey through a variety of means including sending the links to employees, providing survey links in

organizational and community newsletters/announcements, and posting the survey links to websites and social media. Some organizations permitted hardcopy distribution of the survey in locations such as clinic waiting rooms, food bank lines, at educational classes, health fairs, and senior centers. The survey was open from April 19 to August 15, 2017 and resulted in 1,438 respondents.

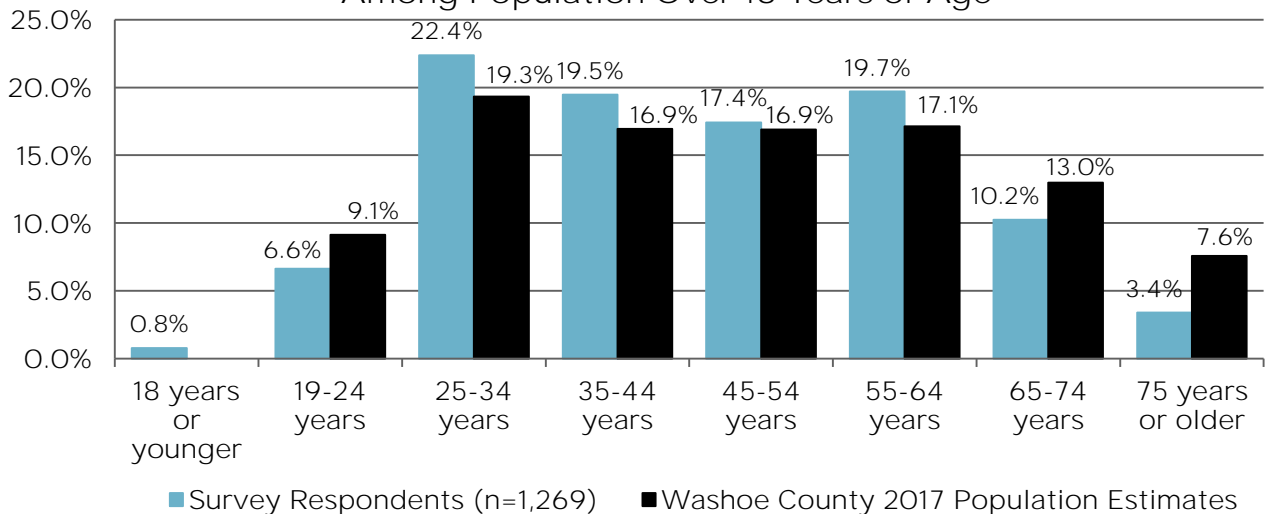
Presentation of Primary Data

Primary data results are included throughout the assessment within associated sections of the report and are always presented after secondary data. In lieu of presenting all community survey results within a single section, the survey results are grouped within associated topic areas. The community survey questions did not include all health-related topics, therefore not every section of the report contains primary data.

2018-2020 Online Community Survey Demographics

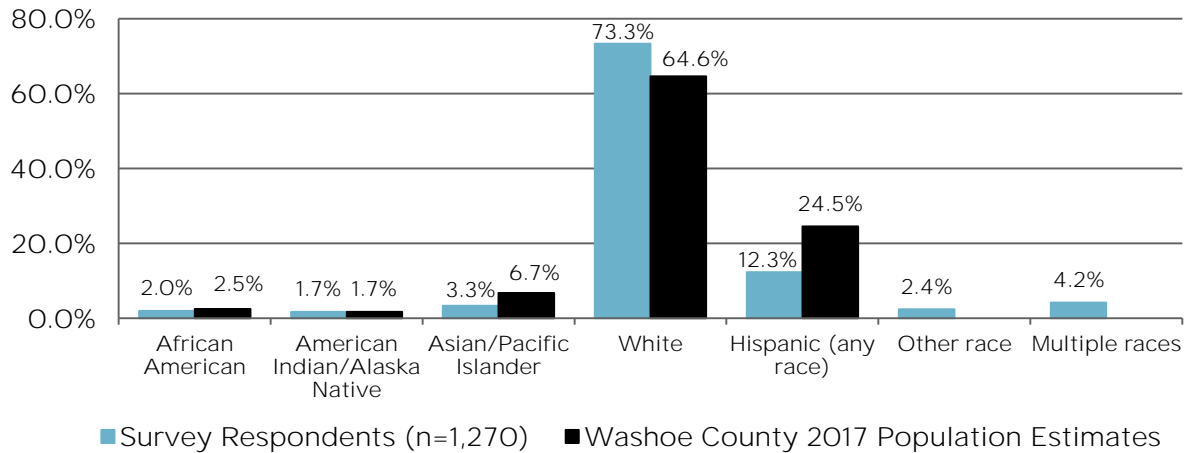
The online community survey was not designed to obtain a statistically reliable population sample and data were not weighted for age, race/ethnicity, or any other demographic variable. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the 1,438 online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to Washoe County’s general population.

Fig 1: Comparison of Survey Respondents by Age Group Among Population Over 18 Years of Age



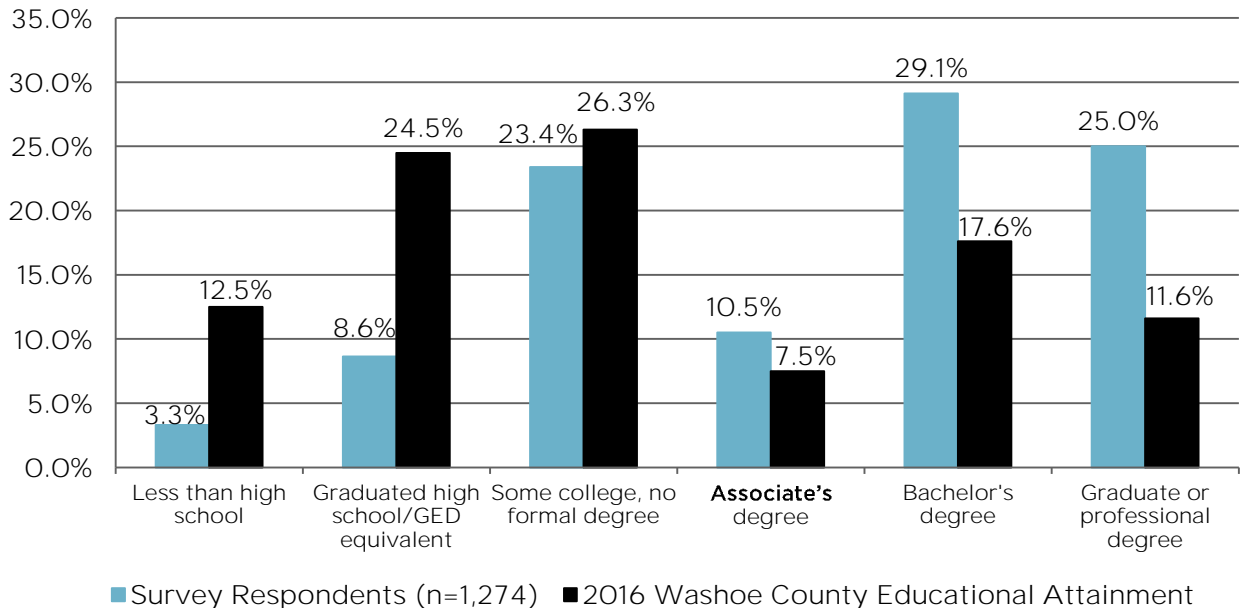
- Among the 1,269 survey respondents who indicated which age group they were in, they were proportionately similar in age to Washoe County residents overall. Slightly less percentage of survey respondents were aged 65 years and older compared to county population.
- Age was unknown (left blank) for approximately 11.7% of the 1,438 total survey respondents.

Fig 2: Comparison of Survey Respondents by Race & Ethnicity



- Among the 1,270 survey respondents who indicated their race and ethnicity, a higher proportion of were white, non-Hispanic (73.3%) compared to Washoe County’s overall populations (64.6%).
- Additionally a lower proportion of survey respondents were Hispanic (12.3%) compared to Washoe County overall (24.5%).
- Race and ethnicity were unknown (left blank) for 11.7% of the 1,438 total survey respondents.

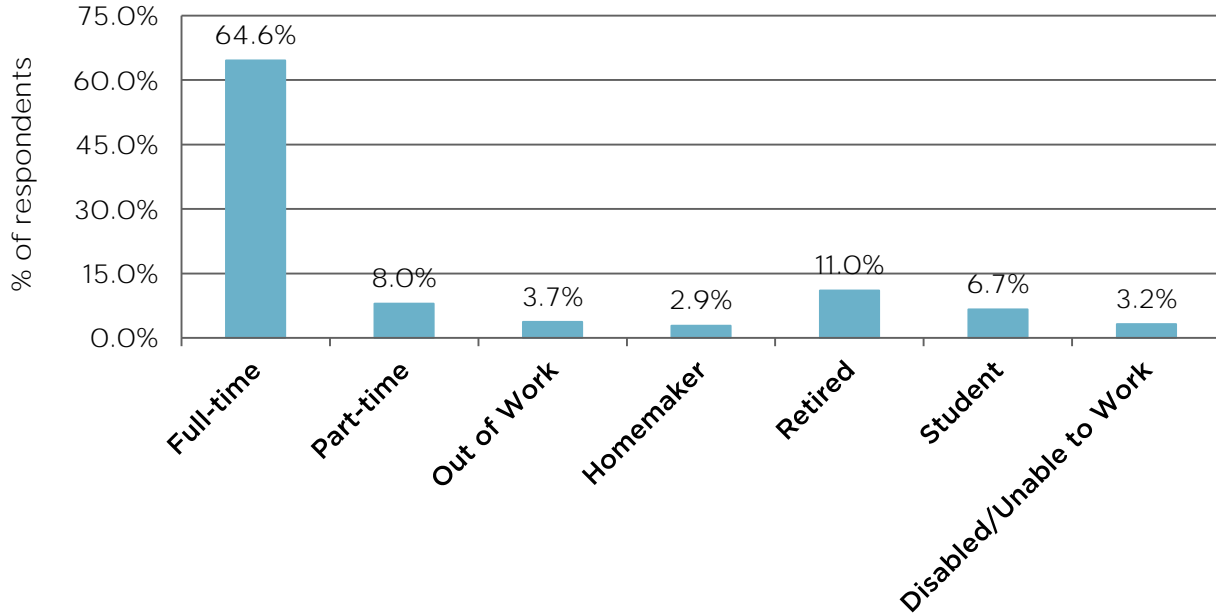
Fig 3: Comparison of Survey Respondents by Educational Attainment



- Among the 1,274 survey respondents who indicated their educational attainment, a higher proportion had a Bachelor’s degree (29.1%) compared to the overall Washoe County population (17.6%).
- A higher proportion had a Graduate or professional degree or higher (25.0%) compared to the overall Washoe County population (11.6%).

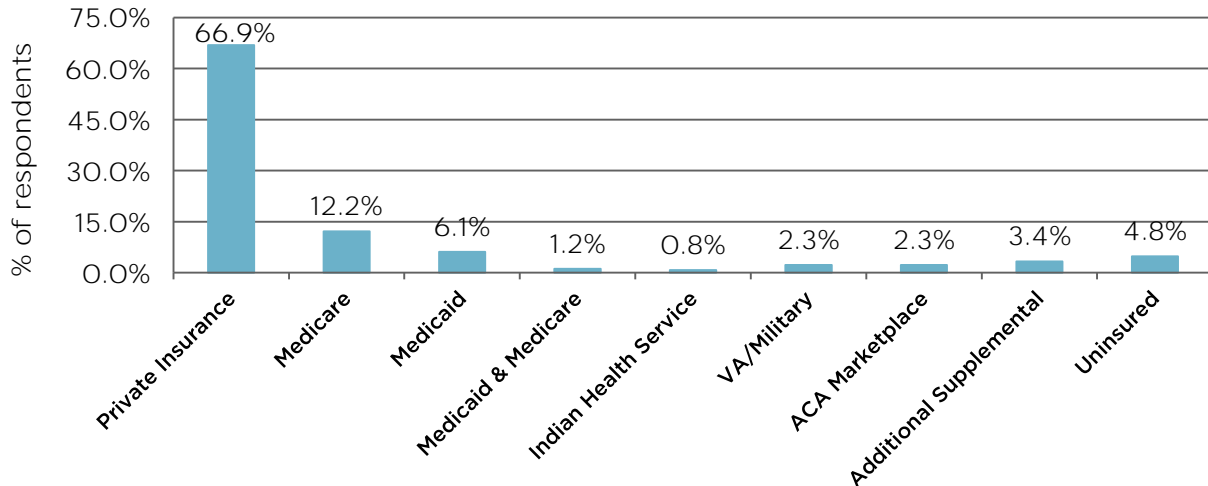
- Educational attainment was unknown (left blank) for 11.4% of the 1,438 total survey respondents.

Fig 4: Employment Status Among Survey Respondents (n=1,263)



- Among the 1,263 survey respondents who indicated their current employment status, the majority were employed full-time (64.6%), while 11.0% were retired, and 8.0% were employed in one or more part-time positions.
- Employment status was unknown (left blank) by 12.2% of survey respondents.

Fig 5: Insurance Coverage Among Survey Respondents (n=1,304)

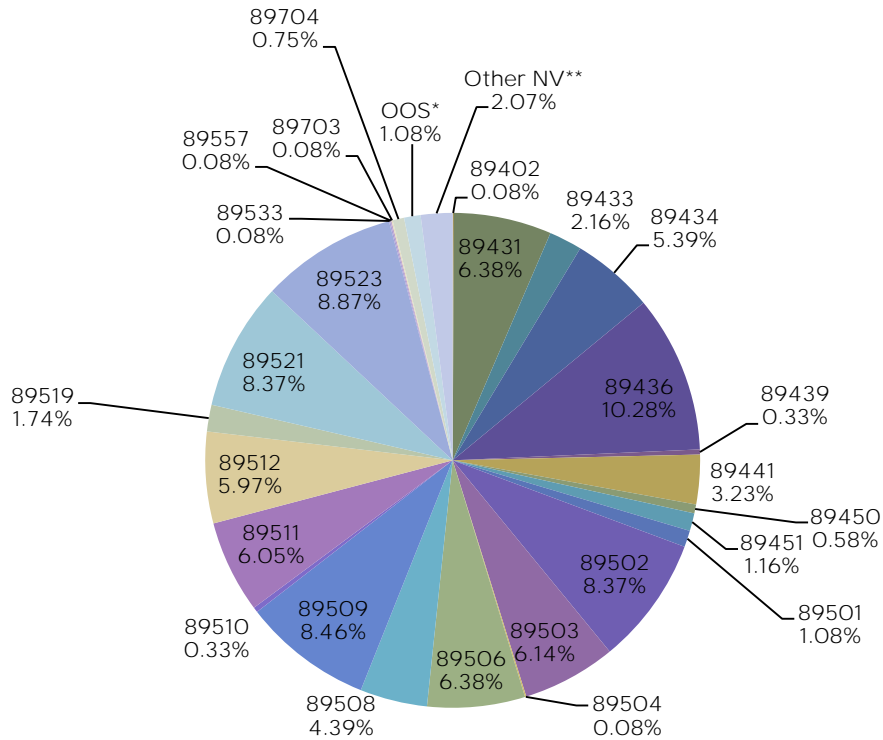


- Among the 1,304 survey respondents who indicated their current health insurance status, the majority were insured through private insurance including an employer (66.9%), while 12.2%

were insured through Medicare, 6.1% were insured through Medicaid, and 4.8% were uninsured.

- Health insurance status was unknown for 9.3% of survey respondents.

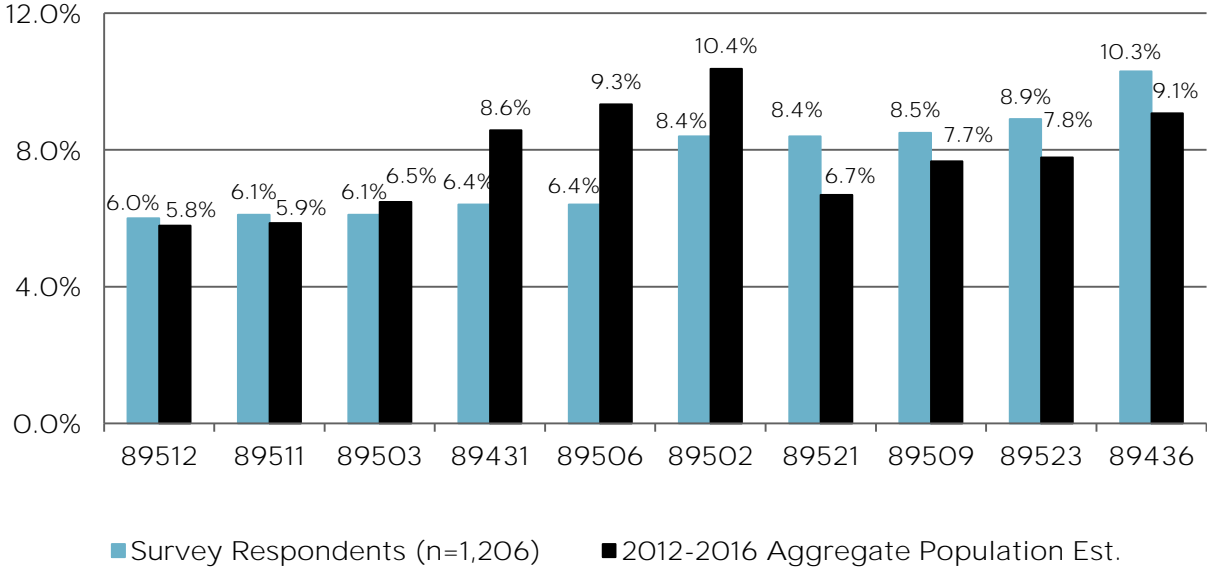
Fig 6: Survey Responents by ZIP Code (n=1,206)



Note: *OOS is out of state; **Other NV is other Nevada county

- It was important to the CHNA Workgroup to include those who were homeless as well as those who were obtaining services in Washoe County, but from other Nevada counties, therefore all survey respondents regardless of ZIP code (or lack of ZIP code) were included.
- Zip code was unknown for 16.1% of survey respondents.

Fig 7: Comparison of Survey Respondent Top 10 ZIP Codes



Technical Notes

The following describes major sources of secondary data utilized throughout the assessment and the methods by which those data are collected. These sources of data are commonly utilized and referenced by public health professionals as well as other entities, on regular basis. Additionally, these data are publically available and most are updated annually.

American Community Survey

The American Community Survey (ACS) is administered by the United States Census Bureau each year. Approximately one in 38 U.S. households receives an invitation to complete the survey either as a hardcopy or online. Questions are diverse and relate to socioeconomics, demographics, household composition, occupational status, housing status, educational attainment, and more. The resulting data are available from the national to the local levels and are often available at the census tract or census block level.

Nevada Behavioral Risk Factor Surveillance Survey

The Behavioral Risk Factor Surveillance Survey (BRFSS) is a health survey administered via telephone annually in all 50 states, the District of Colombia, and three U.S. territories. The BRFSS is the largest continuously conducted health survey in the world and asks adults questions regarding risk behaviors, chronic health conditions, and use of preventive screening and immunization services. There is a fixed core module, rotating modules which are asked in either even or odd years, emerging modules, and states may elect to include state-specific questions within the BRFSS.

Nevada Office of Public Health Informatics and Epidemiology

The Nevada Office of Public Health Informatics and Epidemiology (OPHIE) operates under the Nevada Division of Public and Behavioral Health and is largely in charge of investigations, data collection, and the compiling of statistics related to the following areas:

- Communicable and infectious diseases
- Sexually transmitted diseases
- Adult hepatitis
- Behavioral Risk Factor Surveillance System (BRFSS)
- Nevada Birth Outcomes Monitoring System
- Nevada Central Cancer registry
- Syndromic surveillance
- Youth Risk Behavioral Survey (YRBS)

Nevada Youth Risk Behavioral Survey

The Youth Risk Behavioral Survey (YRBS) is administered to middle and high school students on odd years in every state across the nation. The YRBS provides an estimated prevalence of risk behaviors and protective factors among adolescents. The survey is voluntary and results include self-reported responses to questions related to the following areas:

- Violence and violent behaviors
- Physical activity, nutrition, and obesity
- Substance use
- Sexual health behaviors
- Home and family environment

Nevada Report Card

Nevada Department of Education releases school district data on an annual basis and makes most data elements available at the state, district (county), and school level. Most data are collected from students or as reported by the schools and include topics such as demographics, funding, staff, test scores among others.

Geography & Demographics

Nevada is the 7th largest state in size, with an estimated population of 2.8 million as of 2017.³ There are few urban areas across the state, which are separated by large tracts of unoccupied rural and frontier land. Washoe County is home to approximately 15.2% of the state’s population, making it the second most populated county in the state.

Table 1: Comparative Population & Geographic Summary, 2017

Location	2017 projected population	Square land miles	Population Density (persons per square mile)	% of State Population
Washoe County	439,221	6,302 mi ²	69.7	15.2%
Clark County	2,122,899	7,891 mi ²	269.0	73.4%
All other counties	328,876	95,588 mi ²	3.4	11.4%
Nevada	2,890,996	109,781 mi²	26.3	100.0%

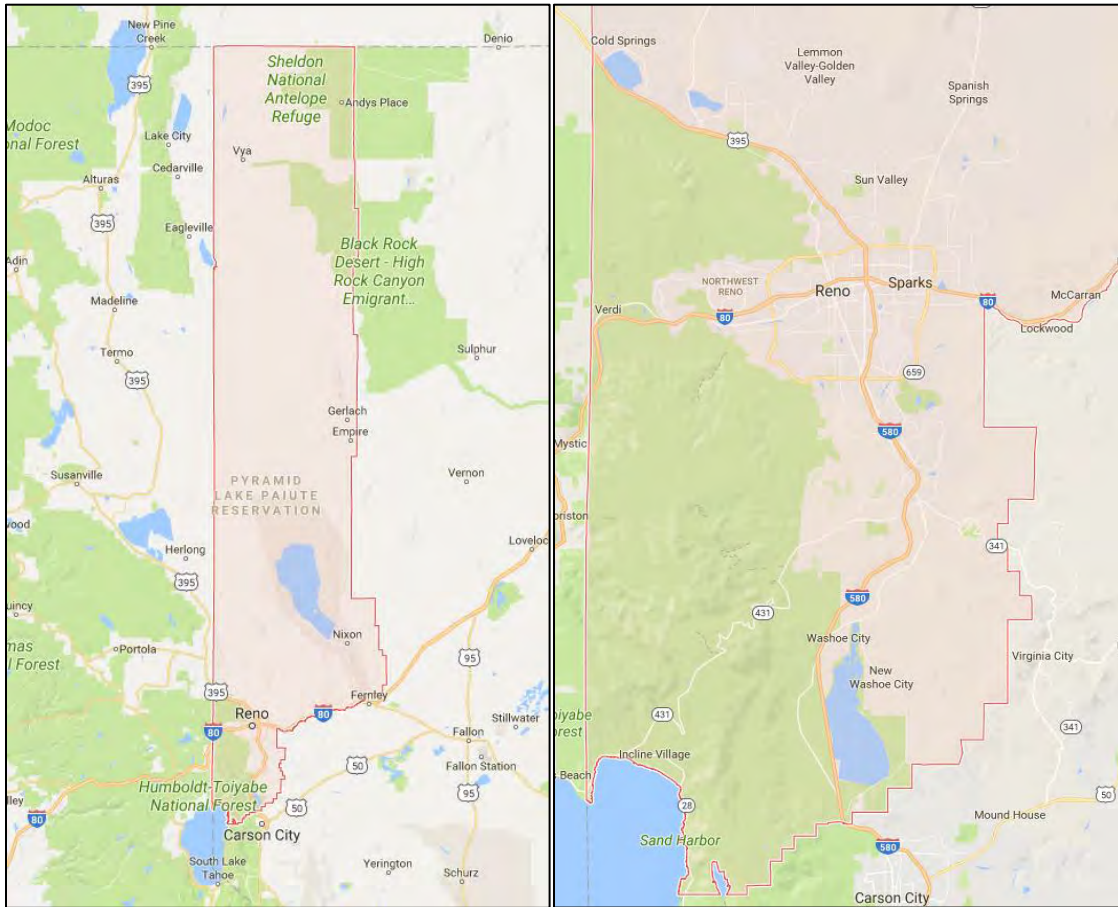
Washoe County is located in the Northwestern corner of the state along the east side of the Sierra Nevada mountain range and shares borders with California to the west and Oregon to the north. The county is long and narrow as it takes over five hours to drive the length of the county north to south and only one hour to drive the width - east to west. Washoe County is approximately 6,302 square land miles and contains two incorporated cities, Reno and Sparks, and several smaller towns. Reno is the county seat of Washoe County and the third largest city in Nevada, while Sparks is a smaller city, just east of Reno. Two major highways intersect in the Reno-Sparks area, Interstate 80 running east to west and Highway 395/Interstate 580 running north to south. This intersection is viewed as a hub for commerce, transit of goods, and as a strategic location for storage and shipping of textiles.

Although the Reno-Sparks area is largely urbanized, there are unique health issues for residents of the rural and frontier parts of the county, including challenges to accessing various types of services, especially healthcare. Additionally, Washoe County contains services and amenities, not available in other rural counties across Northern Nevada. Therefore, residents of neighboring counties often travel to the Reno-Sparks area to obtain health-related services.

³ Nevada Department of Taxation, Nevada State Demographer (2016). Source: Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2035. Accessed <https://tax.nv.gov>.

Image 1: Washoe County

Image 2: Reno-Sparks Enlarged



Defining a community in terms of size, growth, and demographic characteristics helps determine public health needs and potentially where to allocate resources to meet those needs. From 2000 to 2010 the national growth rate was 9.7% however, during the same time period Nevada saw a population increase of 35.1%. Nevada is the only state that experienced a growth rate exceeding 25% over the past three decades and has remained the fastest growing state in the nation for the past five decades.⁴ Although the rate of growth did slow down during the recession, estimates continue to predict continued growth in the future.

Washoe County has become more ethnically diverse, with the largest increase among the Hispanic population (+27.3%) from 2007 to 2017. Another subpopulation experiencing continued growth during this time were among elderly adults; one in five Washoe County residents were 60 years or older in 2017. Issues related to the health of these two growing subpopulations are important to take into consideration for future planning.

⁴ Mackun, P. & Wilson, S. (2011). Population Distribution and Change: 2000 to 2010. United States Census Brief Accessed <https://www.census.gov/prod/cen2010/briefs/c2010br-01.pdf>

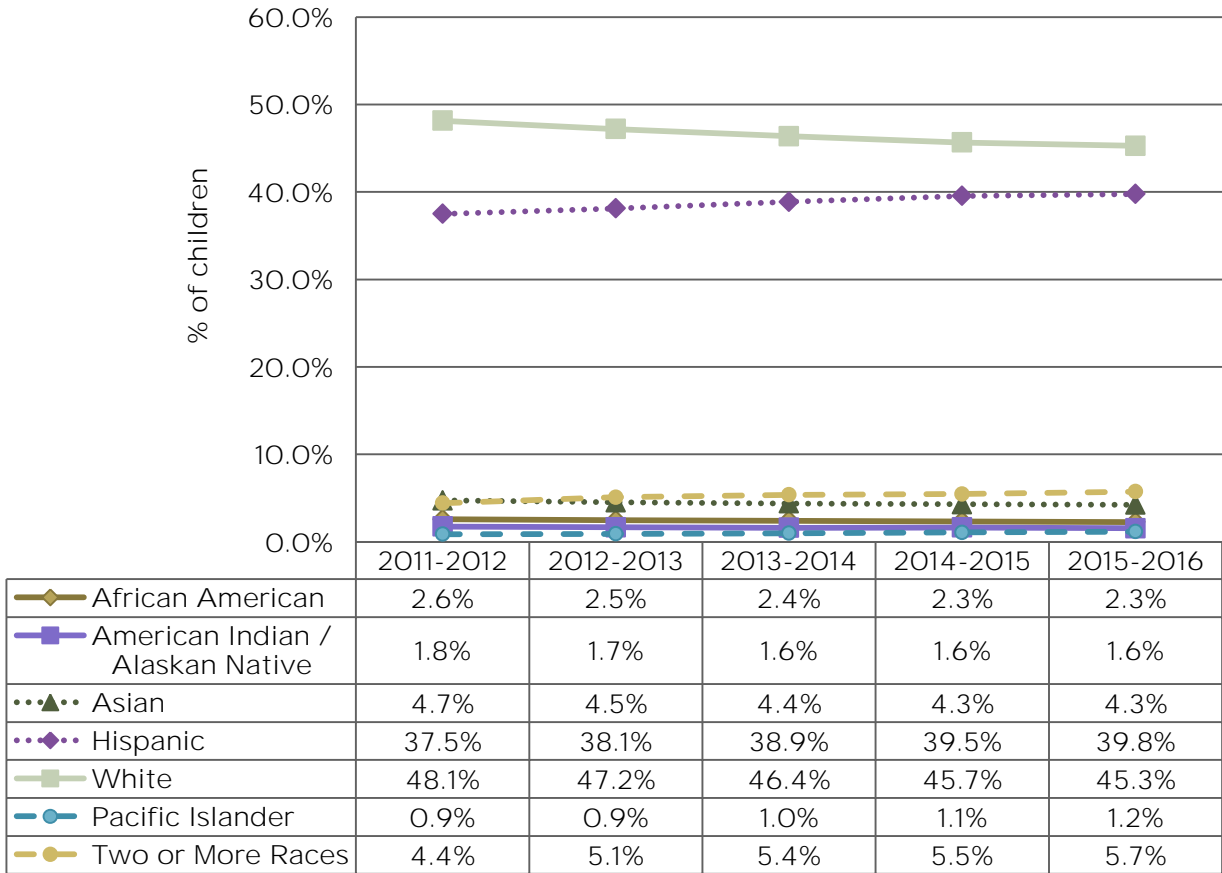
1.0 GEOGRAPHY & DEMOGRAPHICS

Table 2: Estimated Population Growth by Select Demographics, Washoe County, 2007 & 2017

Demographics	2007		2017		% Change
	#	%	#	%	
Sex					
Female	199,209	49.5%	218,752	49.8%	9.8%
Male	203,142	50.5%	220,469	50.2%	8.5%
Age Group					
0-9 years	57,231	14.2%	54,605	12.4%	-4.6%
10-19 years	53,493	13.3%	58,337	13.3%	9.1%
20-29 years	59,009	14.7%	59,960	13.7%	1.6%
30-39 years	52,252	13.0%	61,058	13.9%	16.9%
40-49 years	57,987	14.4%	53,019	12.1%	-8.6%
50-59 years	54,896	13.6%	57,294	13.0%	4.4%
60-69 years	38,597	9.6%	51,603	11.7%	33.7%
70-79 years	18,460	4.6%	30,807	7.0%	66.9%
80 + years	10,427	2.6%	12,539	2.9%	20.3%
Race/Ethnicity					
African American, non-Hispanic	9,355	2.3%	10,894	2.5%	16.5%
American Indian/Alaska Native, non-Hispanic	6,725	1.7%	7,289	1.7%	8.4%
Asian/Pacific Islander, non-Hispanic	24,978	6.2%	29,614	6.7%	18.6%
White, non-Hispanic	276,679	68.8%	283,687	64.6%	2.5%
Hispanic (any race)	84,614	21.0%	107,736	24.5%	27.3%
Total	402,351	100.0%	439,221	100.0%	9.2%

- From 2007 to 2017 the overall Washoe County estimated population growth increased by 9.2%.
- Growth was largest among those 30 to 39 years of age and among those 60 years and older.
- Washoe County experienced a noted increase among Hispanic population (27.3%), the Asian/Pacific Islander population (18.6%), and the African American population (16.5%).
- In 2017, white, non-Hispanics accounted for 64.6% of Washoe County's population, Hispanics were an estimated 24.5%, Asian/Pacific Islanders 6.7%, African Americans 2.5%, and American Indian/Alaska Natives were an estimated 1.7% of the county population.

Fig 8: Washoe County School District Grade K-12 by Race/Ethnicity, 2011-2012 to 2015-2016



- The proportion of students in Washoe County School District (grade K-12) who were white decreased from the 2011-2012 school year (48.1%) to the 2015-2016 school year (45.3%).
- The proportions of students in Washoe County School District (grade K-12) who were Hispanic increased from the 2011-2012 school year (37.5%) to the 2015-2016 school year (39.8%).
- The proportion of students in Washoe County School District (grade K-12) who were African American, American Indian/Alaska Native, Asian, Pacific Islander, or two or more races combined remained low from the 2011-2012 school year to the 2015-2016 school year.

Predicted Growth

Table 3: Estimated Predicted Population Growth by Select Demographics, Washoe County, 2017 & 2022

Demographics	2017		2022		% Change
	#	%	#	%	
Sex					
Female	218,752	49.8%	232,527	49.9%	6.3%
Male	220,469	50.2%	233,017	50.1%	5.7%
Age group					
0-9 years	54,605	12.4%	56,321	12.1%	3.1%
10-19 years	58,337	13.3%	62,207	13.4%	6.6%
20-29 years	59,960	13.7%	63,247	13.6%	5.5%
30-39 years	61,058	13.9%	64,540	13.9%	5.7%
40-49 years	53,019	12.1%	56,269	12.1%	6.1%
50-59 years	57,294	13.0%	55,416	11.9%	-3.3%
60-69 years	51,603	11.7%	55,383	11.9%	7.3%
70-79 years	30,807	7.0%	36,504	7.8%	18.5%
80 + years	12,539	2.9%	15,657	3.4%	24.9%
Race/Ethnicity					
African American, non-Hispanic	10,894	2.5%	12,061	2.6%	10.7%
American Indian/Alaska Native, non-Hispanic	7,289	1.7%	7,486	1.6%	2.7%
Asian/Pacific Islander, non-Hispanic	29,614	6.7%	33,083	7.1%	11.7%
White, non-Hispanic	283,687	64.6%	289,656	62.2%	2.1%
Hispanic (any race)	107,736	24.5%	123,259	26.5%	14.4%
Total	439,220	100.0%	465,544	100.0%	6.0%

- The estimated predicted population growth from 2017 to 2022 for Washoe County overall is 6.0%.
- Growth is predicted to be largest among those 70 years of age and older.
- Continued growth among Hispanic population (14.4%), the Asian/Pacific Islander population (11.7%), and the African American population (10.7%) is predicted over the next 5 years.

Summary of Geography & Demographics

Washoe County’s population faces unique dichotomous challenges due to the geographic nature of the county. The majority of the county’s population resides in the Reno-Sparks metropolitan area. Due to rapid population growth, many urban residents face issues related to the limited amount of resources being stretched thin. There have been shortages of adequate and affordable housing, the schools are overcrowded, and many healthcare facilities are often at or nearing capacity. Conversely, much of the county land is rural in nature and although relatively few people reside in the rural and frontier areas, they face a different set of challenges. Rural issues include having a lack of choices in services and resources such as grocery stores, health clinics, libraries, and indoor recreation options. Many rural residents travel long distances (over an hour) to reach the nearest hospital or health clinic and full-service grocery stores. Additionally, Washoe County receives residents of surrounding rural counties; therefore examining only the population of Washoe County may underestimate the true utilization of certain services, especially healthcare providers and facilities.

Although population growth has slowed, relative to the population boom of the 1990's through the late 2000's, continued growth is expected. Notable growth of the Hispanic and elderly (60 years and older) populations has occurred and is predicted to continue. Additionally, Washoe County has continued to become increasingly ethnically diverse, as the school-aged children (grades K-12) are no longer majority white, non-Hispanic. Service providers across all spectrums should actively ensure they have resources in place to meet the needs of a growing population and are able to communicate effectively with clients of all ages and diverse cultural backgrounds.

Geography & Demographics Sources

Table 1: Comparative Population & Geographic Summary, 2017

Nevada State Demographer's Office. (2016). Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2032 Estimates from 2000 to 2015 and Projections from 2016 to 2032. Carson City, NV.

Square land miles: United States Census Bureau Factsheet

Image 1-Image 2 SAME SOURCE

Image 1: Washoe County

Image 2: Reno-Sparks Enlarged

Google Maps

Table 2: Estimated Population Growth by Select Demographics, Washoe County, 2007 & 2017

Nevada State Demographer's Office. (2016). Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2032 Estimates from 2000 to 2015 and Projections from 2016 to 2032. Carson City, NV.

Fig 8: Washoe County School District Grade K-12 by Race/Ethnicity, 2011-2012 to 2015-2016

Nevada Department of Education. Nevada Report Card. Accessed <http://nevadareportcard.com/di/>

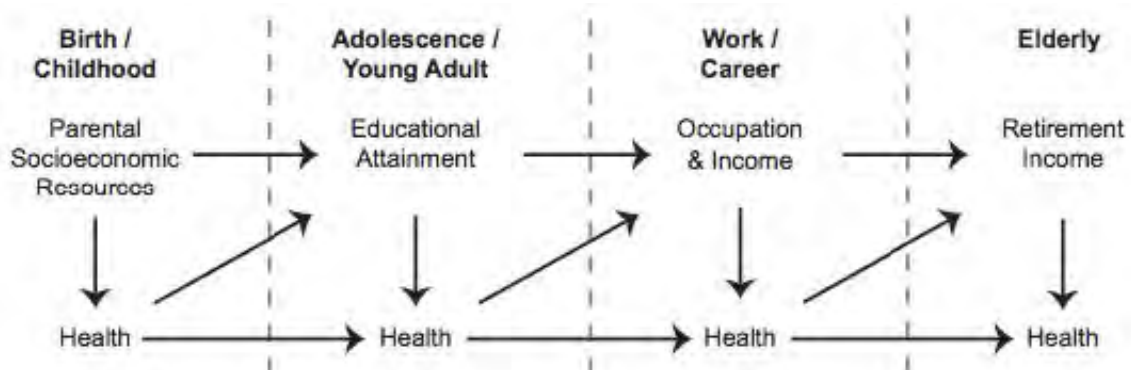
Table 3: Estimated Predicted Population Growth by Select Demographics, Washoe County, 2017 & 2022

Nevada Department of Taxation, Nevada State Demographer (2016). Source: Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2035. Carson City, NV.

Socioeconomic Status

Socioeconomic status (SES) is measured by education, occupation, and earned income, which frame the hierarchy of a person’s social standing. The factors used to measure SES are predictors of health across the lifespan and overall life expectancy. Those with a higher SES are more likely to achieve higher levels of education, find employment in higher paying jobs, and have increased access to healthcare and preventive services. Additionally, research shows those with a higher SES have lower levels of chronic stress as measured by cortisol in the bloodstream.^{5,6} Conversely people with a lower SES are more likely to engage in unhealthy behaviors such as smoking and physical inactivity, and they often live in low-income neighborhoods with fewer resources.⁷ Persons with a lower SES experience higher rates of poor health outcomes such as obesity, stroke, cardiovascular disease, depression, and diabetes.^{8,9,10} The effects of socioeconomic status on quality of life and life expectancy are interrelated and challenging to measure independent of one another.

Image 3: How SES & Health Affect Each Other Over Time



⁵ National Center for Health Statistics. (2012). Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD.

⁶ Agency for Healthcare Research and Quality. (2012). National Healthcare Disparities Report, 2011. Rockville, MD.

⁷ National Center for Health Statistics. (2012). Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD.

⁸ Telfair, J. & Shelton, T.L. (2012). Educational Attainment as a Social Determinant of Health. *North Carolina Medical Journal*. 73(5); 358-365.

⁹ Chen, Edith & Paterson, Laurel, Q. (2006). Neighborhood, Family and Subjective Socioeconomic Status: How Do They Relate to Adolescent Health?. *Health Psychology*. 25(6); 704-714.

¹⁰ Goodman, E. (1999). The Role of Socioeconomic Status Gradients in Explaining Differences in US Adolescents’ Health. *American Journal of Public Health*. 89; 1522-1528.

1.1 SOCIOECONOMIC STATUS

Indicator	Trend	Most Recent Year
Education		
3 rd grade reading proficiency	~	44.0% proficient (2016-2017)
3 rd grade mathematics proficiency	~	49.7% proficient (2016-2017)
11 th grade mathematics proficiency	Increasing	81.1% proficient (2014-2015)
11 th grade reading proficiency	Decreasing	83.9% proficient (2014-2015)
11 th grade science proficiency	Increasing	82.0% proficient (2014-2015)
11 th grade writing proficiency	STABLE	82.7% proficient (2014-2015)
High school graduation rates	Increasing	76.6% (2016)
Transiency rates	Decreasing	18.8% (2016-2017)
Remediation rates	Decreasing	27.4% (2015-2016)
School district funding source	~	various
Per pupil expenditures	Increasing	\$9,308 (2015-2016)
Educational attainment adults 18-24 years	~	various
Educational attainment adults 25+ years	~	various
Employment		
Unemployment rate	Decreasing	5.0% (2016)
Occupation & Industry		
Industry as a percent of employment	~	various
Employment by occupation	Increasing	Varies by occupation
Growing and declining occupations	~	various
Growing and declining industries	~	various
Top 10 employers	~	various
Income & Wages		
Median household income	Increasing	\$58,175 (2016)
Median family income, by family type	~	various
Living wage, by family type	~	various
Percent of income by expense type, family of 4	~	various
Personal bankruptcy filing rate	Decreasing	2.5 per 1,000 population (2016)
Poverty		
Population in poverty	Decreasing	12.2% (2016)
Children <18 years in poverty	Decreasing	16.0% (2016)
Seniors 65+ in poverty	Increasing	8.0% (2016)
~ not able to assess for trend		

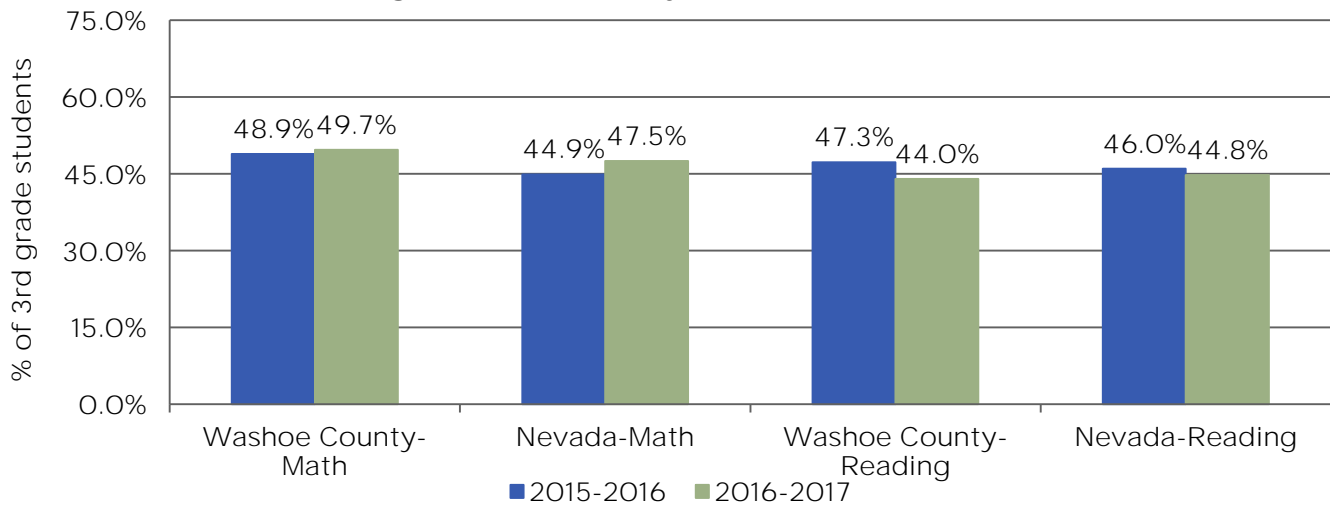
1.1 SOCIOECONOMIC STATUS

Education

Overall quality of life is largely impacted and influenced by educational attainment. Persons without a high school diploma or GED equivalent are more likely to have poorer health and live shorter lives. The relationship between education and quality of life has been demonstrated worldwide; however, the relationship is much more apparent in the United States. Education impacts various health outcomes such as decision-making in regard to healthy choices, occupational options, and income.^{11,12,13}

3rd Grade Proficiency

Fig 9: Percent of 3rd Grade Students Proficient in Mathematics & Reading, Washoe County & Nevada, 2015-2016 & 2016-2017



- Although higher than the state, less than half of 3rd grades students in Washoe County were proficient in mathematics during both the 2015-2016 (48.9%) and 2016-2017 (49.7%) school years.
- Less than half of 3rd grades students in Washoe County were proficient in reading during both the 2015-2016 (47.3%) and 2016-2017 (44.0%) school years.

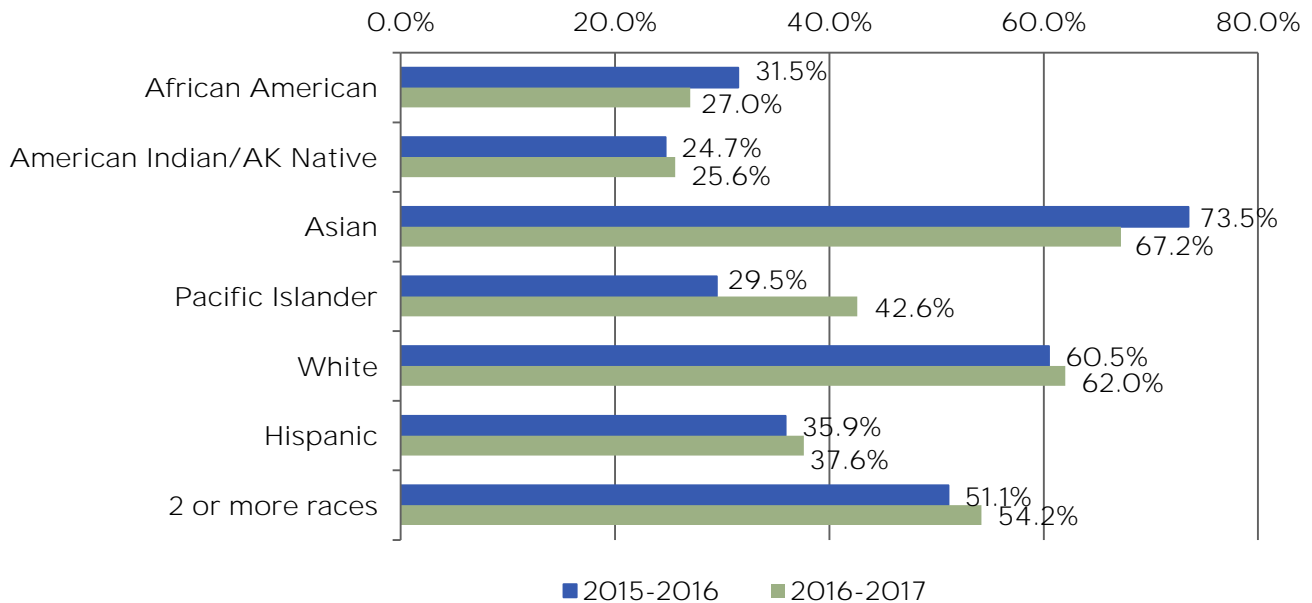
¹¹ Cutler, D.M. & Lleras-Muney, A. (2006). Education and Health: Evaluating Theories and Evidence. National Bureau of Economic Research. Cambridge, MA.

¹² National Center for Health Statistics. (2012). Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD.

¹³ Telfair, J. & Shelton, T. L. (2012). Educational Attainment as a Social Determinant of Health. 2012. *North Carolina Medical Journal*. 73(5); 358-365.

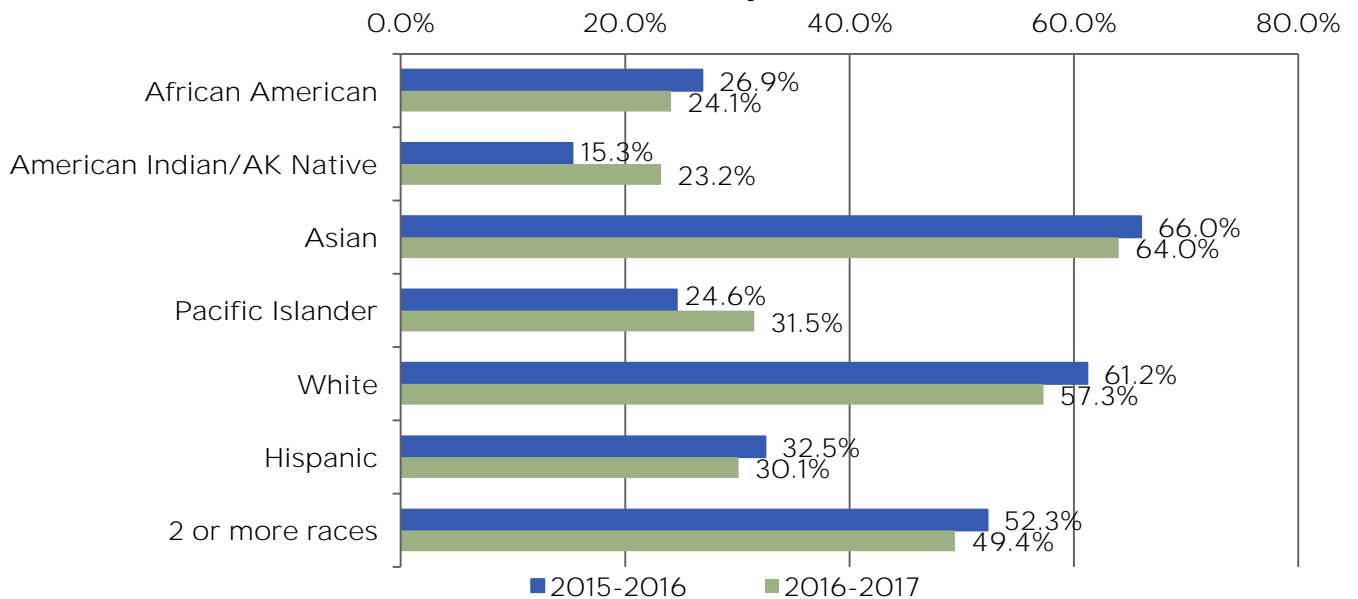
1.1 SOCIOECONOMIC STATUS

Fig 10: Percent of 3rd Grade Students Proficient at Mathematics by Race/Ethnicity, Washoe County, 2015-2016 & 2016-2017



- The percentage of 3rd grade students in Washoe County who were proficient in mathematics was highest among Asians and whites and lowest among American Indian/Alaska Natives, as well as African American, and Hispanic students during both the 2015-2016 and 2016-2017 school years.

Fig 11: Percent of 3rd Grade Students Proficient at Reading by Race/Ethnicity, Washoe County, 2015-2016 & 2016-2017

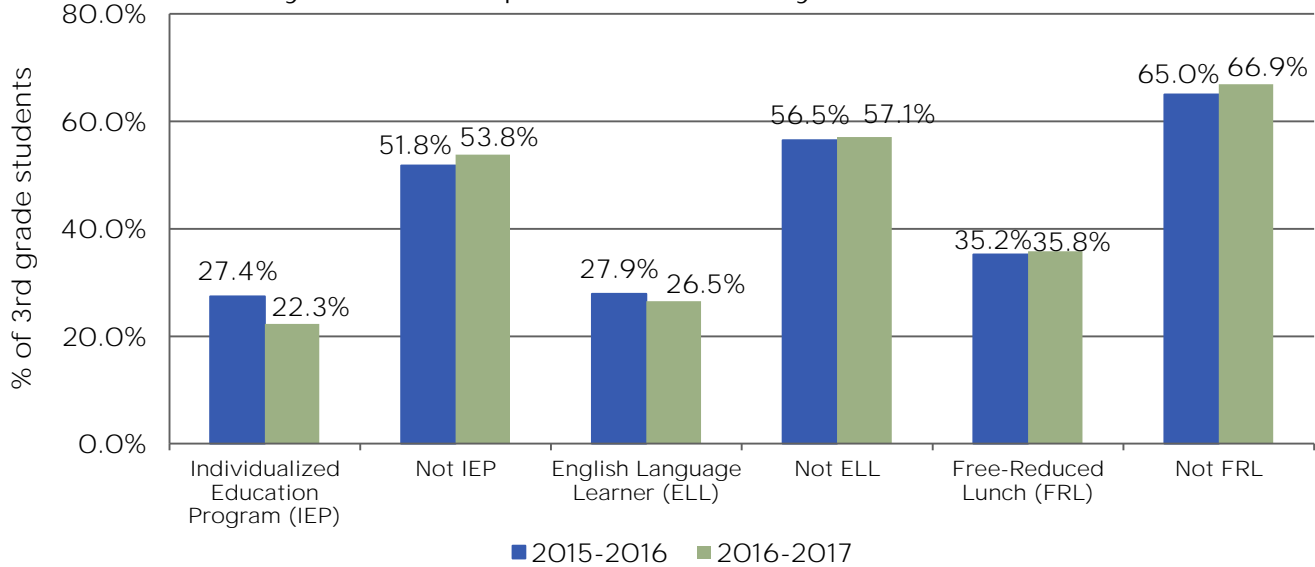


- The percentage of 3rd grade students in Washoe County who were proficient at reading was highest among Asians, whites, and students of two or more races.

1.1 SOCIOECONOMIC STATUS

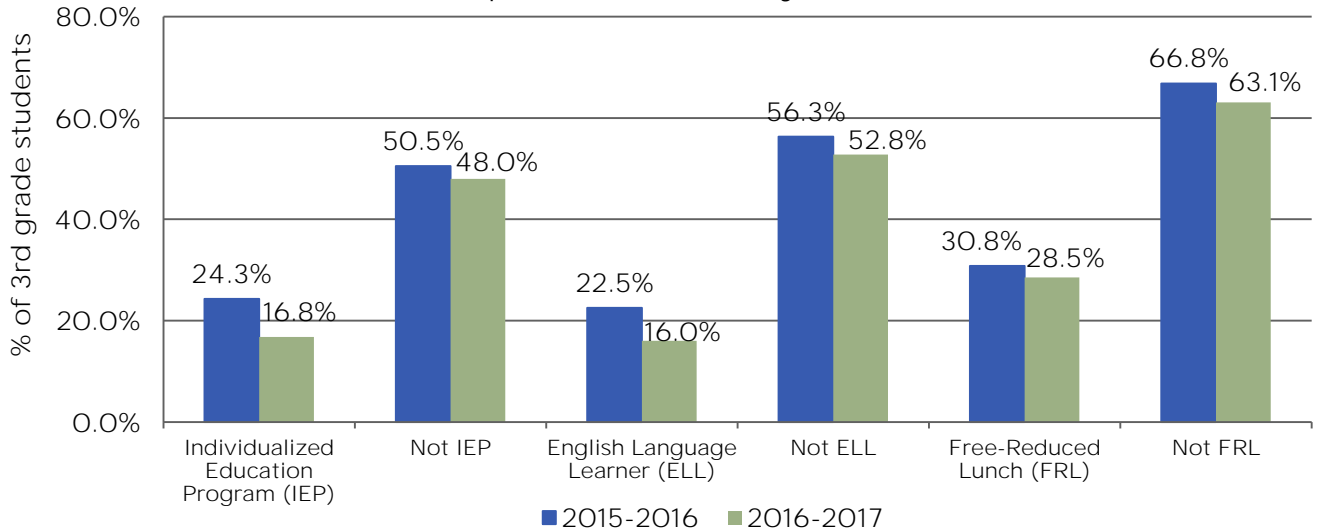
- The percentage of 3rd grade students in Washoe County who were proficient at reading was lowest among American Indian/Alaska Natives, African American, and Pacific Islander students during both the 2015-2016 and 2016-2017 school years.

Fig 12: Percent of 3rd Grade Students Proficient at Mathematics by Select Groups, Washoe County, 2015-2016 & 2016-2017



- Students who had an Individualized Education Program (IEP) or were English language learners (ELL) had among the lowest proficiency rates for mathematics during both the 2015-2016 and 2016-2017 school years.
- Students who were not qualified for free-reduced lunch had among the highest rates of proficiency for mathematics during both the 2015-2016 and 2016-2017 school years.

Fig 13: Percent of 3rd Grade Students Proficient at Reading by Select Groups, Washoe County, 2015-2016 & 2016-2017



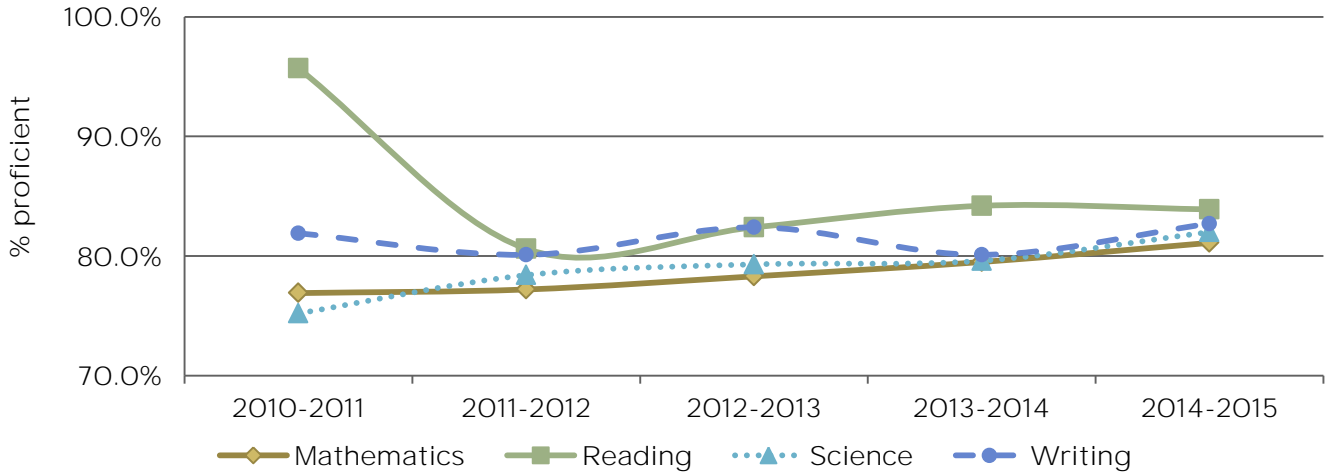
- Students who had an Individualized Education Program (IEP) or were English language learners (ELL) had among the lowest reading proficiency rates during both the 2015-2016 and 2016-2017 school years.

1.1 SOCIOECONOMIC STATUS

- Students who were not qualified for free-reduced lunch had among the highest reading proficiency rates during both the 2015-2016 and 2016-2017 school years.

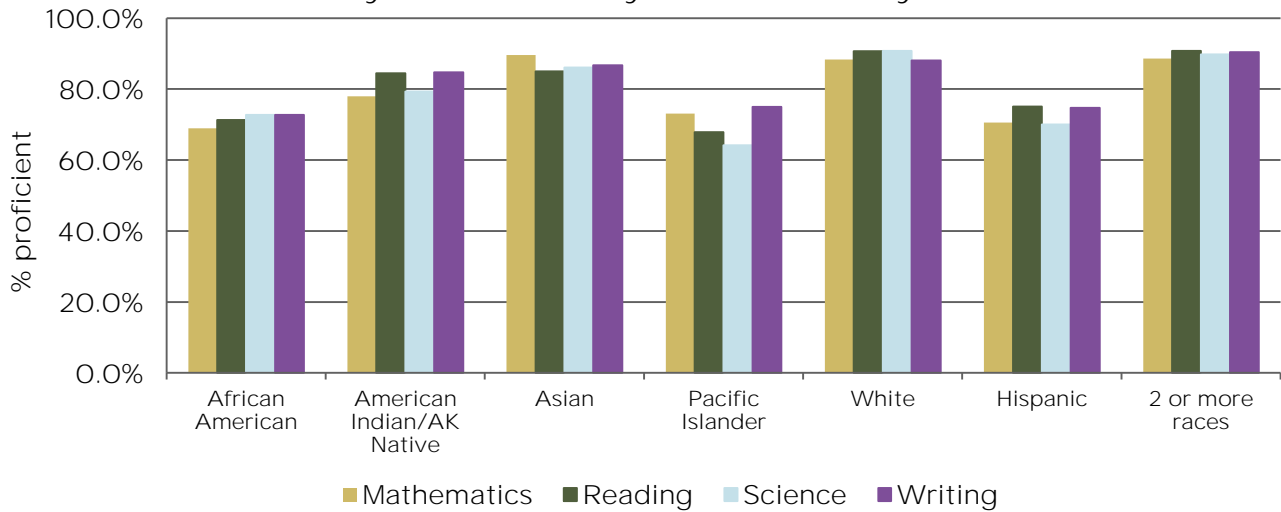
11th Grade Proficiency

Fig 14: High School Proficiency Exam, Percent of 11th Graders Proficient by Subject, Washoe County, 2010-2011 through 2014-2015



- The percentage of 11th grade students who were proficient in mathematics increased from 2010-2011 (76.9%) to 2014-2015 (81.1%).
- The percentage of 11th grade students who were proficient in reading decreased from 2010-2011 (95.7%) to 2014-2015 (83.9%). The high percentage noted in 2010-2011 is accurate according to the data and the decrease in following years was not explained.
- The percentage of 11th grade students who were proficient in science increased from 2010-2011 (75.2%) to 2014-2015 (82.0%).
- The percentage of 11th grade students who were proficient in writing increased from 2010-2011 (81.9%) to 2014-2015 (82.7%).

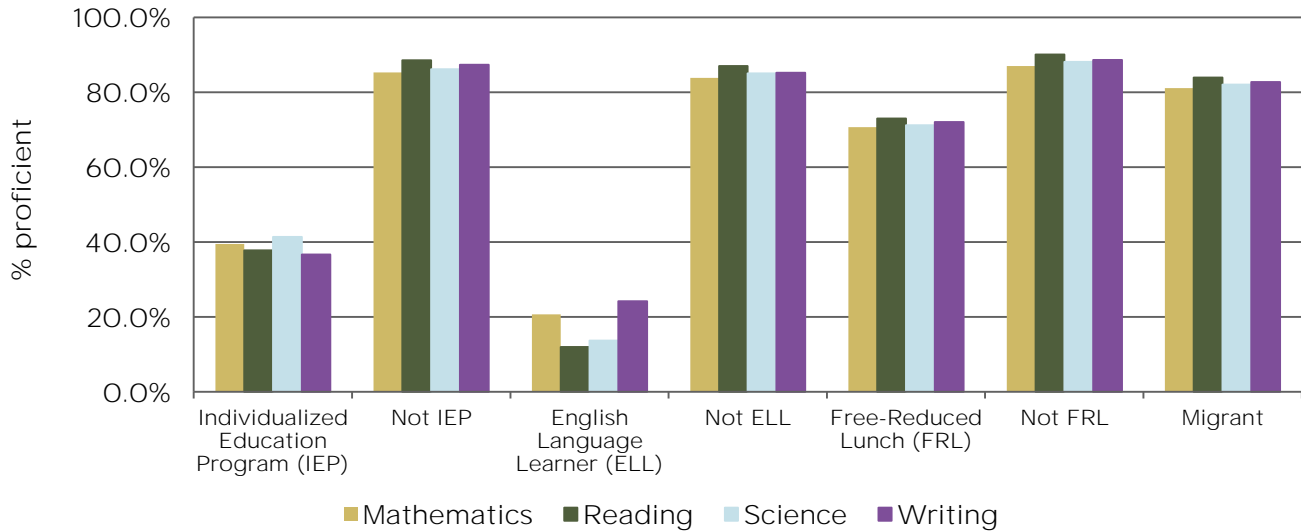
Fig 15: Percent of 11th Grade Students Proficient by Subject & by Race/ Ethnicity, Washoe County, 2014-2015



1.1 SOCIOECONOMIC STATUS

- During the 2014-2015 school year, proficiency in mathematics, reading, science and writing was highest among 11th grade students who were Asian, white, or 2 or more races.
- Proficiency was lowest among 11th grade students who were African American, Pacific Islander, or Hispanic.

Fig 16: Percent of 11th Grade Students Proficient by Subject & by Select Groups, Washoe County, 2014-2015



- During the 2014-2015 school year, proficiency in mathematics, reading, science and writing was highest among 11th grade students who were migrants, students who were not receiving free-reduced lunch (FRL), students who were not on an Individualized Education Program (IEP), as well as those who were not an English language learner (ELL).

High School Graduation Rates

Graduation rates in Washoe County have been increasing and reached a new record high with the Class of 2017 graduation rate at 84%; however those with limited English proficiency (LEP), also known as English language learners (ELL), as well as students with disabilities who require an Individualized Education Program or plan (IEP), continue to experience much lower graduation rates.¹⁴ As of the 2016-2017 school year students who require an IEP (13%) and those who qualify as an ELL (15%) equate to 28% of the total Washoe County School District student population.¹⁵ Although not provided in Figure 17, the preliminary estimated high school graduation rate for the Washoe County School District Class of 2017 was reported be a new high of 83.7%.¹⁶

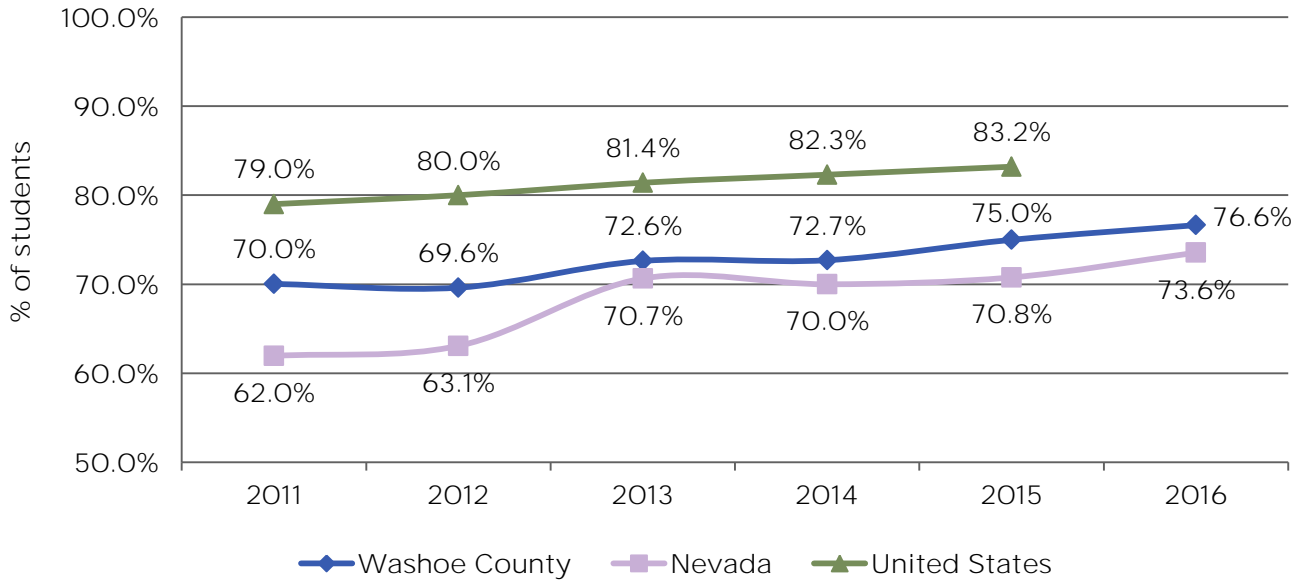
¹⁴ Washoe County School District. WCS D Sets new Graduation Record for Fifth Consecutive Year. Accessed <https://www.washoeschools.net/site/default.aspx?PageType=3&ModuleInstanceID=2000&ViewID=7b97f7ed-8e5e-4120-848f-a8b4987d588f&RenderLoc=0&FlexDataID=21614&PageID=1>

¹⁵ Nevada Department of Education. Nevada Report Card Demographic Profile. Accessed nevadareportcard.com

¹⁶ Washoe County School District. Graduation by the Numbers. Accessed <http://www.wcsddata.net/data-topics/graduation/>

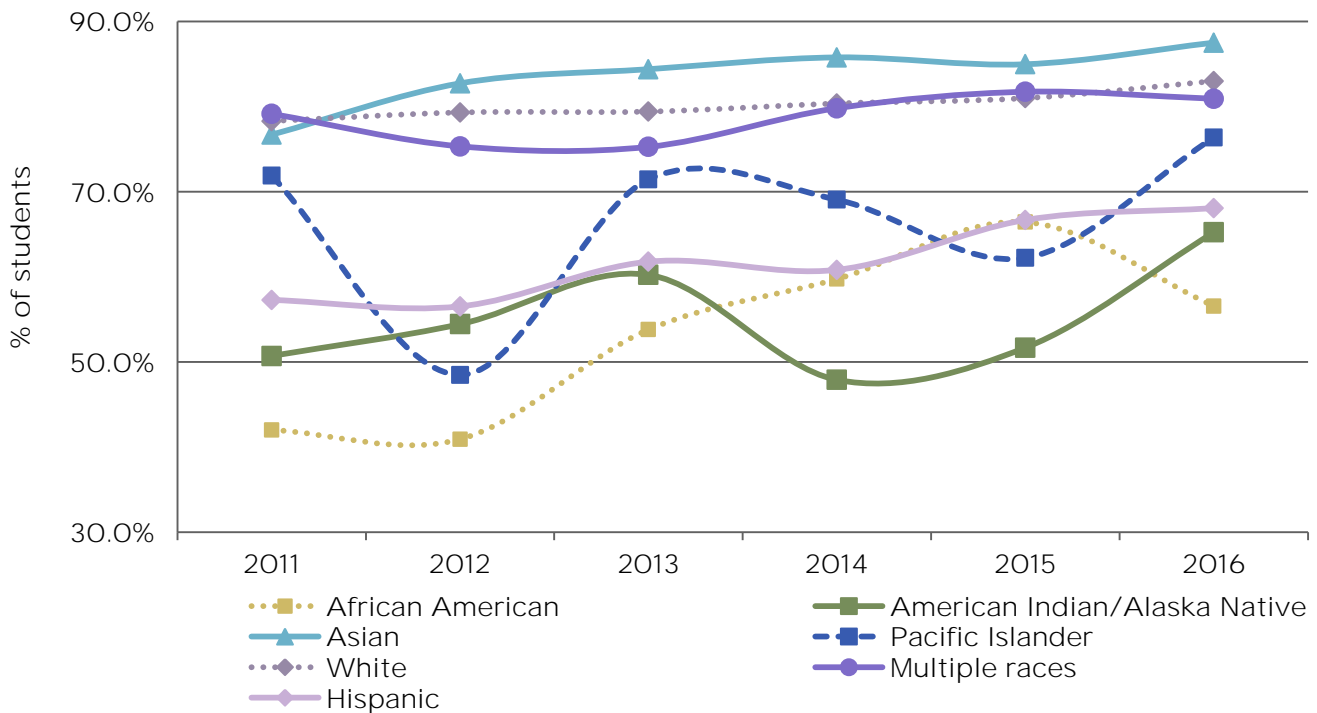
1.1 SOCIOECONOMIC STATUS

Fig 17: High School Cohort Graduation Rates, Washoe County, Nevada, & the United States, Class of 2011 - Class of 2016



- The high school graduation rates in Washoe County increased from 2011-2012 (70.0%) to 2016-2017 (76.6%).
- During the 2016-2017 school year the high school graduation rates in Washoe County (76.6%) were higher than Nevada (73.6%).

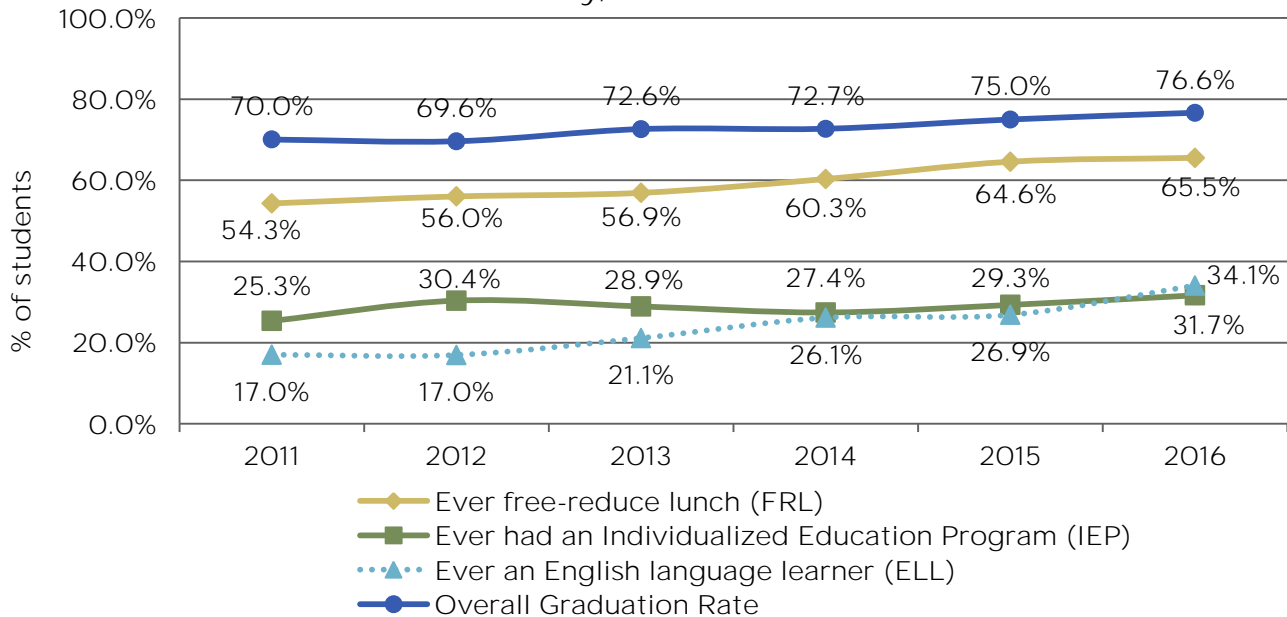
Fig 18: High School Graduation Rate, by Race/Ethnicity, Washoe County, Class of 2011-Class of 2016



1.1 SOCIOECONOMIC STATUS

- High school graduation rates from 2011-2012 through 2016-2017 were highest among Asian, white, and students who were multiple races.
- Although still among the lowest, high school graduation rates improved among African American, American Indian/Alaska Native, and Hispanic students from 2011-2012 through 2016-2017.

Fig 19: High School Graduation Rate, by Select Groups, Washoe County, Class of 2011-Class of 2016



- Graduation rates among all select groups in Washoe County increased from 2011-2012 to 2016-2017, however students in these groups still remain at risk for not completing high school education.

Transiency & Remediation

Transiency is defined as a student who moves after starting the school year; those who move due to school rezoning changes do not count as transient. Transient students may face challenges including disrupting social supports and friend groups, curriculum gaps or repetition from one school to the next, and inconsistency in environment and educational expectations. Developing a sense of belonging and self-worth are foundational needs, which must be met prior to engaging in higher-level thinking.¹⁷ Studies have demonstrated a link between higher mobility (transiency) rates and lower test scores.¹⁸

The percentage of freshmen students enrolled in remedial courses in an institution of higher education is an indication of the readiness of those students once they have completed high school. Remedial courses are designed for students who are not ready for college level course work, remedial credits do not count towards graduation and are not covered by all forms of financial aid. The University of Nevada, Reno (UNR) created stretch courses, a remedial course with additional lecture time. These stretch courses are covered by financial

¹⁷ Maslow, A.H. (1970). *Motivation and Personality*. New York City, NY.

¹⁸ Welsh, R.O. (2016). *Student Mobility, Segregation, and Achievement Gaps: Evidence from Clark County, Nevada*. *Urban Education*. <https://doi.org/10.1177/0042085916660349>

1.1 SOCIOECONOMIC STATUS

aid and they do count towards graduation.¹⁹ As of fall 2015, a shift occurred from enrollment in traditional remedial courses to the stretch courses [Table 4].

Table 4: Percent of Students who were Transient & Percent Remediated, Washoe County, 2010-2011 through 2016-2017

% of students	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Transient	30.9%	22.1%	23.7%	22.8%	22.0%	19.1%	18.8%
Remediated	48.0%	44.0%	43.2%	40.9%	41.3%	27.4%	~

Note: Transient defined as a student who does not enroll for an entire school year in the same school starting Count Day

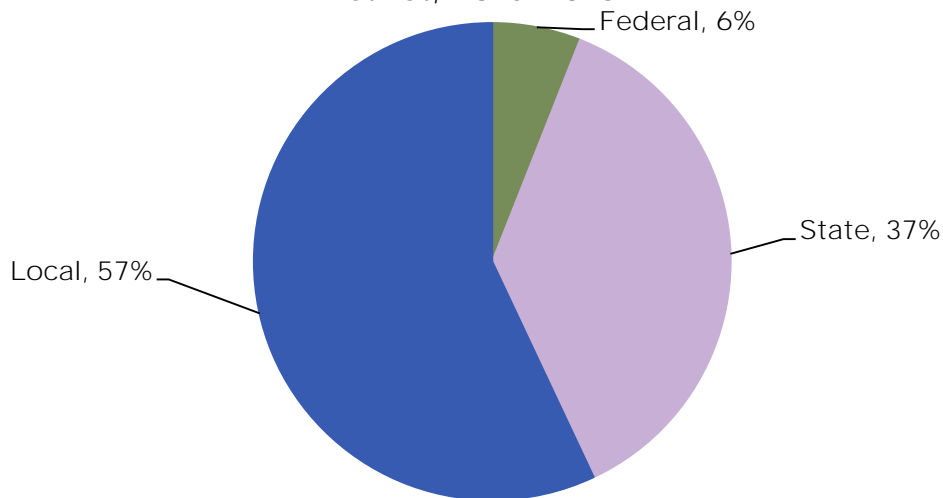
Note: Remedial defined as the percentage of students who graduated in the immediately preceding year and enrolled in remedial courses in reading, writing, or mathematics at a university or community college within the Nevada System of Higher Education (NSHE).

- The percentage of students grades K-12 considered to be transient decreased from 2010-2011 (30.9%) to 2016-2017 (18.8%).
- The percentage of students who graduated and enrolled in remedial courses in a university or community college within the Nevada System of Higher Education declined from 2010-2011 (48.0%) to 2015-2016 (27.4%).

Education Funding Sources

The proportion of Washoe County School District funds provided by local government decreased from 63% (2003-2004) to 57% (2015-2016), while state funding increased from 29% (2003-2004) to 37% (2015-2016). The proportion of federal funds remained relatively stable over the same time period, 8% (2003-2004) to 6% (2015-2016).²⁰

Fig 20: Percent of Funding by Source, Washoe County School District, 2015-2016



¹⁹ Reno Gazette Journal. Fast tracking remediation at UNR. Nov 13, 2016. Accessed <http://www.rgj.com/story/news/education/2016/11/13/fast-tracking-remediation/93619594/>

²⁰ Nevada Department of Education. Nevada Report Card. Fiscal Information (Reported for Prior School Year). Accessed nevadareportcard.com

1.1 SOCIOECONOMIC STATUS

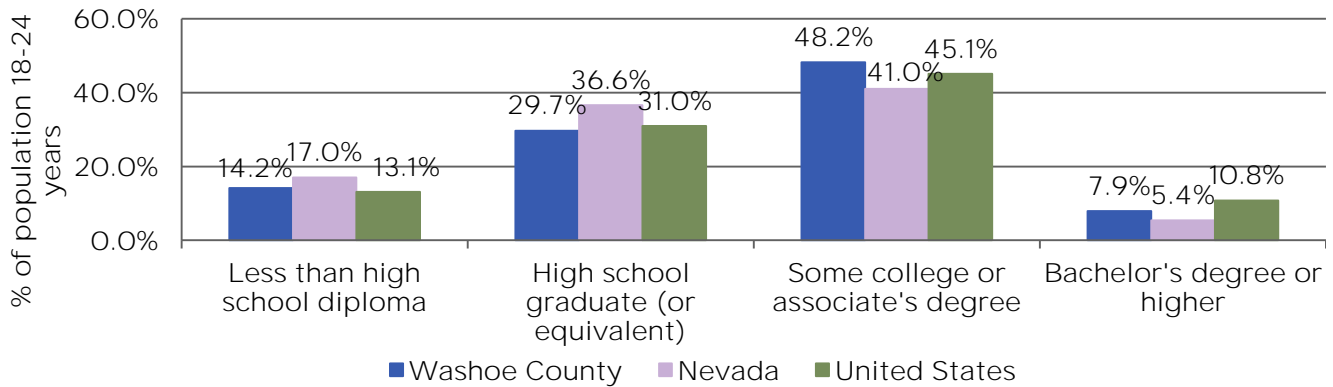
Expenditures per Student

Location	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Washoe County	\$7,992	\$8,635	\$8,506	\$8,638	\$9,029	\$9,308
Nevada	\$7,716	\$8,353	\$8,274	\$8,576	\$8,785	\$9,079

- The expenditures per student by Washoe County School District increased from 2010-2011 (\$7,992) to 2015-2016 (\$9,308).
- In 2015-2016, the expenditures per student in Washoe County School District were higher (\$9,308) than Nevada overall (\$9,079).

Educational Attainment

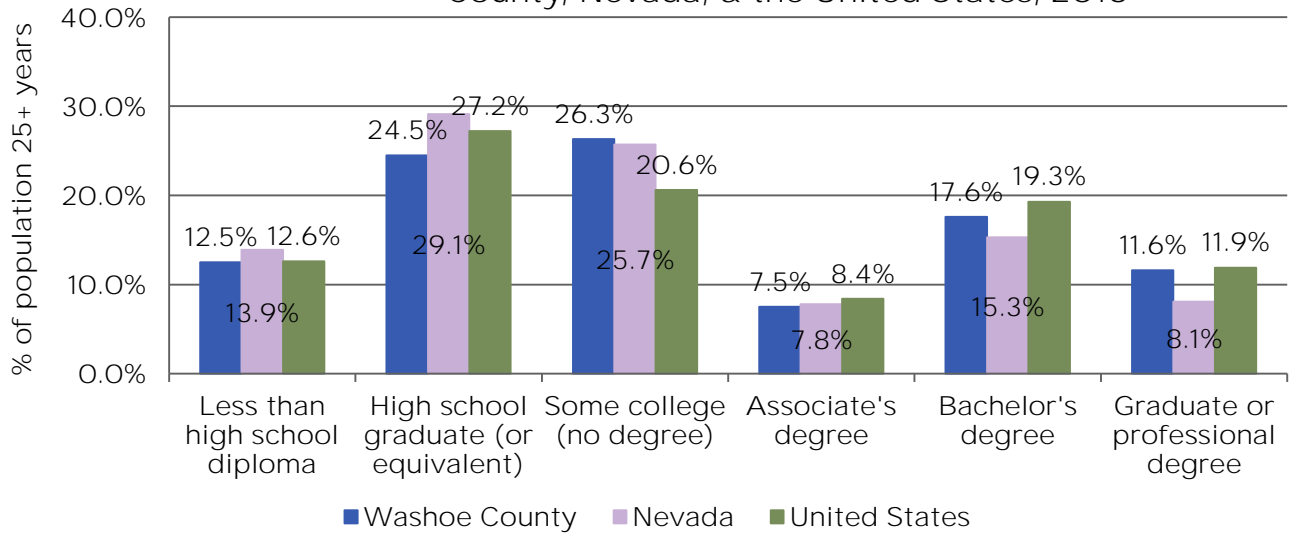
Fig 21: Educational Attainment among those 18-24 years, Washoe County, Nevada, & the United States, 2016



- In 2016, 14.2% of Washoe County residents aged between 18 and 24 years had less than a high school diploma, which was lower than Nevada (17.0%), however slightly higher than the United States (13.1%).
- Approximately 29.7% of Washoe County residents aged between 18 and 24 years had a high school diploma or a GED equivalent, which was lower than Nevada (36.6%), and the United States (31.0%).
- Approximately 48.2% of Washoe County residents aged between 18 and 24 years had some college or an associate’s degree, which was higher than Nevada (41.0%), and the United States (45.1%).
- In 2016, 7.9% of Washoe County residents aged between 18 and 24 years had a bachelor’s degree or higher, which was higher than Nevada (5.4%), however lower than the United States (10.8%).

1.1 SOCIOECONOMIC STATUS

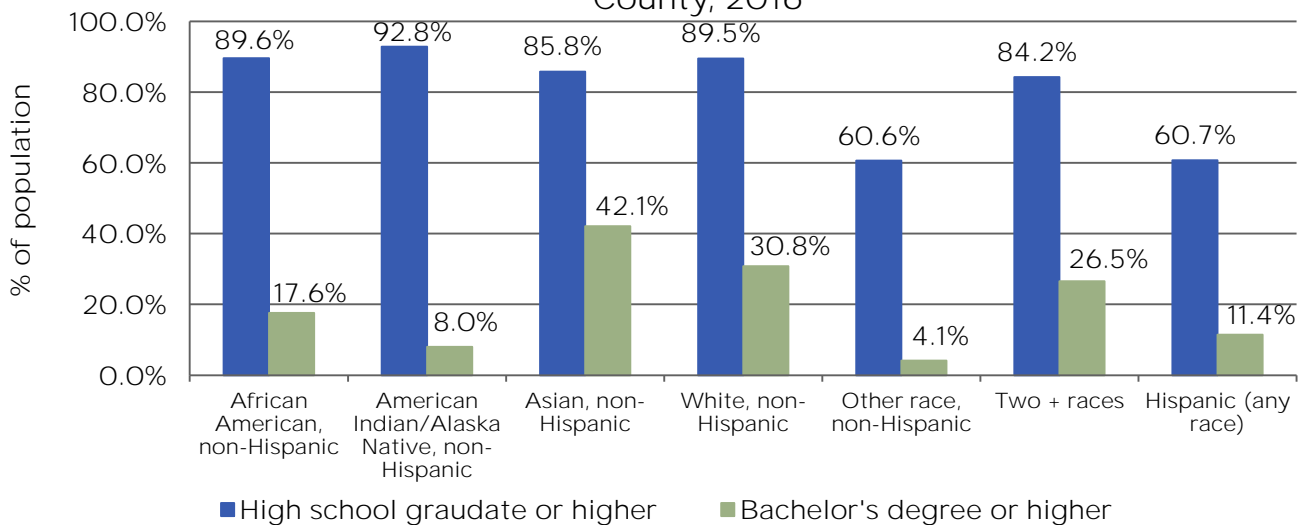
Fig 22: Educational Attainment among those 25+ Years, Washoe County, Nevada, & the United States, 2016



- In 2016, 37% of Washoe County residents 25 years and older had a high school diploma or less (combined), which was lower than Nevada (43.0%), and the United States (39.8%).
- Approximately 87.5% of Washoe County residents 25 years and older had at least a high school diploma more (combined), which was higher than Nevada (86.0%), and relatively similar to the United States (87.4%).
- In 2016, 29.2% of Washoe County residents 25 years and older had a bachelor’s degree or higher (combined), which was higher than Nevada (23.4%), however lower than the United States (31.2%).

Figure 23 shows the percentage of the population that has obtained at least a high school graduation or more as well as the percentage of the population that has at least a bachelor’s degree or more by race/ethnicity.

Fig 23: Educational Attainment by Race/Ethnicity, Washoe County, 2016



Note: All persons identified within each specific race/ethnicity with a bachelor’s degree or higher are also counted in the high school graduate or higher column. Combined, columns do not equate to 100% of the population.

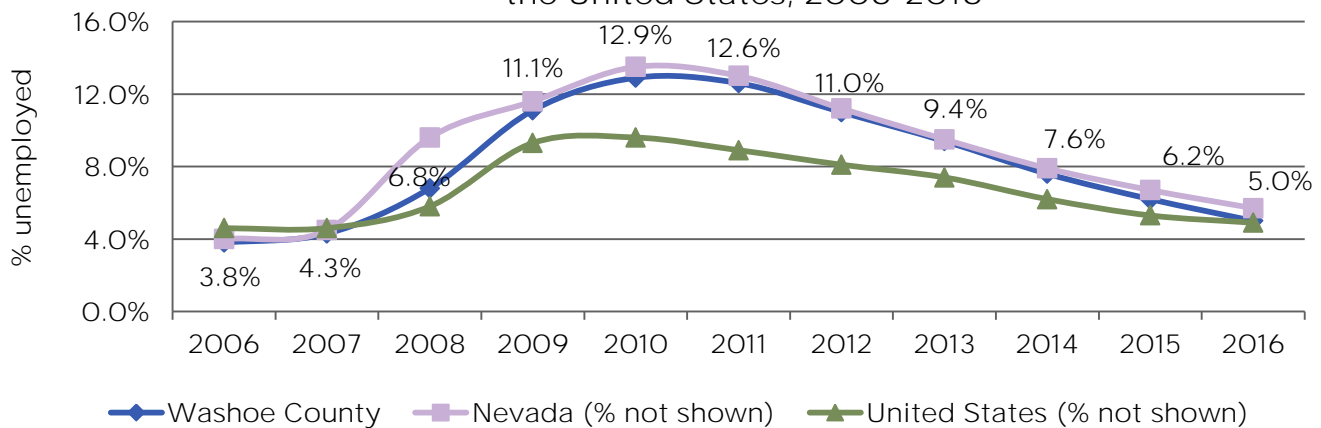
1.1 SOCIOECONOMIC STATUS

- In 2016, educational attainment was lowest among Washoe County residents who identify as an “other race” (60.6% high school graduate or higher) as well as those who identify as Hispanic (60.7% high school graduate or higher).
- Although 92.8% of those who identify as American Indian/Alaska Native had graduated from high school or attained a higher level of education, only 8.0% had a bachelor’s degree or higher.
- Educational attainment was highest among Washoe County residents who identify as Asian, non-Hispanic as 42.1% had a bachelor’s degree or higher, followed by residents who identify as white, non-Hispanic as 30.8% had a bachelor’s degree or higher.

Employment

A steady and reliable source of income is important to be able to afford the basic amenities such as housing, transportation, and food. However, when unemployment remains high for long periods of time, the entire health and wellness of the community can be negatively impacted due to the increased demand on public services and resources. Following the Great Recession of 2007, there were more people unemployed nationwide for longer periods of time and the consequences of long-term unemployment can be even more devastating.²¹ The unemployment rates during the Recession in Washoe County were among the highest in the nation and although have declined to near pre-Recession rates, there has been an ongoing impact to the community.

Fig 24: Annual Unemployment Rate, Washoe County, Nevada, & the United States, 2006-2016



- Prior to the Great Recession, the rate of unemployment in Washoe County during 2006 was (3.8%) lower than Nevada (4.0%) and the United States (4.6%).
- During the Great Recession the unemployment rate in Washoe County more than tripled over a four year period (2006-2010). The Washoe County unemployment rate reached a high of 12.9% in 2010, which was lower than the statewide rate (13.0%) and higher than the United States (9.6%).
- In 2016, the unemployment rate in Washoe County fell to 5.0%, which was lower than Nevada (5.7%) and slightly higher than the United States rate (4.9%).

²¹ Nichols, A., Michell, J., & Linder, S. (2013). Consequences of Long-Term Unemployment. Urban Institute, Washington, D.C.

Occupation & Industry

Reno-Sparks is widely recognized as an events town, hosting multiple large annual gatherings including the Reno Rodeo, Artown, Hot August Nights, Street Vibrations, Barracuda Championship PGA Tour Golf Tournament, Great Reno Balloon Races, the International Air Races and serves as a hub for visitors attending Burning Man. These events in combination with the gaming sector, have created a larger than average market for jobs in the service industries, specifically food and beverage services. In 2016, food preparation and serving-related jobs were the third largest occupational group in Washoe County, defined by the number of persons employed in that profession; however, they represented the lowest average wage (\$10.99) among all major occupational groups.²² Employees in the service industry typically earn a lower base wage, relying largely on tips for income.

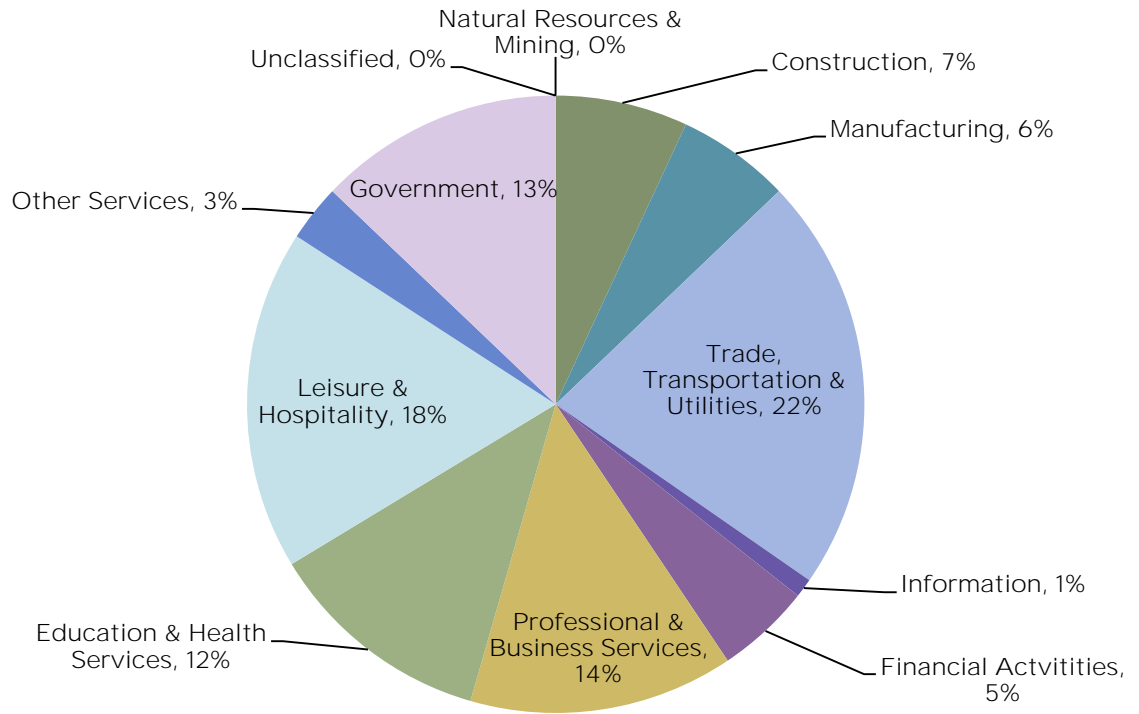
Washoe County is also home to one of the largest Federal Trade Zones (FTZ) in the United States. Companies that operate in a FTZ can defer, reduce or eliminate customs duties, entry procedures, and federal excise taxes on foreign products admitted into area for storage, exhibition, assembly, manufacturing and processing.²³ Several national and international corporations have massive warehouses for storage and shipping in the Reno-Sparks area, largely due to the pro-business tax structure in Nevada and the geographic location of Reno-Sparks. Many freight, stock, storage, and warehouse-affiliated jobs (materials movers) pay among the lowest wages, involve semi-automated and repetitive tasks, and require little to no higher education.²⁴ Being employed is important; however having a decent paying job may be more difficult to come by.

²² Nevada Department of Employment, Training and Rehabilitation. Occupational Employment Statistics. Accessed <http://nevadaworkforce.com/OES>

²³ Nevada Governor's Office of Economic Development, Diversify Nevada. The ABC's of Foreign Trade Zones in Nevada. Accessed http://www.diversifynevada.com/documents/division_documents/THE_ABCs_of_FTZs-Nevada.pdf

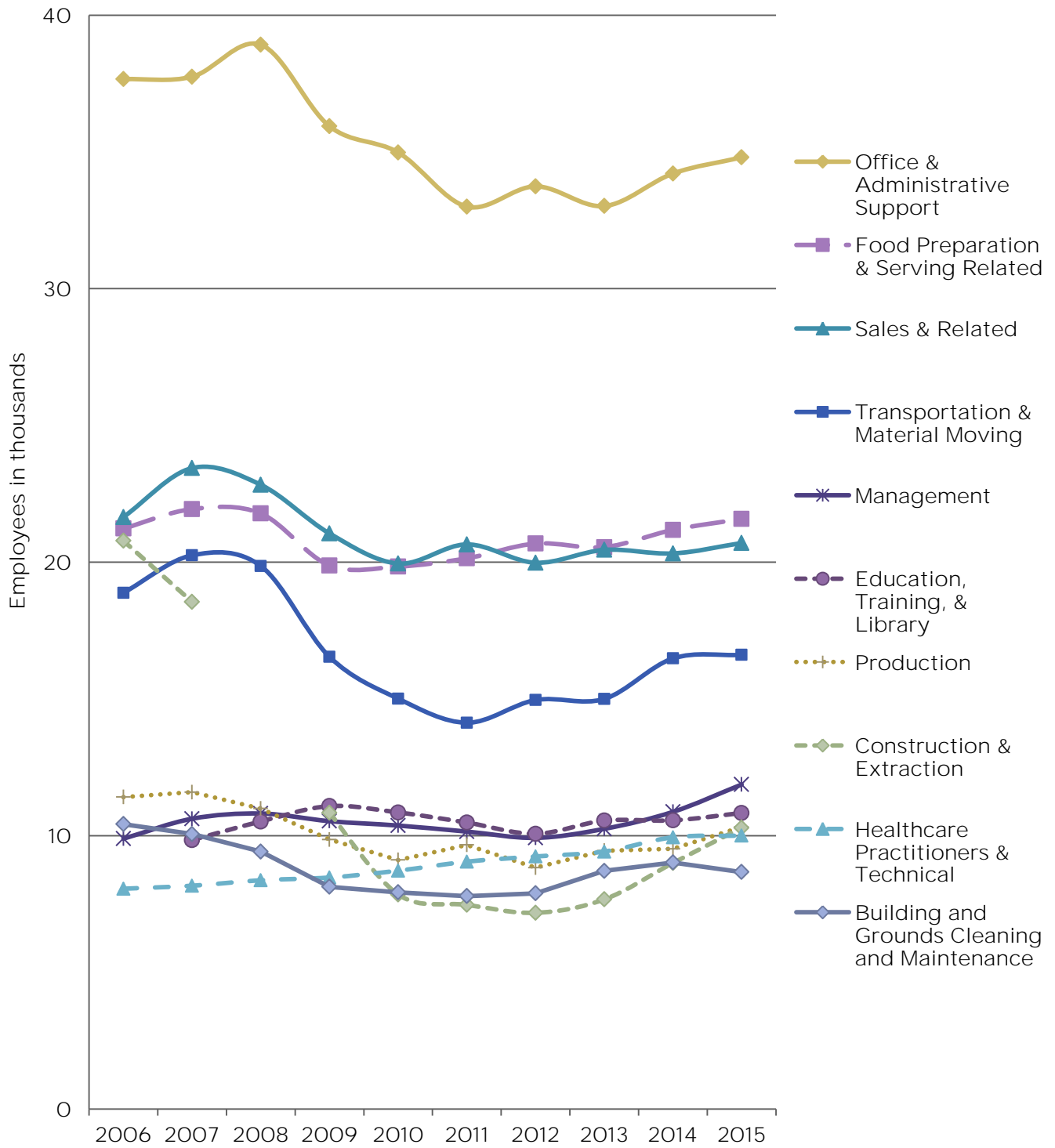
²⁴ Nevada Department of Employment, Training and Rehabilitation. (2016). Occupational Employment Statistics (OES) Wages Data. Reno MSA. Accessed <http://nevadaworkforce.com/OES>

Fig 25: Percent of Total Employment by Industry, Washoe County, 2016



1.1 SOCIOECONOMIC STATUS

Fig 26: Employees in Thousands, Top 10 Major Occupational Groups, Reno-Sparks, 2006-2015



Note: Excludes self-employed

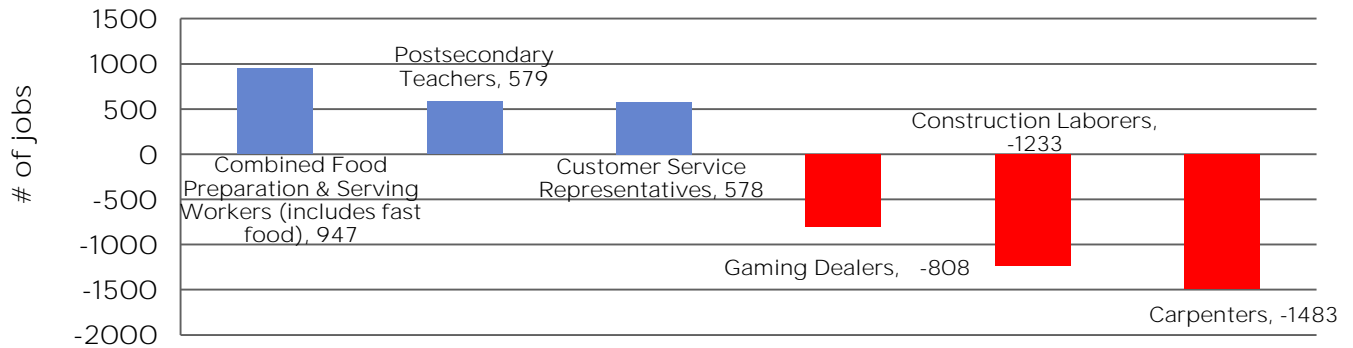
Note: Education, Training and Library not classified as a Major Occupational Group in 2006

1.1 SOCIOECONOMIC STATUS

Occupational Trends

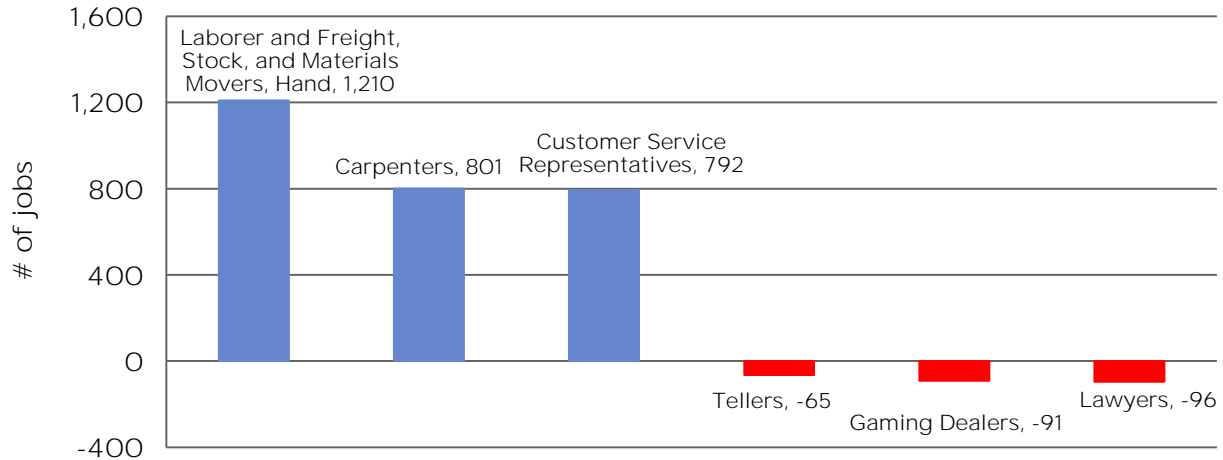
The following graphs illustrate differences in occupational employment over a 10-year period, 2006-2016 [Figure 27] and post-Recession, 2010-2016 [Figure 28].

Fig 27: Change in Jobs, by Occupation, Washoe County, 2006 to 2016



- Over the past 10 years (2006-2016), the number of jobs by occupation increased for Food Preparation and Service Industry, Postsecondary Teachers, and Customer Service Representatives.
- Over the past 10 years (2006-2016), the number of jobs by occupation decreased for Gaming Dealers, Construction Laborers, and Carpenters.

Fig 28: Change in Jobs, by Occupation, Washoe County, 2010 to 2016



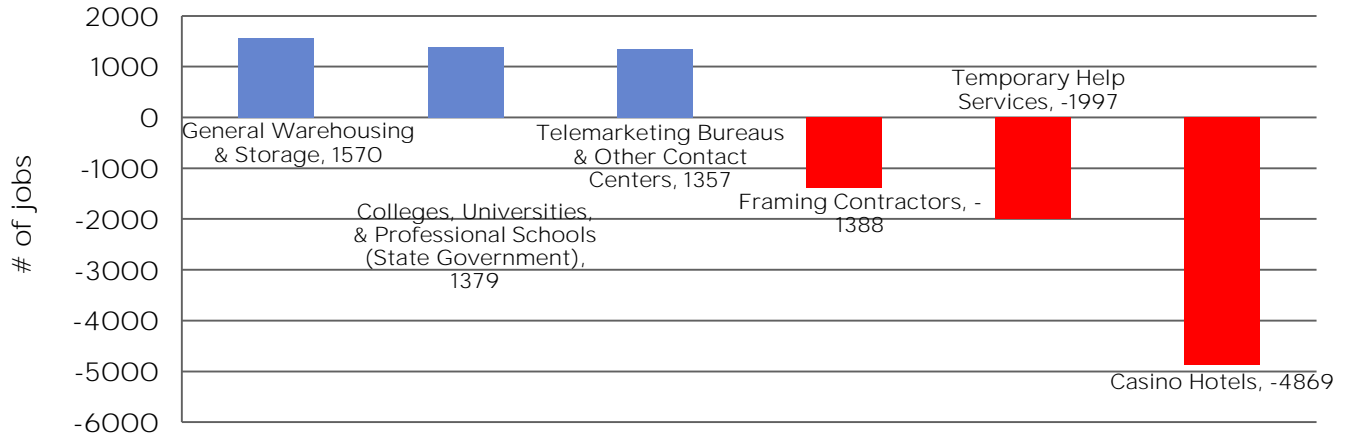
- Measured from 2010 to 2016, jobs in the laborers and freight, stock, and materials movers, carpenter, and customer service representative occupations have increased, while tellers, gaming dealers and lawyers have decreased.

1.1 SOCIOECONOMIC STATUS

Industrial Trends

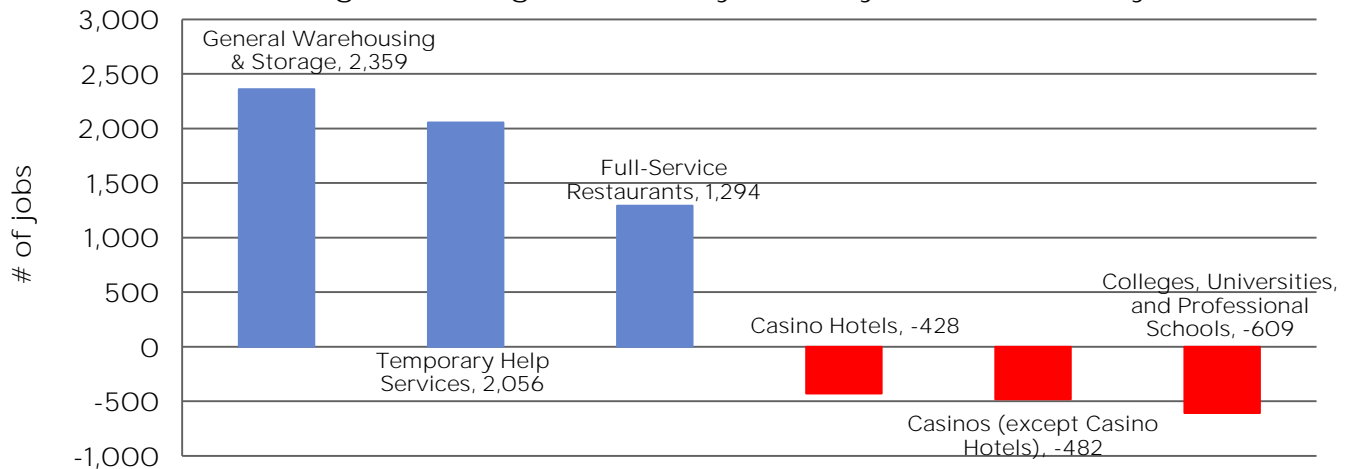
The following graphs illustrate differences in industrial job growth over a 10-year period, 2006-2016 [Figure 29] and post-Recession, 2010-2016 [Figure 30].

Fig 29: Change in Jobs, by Industry, Washoe County, 2006-2016



- Over the past 10 years (2006-2016), the number of jobs by industry increased for General Warehousing and Storage, Colleges, Universities, and Professional Schools, and Telemarketing Bureaus and Other Contact Centers.
- Over the past 10 years (2006-2016), the number of jobs by industry decreased for Framing Contractors, Temporary Help Services, and Casino Hotels.

Fig 30: Change in Jobs, by Industry, Washoe County, 2010-2016

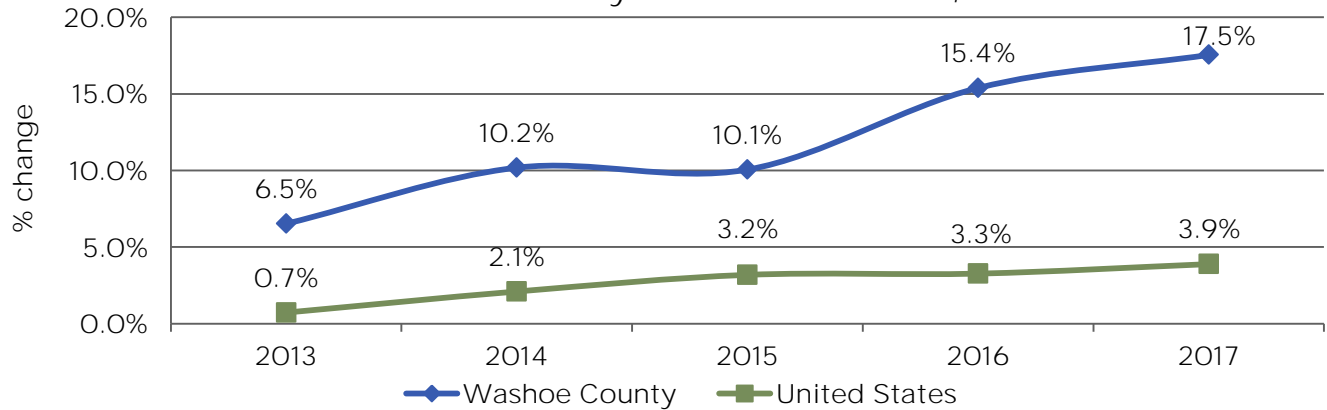


- Measured from 2010 to 2016, jobs in the general warehousing and storage, temporary help, and full-service restaurants industries have increased, while casino hotels, casinos (except casino hotels), and colleges, universities, and professional schools decreased.

1.1 SOCIOECONOMIC STATUS

There has been a regional focus on bringing in manufacturing industries to the area. As a result, manufacturing as an industry has experienced an increase in more recent years relative to the United States overall, as demonstrated by Figure 31.

Fig 31: Percent Change in Payroll Employment for Manufacturing, Washoe County & the United States, 2012-2017



Top Employers

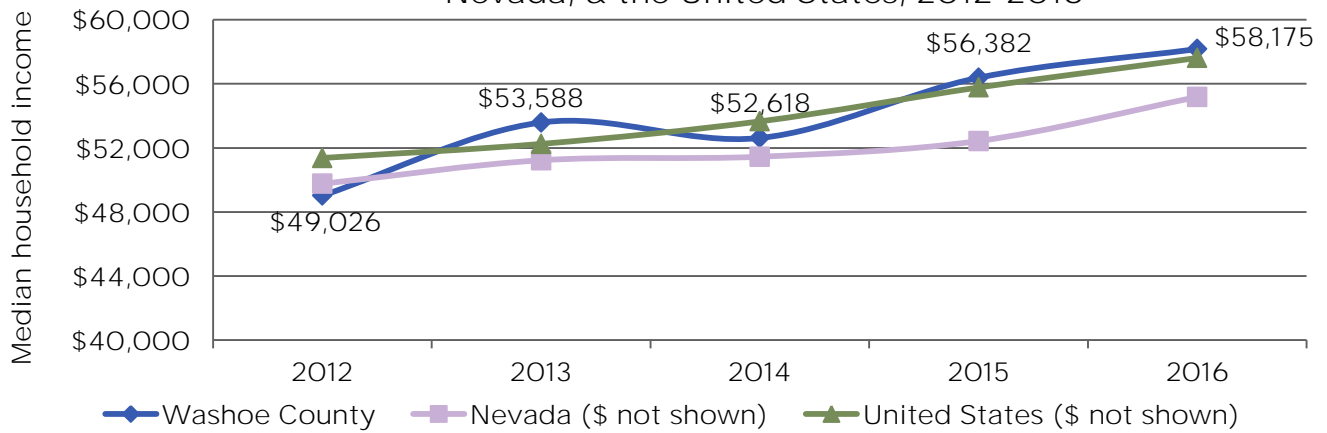
Table 6: Top 10 Employers, Washoe County, 3rd quarter-2016

Rank	Trade Name	Sizeclass
1	Washoe County School District	7000 to 7499 employees
2	University of Nevada, Reno	4500 to 4999 employees
3	Renown Regional Medical Center	3000 to 3499 employees
4	Washoe County Comptroller	2500 to 2999 employees
5	Peppermill Hotel Casino (Reno)	2000 to 2499 employees
6	Grand Sierra Resort and Casino	2000 to 2499 employees
7	IGT	1500 to 1999 employees
8	Atlantis Casino Resort	1500 to 1999 employees
9	Silver Legacy Resort Casino	1500 to 1999 employees
10	Saint Mary's	1500 to 1999 employees

- During the 3rd quarter of 2016, the top employer in Washoe County was the Washoe County School District, followed by the University of Nevada, Reno, and Renown Regional Medical Center.

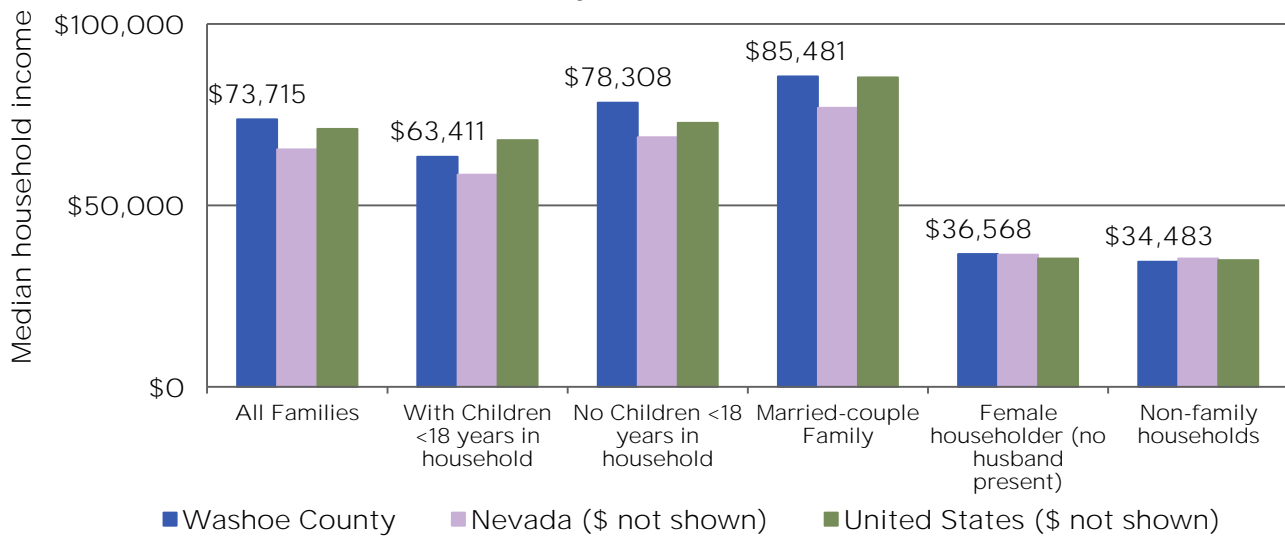
Income & Wages

Fig 32: Median Annual Household Income, Washoe County, Nevada, & the United States, 2012-2016



- The median household income in Washoe County increased from 2012 (\$49,026) 2016 (\$58,175).
- In 2016, the median household income in Washoe County (\$58,175) was higher than Nevada (\$55,180) and the United States (\$57,617).

Fig 33: Median Annual Household Income by Family Type, Washoe County, Nevada, & the United States, 2016



- In 2016, with the exception of non-family households, all types of households in Washoe County reported a higher median household income than Nevada and the United States.
- Families with a female head of household (no husband present) and non-family households reported the lowest median household income.
- Married-couple families reported the highest median incomes compared to other types of family and non-family households.

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Table 7: Select Hourly Wages by Family Type, Washoe County, 2016

Family Type	Living Wage	Poverty Wage
1 Adult, 1 Child	\$22.76	\$7.00
1 Adult, 2 Children	\$29.01	\$10.00
2 Adults (both working), 1 Child	\$12.62	\$5.00
2 Adults (both working), 2 Children	\$15.80	\$5.00

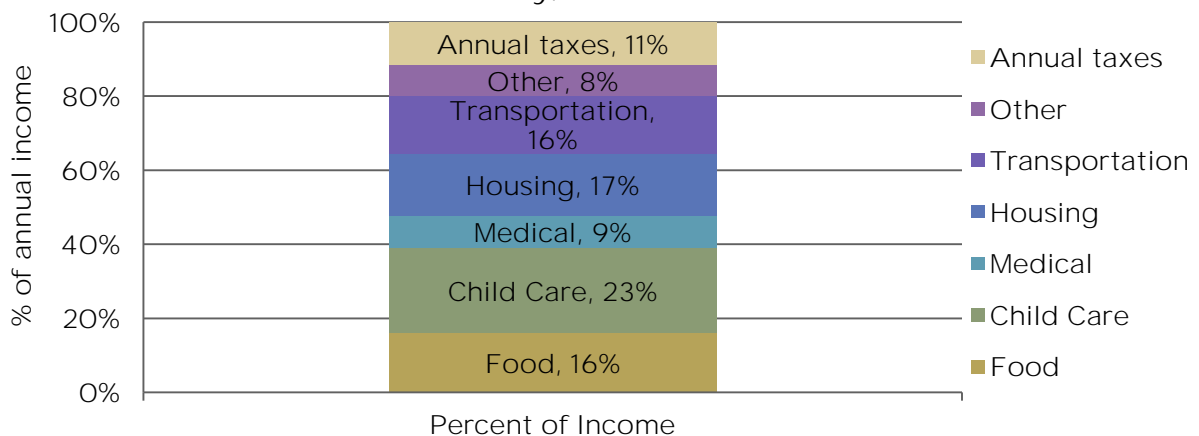
- The estimated living wage for one working adult with one child was \$22.76 in 2016, while the living wage for one adult (single earner) with two children increased to \$29.01/hour.
- In Washoe County, one working adult supporting two children and making \$10/hour or less was estimated to be living in poverty.

Table 8: Select Wages for Single Adult with no Children, Washoe County & Nevada, 2016

Location	Living Wage	Poverty Wage	Current Minimum Wage
Washoe County	\$10.02	\$5.00	\$8.25
Nevada	\$10.44	\$5.00	\$8.25

- The estimated living wage for a single adult with no children in 2016 for Washoe County was \$10.02/hour, which was 42 cents lower than the estimated living wage for Nevada overall at \$10.44/hour.

Fig 34: Estimated Percent of Annual Income per Expense Type, for Two Adults Working Full Time with Two Children, Washoe County, 2016



- According to the 2016 MIT Living Wage Estimates for Washoe County, the proportion of income earned by two adults working full time with two children (dependents) primarily goes towards child care (23%), housing (17%), transportation (16%), and food (16%).

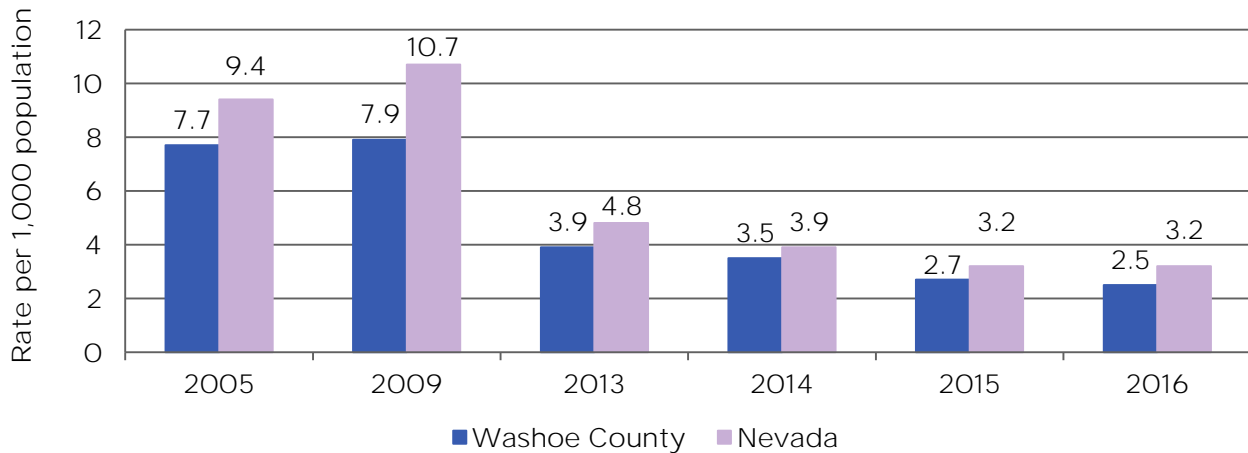
Bankruptcy & Financial Assets

According to 2013 CFED estimates approximately 18.1% of the population in Washoe County was underbanked, while 7.4% was unbanked, meaning they do not have a checking or savings account. Underbanked is defined as a household with either a checking or savings account that has used an alternative financial service from non-bank providers in the past year, money order, check cashing, remittances, payday loans, refund anticipation loans, rent to own services, pawn shop loans, or auto title loans. Additionally, nearly one in four

1.1 SOCIOECONOMIC STATUS

people (24.8%) were estimated to be living in a household without sufficient new worth to live at the FPL for three months in the absence of income.²⁵

Fig 35: Personal Bankruptcy Filing Rate, Washoe County & Nevada, 2005, 2009, & 2013-2016



- The personal bankruptcy rate in Washoe County has decreased from a high of 7.9 per 100,000 population in 2009 to 2.5 per 100,000 population in 2016.
- The personal bankruptcy rate in Washoe County was lower than Nevada for all years depicted in Figure 35.

Poverty

Poverty is one of the strongest predictors of negative health outcomes, which include high infant and maternal mortality rate and a higher prevalence of risk factors for disease such as obesity, depression, high blood pressure, and substance use. Higher rates of poverty are associated with higher prevalence of poor health behaviors and poor health outcomes, thus resulting in premature death.^{26,27}

Table 9: Percent of Population at or Below Poverty Level, 2012-2016					
Location	2012	2013	2014	2015	2016
Washoe County	18.3%	15.1%	15.6%	13.7%	12.2%
Nevada	16.4%	15.8%	15.2%	14.7%	13.8%
United States	15.9%	15.8%	15.5%	14.7%	14.0%

- The rate of poverty in Washoe County decreased from 2012 (18.3%) to 2016 (12.2%).
- In 2016, the poverty rates in Washoe County (12.2%) were lower than Nevada (13.8%) and the United States (14.0%).

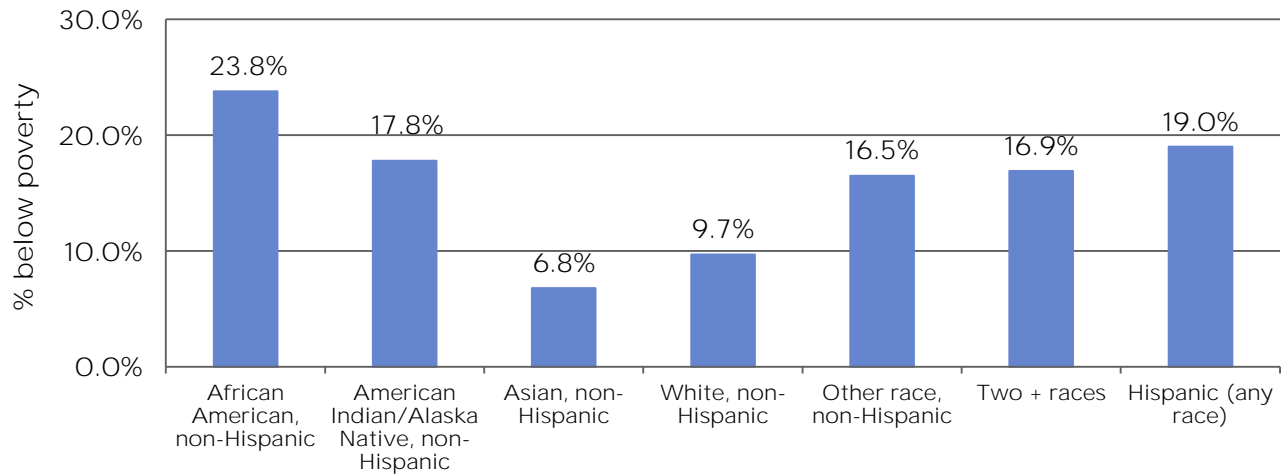
²⁵ CEFD, CITI Community Development. Assets & Opportunity Local Data Center. Washoe County. Accessed <http://localdata.assetsandopportunity.org/reports>

²⁶ UC Davis Center for Poverty Research. (2014). Focus on Poverty and Health. Spring Issue. Davis, CA

²⁷ World Health Organization, Organisation for Economic Co-operation and Development. (2003). DAC Guidelines and Reference Series Poverty and Health. OECD Publications Service, Paris France.

1.1 SOCIOECONOMIC STATUS

Fig 36: Percent of Population Living Below Poverty by Race/Ethnicity, Washoe County, 2016



- In 2016, the proportion of people living below poverty was highest among non-Hispanic African Americans (23.8%), followed by those of Hispanic ethnicity (19.0%), and non-Hispanic American Indian/Alaska Natives (17.8%).
- In 2016, the proportion of people living below poverty was lowest among non-Hispanic Asian (6.8%) residents and whites (9.7%).

Table 10: Percent of Children Under 18 years at or Below Poverty Level, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	27.2%	19.2%	18.8%	17.7%	16.0%
Nevada	24.0%	22.7%	22.0%	20.9%	19.1%
United States	22.6%	22.2%	21.7%	20.7%	19.5%

- The rate of poverty among children under 18 years in Washoe County decreased from 2012 (27.2%) to 2016 (16.0%).
- In 2016, the poverty rate among children in Washoe County (16.0%) was lower than Nevada (19.1%) and the United States (19.5%).

Table 11: Percent of Seniors 65+ years at or Below Poverty Level, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	7.3%	7.3%	7.6%	6.4%	8.0%
Nevada	8.1%	8.7%	8.3%	8.4%	8.7%
United States	9.5%	9.6%	9.5%	9.0%	9.2%

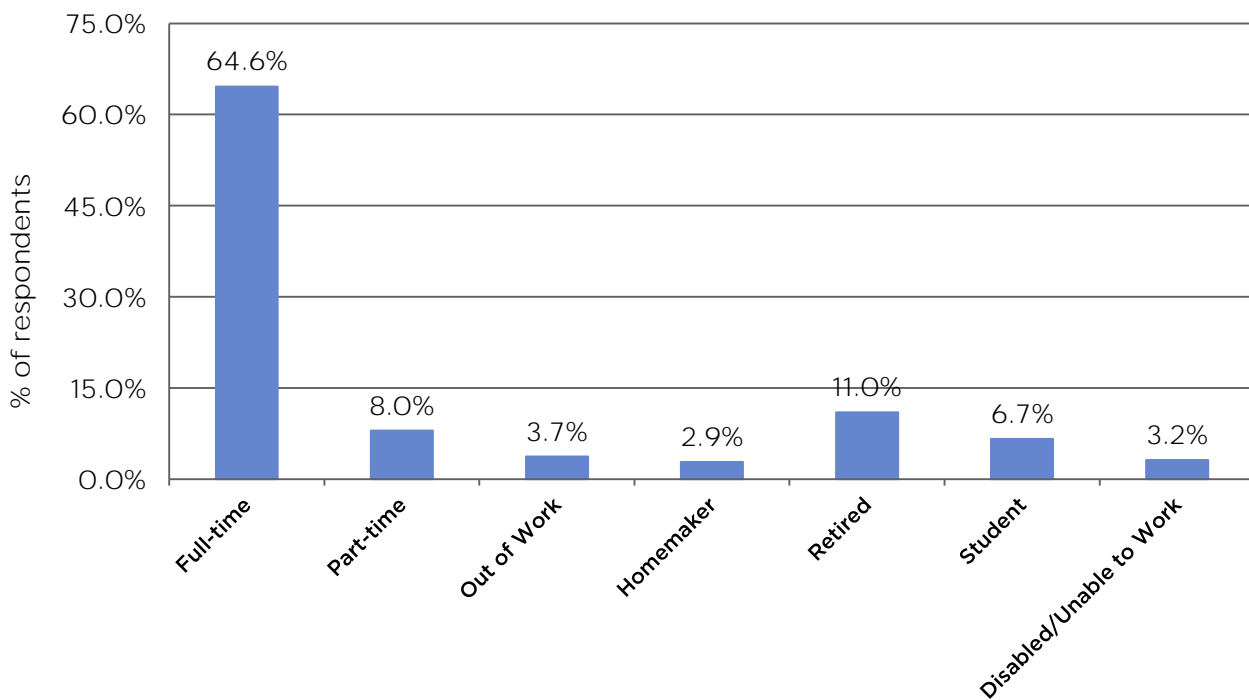
- The rate of poverty among seniors 65 years and older in Washoe County increased from 2012 (7.3%) to 2016 (8.0%).
- From 2012 through 2016 the poverty rate among seniors 65 years and older in Washoe County was lower than Nevada and the United States.
- In 2016 the poverty rate among seniors 65 years and older in Washoe County (8.0%) was lower than Nevada (8.7%) and the United States (9.2%).

Primary Data Related to Socioeconomic Status

Primary data were collected via an online community survey from over 1,400 survey participants. The survey included 44 questions and analysis for questions related to socioeconomics are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community Survey Demographics section.

Question: “What is your current employment status? Select all that apply.”

Fig 37: Employment Status among Survey Respondents (n=1,263)



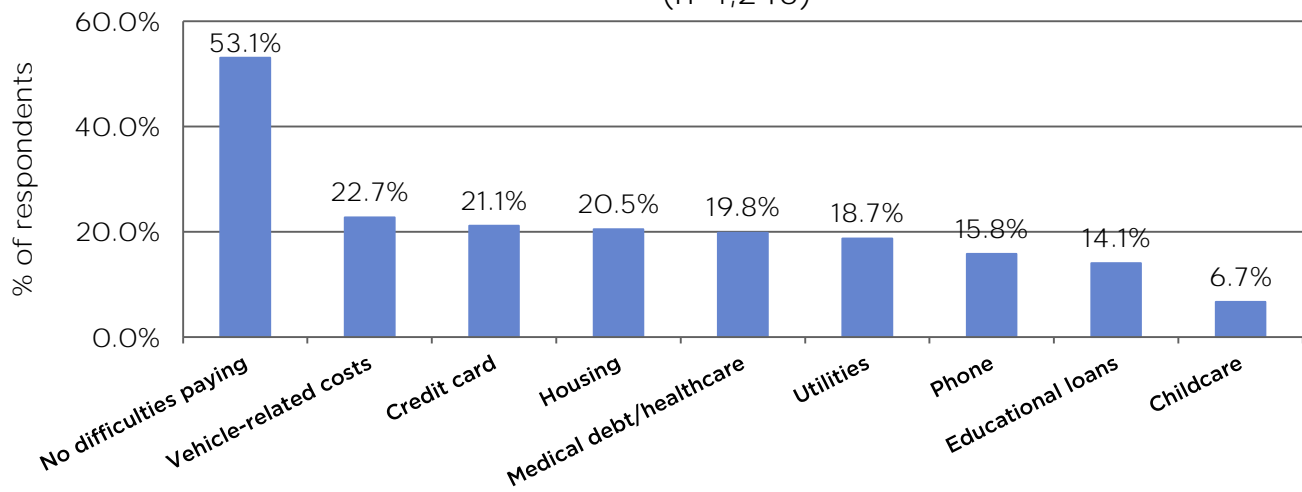
- The majority of respondents were employed full-time (64.6%), while 11.0% were retired, 8.0% were employed part-time, 6.7% were students, 3.7% were out of work and another 3.2% were disabled or unable to work.

1.1 SOCIOECONOMIC STATUS

Question: “Indicate if your household has had a hard time paying for any of the following within the past 12 months.”

Among the 1,245 respondents to the above question, 53.1% indicated they did not have difficulties paying for necessities or other amenities; however, 46.9% of respondents indicated they had difficulties paying for at least one of these services.

Fig 38: Household had Difficulties Paying in the Past 12 Months (n=1,245)

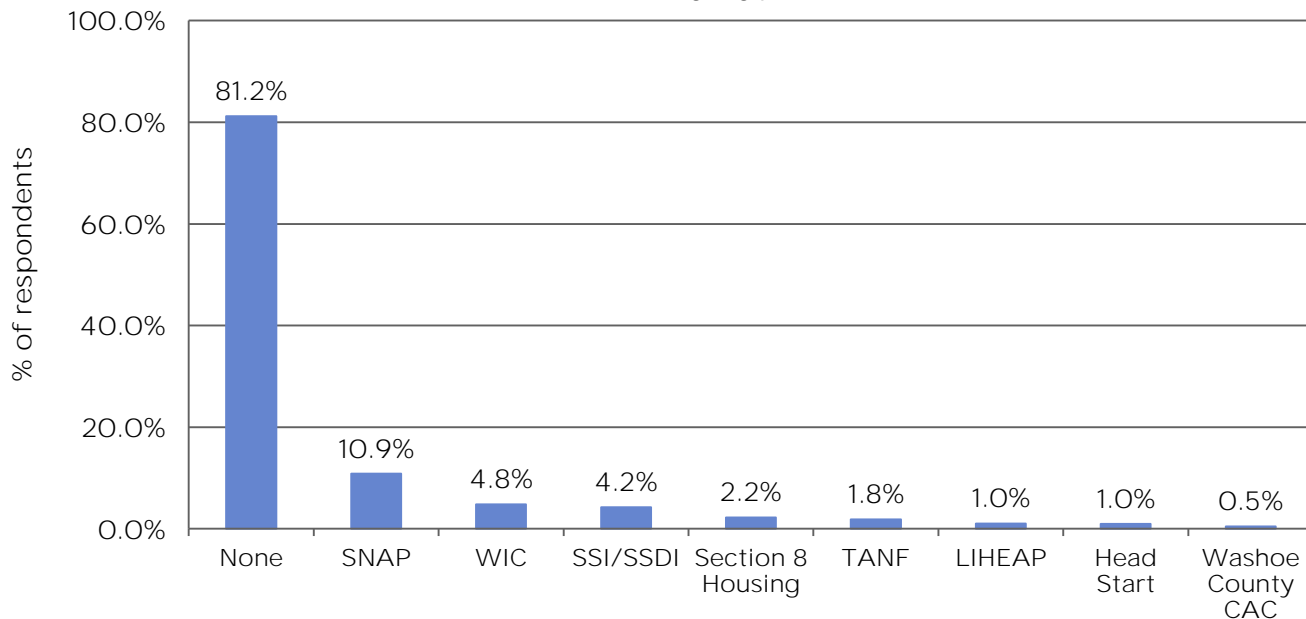


- Over one in five (22.7%) respondents indicated they had difficulties paying for vehicle-related costs, including car payments, vehicle maintenance, or transportation.
- Credit card payments were the second most commonly indicated financial challenge with 21.1% indicating their household had difficulties paying within the past 12 months.
- Housing (20.5%) and medical care/healthcare (19.8%) were the third and fourth most commonly identified financial strain on households, followed by utilities (18.7%).
- Phone bills (15.8%) and educational loans (14.1%) were among the least frequently identified financial strain, as over one in 10 respondents indicating they had difficulties paying for those over the past 12 months.
- Childcare costs were the least frequently identified financial challenge with 6.7% of respondents indicating their household had difficulties paying those in the past 12 months.

1.1 SOCIOECONOMIC STATUS

Question: “Which of the following services have you or someone in your household received benefits from or been enrolled in within the past 12 months?”

Fig 39: Percent of Respondents Enrolled in Services in Past 12 Months, by Type (n=1,253)



Note: SNAP= Supplemental Nutrition Assistance Program; WIC= Women Infants Children, nutritional assistance; SSI/SSDI = Supplemental Security Income/Social Security Disability Income; TANF = Temporary Assistance for Needy Families; LIHEAP= Low-income Home Energy Assistance Program; Washoe County CAC= Community Assistance Center

- The majority of respondents (81.2%) indicated no one in their household were enrolled or received benefits from the above programs within the past 12 months.
- The food assistance programs, SNAP (10.9%) and WIC (4.8%), were among the top services respondents received benefits from/were enrolled in within the past 12 months.

Summary of Socioeconomic Status

Education has been a longstanding focal point in Washoe County, with an emphasis in improving test scores across all subjects and increasing graduation rates. While proficiency scores for science, mathematics, and writing have increased, reading proficiency has declined. Additionally, approximately 20% of 11th grade students were not proficient in each of the major subjects during the 2015-2016 school year. County-wide high school graduation rates have improved; however, there are populations of students that have historically continued to see a low rate of graduation. Although trend data for educational attainment were not presented within the document, the proportion of the population without a high school diploma has declined over recent years, a positive trend for Washoe County. When split by race and ethnicity there are staggering discrepancies in educational attainment, with nearly 42.1% of Asians having received a Bachelor’s degree or higher, compared to only 8.0% of American Indian/Alaskan Natives, or 11.4% of Hispanics.

1.1 SOCIOECONOMIC STATUS

The Washoe County region appears to be recovering from the Great Recession of 2007, as measured by the usual economic indicators, a decline in unemployment rates, an increase in median household incomes, and a reduction of the population living in poverty. Despite broad economic recovery, some of the occupations that employ a larger proportion of workers are the lowest paying wages. Simply having a low unemployment rate does not equate to a healthy community; according to MIT analysts, the living wage in Washoe County for a single adult with no children is \$10.02/hour, while minimum wage is \$8.25/hour and the living wage for one working adult supporting one child is \$22.76/hour.²⁸ Additional challenges remains as there are large disparities in income, earnings, and poverty among various racial and ethnic groups in Washoe County, these disparities mirror the trends in educational attainment.

According to the Community Health Needs Assessment survey respondents, one in five people reported difficulties paying for vehicle related costs, credit card payments, housing, and medical debt or healthcare within the past 12 months. Simply because a person has a job, does not equate to quality of life, the ability to support basic needs such as housing, food, transportation, financial stability, or ensure equal access to amenities. Unfortunately, many indicate that they no longer qualify for governmental or supplemental assistance because they earn an income just above the cut-off point. This often leaves them and their families in a weaker financial situation although they have employment.

Continued improvement in educational outcomes will help to ensure youth in Washoe County will have the option to enroll in higher education or skilled training programs. This can improve chances for success in obtaining an adequate paying job or the opportunity to be employed in an occupation of interest. Additionally, supporting economic growth and diversity in the types of high skilled jobs and industries of the future, that encourage employees to engage in continued learning and opportunities to better their career, will help foster economic stability and improve overall health outcomes.

For detailed documents related to socioeconomics in Washoe County refer to:

- Education Alliance’s Washoe County School District data profiles <https://ed-alliance.org/resources/data-profile-information/>
- EDAWN EPIC Reports: <http://edawn.org/epic-report/>
- Nevada Office of Economic Development <http://nevadadashboard.com/statewide>
- Nevada Department of Employment, Training and Rehabilitation employment and wages reports <http://nevadaworkforce.com/QCEW>

²⁸ Glasmeier, A.K. Massachusetts Institute of Technology. Living Wage Calculation for Washoe County, Nevada. Accessed <http://livingwage.mit.edu/counties/32031>

Socioeconomic Sources

Image 3: How SES & Health Affect Each Other Over Time

Robert, Stephanie. (2012). Social Policy Is Health Policy: The Importance of Non-Medical Determinants of Health. [Slide presentation.] Institute for Research on Poverty Lecture to Morgridge Badger Volunteers. University of Wisconsin–Madison.

Fig 9-Fig 16; Table 4-Table 5; Same Source

Fig 9: Percent of 3rd Grade Students Proficient in Mathematics & Reading, Washoe County & Nevada, 2015-2016 & 2016-2017

Fig 10: Percent of 3rd Grade Students Proficient at Mathematics by Race/Ethnicity, Washoe County, 2015-2016 & 2016-2017

Fig 11: Percent of 3rd Grade Students Proficient at Reading by Race/Ethnicity, Washoe County, 2015-2016 & 2016-2017

Fig 12: Percent of 3rd Grade Students Proficient at Mathematics by Select Groups, Washoe County, 2015-2016 & 2016-2017

Fig 13: Percent of 3rd Grade Students Proficient at Reading by Select Groups, Washoe County, 2015-2016 & 2016-2017

Fig 14: High School Proficiency Exam, Percent of 11th Graders Proficient by Subject, Washoe County, 2010-2011 through 2014-2015

Fig 15: Percent of 11th Grade Students Proficient by Subject & by Race/Ethnicity, Washoe County, 2014-2015

Fig 16: Percent of 11th Grade Students Proficient by Subject & by Select Groups, Washoe County, 2014-2015

Fig 18: High School Graduation Rate, by Race/Ethnicity, Washoe County, Class of 2011-Class of 2016

Fig 19: High School Graduation Rate, by Select Groups, Washoe County, Class of 2011-Class of 2016

Table 4: Percent of Students who were Transient & Percent Remediated, Washoe County, 2010-2011 through 2016-2017

Fig 20: Percent of Funding by Source, Washoe County School District, 2015-2016

Table 5: Per Student Expenditures, Washoe County, 2010-2011 through 2015-2016

Nevada and Washoe County: Nevada Department of Education. Nevada Report Card. Accessed <http://nevadareportcard.com/di/>

Fig 17: High School Cohort Graduation Rates, Washoe County, Nevada, & the United States, Class of 2011 - Class of 2016

Nevada and Washoe County: Nevada Department of Education. Nevada Report Card. Accessed

<http://nevadareportcard.com/di/>

United States: U.S. Department of Education, national center for Education Statistics; EDfacts, Four-year adjusted cohort graduation rate data. Accessed

<https://www.whitehouse.gov/sites/whitehouse.gov/files/images/State%20by%20State%20Graduation%20Rates.pdf>

Fig 18-Fig 20 Same Source

Fig 18: High School Graduation Rate, by Race/Ethnicity, Washoe County, Class of 2011-Class of 2016

Fig 19: High School Graduation Rate, by Select Groups, Washoe County, Class of 2011-Class of 2016

Table 4: Percent of Students who were Transient & Percent Remediated, Washoe County, 2010-2011 through 2016-2017

Fig 20: Percent of Funding by Source, Washoe County School District, 2015-2016

Table 5: Per Student Expenditures, Washoe County, 2010-2011 through 2015-2016

Nevada and Washoe County: Nevada Department of Education. Nevada Report Card. Accessed

<http://nevadareportcard.com/di/>

Fig 21-Fig 23 Same Source

Fig 21: Educational Attainment among those 18-24 years, Washoe County, Nevada, & the United States, 2016

Fig 22: Educational Attainment among those 25+ Years, Washoe County, Nevada, & the United States, 2016

Fig 23: Educational Attainment by Race/Ethnicity, Washoe County, 2016

U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S1501- Educational Attainment

Fig 24: Annual Unemployment Rate, Washoe County, Nevada, & the United States, 2006-2016

Nevada Department of Employment, Training and Rehabilitation, Nevada Labor Market Information, Local Area Unemployment Statistics (LAUS). Accessed <http://nevadaworkforce.com/LAUS>

Fig 25: Percent of Total Employment by Industry, Washoe County, 2016

Nevada Department of Employment, Training and Rehabilitation Research and Analysis Bureau. (2016). Nevada Employment and Payrolls, 2016. Accessed

<http://nevadaworkforce.com/Portals/139/Other%20Publications/Employment%20and%20Payrolls/2016%20E%20and%20P%20Final.pdf>

Fig 26: Employees in Thousands, Top 10 Major Occupational Groups, Reno-Sparks, 2006-2015

U.S. Department of Labor, Bureau of Labor Statistics, Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates. Accessed <https://www.bls.gov/oes>

1.1 SOCIOECONOMIC STATUS

Fig 27: Change in Jobs, by Occupation, Washoe County, 2006 to 2016

Nevada Governor's Office of Economic Development. (2016). Washoe County Economic Overview. Accessed <http://www.diversifynevada.com/images/uploads/Washoe.pdf>

Fig 28: Change in Jobs, by Occupation, Washoe County, 2010 to 2016

Nevada Governor's Office of Economic Development. (2017). Washoe County Economic Overview. Accessed <http://nevadadashboard.com/pdf/Washoe.pdf>

Fig 29: Change in Jobs, by Industry, Washoe County, 2006-2016

Nevada Governor's Office of Economic Development. (2016). Washoe County Economic Overview. Accessed <http://www.diversifynevada.com/images/uploads/Washoe.pdf>

Fig 30: Change in Jobs, by Industry, Washoe County, 2010-2016

Nevada Governor's Office of Economic Development. (2017). Washoe County Economic Overview. Accessed <http://nevadadashboard.com/pdf/Washoe.pdf>

Fig 31: Percent Change in Payroll Employment for Manufacturing, Washoe County & the United States, 2012-2017

Nevada Governor's Office of Economic Development. Data provided upon request. Carson City, NV.

Table 6: Top 10 Employers, Washoe County, 3rd quarter-2016

Nevada Department of Employment, Training, and Reinforcement. Nevada Labor Market Information. Accessed <http://nevadaworkforce.com/top-employers>

Fig 32: Median Annual Household Income, Washoe County, Nevada, & the United States, 2012-2016

U.S. Census, 2016 American Community Survey -1 year estimates-TABLE S1901 - MEDIAN INCOME IN THE PAST 12 MONTHS

Fig 33: Median Annual Household Income by Family Type, Washoe County, Nevada, & the United States, 2016

Source: U.S. Census, 2016 American Community Survey -1 year estimates-TABLE S1903 - MEDIAN INCOME IN THE PAST 12 MONTHS

Table 7-Table 8; Fig 34 Same Source

Table 7: Select Hourly Wages by Family Type, Washoe County, 2016

Table 8: Select Wages for Single Adult with no Children, Washoe County & Nevada, 2016

Fig 34: Estimated Percent of Annual Income per Expense Type, for Two Adults Working Full Time with Two Children, Washoe County, 2016

Glasmeyer, A.K. Massachusetts Institute of Technology. Living Wage Calculation for Washoe County, Nevada. Accessed <http://livingwage.mit.edu/counties/32031>

Fig 35: Personal Bankruptcy Filing Rate, Washoe County & Nevada, 2005, 2009, & 2013-2016

University of Nevada, Reno, School of Medicine, Office of Statewide Initiatives. Instant Atlas. Accessed <http://med.unr.edu/statewide/instant-atlas/county-data-map>

Table 9: Percent of Population at or Below Poverty Level, 2012-2016

U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S1701 - POVERTY STATUS IN THE PAST 12 MONTHS

Fig 36; Table 10-Table 11 Same Source

Fig 36: Percent of Population Living Below Poverty by Race & Ethnicity, Washoe County, 2016

Table 10: Percent of Children Under 18 years at or Below Poverty Level, 2012-2016

Table 11: Percent of Seniors 65+ years at or Below Poverty Level, 2012-2016

U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S1701 - POVERTY STATUS IN THE PAST 12 MONTHS

Following Figures from the Online Community Survey

Fig 37: Employment Status among Survey Respondents (n=1,263)

Fig 38: Household had Difficulties Paying in the Past 12 Months (n=1,245)

Fig 39: Percent of Respondents Enrolled in Services in Past 12 Months, by Type (n=1,253)

Housing

Safe, adequate, and affordable housing plays a major role in a person’s ability to have sufficient funds to pay for necessities such as utilities, food, clothing, transportation, and services, including higher education and healthcare. The U.S. Department of Housing and Urban Development states those paying more than 30% of monthly income on housing are cost burdened and the associated housing cost is therefore deemed to be “unaffordable”.²⁹ In addition to being affordable, housing needs to be of sufficient-quality to minimize the potential impacts of environmental toxins such as lead, which may be present in older paints or water lines, or mold, due to inadequate or outdated flooring and roofing. In 2015, a summary of research found several additional health factors associated with housing including food security, stress, mental health, asthma, unintended injury, and linkage and connectivity to supportive services.³⁰

According to a recent housing study conducted by Truckee Meadows Regional Planning Authority (TMRPA), over the past two decades the cost of single-family detached house has increased by 60%, while household incomes have only increased 17%.³¹ This outlines the burden of the cost of housing in Washoe County.

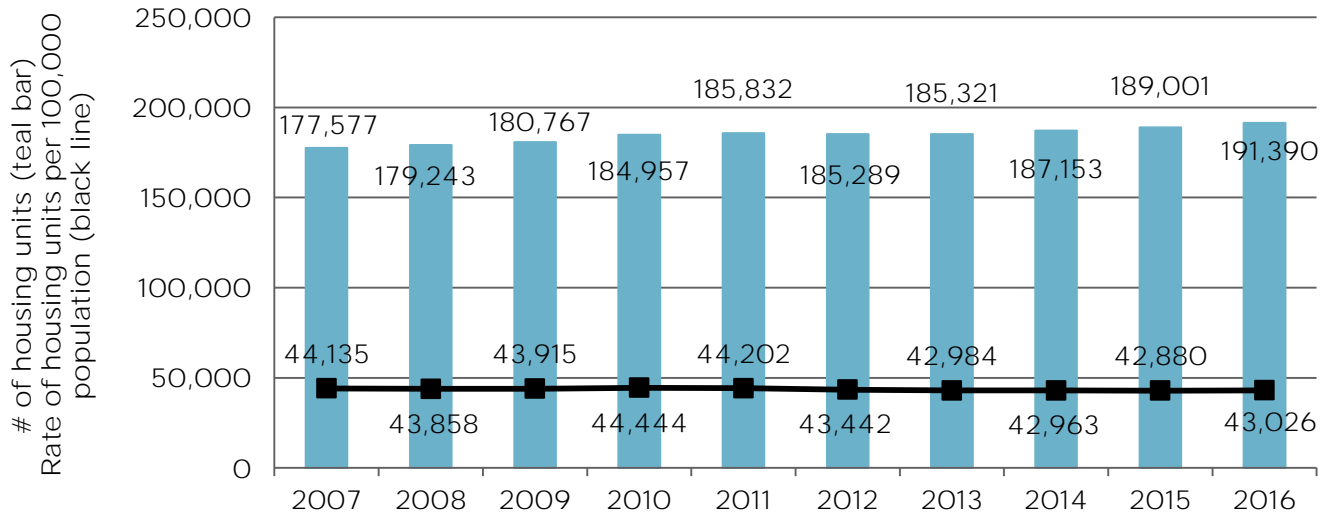
Indicator	Trend	Most Recent Year
Number of housing units	Increasing	191,390 (2016)
Number of housing units per capita	Decreasing	43,026 houses per 100,000 population (2016)
Percent of homes occupied	Increasing	91.3% (2016)
Percent of homes occupied by owner	Decreasing	57.3% (2016)
Median household value	Increasing	\$299,100 (2016)
Unaffordable mortgage	Decreasing	29.3% (2016)
Unaffordable rent	STABLE	48.7% (2016)
Number of homeless persons	Increasing	989 persons (2016)
Shelter type among homeless	~	various
Children in Transition (CIT-homeless youth)	Increasing	3,359 grades K-12 (2016-2017)
~not able to assess for trend		

²⁹ U.S. Department of Housing and Urban Development. Affordable Housing. Accessed https://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing/

³⁰ Maqbool, N., Viveiros, J., & Ault, M. (2015). The Impacts of Affordable Housing on Health: A Research Summary. Center for Housing Policy. Washington, DC.

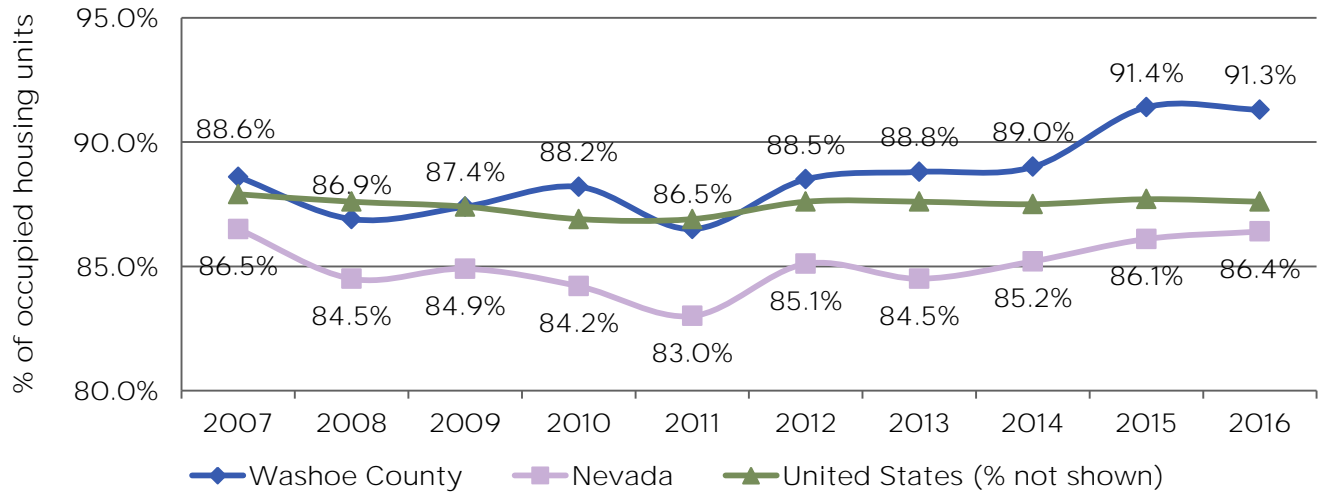
³¹ Truckee Meadows Regional Planning Agency. (2017). Truckee Meadows Housing Study. Accessed <http://tmrpa.org/truckee-meadows-housing-study/>

Fig 40: Number & Rate of Housing Units, Washoe County, 2007-2016



- The estimated number of housing units in Washoe County increased from 2007 through 2010 and again from 2012 to 2016.
- Although the overall number of housing units increased, the rate of housing units per 100,000 population decreased from 2007 (44,135 housing units per 100,000) to 2016 (43,026 housing units per 100,000). This indicates there were fewer houses available per capita.

Fig 41: Percent of Occupied Housing Units, Washoe County, Nevada, & the United States, 2007-2016



- There was a decline in the percent of housing units that were occupied from 2010 to 2011, largely due to the 2007 Great Recession and housing market crash.
- Since 2011, the percent of occupied housing units in Washoe County increased and remained higher than Nevada and the United States.

Table 12: Percent of Occupied Households Occupied by Owner, 2007-2016

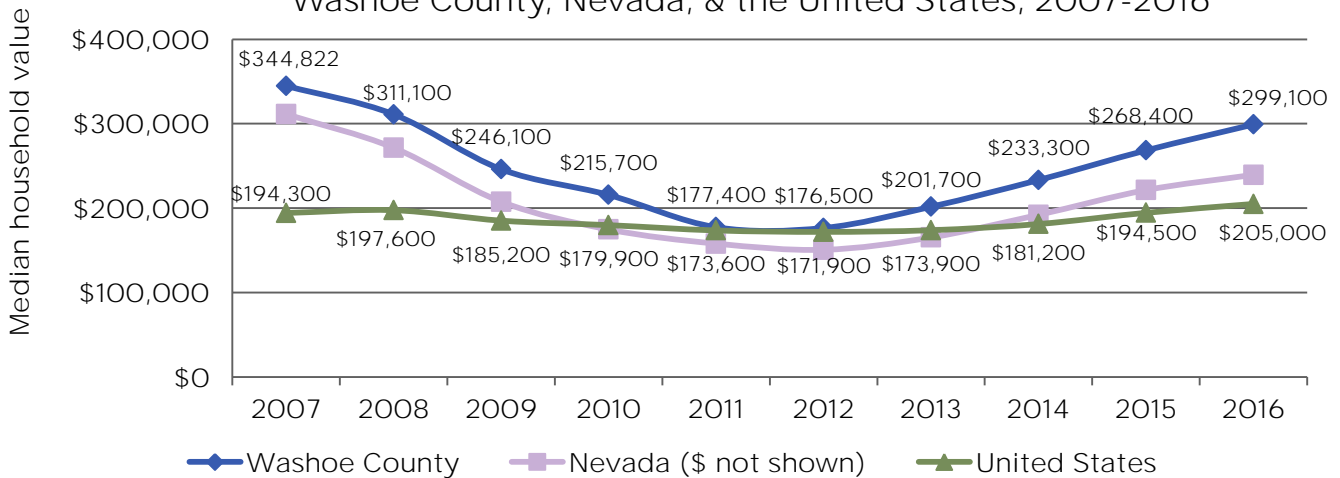
Location	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Washoe County	60.9%	59.8%	60.9%	57.5%	57.5%	56.9%	56.0%	57.1%	55.7%	57.3%
Nevada	60.4%	59.7%	59.3%	57.2%	56.3%	54.9%	54.3%	53.6%	54.0%	54.9%
United States	67.2%	66.6%	65.9%	65.4%	64.6%	63.9%	63.5%	63.1%	63.0%	63.1%

- The percentage of households occupied by the owner of the house decreased from 2007 (60.9%) to 2016 (57.3%) and has remained lower than the United States over the same time period.

Median Household Value

Although 2017 data are not provided in Figure 42, the median sales price for single-family residential homes sold in Washoe County during the 3rd quarter of 2017 was \$350,000, indicating continued increase since the end of calendar year 2016.³²

Fig 42: Median Household Value (Owner-occupied Houses), Washoe County, Nevada, & the United States, 2007-2016

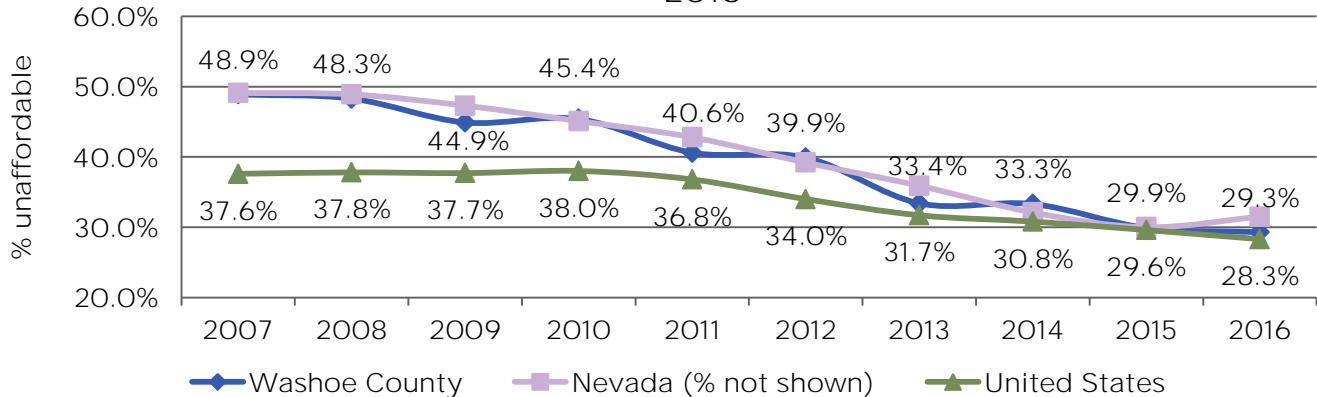


- The median household value in Washoe County, among houses occupied by owners, decreased sharply during the Great Recession. However, since 2012 the median price of owner-occupied houses has increased and in 2016 was \$299,100.
- The median household value of owner-occupied houses in Washoe County has been higher than the median household value of owner-occupied houses in Nevada and the United States from 2007 through 2016.

³² Washoe County Assessor. Real Property, Median Sales Chart. Accessed <https://www.washoecounty.us/assessor>

1.2 HOUSING

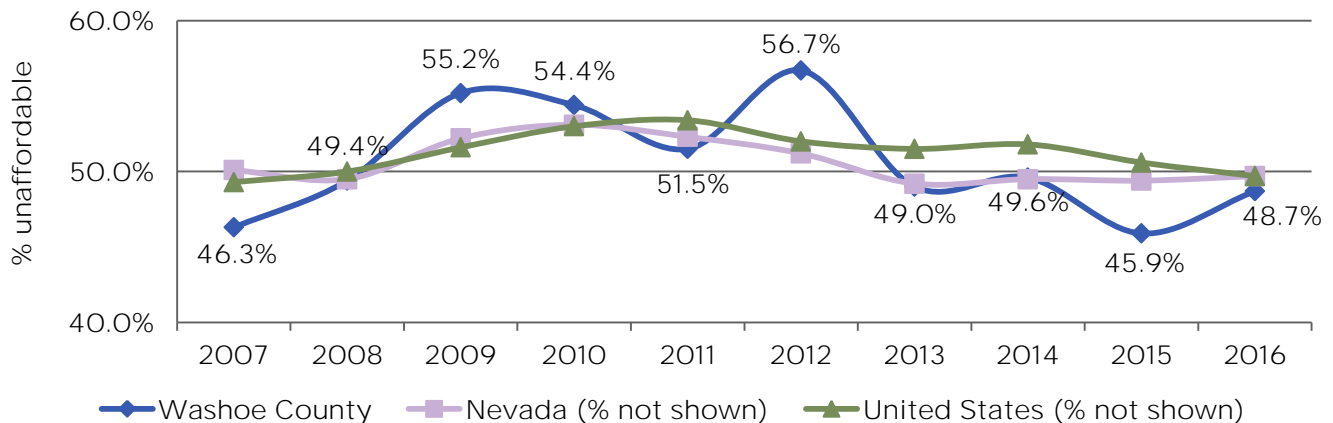
Fig 43: Percent of Owners Who Pay Unaffordable* Monthly Mortgage, Washoe County, Nevada, & the United States, 2007-2016



*Note: Unaffordable mortgage defined as a monthly mortgage greater than 30% of the monthly income

- Prior to the Great Recession a higher proportion of home owners in Washoe County were paying an unaffordable monthly mortgage.
- The proportion of home owners in Washoe County that pay an unaffordable monthly mortgage in Washoe County decreased from 2007 (48.9%) to 2016 (29.3%).
- In 2016, the proportion of home owners in Washoe County that were paying an unaffordable monthly mortgage was slightly lower (29.3%) than Nevada (31.5%) and slightly higher than the United States (28.3%).

Fig 44: Percent of Renters Who Pay Unaffordable* Monthly Rent, Washoe County, Nevada, & the United States, 2007-2016



*Note: Unaffordable rent is monthly rent greater than 30% of the monthly income

- The proportion of renters in Washoe County that paid an unaffordable monthly rent increased between 2007 (46.3%) to 2009 (55.2%) and again in 2012 (56.7%).
- In 2016, the proportion of renters in Washoe County paying an unaffordable monthly rent was lower (48.7%) than Nevada (49.7%) and the United States (49.7%).

Homelessness

Table 13: Homelessness by Shelter Type, Washoe County, 2009-2016

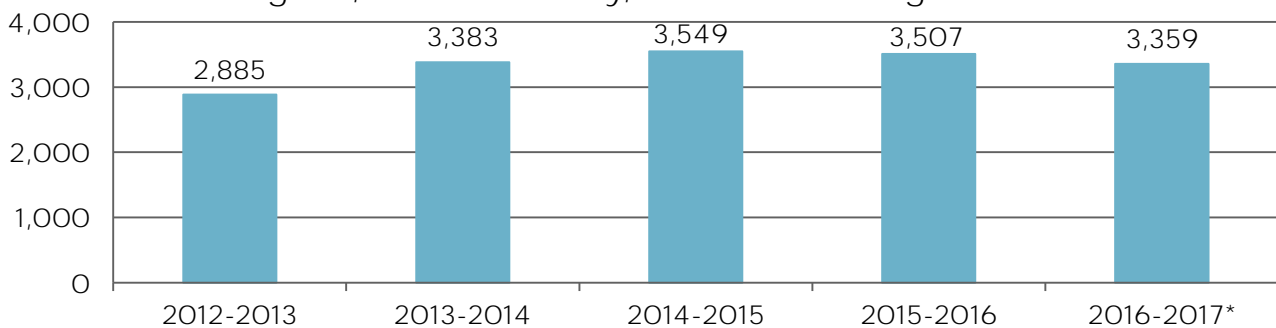
Number of Persons	2009	2010	2011	2012	2013	2014	2015	2016
Emergency Shelter	432	464	409	407	380	349	454	452
Transitional Housing	213	231	266	298	277	323	340	417
Unsheltered	55	239	175	164	89	97	113	120
Total	700	934	850	869	746	769	907	989

- From 2009 through 2016, the number of homeless persons in Washoe County has fluctuated between 700 to just under 1,000.
- The number of people in emergency shelters remained relatively stable from 2009 (432) through 2016 (452), however the number of people residing in transitional housing nearly doubled, and persons living in unsheltered conditions has more than doubled over the same time period.

Homeless Youth

The Washoe County Children in Transition (CIT) program collaborates with other agencies to locate homeless school aged (k-12) children and youth. A child qualifies for CIT if they meet the definition of “homeless children and youths” meaning individuals who lack a fixed, regular, and adequate nighttime residency. This includes youth who live in a shelter, hotel/motel, campgrounds, cars, or on the streets. The CIT Advocates and CIT Liaisons help provide homeless youth with access to transportation to and from school, enrolling in free school meals, and obtaining backpacks and other school supplies, as well as clothing if necessary. CIT removes barriers to school enrollment specifically for those without mandatory documents such as birth certificates, medical records, or proof of guardianship.³³

Fig 45: Number of Students in the Children in Transition Program, Washoe County, 2012-2013 through 2016-2017



Note: The federal qualifying definition “homeless children and youths” changed, effective 2016 and youth awaiting foster care placement are no longer included, unless they meet requirement through another defined category.

³³ Washoe County School District. Children in Transition, FAQ. Accessed <https://www.washoeschools.net/cms/lib/NV01912265/Centricity/Domain/164/Frequently%20Asked%20Questions.pdf>

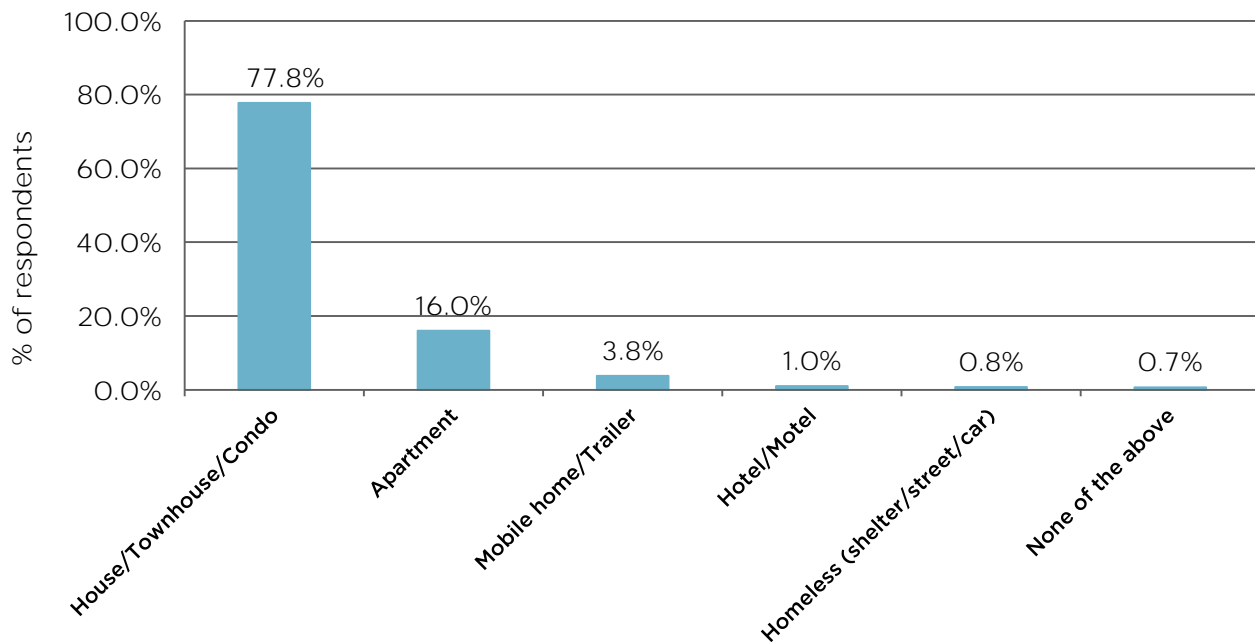
- The number of school-aged (grades k-12) youth enrolled in the CIT program increased from the 2012-2013 school year (n=2,885) to the 2016-2017 school year (n=3,359).
- Although the 2016-2017 school year illustrates a decrease in number of students qualified as CIT, the definition changed under McKinney-Vento Act (a primary CIT program funding source) per the Every Student Success Act (ESSA) reauthorization. As of 2016 youth awaiting foster care are no longer defined as a “homeless child or youth”, therefore do not qualify for CIT programming. The decrease may be a reflection of the change in definition and not a reflection of the number of homeless youth.

Primary Survey Data Related to Housing

Primary data were collected via an online community survey from over 1,400 survey participants. The survey included 44 questions and analyses for questions related to housing are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community Survey Demographics section.

Question: “Which type of place best describes where you currently live?”

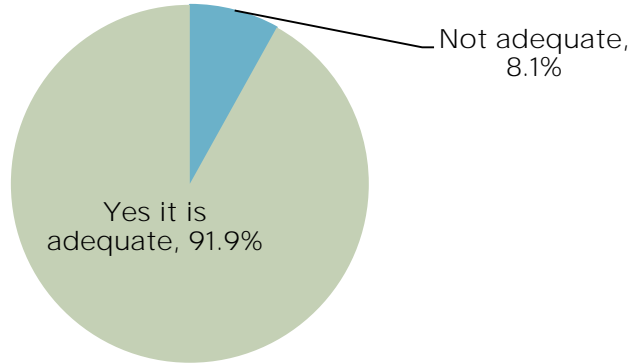
Fig 46: Housing Type (n=1,299)



- The majority (77.8%) of survey respondents indicate they currently lived in a house, townhouse or condo.
- Apartments were the second most frequently identified type of housing (16.0%).

Question: “Do you consider where you currently live to be an adequate size for the number of people living in your household?”

Fig 47: Adequate Size for Number of People in Household (n=1,300)

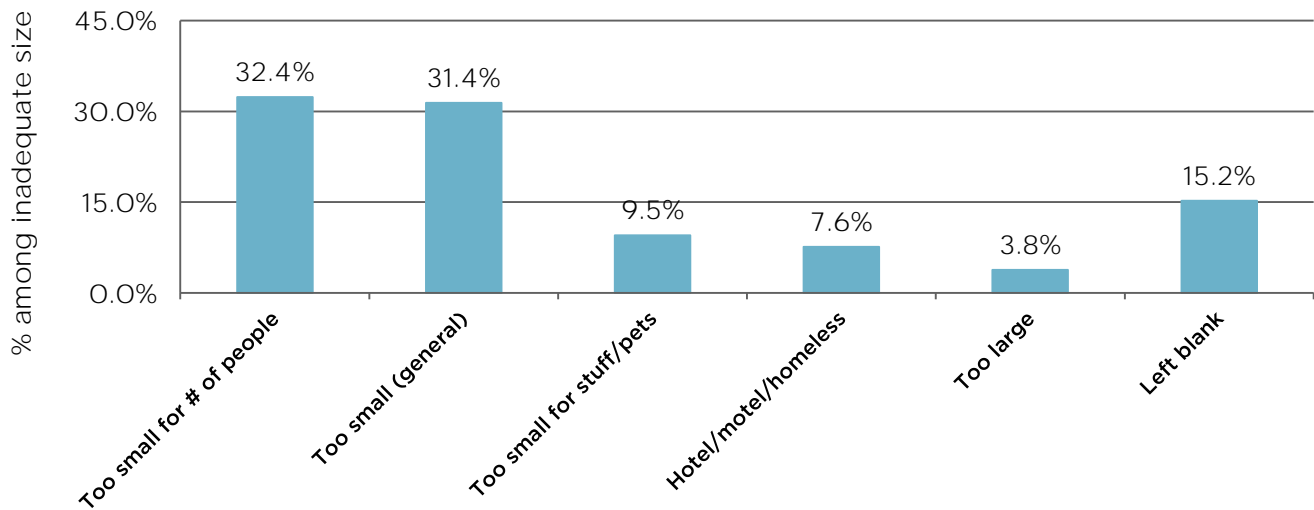


- Among the 1,300 respondents to the above question, the vast majority (91.9%) indicated they perceive their current house to be an adequate size.
- Of note, not all respondents who indicated their house was not an adequate size thought their house was too small. Further details regarding the adequacy of the size of the house are provided in the following figure.

***Question: “Explain why your household is not an adequate size.”**

*Asked only among the 105 respondents who indicated the place they currently live is NOT an adequate size for the number of people living the household.

Fig 48: Reason Household Not Adequate Size (n=105)



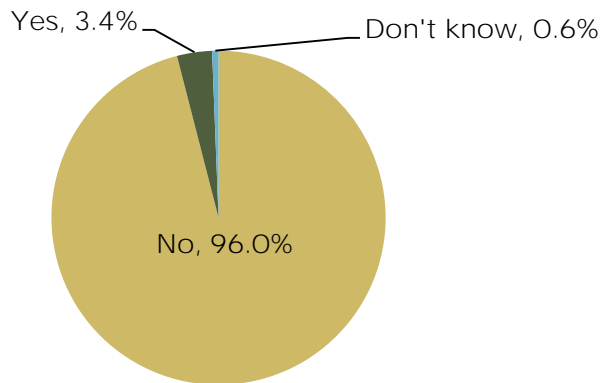
- The majority of respondents who indicated their household was not an adequate size felt the space was too small (63.8%). About one in three respondents explained specifically that people are doubled up, sharing bedrooms or there are not enough bathrooms per people (32.4%), while another 31.4% of respondents indicated only that the house is too small, with no reference to number of people.

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- Nearly one in 10 respondents (9.5%) indicated they did not have enough space for pets or storage for objects.
- Some survey respondents were homeless/living in a hotel/motel (7.6%), indicating they were in an inadequate living situation.
- A handful of respondents (3.8%) indicated their living space was too large for the number of people.

Question: “Have you ever been evicted while living in Washoe County?”

Fig 49: Ever Been Evicted in Washoe County (n=1,247)

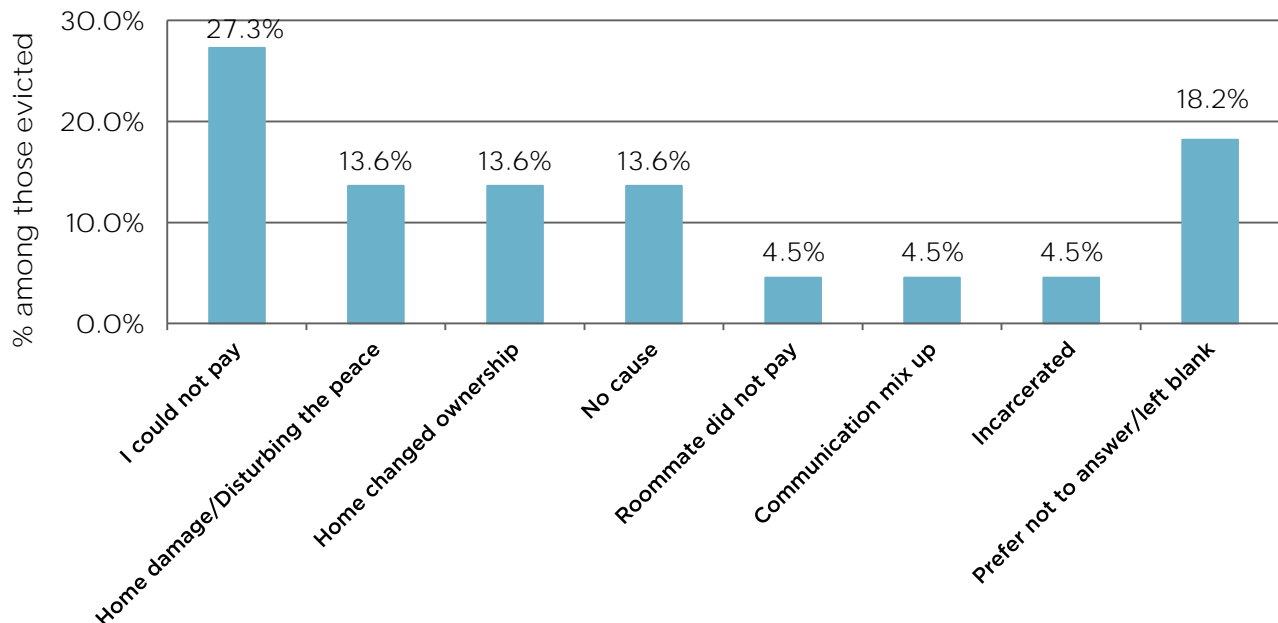


- The majority of respondents (96.0%) indicated they had never been evicted while living in Washoe County.

***Question: “Explain why you were evicted.”**

*Asked only of the 44 respondents who indicated they had ever been evicted in Washoe County.

Fig 50: Reason for Eviction (n=44)



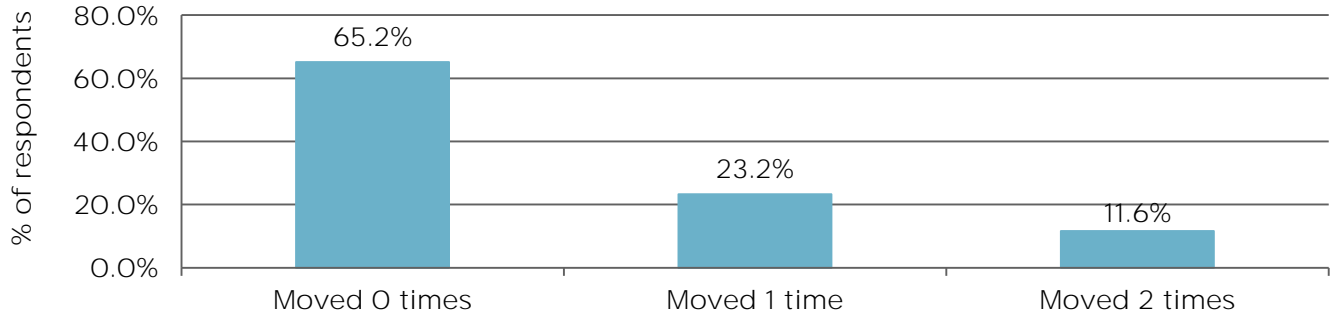
- Among the 44 respondents who had been evicted in Washoe County, 27.3% stated the reason for their eviction was due to inability to pay rent.

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- Approximately 13.6% indicated someone they lived with or they themselves were accused of domestic disturbance or damage to the structure, 13.6% stated the home changed owners and they were asked to leave, and another 13.6% stated there was no cause for the eviction.

Question: “How many times have you moved in the past 2 years?”

Fig 51: Number of Times Moved in the Past 2 Years (n=1,300)



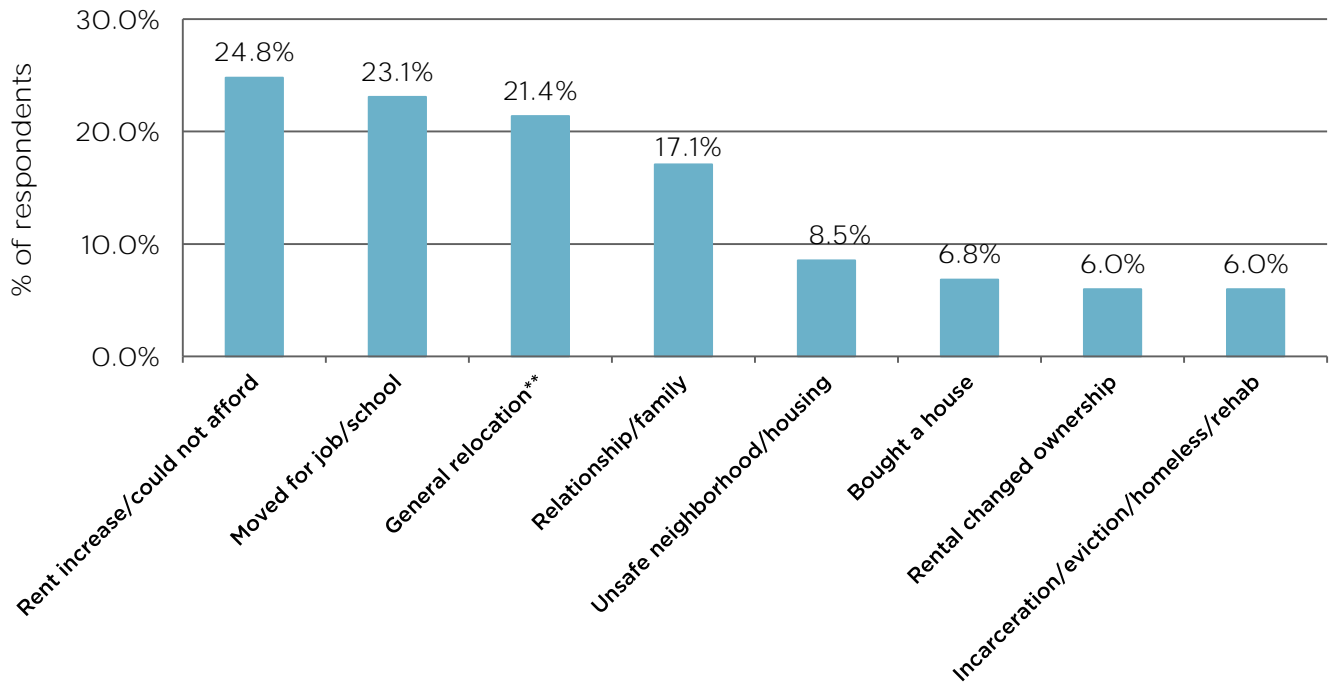
- The majority of respondents (65.2%) indicated they had not moved within the past 2 years. While slightly less than one in three indicated they had moved once (23.2%) or two or more times (11.6%).

***Question: “Describe why you had to or chose to move 2 or more times in the past 2 years.”**

*Asked only of the 151 respondents who indicated they had moved 2+ times in the past 2 years.

Only 117 of those respondents identified reasons why they moved.

Fig 52: Reasons Moved 2+ Times in Past 2 Years (n=117)*



*151 survey respondents indicated they had moved 2 or more times in the past 2 years however, only 117 responded to the follow up question. Respondents listed different reasons for each move; therefore, answers may fall into one or more categories.

**No mention of work or financial-related reasons for moving, often listed as moving into out of state or country.

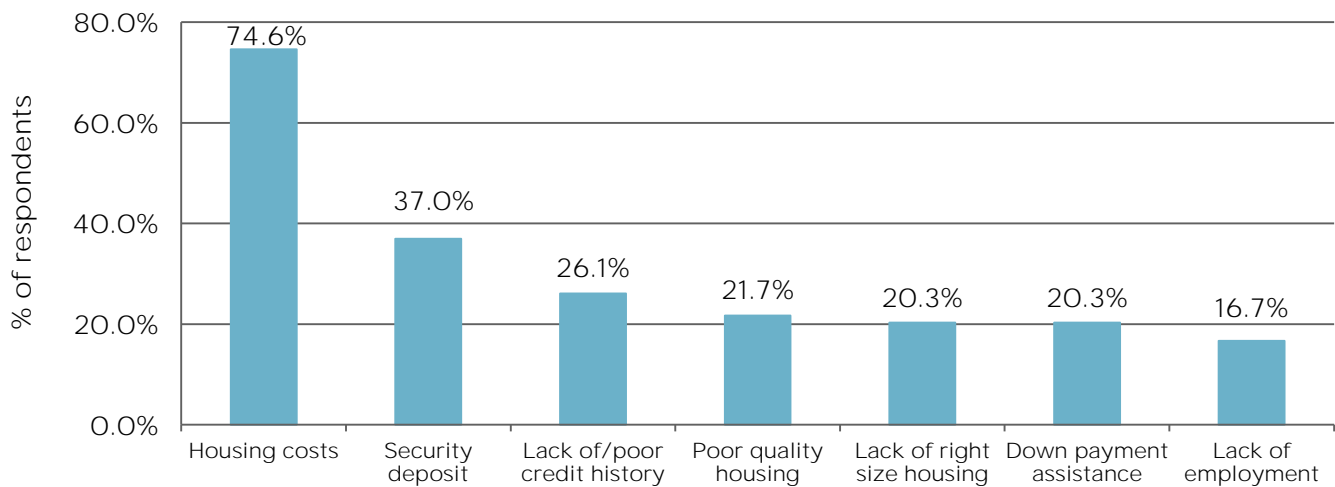
1.2 HOUSING

- Nearly one in four of the 117 respondents indicated they moved to avoid a rent increase or that they could no longer afford the rent (24.8%), while nearly another quarter indicated they had to move for a job or school (23.1%).
- Nearly one in five did not list specific reasons (21.4%), only that they relocated from another state or country or listed “relocation” without specific mention of financial or employment-related reasons.
- Relationship changes, roommate changes, family reasons were mentioned by 17.1% of respondents as reasons for moving two or more times.

***Question: “Which of the following are barriers to finding stable housing?”**

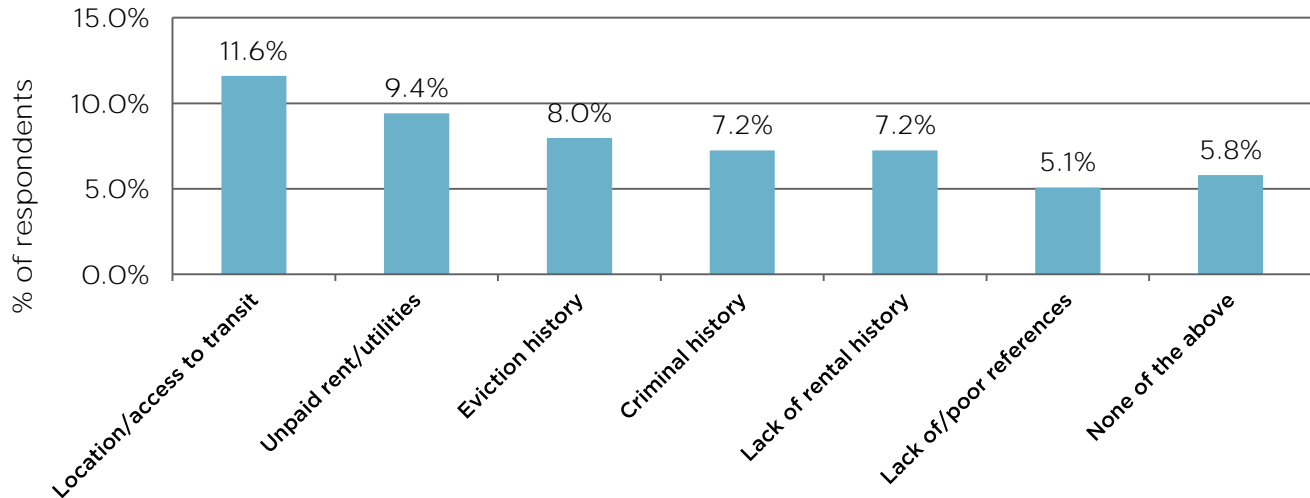
*Asked only of the 151 respondents who indicated they had moved 2+ times in the past 2 years. Only 138 of those respondents identified barriers.

Fig 53: Top 7 Barriers to Finding Housing (n=138)



- The majority of those who had moved 2 or more times in the past 2 years indicated housing cost (74.6%) were a barrier to finding stable housing.
- Over one in three indicated the security deposit (37.0%) was a barrier to finding stable housing.
- Another one in four indicated they had a lack of or poor credit history (26.1%), while one in five indicated housing was of poor quality (21.7%), there was a lack of right sized housing (20.3%), or they needed down payment assistance (20.3%).
- 16.7% of question respondents indicated employment as a barrier to stable housing.

Fig 54: Other Barriers to Finding Housing (n=138)



- The housing location or lack of access to public transit was identified as barriers by 11.6% of the 138 respondents.
- Fewer than one in ten indicated unpaid rent/utilities (9.4%), eviction history (8.0%), criminal history (7.2%), lack of rental history (7.2%), or a lack of or poor references (5.1%) were barriers to obtaining stable housing.

Summary of Housing

Washoe County faces three major housing challenges. The first is the unavailability of housing in general. The number of houses per capita decreased each year from 2012 through 2016, creating a shortage of available housing on the market for buyers, as well as a reduction in housing available for rent. Although representative of a small subset of houses, a 3rd Quarter (2017) Reno/Sparks Metro Area apartment survey found apartment vacancy was only 2.41% compared to 5.64% during 2011, following the highest unemployment peak of the 2007 Great Recession.³⁴ This demonstrates that the traditional more affordable styles of housing are in high demand as well.

A second major challenge is the financial burden and high cost of housing, again both for residents looking to purchase a house as well as those who are renting. Although the percentage of persons paying an unaffordable mortgage declined from a high in 2007 (48.9%) to 2016 (29.3%), the percentage of renters paying an unaffordable monthly rent has remained relatively stable at approximately 50% from 2007 through 2016. Affordable housing is a challenge many people face including those who are gainfully employed, best demonstrated by the disparity in cost of housing relative to wages. From 2012 to 2016, there was a 70% increase in median home value, while the median income only increased 19% over the same period.

³⁴ Johnson, Perkins, Griffin. (2017). Apartment Survey: 3rd Quarter 2017 Data, Reno/Sparks Metro Area. Accessed <http://jggnv.com/wp-content/uploads/2017/10/Q3-ApartmentSurvey2017.pdf>

The third major challenge related to housing is an increase in the number of homeless persons, largely in the downtown Reno area. Several motels and hotels near the downtown corridor advertise as “weekly motels” and are used as semi-permanent housing. The homeless Point in Time (PIT) counts do not indicate a massive increase in overall number of homeless individuals; however, the homeless shelters have been reaching capacity more and more frequently and the number of unsheltered persons has more than doubled from 2009 to 2016, indicating more and more persons are in the streets.

Although high household values are beneficial for sellers, buyers are finding both availability and affordability a challenge, motivating many to look for housing in neighboring counties. Many renters already faced with financial burdens are being displaced as current property owners are finding the market attractive and selling to prospective homeowners. Addressing the housing issue in the Reno-Sparks metropolitan area needs to incorporate not just housing, but amenities and key infrastructure such as schools, hospitals, and other municipal services, as those are already strained and over capacity.

For detailed documents related to housing in Washoe County refer to:

Truckee Meadows Regional Planning Agency Housing Study <http://tmrpa.org/truckee-meadows-housing-study/>

Washoe County Assessor data <https://www.washoecounty.us/assessor/index.php>

Housing Sources

Fig 40-Fig 41; Table 12 Same Source

Fig 40: Number & Rate of Housing Units, Washoe County, 2007-2016

Fig 41: Percent of Occupied Housing Units, Washoe County, Nevada, & the United States, 2007-2016

Table 12: Percent of Occupied Households Occupied by Owner, 2007-2016

2007-2009: U.S. Census, American Community Survey. Table CP04 1-year estimates – Selected Housing Characteristics.

2010-2016: U.S. Census, American Community Survey. Table DP04 1-year estimates – Selected Housing Characteristics.

Fig 42: Median Household Value (Owner-occupied Houses), Washoe County, Nevada, & the United States, 2007-2016

U.S. Census, American Community Survey. Table B25077 1-year estimates – Median Value (Dollars) Universe: Owner-occupied housing units.

Fig 43-Fig 44 Same Source

Fig 43: Percent of Owners Who Pay Unaffordable* Monthly Mortgage, Washoe County, Nevada, & the United States, 2007-2016

Fig 44: Percent of Renters Who Pay Unaffordable* Monthly Rent, Washoe County, Nevada, & the United States, 2007-2016

2007-2009: U.S. Census, American Community Survey. Table CP04 1-year estimates – Selected Housing Characteristics.

2010-2016: U.S. Census, American Community Survey. Table DP04 1-year estimates – Selected Housing Characteristics.

Table 13: Homelessness by Shelter Type, Washoe County, 2009-2016

HUD Exchange, Continuum of Care Homeless Populations and Subpopulations Reports. Reno, Sparks/Washoe County CoC. Accessed www.hudexchange.info

Fig 45: Number of Students in the Children in Transition Program, Washoe County, 2012-2013 through 2016-2017

Washoe County School District, Children in Transition program. Data provided upon request. Reno, NV.

Following Figures from the Online Community Survey

Fig 46: Housing Type (n=1,299)

Fig 47: Adequate Size for Number of People in Household (n=1,300)

Fig 48: Reason Household Not Adequate Size (n=105)

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Fig 49: Ever Been Evicted in Washoe County (n=1,247)

Fig 50: Reason for Eviction (n=44)

Fig 51: Number of Times Moved in the Past 2 Years (n=1,300)

Fig 52: Reasons Moved 2+ Times in Past 2 Years (n=117)

Fig 53: Top 7 Barriers to Finding Housing (n=138)

Fig 54: Other Barriers to Finding Housing (n=138)

Food & Hunger

Access to healthy and affordable food can vary greatly based on a variety of factors including income, financial stability, the neighborhood in which one lives, and a person’s race or ethnicity.³⁵ Having the ability to afford and access a variety of healthy foods is instrumental for proper development and health through all stages of life and plays a major role in maintaining a healthy weight. While the rate of adults who are overweight or obese continues to increase, the number of people reliant on federal nutrition support and public assistance in order to obtain food has reached an all-time high.^{36,37,38} This trend has been attributed to various factors including economic recovery and the abundance and accessibility of cheap, unhealthy food.³⁹

Those who are unable to afford food are often unable to afford other basic living necessities, such as housing, utilities, or healthcare, and have to make choices on which to forego each month. The 2014 Hunger in America survey of the Food Bank of Northern Nevada clients found 85% of respondents reported they purchase inexpensive, unhealthy food simply because it is more affordable and accessible than healthy food.⁴⁰ Seniors, and other populations on fixed incomes, are especially vulnerable to financial burdens and food is often a basic need that presents an ongoing challenge. While there are many programs working to address food access and hunger, the need to increase access to healthy food remains.

The largest and most predominant federal nutrition programs will be discussed in the section including the Supplemental Nutrition Assistance Program (SNAP) and the national School Lunch Program. Although the Women, Infants, and Children (WIC) Program is a federally funded supplemental nutrition program, WIC indicators are presented in the Maternal Child Health section of the assessment.

Indicator	Trend	Most Recent Year
Free and Reduced Lunch eligibility	STABLE	46.7% (2016-2017)
Free and Reduced Lunch participation	STABLE	39.2% (2016-2017)
SNAP enrollment	Increasing	12.9% (2014)
Food insecurity estimates	Decreasing	12.7% (2015)
Food deserts	~	10 census tracts
~ not able to assess for trend		

³⁵ Morland K., Wing S., Diez Roux A., & Poole C. (2002). Neighborhood Characteristics Associated with the Location of Food Stores and Food Service Places. *American Journal of Preventive Medicine*. 22(1): 23-29.

³⁶ Hales, C.M., Carroll, M.D., Fryar, C.D., & Ogden, C.L. (2017). Prevalence of Obesity among Adults and Youth: United States, 2015-2016. NCHS Data Brief, No 288. Hyattsville, MD: National Center of for Health Statistics.

³⁷ Weinfield N.S., Mills G., Borger C., et al. (2014). *Hunger in America 2014 Report for Food Bank of Northern Nevada*. Westat and the Urban Institute, Washington D.C. 2014.

³⁸ Weinfield N.S., Mills G., Borger C., et al. (2014). *Hunger in America 2014 National Report*. Westat and the Urban Institute, Washington D.C. 2014. Provided upon request by Food Bank of Northern Nevada.

³⁹ Ver Ploeg M., Breneman V., Farrigan T., et al. (2009). *Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences*. Administrative Publication No. (AP-036) Report to Congress. United States Department of Agriculture, Economic Research Service.

⁴⁰ Weinfield N.S., Mills G., Borger C., et al. (2014). *Hunger in America 2014 Report for Food Bank of Northern Nevada*. Westat and the Urban Institute, Washington D.C. 2014. Provided upon request by Food Bank of Northern Nevada.

Free and Reduced Price Meals

The National School Lunch Program is a federal program that provides free and reduced-price (FRP) meals to school-aged children nationwide. Eligibility requirements for the reduced-price and free meals are based on household income which is reported by households to each school district, although any student at a participating school is able to access school meals offered.⁴¹ According to Washoe County School District data, although nearly half of the students in Washoe County School District are eligible for the National School Lunch Program, only 39% of students participated and participation rates have remained stable over the past five years.⁴² This indicates that while the proportion of students who qualify for FRP lunch is high, less than half of the eligible students utilize the service.

Table 14: Percent of Students Eligible for Free & Reduced Lunch Program, 2012-2013 through 2016-2017

Location	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Washoe County	45.3%	47.2%	47.8%	47.1%	46.7%
Nevada	53.6%	54.7%	55.3%	59.8%	57.9%

- Nearly half of children enrolled in the Washoe County School District from 2012-2013 school year through 2016-2017 school year were estimated to be eligible for FRP lunch.
- A lower proportion of children enrolled in the Washoe County School District were eligible for FRP lunch compared to Nevada overall from 2012-2013 through 2016-2017.

Table 15: Percent of Students who Participate in the National School Lunch Program, Washoe County by Grade, Nevada, & the United States 2012-2013 through 2016-2017

Location	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Washoe County (Overall)	39.6%	41.2%	41.1%	41.3%	39.2%
<i>WCSD Elementary Schools</i>	53.3%	56.4%	56.3%	56.5%	53.6%
<i>WCSD Middle Schools</i>	32.5%	31.6%	31.3%	31.0%	31.1%
<i>WCSD High Schools</i>	19.5%	19.3%	19.1%	19.5%	17.3%
Nevada	47.7%	45.9%	49.4%	50.3%	45.8%
United States	59.5%	58.9%	58.5%	59.0%	58.1%

- The percentage of students who are eligible for the National School Lunch Program in Washoe County remained relatively stable from the 2012-2013 school year through the 2016-2017 school year, at approximately 40%.
- In Washoe County, the proportion of total students participating decreases as grade level increases. Participation declines from just over 50% in elementary schools to less than 20% by the time students are in high school.
- During the 2016-2017 school year, a lower percentage of Washoe County students participated in the National School Lunch Program (39.2%) compared to Nevada (45.8%) and the United States (58.1%).

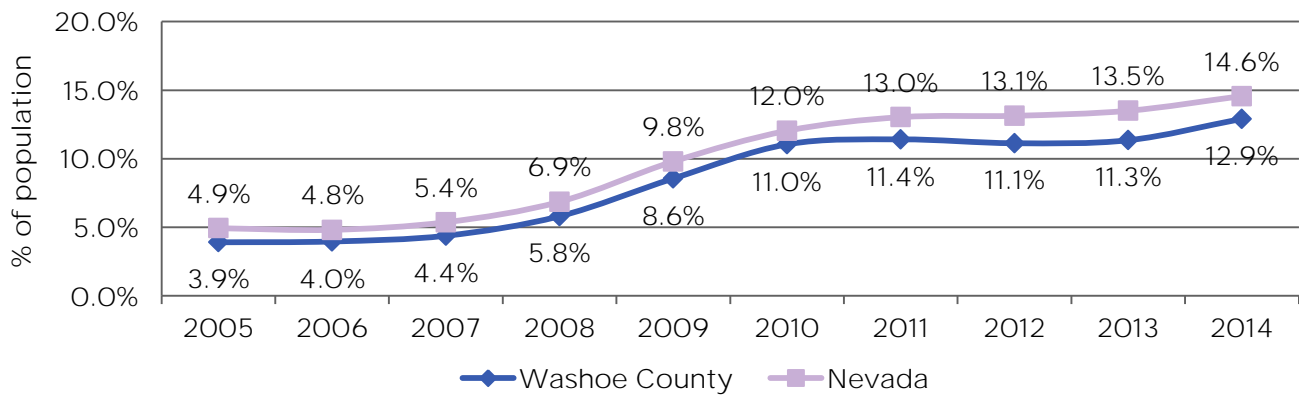
⁴¹ Nevada Department of Agriculture, Child Nutrition Program. National School Lunch Program Overview. Accessed [http://nutrition.nv.gov/Programs/National_School_Lunch_Program_\(NSLP\)/](http://nutrition.nv.gov/Programs/National_School_Lunch_Program_(NSLP)/)

⁴² Washoe County School District. Data provided upon request. Reno, NV.

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, is a federal program that provides eligible individuals and families with funds to purchase food, or seeds and plants that produce food, from SNAP authorized retailers. SNAP benefits are not allowed to be redeemed for alcoholic beverages, non-food items, vitamins, medicine, or foods that are to be eaten in a store (hot foods, prepared foods).⁴³ Nevada SNAP recipients receive SNAP funds at midnight of the first day of each month. Data from June 9, 2017 estimated 224,551 households in Nevada were enrolled in SNAP during March, 2017 and participants received on average \$118.48 per person for food expenditures for one month.⁴⁴ As of 2017, 41.4% of the 51,382 SNAP participants in Washoe County were children.⁴⁵ SNAP participation rates in Nevada have remained relatively low, most recent aggregate data from 2012-2014 show only an estimated 65% of eligible persons were participating, one of the lowest in the nation.⁴⁶

Fig 55: Percent of Population Enrolled in SNAP, Washoe County & Nevada, 2005-2014



- The proportion of the population in Washoe County enrolled in SNAP increased from 2005 (3.9%) to 2014 (12.9%).
- The proportion of the population in Washoe County enrolled in SNAP has remained lower than Nevada from 2005 through 2014.

Food Security

Food security as defined by the United States Department of Agriculture is a “household-level economic and social condition of limited or uncertain access to adequate food”, or having a reduced quality, variety or

⁴³ U.S. Department of Agriculture, Food and Nutrition Service. Supplemental Nutrition Assistance Program (SNAP). Accessed <https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap>

⁴⁴ U.S. Department of Agriculture, Food and Nutrition Service. Supplemental Nutrition Assistance Program National and/or State Level March 2017 Participation & Benefits. Accessed <https://www.fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap>

⁴⁵ Nevada Department of Health and Human Services, Division of Welfare and Supportive Services. Data provided upon request. Carson City, NV.

⁴⁶ U.S. Department of Agriculture, Mathematics Policy Research, (2017). Reaching those in Need: Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2014. Washington, DC.

desirability of diet or disrupted eating patterns and reduced food intake.⁴⁷ Long-term or severe food insecurity may result in hunger, adverse health outcomes and developmental delays, among other challenges.

According to 2015 Mind the Meal Gap data, an estimated 13.7% of Nevadans were food insecure, while 12.7% of Washoe County residents and 21.6% of children in Washoe County were estimated to be food insecure.⁴⁸ The Nevada Office of Health Informatics and Epidemiology recently published a report which utilized data from the 2015 Youth Risk Behavior Survey (YRBS) to estimate food insecurity among middle and high school students. The report estimated 16.0% of middle school students and 17.0% of high school students in Washoe County were food insecure.⁴⁹

Location	2013	2014	2015
Washoe County	14.7%	13.7%	12.7%
Nevada	15.8%	14.9%	13.7%
United States	15.8%	15.4%	13.4%

Food Deserts

Having access to affordable healthy food is important to maintain a healthy balanced diet and research has shown lack of access to a supermarket is associated with fewer purchases of healthy foods.⁵⁰ A food desert is a term used to categorize low-income census tracts which have limited access to supermarkets, grocery stores, or other sources of healthy and affordable food. The U.S. Department of Agriculture (USDA) has defined food deserts across the nation as low-income neighborhoods with low-access to healthy food.

A low-income neighborhood is defined as any census tract where: A) 20% or more of the census tract population is living at the poverty rate or B) the median family income is less than or equal to 80% of the state or metropolitan areas median family income. Low-access is defined as a significant number (at least 500 people) or 33% of the census tract population is more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store.⁵¹

The USDA-defined food deserts in Washoe County are shown for 2010 and 2015. In 2010, there were nine census tracts in Washoe County that were defined as a food desert, in 2015 this increased to 10 census

⁴⁷ U.S. Department of Agriculture. Definitions of Food Security. Accessed <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security/>

⁴⁸ Feeding American, Map the Meal Gap. 2015 Food Insecurity in Nevada. Accessed <http://map.feedingamerica.org/county/2015/overall/nevada>

⁴⁹ Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Office of Public Health Informatics and Epidemiology. (2016). Food Security in Nevada 2013-2015: A Review of Youth Risk Behavioral Survey (YRBS) and Behavioral Risk Factor Surveillance Survey (BRFSS). Carson City, NV.

⁵⁰ Ver Ploeg M., Breneman V., Farrigan T., et al. (2009). Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences. Administrative Publication No. (AP-036) Report to Congress. United States Department of Agriculture, Economic Research Service.

⁵¹ U.S. Department of Agriculture, Economic Research Service. Food Access Research Atlas Documentation. Accessed <https://www.ers.usda.gov/data-products/food-access-research-atlas/documentation/>

tracts. The area encompassing the Pyramid Lake Paiute Reservation, was classified as a food desert in both 2010 and 2015, and is shown on the following page.

Image 4: 2010 USDA ERS Food Deserts in Washoe County

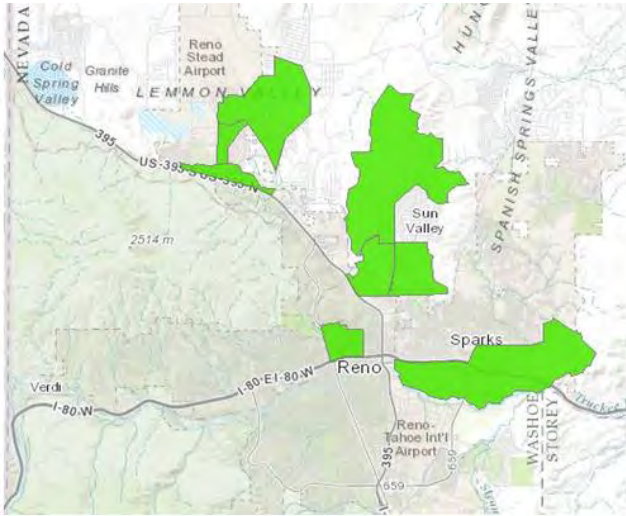


Image 5: 2015 USDA ERS Food Deserts in Washoe County

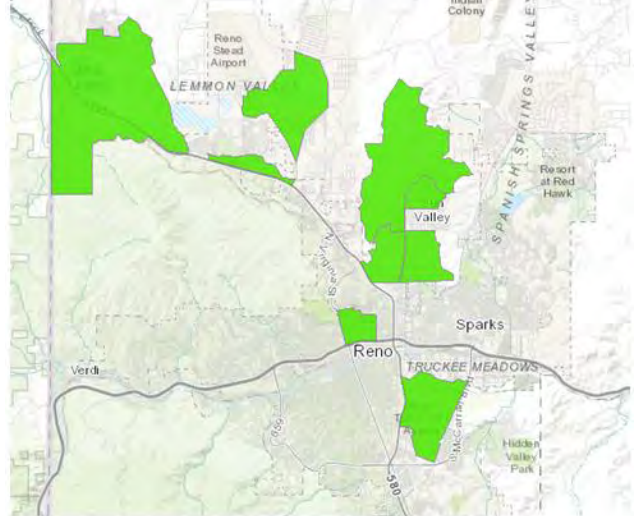
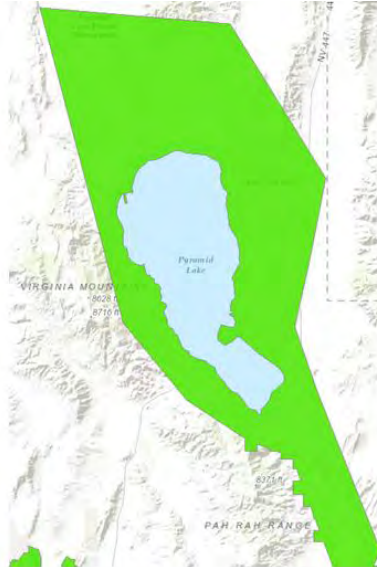


Image 6: 2010 & 2015 USDA ERS Food Desert, Pyramid Lake Paiute Reservation



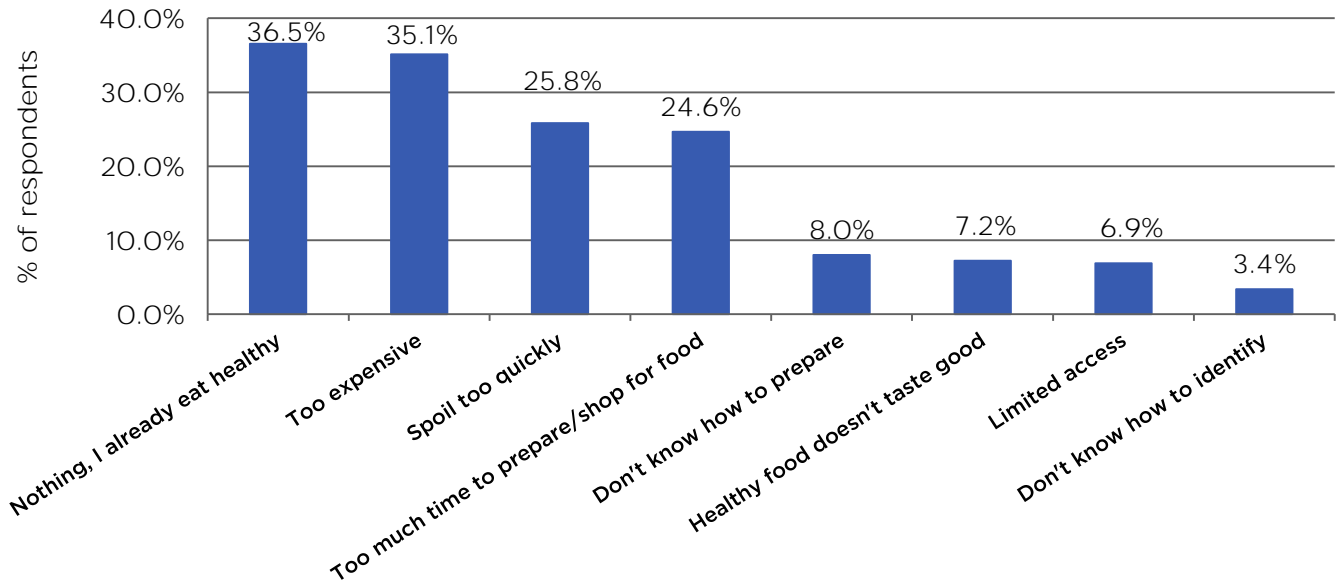
Primary Data Related to Food & Hunger

Primary data were collected via an online community survey from over 1,400 survey participants. The survey included 44 questions and analyses for questions related to food security are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational

attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community Survey Demographics section.

Question: “Which of the following are the largest barriers to you eating healthy food more often? Select up to three.

Fig 56: Barriers to Eating Healthy Food More Often (n=1,412)

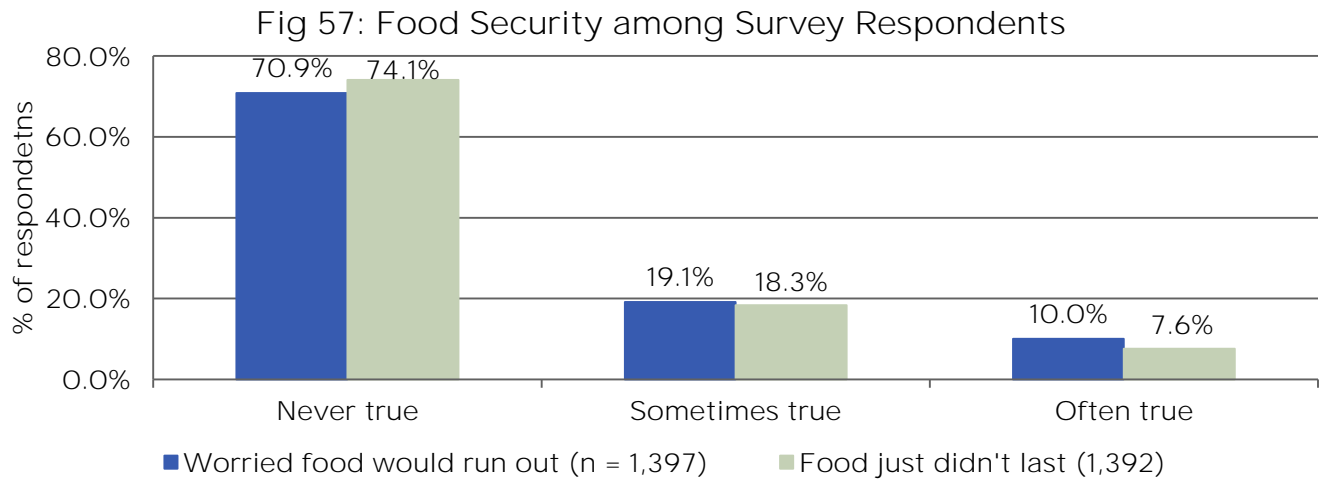


- One in three respondents indicated they already eat enough healthy foods (36.5%).
- Healthy food is expensive (35.1%), spoils too quickly (25.8%) and takes too much time to shop for and/or prepare (24.6%) were the top three barriers identified by respondents.
- Less than 10% of respondents indicated lack of knowledge on food preparation (8.0%), limited access to healthy food (6.9%), not liking the taste of healthy food (7.2%), and lack of ability to identify healthy foods (3.4%) as barriers to eating healthy food more often.

Food Insecurity

A two-item screening tool was utilized to provide a food insecurity estimate among survey respondents. The two-item screening asked respondents to indicate if the two statements were “never true”, “sometimes true” or “often true”. An affirmative answer, “sometimes true” or “often true”, to either or both of the statements is associated with food insecurity.⁵² Additional research has found an affirmative answer to either or both of the statements is also associated with poor child health, increased risk for hospitalization, and developmental risk.⁵³

- 1) **“Within the past 12 months we worried whether our food would run out before we got money to buy more.”**
- 2) **“Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.”**



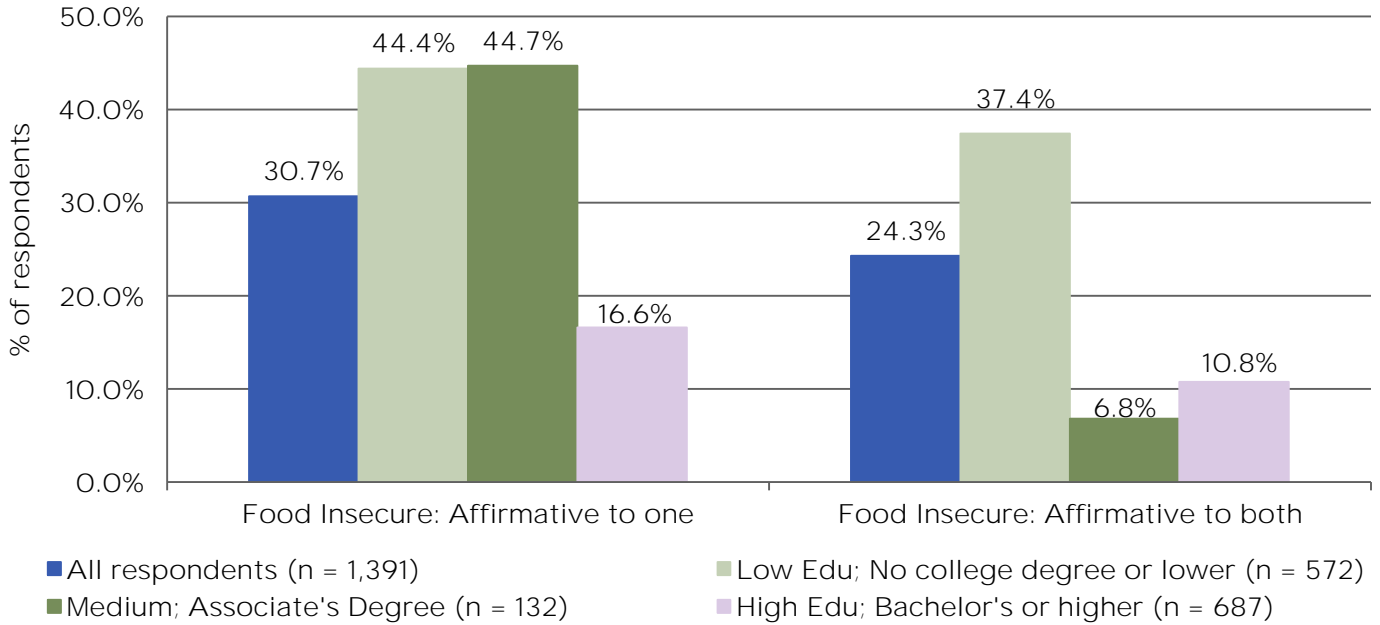
- The majority of survey respondents indicated the above statements were “never true” in the past 12 months.
- Almost one in five survey respondent’s indicated the above statements were “sometimes true”.
- One in ten (10.0%) survey respondents indicated they worried whether their food would run out before they had money to buy more often in the past 12 months, while another 7.6% indicated the food they bought did not last and they did not have money to get more often in the past 12 months.

⁵² Pooler, J.U., Hoffman, V., Karva, F., Levin, M, & Lewin-Zwedling, A. (2016). Addressing Food Insecurity in Primary Care: Models for Patient Screening and Referral. AARP Foundation.

⁵³Hager, E.R., Quigg, A.M., Black, M.M., Coleman, S.M., Heeren, T. & Rose-Jacobs, R. et.al. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. American Academy of Pediatrics. 126; e26-e32.

***Figure 58 shows responses among those who answered both the food security questions as well as the educational attainment question.**

Fig 58: Food Insecurity among Survey Respondents by Educational Attainment

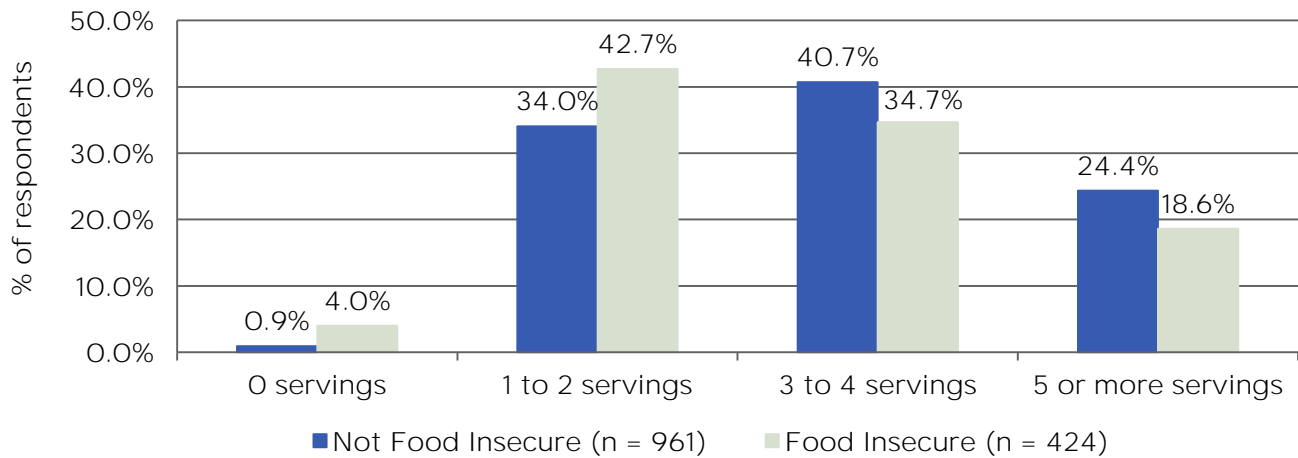


- Among all respondents, 30.7% were estimated to be food insecure, as denoted by answering in the affirmative to either of the screening items.
- Among those with lower educational attainment (no college degree, a high school degree, and those with no high school diploma or GED equivalent) approximately 44.4% were estimated to be food insecure, and among those with an associate’s degree 44.7% were estimated to be food insecure.
- Food insecurity was lowest at 16.6% among survey respondents with a high educational attainment (bachelor’s degree, master’s degree, or PhD).
- Although food insecurity is indicated by an affirmative response to either of the statements, nearly one in four survey respondents (24.3%) indicated an affirmative response to both statements. Among respondent’s with a low educational attainment (no college education, high school graduate, and those without a high school diploma), 37.4% responded in the affirmative to both statements, compared to only 10.8% of those with a high educational attainment (bachelor’s degree, master’s degree, or PhD).

Figure 59 illustrates survey respondents who answered both the food security questions as well as the following question:

“During the past week, about how many servings of fruit and vegetables (combined) did you eat each day? Include fresh, frozen or cooked fruits and vegetables. DO NOT COUNT items such as fruit drinks, French fries, or potato chips.”

Fig 59: Fruit & Vegetable Consumption by Food Security Status



- The number of servings of fruits and vegetables consumed in the previous week differed among those who were not food insecure versus those who were food insecure.
- A higher proportion of respondents who screened positive for food insecurity indicated they ate 0 servings (4.0%) or 1 to 2 servings (42.7%) of fruits and vegetables each day over the past week, compared to those who were not food insecure who reported eating 0 servings (0.9%) or 1 to 2 servings (34.0%) of fruits and vegetables each day.
- Conversely, a higher proportion of respondents who were not food insecure (40.7%) reported consuming 3 to 4 servings of fruits and vegetables each day within the previous week, compared to respondents that were food insecure (34.7%).
- Again, a higher proportion of respondents that were not food insecure (24.4%) reporting eating or 5 or more servings of fruits and vegetables each day over the past week, compared to those who were food insecure (18.6%).

Summary of Food & Hunger

Nevada has historically had low utilization of programs such as SNAP, WIC, and the National School Lunch programs; however, in Washoe County SNAP enrollment increased during the Great Recession and has not yet decreased to pre-Recession levels. Meanwhile, FRP lunch eligibility rates remained relatively stable for the past 5 years and enrollment in WIC has decreased. The number of households and individuals that report being food insecure has decreased from 2013 (15.8%) to 2015 (13.7%). It is challenging to determine overall trend in needs for food assistance using indicators for federal nutrition assistance program enrollment, as they vary from program to program. Utilization of these services may be reflective of successful outreach and program enrollment efforts.

Even though enrollment in social welfare programs can help reduce financial challenges, efforts aimed at reducing food insecurity should recognize perceived barriers to eating more healthy foods including cost, issues with food spoilage (mainly fruits and vegetables), and the time burden of shopping for and preparing food. Although the economy appears to be recovering per employment trends and other economic growth indicators, there are still many competing financial strains on families in Washoe County. These challenges should be considered when developing opportunities to reduce barriers and improve access to healthy foods. Washoe County has a strong collaborative network of engaged organizations working to reduce food insecurity and increase access to healthy food. Implementation of evidence-based solutions, along with a coordinated delivery of strong and consistent messages to the community will further the success of those working to reduce food insecurity and hunger.

Food & Hunger Sources

Table 14: Percent of Students Eligible for Free & Reduced Lunch Program, 2012-2013 through 2016-2017

Nevada Department of Agriculture. Nevada Schools: Number of Free and Reduced Students, School Years 2012-2013 through 2015-2016. Accessed <http://nutrition.nv.gov/data/>

Table 15: Percent of Students who Participate in the National School Lunch Program, Washoe County by Grade, Nevada, & the United States 2012-2013 through 2016-2017

Washoe County: Washoe County School District. Data provided upon request. Reno, NV.
Nevada & United States: United States Department of Agriculture. Data provided upon request. San Francisco, CA.

Fig 55: Percent of Population Enrolled in SNAP, Washoe County & Nevada, 2005-2014

U.S. Census Bureau, Small Area Income and Poverty Estimates. County SNAP benefits data. Accessed <https://www.census.gov/did/www/saipe/data/model/tables.html>

Table 16: Percent of Population Estimated to be Food Insecure

Feeding America. Mind the Meal Gap. Food Insecurity in the United States. Accessed map.feedingamerica.org

Image 4-Image 6 Same Source

Image 4: 2010 USDA ERS Food Deserts in Washoe County

Image 5: 2015 USDA ERS Food Deserts in Washoe County

Image 6: 2010 & 2015 USDA ERS Food Desert, Pyramid Lake Paiute Reservation

United States Department of Agriculture, Economic Research Service. Food Access Research Atlas. Accessed <https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/>

Following Figures from the Online Community Survey

Fig 56: Barriers to Eating Healthy Food More Often (n=1,412)

Fig 57: Food Security among Survey Respondents

Fig 58: Food Insecurity among Survey Respondents by Educational Attainment

Fig 59: Fruit & Vegetable Consumption by Food Security Status

1.4 ACCESS TO HEALTHCARE

Access to Healthcare

Adequate access to healthcare means having the ability to obtain health services in a timely order to achieve the best possible health outcomes. In 2015, the national healthcare expenditures in the United States totaled \$3.2 trillion and the per capita expenditure was an estimated \$9,990.⁵⁴ The costs of healthcare have skyrocketed over the past five decades, while the median income has not. Meanwhile, the quality of care and equity of services fall short of expectations, resulting in poorer health outcomes compared to other developed nations.⁵⁵ Obtaining affordable health insurance is the first challenge in accessing health services in the United States. Additional barriers include the affordability and availability of services, clinic hours and locations, types of health insurance accepted, and having a sufficient number of healthcare providers in the workforce.⁵⁶

Indicator	Trend	Most Recent Year	HP 2020 Objective
Insurance Coverage			
Children <18 years that are uninsured	Decreasing	5.8% (2016)	NA
Adults 18-64 years that have health insurance	Increasing	86.0% (2016)	NA
Medicaid enrollment	Increasing	19.0% (2016)	
Could not see doctor due to cost (adults)	Decreasing	16.3% (2016)	
Provider Access			
Adults that have a personal healthcare provider	Decreasing	72.2% (2016)	NA
Time since last physical (adults)	Increasing	64.7% within past year (2016)	NA
Saw a dentist past year (adolescents)	~	73.6% (2015)	49.0%
Saw a dentist past year (adults)	Increasing	65.4% (2016)	49.0%
Healthcare Provider Workforce			
Percent of population living in HRSA primary care provider shortage area	Increasing	35.4% (2016)	NA
Percent of population living in HRSA dental shortage area	Increasing	35.4% (2016)	NA
Percent of population living in HRSA mental health provider shortage area	STABLE	100.0% (2016)	NA
Ratio of providers to population (primary, dental, and mental care)	~	1,360:1 (Primary Care-2014) 1,480:1 (Dentists-2014) 390:1 (Mental Health-2014)	NA
Physicians by type per 100,000 population	~	~	NA
Full time equivalents at Washoe County Health District	Decreasing	3.4 per 10,000 (FY17-18)	NA
~not able to assess for trend; NA=identical HP 2020 objective not available			

⁵⁴ Department of Health and Human Services. (2017). Health, United States, 2016: With Chartbook on Long-term Trends in Health. Hyattsville, MD.

⁵⁵ Institute of Medicine, Committee on the Learning Health Care System in America. (2013). *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*. Washington, DC.

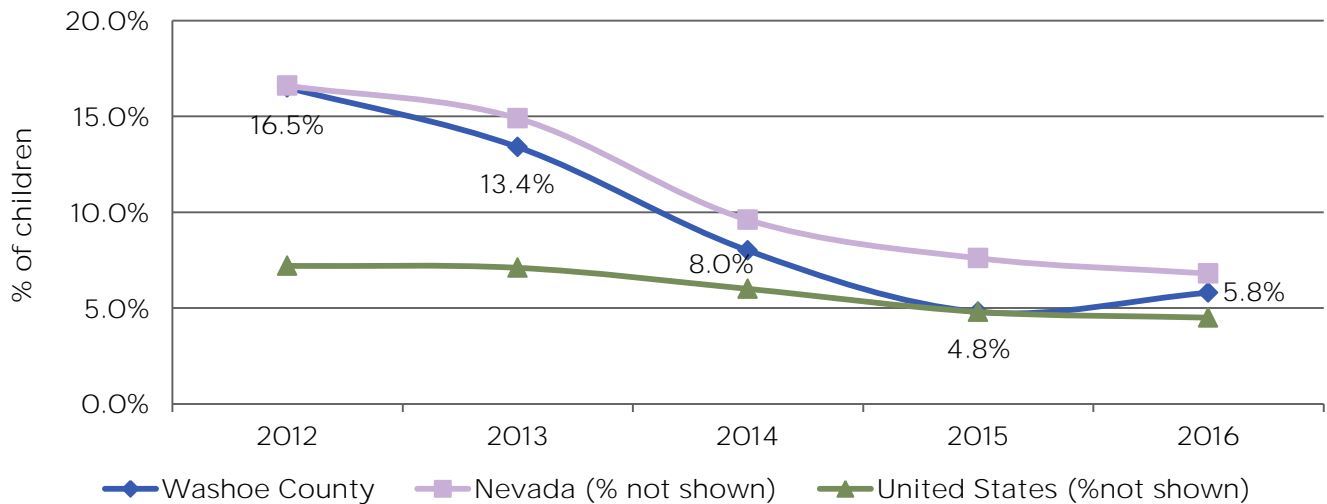
⁵⁶ Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. (1993). *Access to Healthcare in America*. Washington, DC.

1.4 ACCESS TO HEALTHCARE

Insurance Coverage

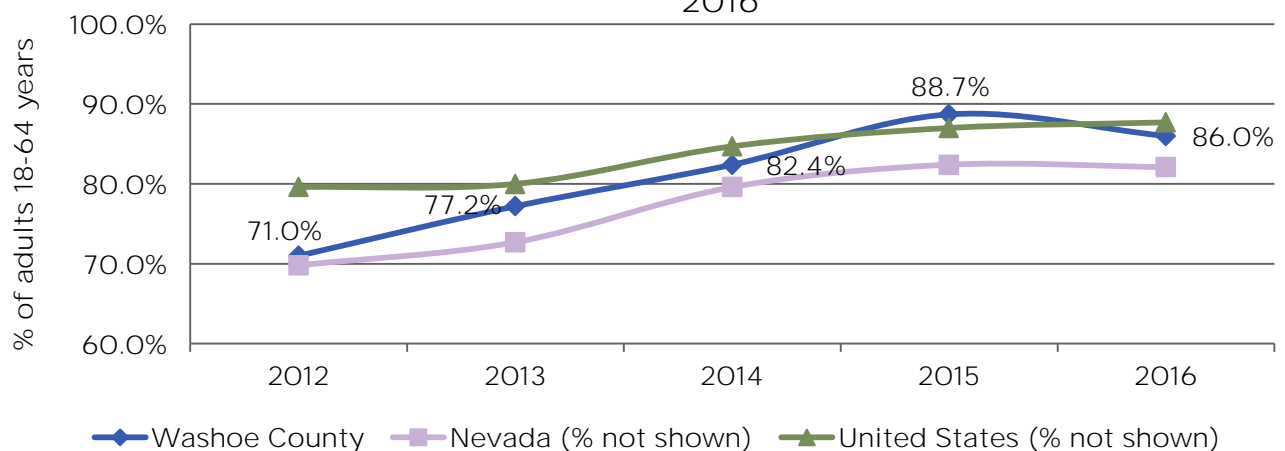
As of 2016, largely due to the passage of the Affordable Care Act (ACA), both the percentage of children and adults who were uninsured and the percentage of adults reporting they could not see a provider due to cost declined.⁵⁷

Fig 60: Uninsured Children < 18 Years, Washoe County, Nevada, & the United States, 2012-2016



- The percentage of uninsured children under 18 years old in Washoe County decreased from 2012 (16.5%) to 2016 (5.8%).
- Historically the rate of uninsured children in Washoe County has been relatively higher than the national average, however starting in 2013, the rates of uninsured children in Washoe County decreased and over the course of three years (2013-2015) fell to the national average.

Fig 61: Percent of Adults 18-64 Years with Any Form of Health Insurance, Washoe County, Nevada, & the United States, 2012-2016



⁵⁷ U.S. Department of Health and Human Services, (2016). Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Hyattsville, MD.

1.4 ACCESS TO HEALTHCARE

- The percentage of adults aged 18 to 64 years in Washoe County with health insurance increased from 2012 (71.0%) to 2016 (86.0%).
- The percentage of adults aged 18 to 64 years in Washoe County with health insurance was lower than the national average from 2012-2014, until 2015 when the percent of adults 18-64 years old with any form of health insurance increased above the national average to 88.7% in Washoe County.

Table 17: Percent of Population Enrolled in Medicaid, 2004, 2011, & 2014-2016

Location	2004	2011	2014	2015	2016
Washoe County	7.0%	12.7%	19.6%	19.5%	19.0%
Nevada	8.3%	13.5%	20.3%	22.6%	21.9%

- The percentage of Washoe County residents enrolled in Medicaid more than doubled from 2004 (7.0%) to 2016 (19.0%), primarily due to Medicaid expansion in 2014.
- In 2004, 2011 and 2014-2016 the percentage of population in Washoe County enrolled in Medicaid was lower than Nevada.

Table 18: Percent of Adults 18 to 64 years who could Not See a Doctor Due to Cost*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	18.0%	17.1%	15.6%	13.0%	16.3%
Nevada	18.5%	17.3%	17.1%	15.1%	16.0%

*in the past 12 months

- The percentage of adults in Washoe County who reported they could not see a doctor due to cost decreased from 2012 (18.0%) to 2016 (16.3%).
- The percentage of adults in Washoe County who reported they could not see a doctor due to cost has been lower than Nevada from 2012 through 2015; in 2016, it rose above statewide rates.

Provider Access

Table 19: Percent of Adults with One Person they think of as their Personal Healthcare Provider, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	74.6%	71.9%	72.4%	75.4%	72.2%
Nevada	60.1%	58.9%	56.5%	66.8%	69.2%
United States	~	77.1%	76.7%	79.0%	77.7%

~ data not available

- The percentage of adults in Washoe County with one person they think of as their personal healthcare provider decreased from 2012 (74.6%) to 2016 (72.2%).
- The percentage of adults in Washoe County with one person they think of as their personal healthcare provider has been higher than Nevada, but lower than the United States from 2012 through 2016.

Table 20: Time since Last Physical among Adults, Washoe County, 2012-2016

Duration	2012	2013	2014	2015	2016
In the past year	60.3%	62.6%	62.0%	65.8%	64.7%
In the past 2 years	15.2%	15.8%	14.9%	14.1%	14.5%
In the past 5 years	12.3%	9.7%	12.7%	8.3%	9.7%
5 years or more	9.9%	9.1%	8.4%	9.5%	9.0%
Never	2.3%	2.9%	2.0%	2.4%	2.1%

- The percentage of adults in Washoe County who obtained a routine physical within the past year increased from 2012 (60.3%) to 2016 (64.7%).

1.4 ACCESS TO HEALTHCARE

- The percentage of adults in Washoe County who obtained a routine physical in the past 2 years, the past 5 years, or more than 5 years ago decreased over the same time period
- Although improving, the percentage of adults in Washoe County who obtained a routine physical within the past year has been lower than the United States from 2012 through 2016.

Table 21: Time since Last Physical among Adults, Nevada, 2012-2016

Duration	2012	2013	2014	2015	2016
In the past year	63.9%	65.8%	63.9%	66.2%	69.1%
In the past 2 years	15.2%	15.5%	14.6%	11.8%	12.7%
In the past 5 years	9.1%	8.1%	10.5%	9.5%	7.4%
5 years or more	9.8%	8.8%	9.2%	9.7%	9.1%
Never	1.9%	1.8%	1.8%	2.8%	1.6%

Table 22: Time since Last Physical among Adults, United States, 2013-2016

Duration	2013	2014	2015	2016
In the past year	68.2%	69.6%	70.2%	70.4%
In the past 2 years	13.1%	13.2%	13.3%	12.8%
In the past 5 years	8.3%	8.2%	8.2%	7.4%
5 years or more	8.4%	8.3%	8.3%	6.9%
Never	1.2%	1.1%	1.1%	1.2%

Table 23: Percent of High School Students who Visited a Dentist*, 2013 & 2015

Location	2013	2015
Washoe County	69.3%	73.6%
Nevada	68.1%	69.7%
United States	~	74.4%

*for a check-up, exam, teeth cleaning, or other dental work during the 12 months before the survey

- The percentage of high school students in Washoe County who visited a dentist within the past year increased from 2013 (69.3%) to 2015 (73.6%).
- In 2015, the percentage of high school students in Washoe County who visited a dentist within the past year was higher (73.6%) than Nevada (69.7%), and it was lower than the United States (74.4%).

Table 24: Percent of Adults who Visited a Dentist or Dental Clinic*, 2012, 2014 & 2016

Location	2012	2014	2016
Washoe County	64.8%	64.0%	65.4%
Nevada	60.8%	60.0%	60.4%
United States	67.2%	65.3%	65.1%

* for any reason within the past 12 months

- The percentage of adults in Washoe County who visited a dentist or dental clinic within the past year increased slightly from 2012 (64.8%) to 2016 (65.4%).
- In 2016 the percentage of adults in Washoe County who visited a dentist or dental clinic within the past year was higher (65.4%) than Nevada (60.4%), and slightly higher than the United States (65.1%).

1.4 ACCESS TO HEALTHCARE

Table 25: Time Since Last Dental Visit* among Adults, Washoe County, 2012, 2014, & 2016

Duration	2012	2014	2016
In the past year	64.8%	64.0%	65.4%
1 to 2 years	11.3%	12.8%	11.0%
2 to 5 years	10.6%	10.4%	12.2%
5 years or more	11.2%	12.1%	10.7%
Never	2.2%	0.9%	0.7%

*visited a dentist or dental clinic for any reason

- The percentage of adults in Washoe County who visited a dentist within the past year increased slightly from 2012 (64.8%) to 2016 (65.4%).

Healthcare Provider Workforce

The rapid population growth in Nevada and Washoe County has resulted in one of the lowest rates of physicians per capita in the nation.⁵⁸ As the population continues to grow, residents face challenges accessing healthcare in a timely manner and finding providers who are accepting new patients. This is due to the limited number of providers per 100,000 population.

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are geographic, population, or facility-based designations indicating a health professional shortage in primary care, dental health, or mental health. A geographic shortage encompasses a shortage of providers for an entire population within a geographic area, e.g. a county. A population-based shortage indicates a shortage of providers within a geographic area for a specific population group, such as low income or migrant workers. A facility-based shortage is a shortage within a specific type of facility, for example, state mental hospitals, federally qualified health centers, Indian health facilities, or correctional facilities. The Health Resources and Services Administration (HRSA) reviews HPSA applications to determine if they meet eligibility criteria for designation. Once designated, each HPSA receives a score indicating severity of the shortage, the higher the score (16-25), the more severe the shortage.⁵⁹

Table 26: Percent of Population Residing in Health Professional Shortage Area by Type, Washoe County, 2012, 2014, & 2016

Provider Type	2012	2014	2016
Primary care	32.2%	34.2%	35.4%
Dental health	32.9%	32.7%	35.4%
Mental health	~	100.0%	100.0%

⁵⁸ U.S. Department of Health and Human Services, (2016). Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Hyattsville, MD.

⁵⁹ Health Resources and Services Administration. Health Professional Shortage Areas (HPSAs). Accessed <https://bh.w.hrsa.gov/shortage-designation/hpsas>

1.4 ACCESS TO HEALTHCARE

2017 HRSA Designated Health Professional Shortage Areas

The 2017 HPSAs have changed in geographic size from previous years; therefore, a direct comparison from 2016 to 2017 HPSAs is not feasible. The following tables illustrate further details regarding the 2017 HPSA designations in Washoe County in conjunction with provider survey data from the Nevada Primary Care Office. Provider surveys are conducted on a period basis to identify primary care and psychiatrist provider practice location, patient care hours, and acceptance of Medicaid and/or sliding fee scale payments. These data inform the population to provider ratios for the 2017 HPSAs illustrated in Table 27, Table 28, and Table 29.

Table 27: Primary Care¹ Health Professional Shortage Areas, Washoe County, 2017

Health Professional Shortage Area (HPSA) Name	Provider FTEs ² Short	HPSA Provider FTE	HPSA Designation Population	Total Population	Population to 1 Provider Ratio	HPSA Score
LI ³ Reno PC ⁴	26.93	16.62	130,595	291,046	7,858	16
Northern Washoe PC Geo ⁵	1.54	0.00	5,403	5,403	5,403	17
Incline Village PC Geo	0.57	1.83	8,395	8,395	4,587	9
Total / Average⁶	29.04	18.45	144,393	304,844	5,949	14

¹Primary care providers include family medicine, internal medicine, general medicine, OB/GYN, pediatric, and geriatric MDs and DOs that provide primary outpatient care.

²Full Time Equivalent (FTE): 1 FTE = 40 hour workweek of outpatient care. FTE short indicates the number of providers needed to remove the HPSA provider shortage in a designated area.

³Low income (LI) FTE is calculated by adding the percentages of care given to Medicaid and sliding fee scale patients and multiplying it by the provider's FTE. A sliding fee scale is designed to provide discounts for low-income individuals based on family size and income. For Low Income HPSAs, the population considered is those at or under the 200% federal poverty threshold. The LI HPSA population to provider ratio threshold needs to be at or above 3000:1 to qualify as a LI HPSA.

⁴PC = Primary Care

⁵Geographic (Geo) HPSA. The FTE for Geo HPSAs include the complete provider FTE. The population utilized is the total civilian non-institutionalized population. The Geo population to provider ratio threshold is 3500:1 to qualify as a shortage area.

⁶Totals are provided for the Provider FTE Short, HPSA Provider FTE, HPSA Designation Population and Total Population columns. The remainder of the columns are averages.

- Among total residents in the county, 304,844 or 71.88% of residents were located within a primary care HPSA in 2017. The increase from previous years is mostly due to a change in the geographic area that was newly designated as primary care HPSA in 2017.
- The primary care physician workforce would need to increase by 157% in Washoe County to meet the demands of the populations within these HPSAs.

Table 28: Mental Health Care¹ Health Professional Shortage Areas in Northern Nevada², 2017

Health Professional Shortage Area (HPSA) Name	Provider FTEs ³ Short	HPSA Provider FTE	HPSA Designation Population	Total Population	Population to 1 Provider Ratio ⁴	HPSA Score
Urban Washoe MH LI ⁵	1.29	4.90	123,803	261,221	25,266	14
Northern Washoe MH Geo ⁶	0.27	0.00	5,403	5,403	5,403	15
Total / Average⁷	1.56	4.90	129,206	266,624	15,334	15

¹Mental health providers are defined as psychiatrists engaged in outpatient care.

²All Mental Health HPSAs are currently under federal review and are subject to change.

³Full Time Equivalent (FTE): 1 FTE = 40 hour workweek of outpatient care. FTE short indicates the number of providers needed to remove the HPSA provider shortage in a designated area.

⁴Population to provider ratio threshold of 20000:1. The threshold determines the value over which an area is considered to have a provider shortage.

⁵Low income (LI) FTE is calculated by adding the percentages of care given to Medicaid and sliding fee scale patients and multiplying it by the provider's FTE. A sliding fee scale is designed to provide discounts for low-income individuals based on family size and income. For Low Income HPSAs, the population considered is those at or under the 200% federal poverty threshold. The LI HPSA population to provider ratio threshold needs to be at or above 20000:1 to qualify as a LI HPSA.

⁶Geographic (Geo) HPSA. The FTE for Geo HPSAs include the complete provider FTE. The population utilized is the total civilian non-institutionalized population. The Geo Population to provider ratio threshold needs to be at or above 20000:1 to qualify as a shortage area.

⁷Totals are provided for the Provider FTE Short, HPSA Provider FTE, HPSA Designation Population and Total Population columns. The remainder of the columns are averages.

1.4 ACCESS TO HEALTHCARE

- Among the total residents in the county, 266,624 or 62.87% of residents are located within a mental health care HPSA. The decrease from previous years is mostly due to a change in the geographic area that was designated as mental health provider HPSA in 2017.
- The mental providers (psychiatrist) workforce would need to increase by 32% in Washoe County to meet the demands of the populations within these HPSAs.

Table 29: Dental Health Care¹ Health Professional Shortage Areas in Northern Nevada², 2017

Health Professional Shortage Area (HPSA) Name	Provider FTEs ³ Short	HPSA Provider FTE	HPSA Designation Population	Total Population	Population to 1 Provider Ratio ⁴	HPSA Score
Washoe County DH LI ⁵	23.80	14.65	153,792	424,089	10,498	18
Total / Average⁶	23.80	14.65	153,792	424,089	10,498	18

¹Dental health providers are defined as dentists.

²This HPSA is currently under federal review and is subject to change.

³Full Time Equivalent (FTE): 1 FTE = 40 hour workweek of outpatient care. FTE short indicates the number of providers needed to remove the HPSA provider shortage in a designated area.

⁴Population to provider ratio threshold of 4000:1. The threshold determines the value over which an area is considered to have a provider shortage.

⁵Low income (LI) FTE is calculated by adding the percentages of care given to Medicaid and sliding fee scale patients and multiplying it by the provider's FTE. A sliding fee scale is designed to provide discounts for low-income individuals based on family size and income. For Low Income HPSAs, the population considered is those at or under the 200% federal poverty threshold. The LI HPSA population to provider ratio threshold needs to be at or above 4000:1 to qualify as a LI HPSA.

⁶Totals are provided for the Provider FTE Short, HPSA Provider FTE, HPSA Designation Population and Total Population columns. The remainder of the columns are averages.

- According to the geographic location of the 2017 HPSA, 100% of Washoe County residents are located within a dental health care HPSA. The increase from previous years is mostly due to a change in the geographic area that was designated as dental health care HPSA in 2017.
- The dental provider workforce would need to increase by 162% in Washoe County to meet the demands of the populations within these HPSAs.

Providers per Population

Table 30: Ratio of Providers to Population, 2014

Provider type	Washoe County	Nevada
Primary care	1,360:1	1,750:1
Dentists	1,480:1	1,690:1
Mental health	390:1	580:1

- In 2014, the ratio of primary care providers per capita (1,360:1), dentists per capita (1,480:1), and mental health providers (390:1) in Washoe County were lower than Nevada.

1.4 ACCESS TO HEALTHCARE

Table 31: Licensed Physicians (MD) per 100,000 Population, 2017

Specialty	Washoe County	Nevada	United States
Aerospace Medicine	-	0.1	0.1
Allergy	1.6	0.7	1.4
Anesthesiology	21.6	14.3	14.6
Cardiovascular Diseases	9.4	6.2	7.5
Child / Adolescent Psychiatry	2.0	1.0	2.6
Colon / Rectal Surgery	0.2	0.1	0.5
Dermatology	4.0	2.0	3.8
Diagnostic Radiology	9.7	6.4	8.5
Emergency Medicine	23.2	10.8	12.1
Family Medicine	36.9	20.3	29.6
Gastroenterology	5.4	3.0	4.5
General Practice	0.9	1.8	2.1
General Surgery	11.5	7.1	12.4
Internal Medicine	50.2	39.0	56.0
Medical Genetics	0.2	0.1	0.2
Neurology	3.6	3.0	5.7
Nuclear Medicine	-	0.0	0.4
Neurological Surgery	3.8	1.2	2.0
Obstetrics / Gynecology	13.5	9.9	14.0
Occupational Medicine	1.1	0.7	0.7
Ophthalmology	7.4	3.9	6.1
Orthopedics	12.8	5.9	8.4
Otolaryngology	3.8	1.7	3.4
Pathology, Anatomic	4.7	3.0	6.1
Pathology, Forensic	0.7	0.1	3.8
Pediatrics	15.1	14.4	26.7
Pediatric Cardiology	0.4	0.5	0.8
Phys Med & Rehab	5.8	2.8	3.3
Plastic Surgery	2.5	1.1	2.5
Psychiatry	13.3	6.2	12.9
PH & Gen Preventive Medicine	0.4	0.1	0.5
Pulmonary Diseases	4.0	1.5	4.0
Radiology	2.2	1.5	3.2
Radiation Oncology	1.1	0.9	1.6
Thoracic Surgery	1.3	0.9	1.5
Urology	3.4	1.7	3.5
Other Specialties	1.6	1.3	3.7
Total	278.3	175.0	261.8

- In 2017, Washoe County had a higher rate (per 100,000 population) of the majority of licensed providers compared to Nevada.
- In 2017, Washoe County had higher rate (per 100,000 population) for 15 of the 37 licensed medical providers, an identical rate for 3 of the 37, and a lower rate (per 100,000 population) for 19 of the 37 licensed medical provider types compared to the United States.

1.4 ACCESS TO HEALTHCARE

Full Time Equivalents (FTE) at Local Health Department

Washoe County Health District has experienced a reduction in the number of budgeted full-time employees (FTE) and rate of FTE per capita over the past decade [Table 32]. In 2016, the national average FTE was 159 among local health departments that serve populations between 250,000-499,999 persons; this equates to a rate of 4.3 FTE per 10,000 population.⁶⁰ The Washoe County Health District serves a population of approximately 439,000 and had 151.4 FTE budgeted for FY17-18, resulting in a rate of 3.4 FTE per 10,000 population.

Table 32: Rate of Budgeted Full Time Equivalents, Washoe County Health District, FY06-07 to FY17-18

Fiscal Year	Budgeted FTE	Rate per 10,000 population
FY06-07	203.93	5.2
FY07-08	203.60	5.1
FY08-09	193.00	4.7
FY09-10	193.00	4.7
FY10-11	166.68	4.0
FY11-12	165.48	3.9
FY12-13	156.72	3.7
FY13-14	149.43	3.5
FY14-15	149.83	3.4
FY15-16	150.01	3.4
FY16-17	151.41	3.4
FY17-18	151.42	3.4

- The number of budgeted full-time employees (FTE) for Washoe County's Health District decreased from FY06-07 (203.93 FTE) to FY17-18 (151.42 FTE).
- The rate of budgeted FTE at the Washoe County Health District per 10,000 Washoe County residents has decreased from FY 06-07 (5.2 per 10,000 population) to FY17-18 (3.4 per 10,000 population).
- The rate of budgeted FTE for the Washoe County Health District has not changed since FY 14-15 through FY17-18 and has remained at a 12-year low of 3.4 FTE per 10,000 population.

Primary Data Related to Access to Healthcare

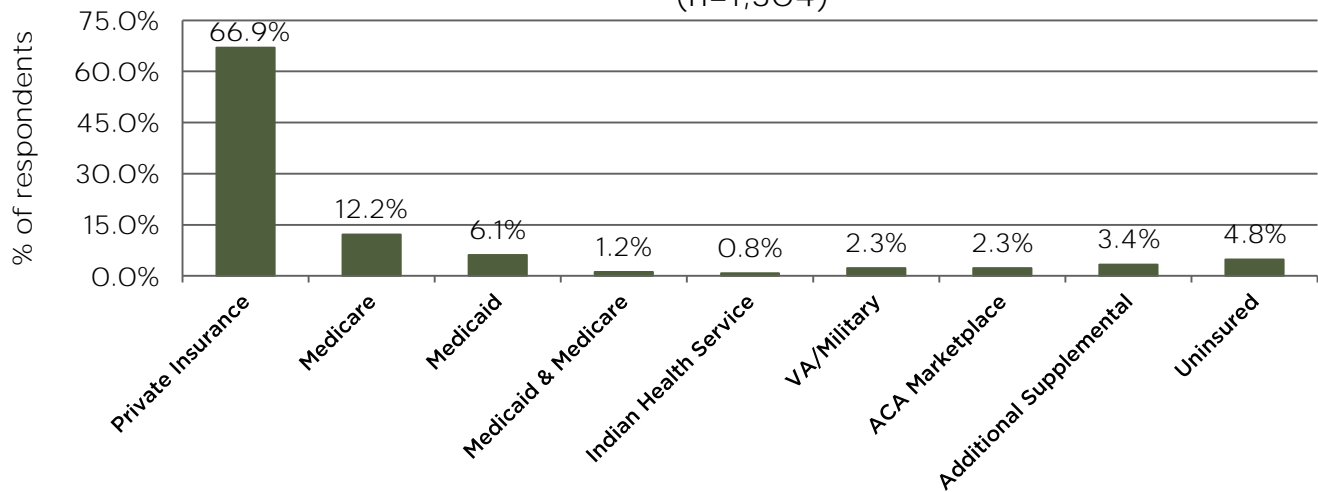
Primary data were collected via an online community survey from over 1,400 survey participants. The survey included 44 questions and analyses for questions related to accessing healthcare are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community Survey Demographics section.

⁶⁰ National Association of County & City Health Officials. (2017). 2016 National Profile of Local Health Departments. Accessed http://nacchoprofilestudy.org/wp-content/uploads/2017/04/ProfileReport_Final3b.pdf

1.4 ACCESS TO HEALTHCARE

Question: “What type of health insurance coverage do you currently have? Select all that apply.”

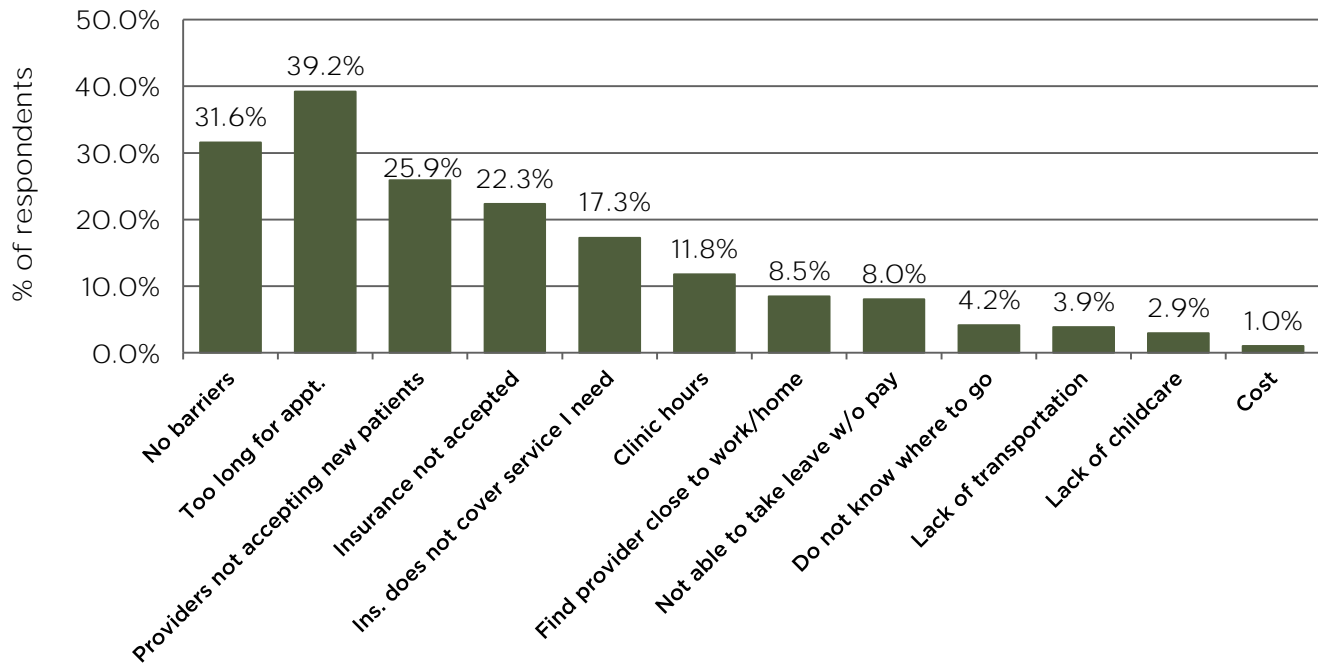
Fig 62: Insurance Coverage among Survey Respondents (n=1,304)



- The majority of survey respondents (66.9%) identified they were insured through a private insurance provider, typically through an employer.
- Approximately 12.2% of respondents indicated they have Medicare coverage, followed by 6.1% covered by Medicaid. Among respondents 1.2% were insured under both Medicare and Medicaid.
- Among the 1,304 respondents to the question, 4.8% indicated they were uninsured.

Question: “What are the main barriers you face when accessing healthcare in Washoe County? Select all that apply.”

Fig 63: Barriers to Accessing Healthcare (n=1,298)

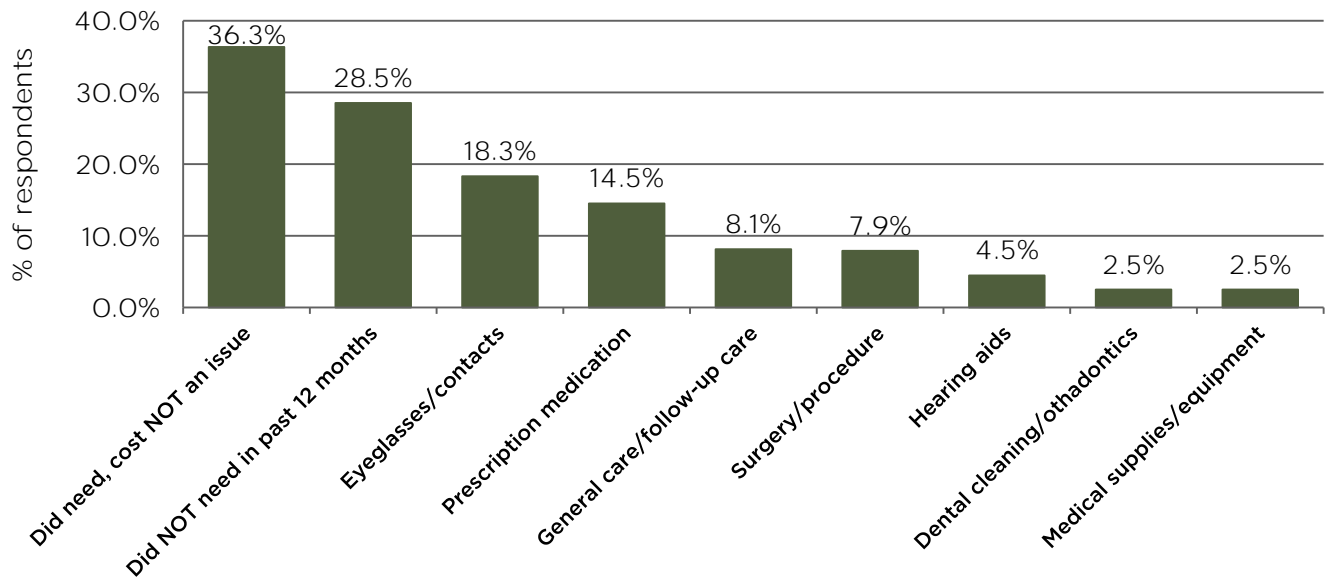


1.4 ACCESS TO HEALTHCARE

- Slightly less than one in three (31.6%) of survey respondents indicated they had no barriers in accessing healthcare.
- The most commonly identified barrier to accessing healthcare was that it takes too long for an appointment (39.2%).
- One in four respondents (25.9%) indicated they have challenges finding providers who are accepting new patients, one in five stated their insurance is not accepted (22.3%), and 17.3% indicate their insurance did not cover the service(s) they needed.

Question: “In the past 12 months did you need any of the following, but could not receive them because of cost? Select all that apply.

Fig 64: Services Needed but Could Not Obtain Due to Cost, Past 12 Months (n=1,256)

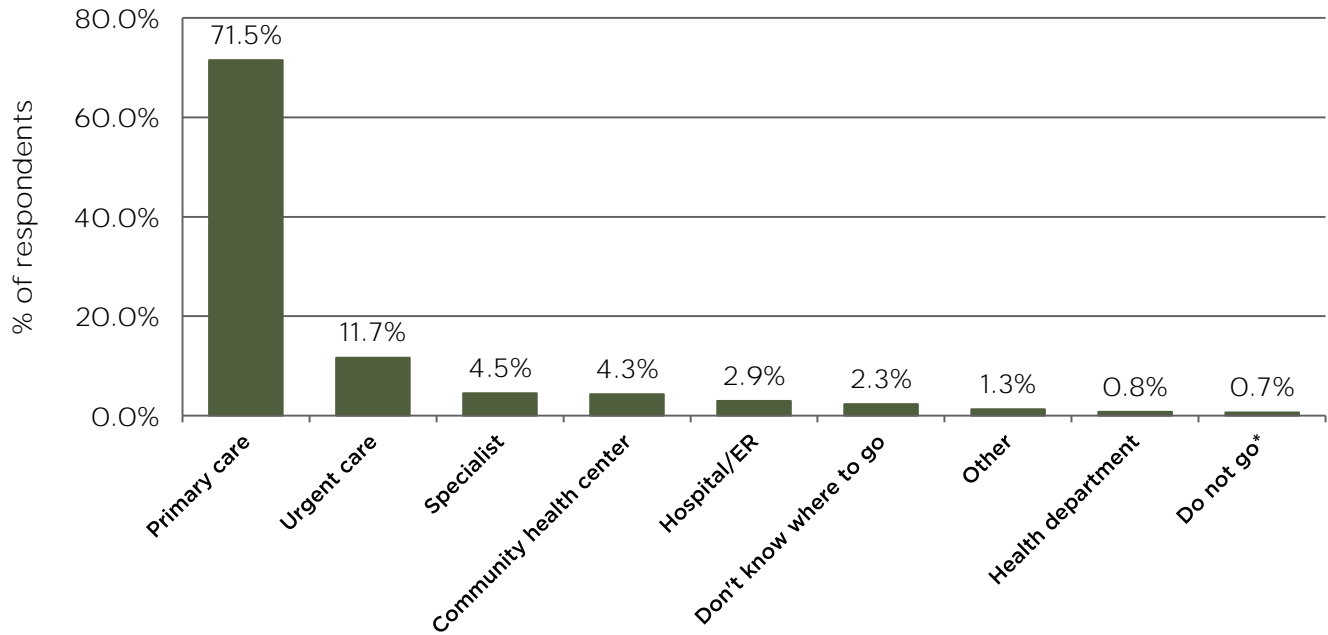


- Slightly over one in three (36.3%) indicated they did need at least one service, but that cost was not a barrier. Another 28.5% of survey respondents indicated they did not need any of the services in the past 12 months.
- The most frequently identified medical need was eyeglasses/contacts (18.3%), followed by prescription medication (14.5%), general care or follow-up care (8.1%), and surgery/medical procedure (7.9%).

1.4 ACCESS TO HEALTHCARE

Question: “If you or someone in your household needs to see a doctor or healthcare provider, where do you go most often?”

Fig 65: Where Receive Healthcare Most Often (n=1,327)



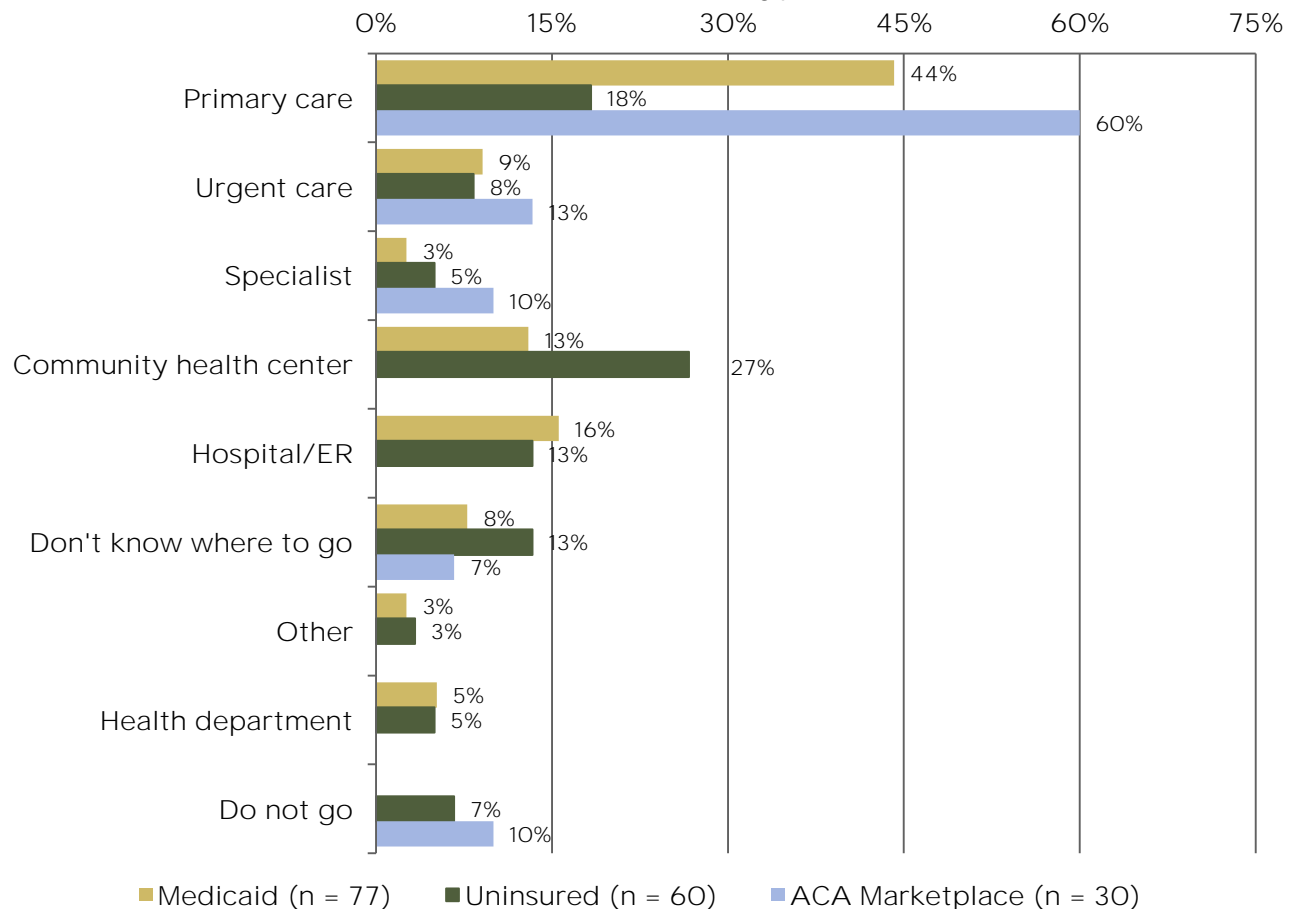
- The majority of survey respondents (71.5%) indicated they/household members most often go to a primary care facility to obtain healthcare. Slightly more than one in ten respondents (11.7%) indicated they go to urgent care facilities most often.

1.4 ACCESS TO HEALTHCARE

Figure 66 illustrates survey respondents who answered both the following questions; however includes only those covered under Medicaid, ACA Marketplace insurance, or were uninsured, as these individuals typically face a larger burden in accessing healthcare.

1. “Where do you go most often?”
2. “The type of insurance they currently were covered under”

Fig 66: Where Receive Healthcare Most Often by Select Health Insurance Type



Among the 77 survey respondents who answered both questions and were insured through Medicaid:

- Less than half (44%) indicated they see a primary care provider most often.
- Approximately 16% indicated they go to a hospital or the emergency room and 13% report most often received healthcare in community health center.

Among the 60 survey respondents who answered both questions and were uninsured:

- More than one in four (27%) indicate they receive healthcare at a community health center most often.
- 18% see a primary care provider, and 13% indicated they don't know where to go or (13%) go to a hospital or an emergency room most often.

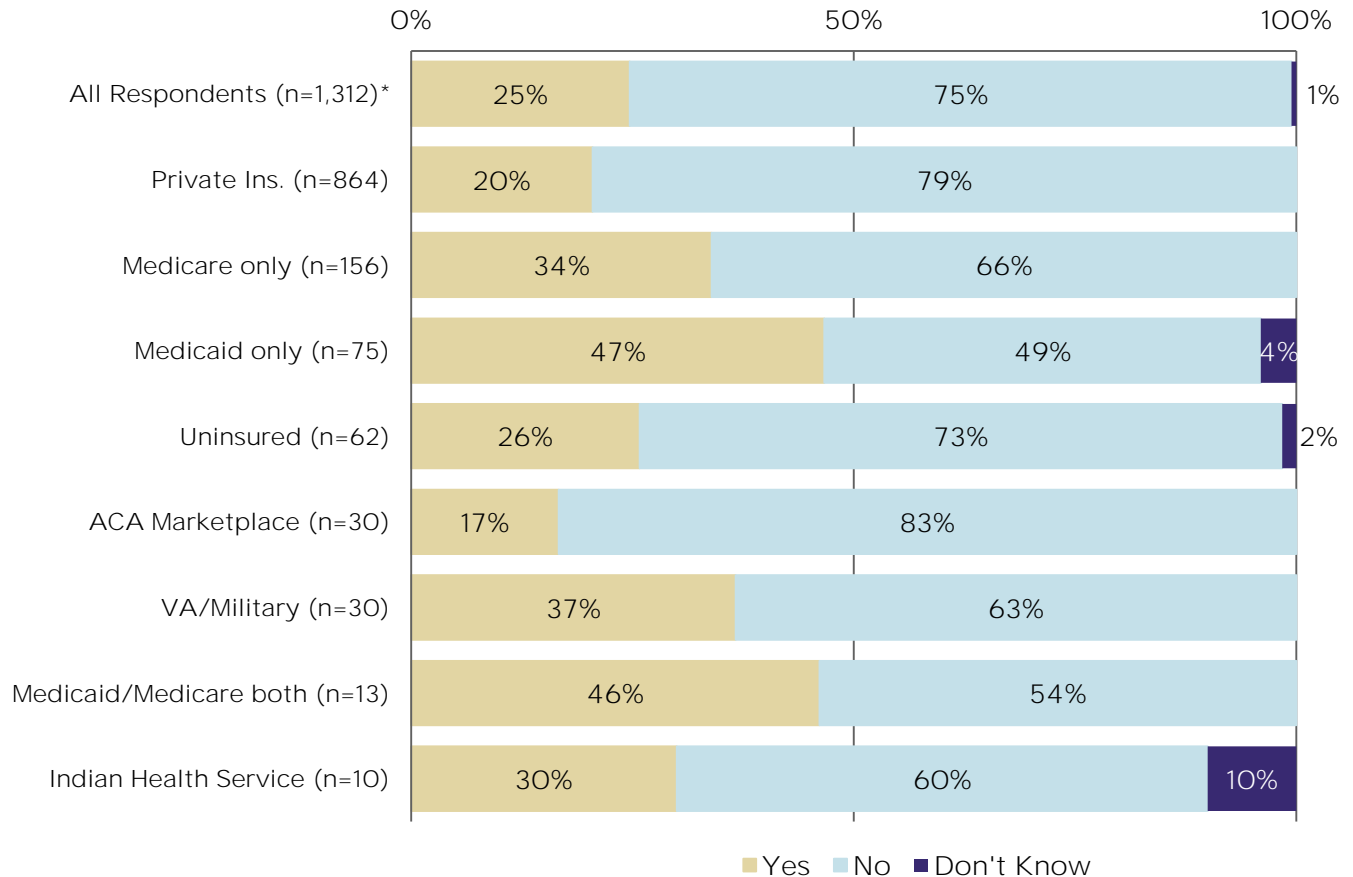
Among the 30 survey respondents who answered both questions and were insured through an ACA Marketplace insurance provider, 60% indicated they most often received healthcare from a primary care provider.

1.4 ACCESS TO HEALTHCARE

Figure 67 illustrates survey respondents who answered both the following questions

1. "In the past 12 months have you used an emergency room?"
2. "The type of insurance they currently were covered under"

Fig 67: Used Emergency Room At Least Once in Past 12 Months by Health Insurance Type



*Note: All Respondents to question about emergency room use in past 12 months, regardless if they answered the insurance type question.

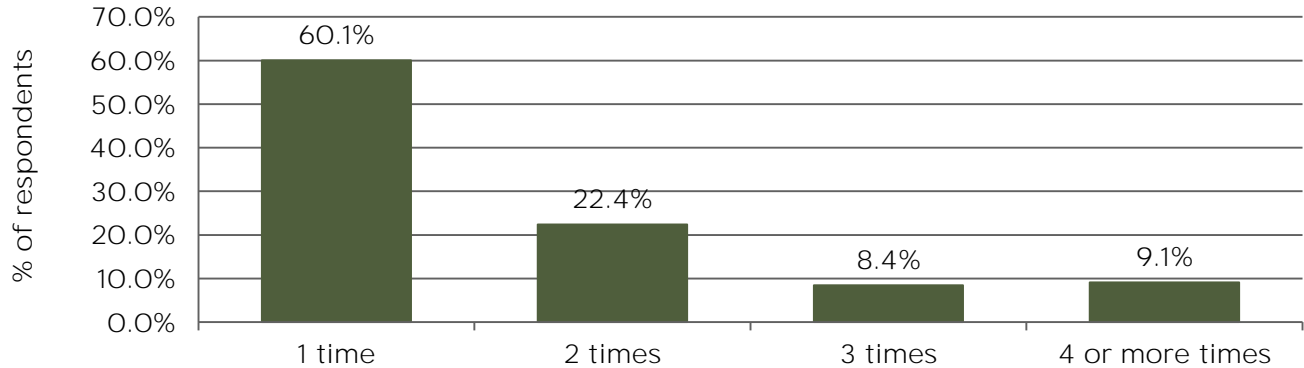
- Among all survey respondents (n = 1,312) one in four (25%) indicated they had gone to the emergency room at least once in the past 12 months.
- A higher percentage of respondents who were covered under only Medicaid (47%), Medicaid and Medicare (46%), the VA/Military (37%), only Medicare (34%), and Indian Health Services (30%) indicated they had gone to the emergency room at least once in the past 12 months.
- A lower percentage of respondents who were covered under an ACA Marketplace insurance provider (17%) or by private insurance (20%) indicated they had gone to the emergency room at least once in the past 12 months.

1.4 ACCESS TO HEALTHCARE

***Question: “How many times in the past 12 months have you gone to the emergency room?”**

*Only asked among the 324 respondents who indicated they had gone to an emergency room at least once in the past 12 months.

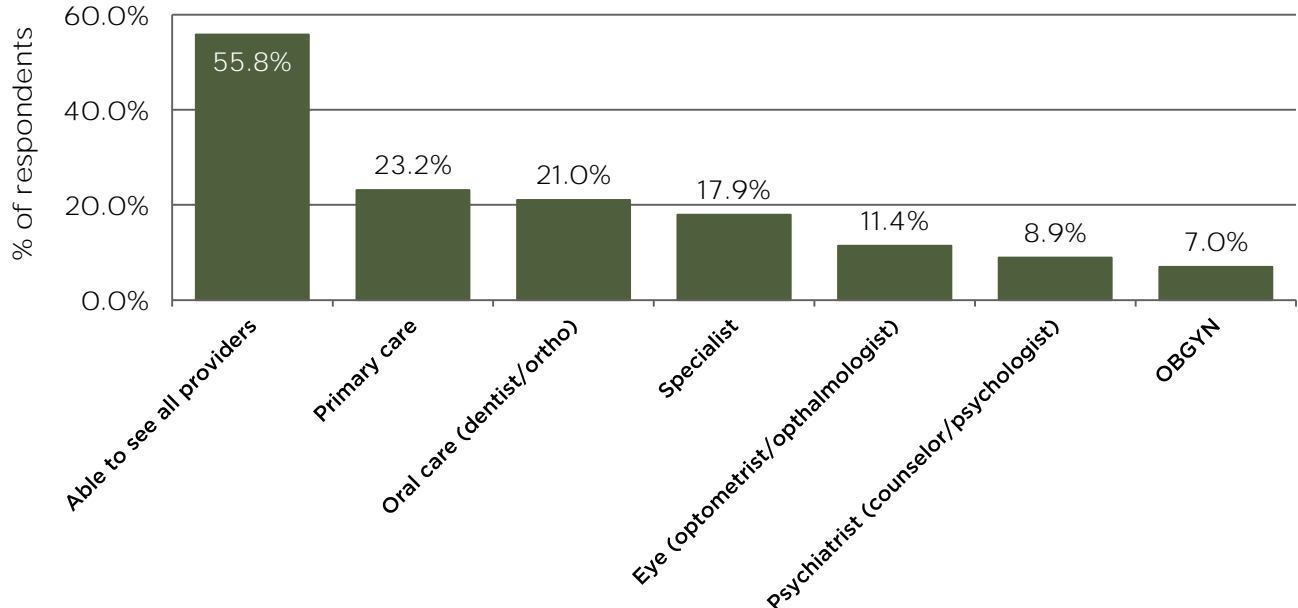
Fig 68: Number of Times Been to the Emergency Room in Past 12 Months (n=308)



- The majority of people who had gone to an emergency room at least once in the past 2 months had only gone 1 time (60.1%); however, one in five respondents had gone twice, and nearly one in ten had gone four or more times in the past 12 months.

Question: “In the past 12 months, which of the following healthcare providers have you needed to see but couldn’t? Select all that apply.”

Fig 69: Type of Provider Needed but Could Not See, Past 12 Months (n=1,304)



- Over half of respondents (55.8%) indicated they were able to see all the providers they needed to see within the past 12 months.
- The most frequently identified provider needed, but unable to see within the past year was primary care (23.2%), followed by oral care -- dentist (21.0%), and a specialist (17.9%).

Summary of Access to Healthcare

The percentage of children (< 18 years) and adults (18-64 years) who were uninsured in Washoe County has decreased in recent years, largely due to the Affordable Care Act (ACA) and resulting Medicaid expansion. In 2016, 19% of Washoe County's population was enrolled in Medicaid, many of whom are served by a few community health clinics. A higher percentage of adults in Washoe County reported having seen a provider in the past year, including dental providers, and fewer people reported cost as a barrier to receiving healthcare services compared to pre-ACA periods.

There are no psychiatrists outside Washoe County in the more rural areas across Northern Nevada, therefore these mental health providers are accessed either through telehealth or long-distance travel, which adds an additional burden to the mental healthcare system in Washoe County. In 2017, Washoe County had a higher rate of licensed providers by specialty (per 100,000 persons) compared to Nevada; however, there is already an existing deficit of internists, OB-GYN, pediatricians and other specialists is critical, this coupled with an aging healthcare workforce and continued population growth does not bode well. The loss of only a few physicians in any specialty could flip the county negatively. Additionally, the Washoe County Health District's budgeted full-time employee rate declined from FY06-07 to FY14-15 and remained at 3.4 FTE per 10,000 residents through FY17-18.

Having access to healthcare begins with affordability of basic preventive services such as immunizations, annual physicals, and screening for chronic diseases. However, the continued growth in population, coupled with the increase in proportion of people with health insurance and an ongoing shortage of healthcare providers across the spectrum, has magnified challenges in accessing healthcare for all residents regardless of insurance status.

Short-term solutions to accessing healthcare include increasing education regarding appropriate pathways for accessing healthcare, which could reduce unnecessary burdens on emergency rooms-- the most expensive entry point. Additionally, creating a continuum of care such as one-stop-shop options for vulnerable populations and frequent utilizers of the healthcare system is another way to maximize efficiency. A cost-effective solution to the overall shortage of providers includes expanding graduate medical education (GME) programs with the University of Nevada, Reno School of Medicine and regional healthcare providers. GME residency programs increase the number of providers available to treat patients during the course of the residency and slightly more than half of individuals stay in the communities where they conduct their residency.⁶¹

⁶¹ Association of American Medical Colleges. (2016). Report on Residents. Table C4. Physician Retention in State of Residency Training, by last Completed SME Specialty, 2006-2015. Accessed <https://www.aamc.org/data/448492/c4table.html>

Access to Healthcare Sources

Fig 60: Uninsured Children Under 18 Years, Washoe County, Nevada, & the United States, 2012-2016

U.S. Census, 2016 American Community Survey -1 year estimates-Table S2701 - SELECTED CHARACTERISTICS OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES

Fig 61: Percent of Adults 18-64 Years with Any Form of Health Insurance, Washoe County, Nevada, & the United States, 2012-2016

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

Table 17: Percent of Population Enrolled in Medicaid, 2004, 2011, & 2014-2016

University of Nevada, Reno school of Medicine, Office of Statewide Initiatives. Nevada Instant Atlas. Accessed <https://med.unr.edu/statewide/instant-atlas/county-data-map>

Table 18-Table 22 Same Source

Table 18: Percent of Adults 18 to 64 years who could Not See a Doctor Due to Cost*, 2012-2016

Table 19: Percent of Adults with One Person they think of as their Personal Healthcare Provider, 2012-2016

Table 20: Time since Last Physical among Adults, Washoe County, 2012-2016

Table 21: Time since Last Physical among Adults, Nevada, 2012-2016

Table 22: Time since Last Physical among Adults, United States, 2013-2016

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

Table 23: Percent of High School Students who Visited a Dentist*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 24-Table 25 Same Source

Table 24: Percent of Adults who Visited a Dentist or Dental Clinic*, 2012, 2014 & 2016

Table 25: Time since Last Dental Visit* among Adults, Washoe County, 2012, 2014, & 2016

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

Table 26: Percent of Population Residing in Health Professional Shortage Area by Type, Washoe County, 2012, 2014, & 2016

University of Nevada, Reno School of Medicine, Office of Statewide Initiatives. Instant Atlas, County data. Accessed <https://med.unr.edu/statewide/instant-atlas/county-data-map>

Table 27-Table 29 Same Source

Table 27: Primary Care¹ Health Professional Shortage Areas, Washoe County, 2017

Table 28: Mental Health Care¹ Health Professional Shortage Areas in Northern Nevada², 2017

Table 29: Dental Health Care¹ Health Professional Shortage Areas in Northern Nevada², 2017

Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Nevada Office of Primary Care. Data provided upon request. Carson City, NV.

Table 30: Ratio of Providers to Population, 2014

Robert Wood Johnson Foundation. 2017 County Health Rankings. Accessed <http://www.countyhealthrankings.org/app/nevada/2017/measure/factors/4/map>

1.4 ACCESS TO HEALTHCARE

Table 31: Licensed Physicians (MD) per 100,000 Population, 2017

University of Nevada School of Medicine, Office of Statewide Initiatives. Data provided upon request. Reno, NV.

Table 32: Rate of Budgeted Full Time Equivalent, Washoe County Health District, FY06-07 to FY17-18

Washoe County Health District, Office of District Health Officer. Data provided upon request. Reno, NV.

Following Figures from the Online Community Survey

Fig 62: Insurance Coverage among Survey Respondents (n=1,304)

Fig 63: Barriers to Accessing Healthcare (n=1,298)

Fig 64: Services Needed but Could Not Obtain Due to Cost, Past 12 Months (n=1,256)

Fig 65: Where Receive Healthcare Most Often (n=1,327)

Fig 66: Where Receive Healthcare Most Often by Select Health Insurance Type

Fig 67: Used Emergency Room At Least Once in Past 12 Months by Health Insurance Type

Fig 68: Number of Times Been to the Emergency Room in Past 12 Months (n=308)

Fig 69: Type of Provider Needed but Could Not See, Past 12 Months (n=1,304)

Environmental Health

Environmental health encompasses the physical, chemical, and biological factors which people are exposed to including indoor and outside ambient air, drinking and recreational water quality, and waste. Natural disasters, occupational hazards, and the built environment (infrastructure) are also considered to be environmental factors which may impact a person’s quality of life and overall health.

Indicator	Trend	Most Recent Year
Air		
Air Quality Index summary	~	various
Air Quality Index summary with most current standards applied	Decreasing (Good days)	235 good days (2016)
Air quality exceedances	STABLE	7 exceedances (2016)
Indoor radon	~	78% homes below EPA action level (1989-2015)
Water		
Percent of community drinking water systems in compliance	STABLE	89.66% (2016)
Cryptosporidiosis rates	Decreasing	2.0 per 100,000 (2016)
Giardia rates	Decreasing	4.5 per 100,000 (2016)
Waste		
Tons of waste per year (recycled + disposed)	Increasing	1,168,235.05 tons (2016)
Pounds of waste per person	Decreasing	2,798 lbs/person (2016)
Recycling rates	Decreasing	32.8% (2016)
~not able to assess for trend		

Air Quality

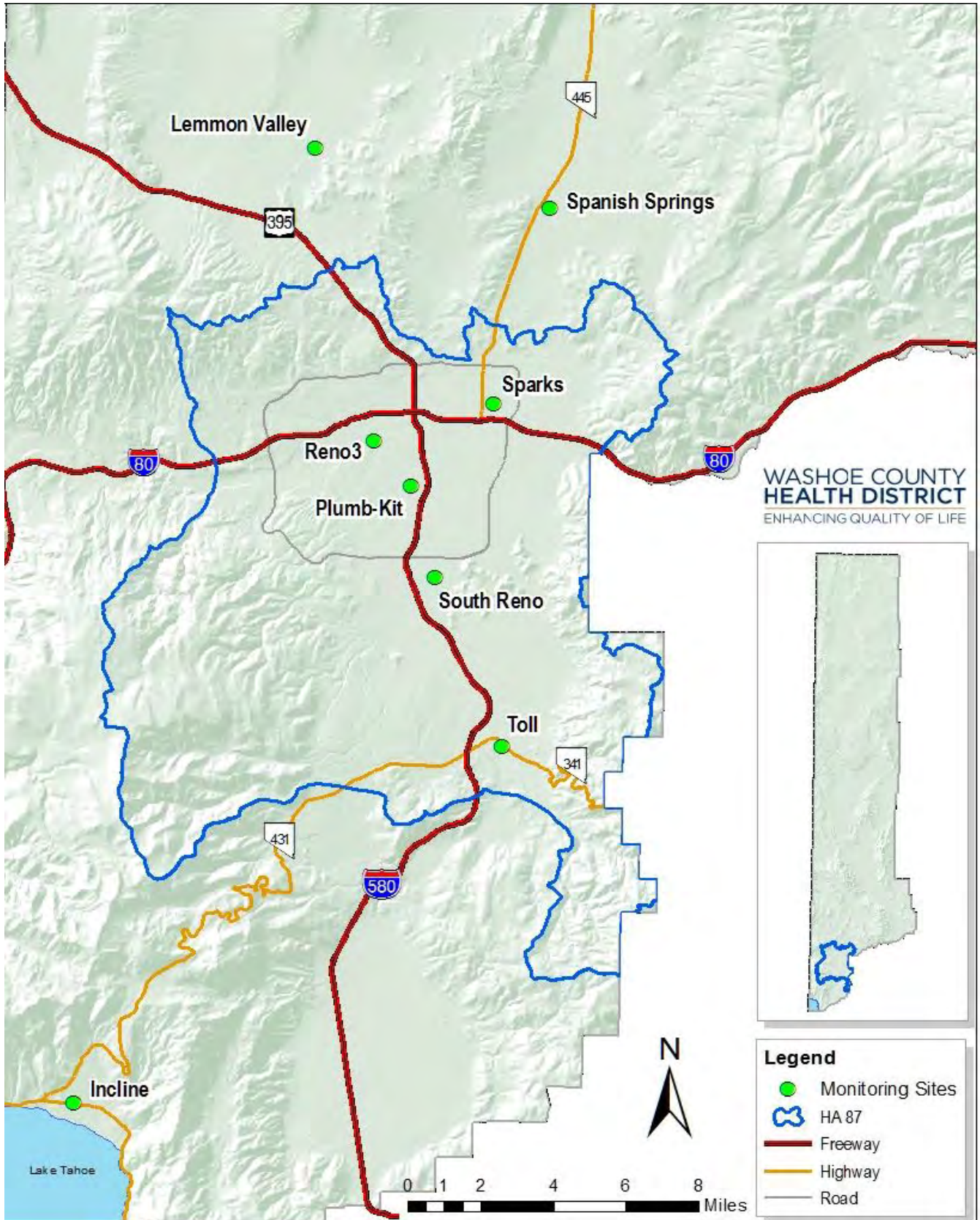
According to the Environmental Protection Agency (EPA), air pollution can lead to health problems including increased respiratory and cardiovascular disease, decreased lung function, increased frequency and severity of respiratory symptoms such as difficulty breathing and coughing, and an increased susceptibility to respiratory infections. Additional negative health impacts of poor air quality include effects on the nervous system, and impacts on learning, memory, and behavior, some cancers, and premature death.⁶²

Criteria Air Quality Pollutants

The Clean Air Act requires the EPA to monitor six criteria air pollutants including particulate matter (PM_{2.5} and PM₁₀), ozone (O₃), nitrogen dioxide (NO₂), carbon monoxide (CO), sulfur dioxide (SO₂) and lead (Pb). Image 7 illustrates the locations of air monitoring stations in Washoe County as of 2017.

⁶² United States Environmental Protection Agency. (2012). National Air Quality: Status and Trends of Key Air Pollutants. Accessed <https://www.epa.gov/air-trends>

Image 7: Washoe County Ambient Air Monitoring Sites 2017



Particulate Matter

Particulate matter is a mixture of exceptionally small particles and liquid droplets composed of acids, organic chemicals, metals, and soil or dust particles. Particles that are 10 micrometers in diameter (PM_{10}) or smaller ($PM_{2.5}$) are of concern because particles that size can pass through the throat, nose and lungs. Once inhaled, these particles affect the heart and lungs and can decrease lung function, aggravate asthma, result in the development of chronic bronchitis, can produce an irregular heartbeat, trigger nonfatal heart attacks, and potentially cause premature death in people with heart or lung disease. People with preexisting heart and lung conditions, children and older adults are the most likely to be affected by exposure to particulate matter, however even healthy people can experience symptoms from exposure to high levels of particulate matter. The EPA categorizes particle pollution into two criteria pollutants:

1. Inhalable coarse particles (PM_{10}), which are usually found near roadways and dusty industries, these are between 2.5 and 10 micrometers in diameter.
2. Fine particles ($PM_{2.5}$), these are typically from fireplace/woodstove or wildfire smoke, or they can form when gases from power plants, industries, and automobiles react in the air. These are 2.5 micrometers in diameter and smaller.

PM levels vary between the seasons. “Unhealthy for Sensitive Groups” and “Unhealthy AQI” levels of $PM_{2.5}$ happen during calm, cold wintertime inversions and wildfire episodes. PM_{10} levels have been increasing, especially during the wintertime inversions and the days after snowstorms. Regulations related to woodstoves, street sanding and sweeping, and industry have all helped decrease particulate pollution in Reno/Sparks.

Ozone

Motor vehicle exhaust and industrial emissions, gasoline vapors, and chemical solvents, as well as natural sources, emit oxides of nitrogen (NO_x) and volatile organic compounds (VOCs) which form ozone. Ground-level ozone is the primary constituent of smog. Sunlight and hot weather cause ground-level ozone to form in harmful concentrations. Ground-level ozone affects the respiratory system by reducing the body’s ability to take in more oxygen. Symptoms such as chest pains, coughing and throat irritation can occur by breathing in ozone. Among individuals with preexisting conditions such as bronchitis, emphysema, or asthma, ingestion of ozone can be extremely dangerous. Ozone levels for Reno/Sparks have been very close to the ambient air quality standards and occasionally have reached the “Unhealthy for Sensitive Groups” air quality index level, since the 2008 standard began. Ozone is a primary summertime pollutant of concern for the area and will remain a challenge as future air quality standards strengthen.

Nitrogen Dioxide

Short-term nitrogen dioxide (NO_2) exposure, ranging from 30 minutes to 24 hours, can cause airway inflammation in healthy people and increase respiratory symptoms in people with asthma. Studies show a connection between short-term exposure to elevated NO_2 concentrations and an increase in emergency room and hospital admissions for respiratory issues, especially asthma. The Washoe County Air Quality Management District has been monitoring NO_2 since 2009; however NO_2 has not been a concern in Washoe County compared to ozone and particulate matter.

Carbon Monoxide

Carbon monoxide (CO) is a colorless, odorless gas which can cause harmful health effects by reducing oxygen delivery to the body’s organs and tissues. For a person with heart disease, a single exposure to low levels of CO may cause chest pain and reduce the ability to exercise. Exposure to high levels of CO can result in vision problems, reduced ability to work or learn, reduced manual dexterity, and difficulty performing complex tasks. At extremely high levels, CO is poisonous and can cause death. Carbon monoxide has not been an ambient air quality problem since the early 1990s in Washoe County.

Sulfur Dioxide

Short-term exposure to sulfur dioxide (SO_2) has been linked to constricted airway passages in the lungs and exacerbate asthma symptoms. SO_2 and other sulfur oxides react with compounds to create small particles, which can cause or worsen respiratory diseases such as emphysema and bronchitis, as well as aggravate heart disease causing increased hospital admissions and even premature death.

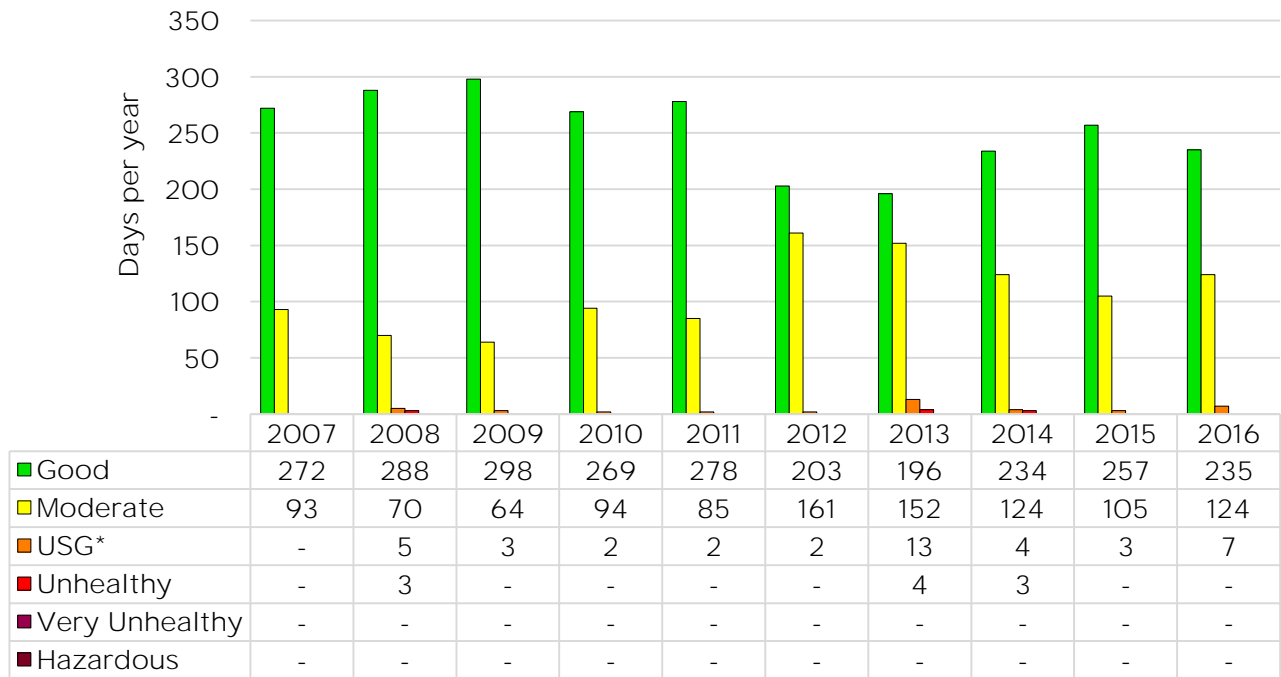
Lead

Lead (Pb) is a naturally occurring metal, which historically was used in gasoline, water pipes and paint. Pb accumulates in the bones impacting the nervous system, immune system, reproductive systems, developmental systems, and impairing kidney function. Pb exposure has been linked to high blood pressure and heart disease in adults and is associated with behavioral problems, learning deficits, and decreased IQ levels in children.

National Ambient Air Quality Standards & Air Quality Index

The EPA developed standards known as National Ambient Air Quality Standards (NAAQS), these are the regulatory levels at which air is considered unhealthy. The Air Quality Index (AQI) is a metric for reporting air quality each day; the AQI was also established by the EPA and accounts for the major air pollutants combined. There have been NAAQS revisions in 2008, 2012, and 2015 which changed the AQI category ranges and number of days per year in each range. Fig 70 provides a summary of the AQI for the measured criteria air pollutants combined, Fig 71 shows summary of the AQI for the measured criteria air pollutants compared to most current NAAQS, and Fig 72 illustrates the number of NAAQS exceedances occurring each year (2007-2016) in Washoe County by criteria air pollutant type.

Fig 70: Air Quality Index Summary, Washoe County, 2007-2016



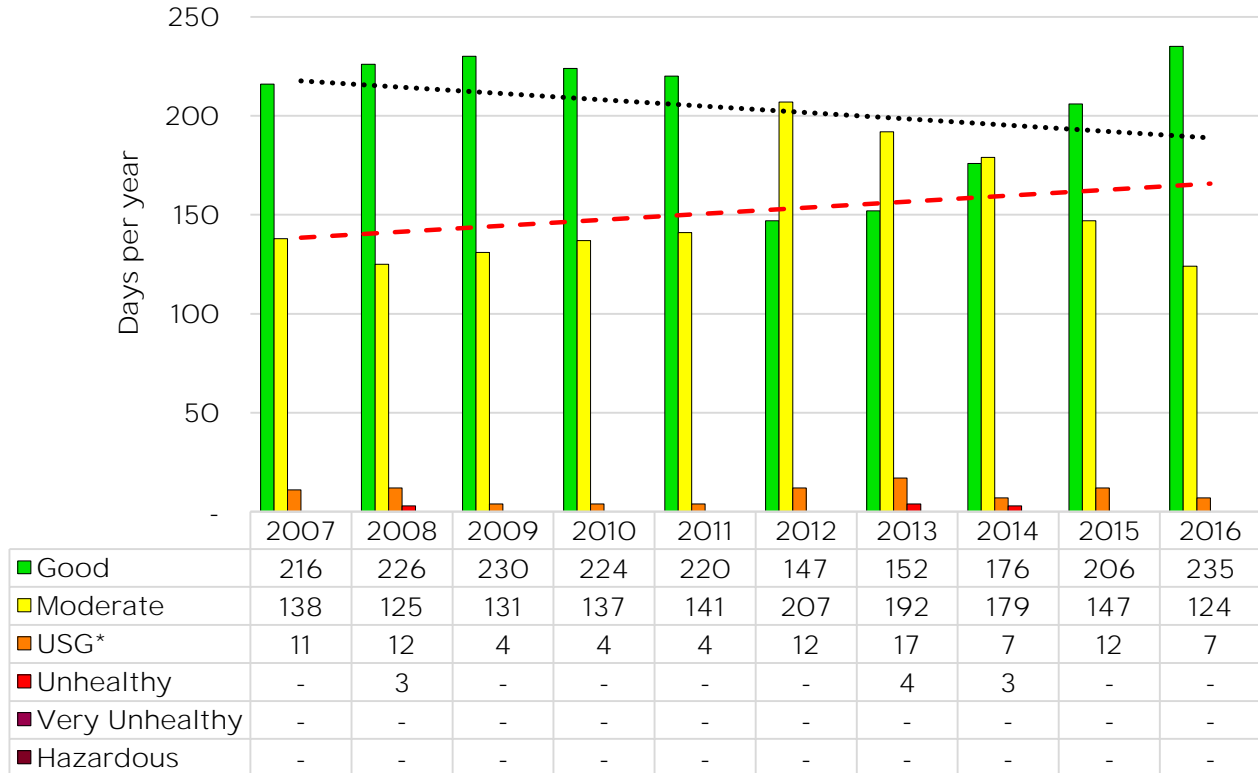
*USG: Unhealthy for Sensitive Groups;

Note: 2008: 8-hour O₃ NAAQS strengthened from 0.08 to 0.075 ppm; 2012: Annual PM_{2.5} NAAQS strengthened from 15.0 to 12.0 µg/m³; 2015: 8-hour O₃ NAAQS strengthened from 0.075 to 0.070 ppm

- From 2007 through 2016 Washoe County experienced over 200 days of “good” air quality annually, with the exception of 2013 (196 “good” days).

- The number of days categorized as “moderate” in Washoe County doubled from 2011 (85 days) to 2012 (161 days), and remained above 100 days since 2012. This due to the changes in the NAAQS and not a reflection of air quality, see following Figure 71 for comparative trend.
- From 2007 through 2016 there were only three years with measured “unhealthy” air quality days in Washoe County, 2008 (three “unhealthy” days), 2013 (four “unhealthy” days), and 2014 (three “unhealthy” days). Unhealthy days are typically due to smoke from wild fires across northern California and Nevada.

Fig 71: Air Quality Index Summary, Washoe County, 2007-2016 with NAAQS as of 12/31/2016 Applied Across all Years

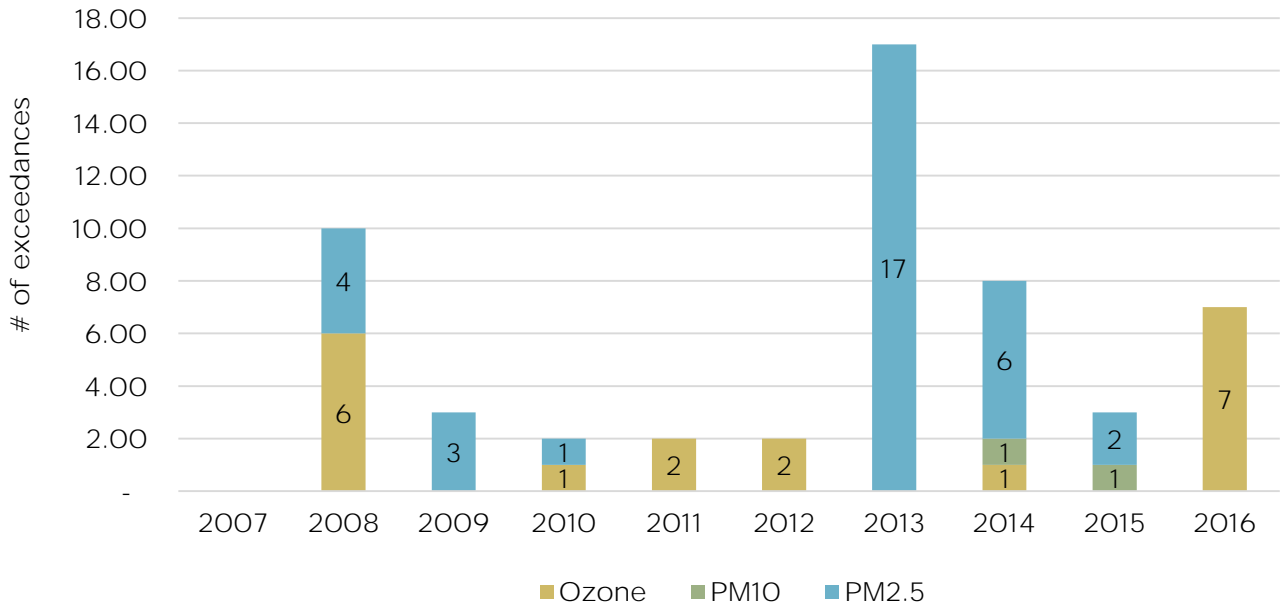


*USG: Unhealthy for Sensitive Groups;

Note: NAAQS as of 12/31/2016 were applied across all years

- With the most recent NAAQS applied across all years, overall the number of days categorized as “good” in Washoe County have trended down over the 10 year period illustrated by the dotted black line, although the number between 2007 (216 good days) to 2016 (235 good days) increased.
- With the most recent NAAQS applied across all years, overall the number of days categorized as “moderate” in Washoe County have trended upward over the 10 year period illustrated by the red dashed line, although the number of days between 2007 (138 days) to 2016 (124 days) decreased.
- These trends are due to relatively worse air quality that occurred during the three-year period 2012 to 2014. Aside from these three years, the other seven years are quite similar with respect to better air quality.

Fig 72: Number of Air Quality Pollutant Exceedances by Criteria Pollutant Type, Washoe County, 2007-2016



Note: There were no exceedances for carbon monoxide, lead, nitrogen dioxide, or sulfur dioxide in Washoe County from 2007-2016; therefore data are not shown for those criteria air pollutants.

- The criteria air pollutant which most frequently exceeded EPA standards between 2007 and 2016 in Washoe County was PM_{2.5}, followed by ozone, and PM₁₀.

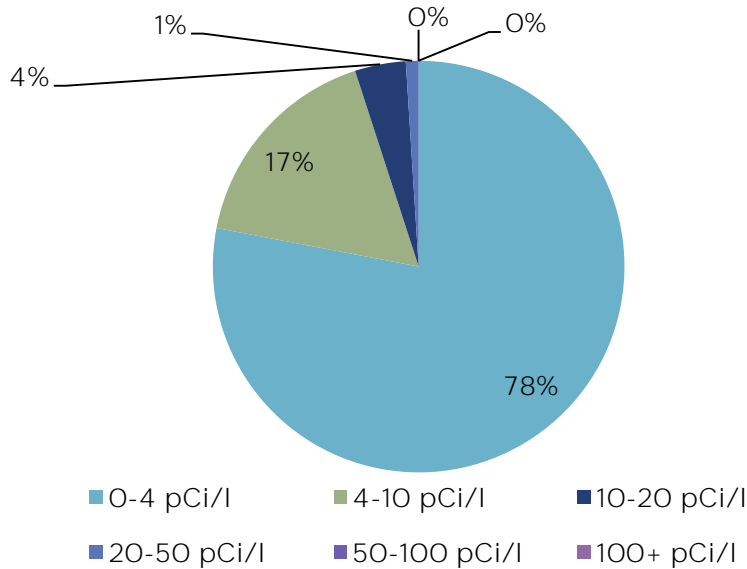
Indoor Radon

Radon is a naturally occurring colorless, odorless, and tasteless radioactive gas. Radon is produced when uranium, radium and thorium break down in rocks, soil, and groundwater. Radon is estimated to be the second leading cause of lung cancer in the United States responsible for 21,000 lung cancer deaths each year. Lung cancer due to radon exposure costs an estimated \$2 billion in medical expenses and lost productivity every year. People are exposed to radon primarily through cracks and gaps in homes and other buildings. The EPA estimates 1 in 15 homes in the United States have high radon levels. The Surgeon General and EPA recommend fixing homes that have an indoor air radon level of 4pCi/l or higher.⁶³

The only way to know the radon level in a home is to have it tested. The University of Nevada, Reno’s Cooperative Extension offers short-term radon test kits for \$10. For more information and to find the nearest location offering test kits call 1-888-RADON10 (888-723-6610).

⁶³ Centers for Disease Control and Prevention. Household Radon. Accessed <https://www.cdc.gov/cancer/dccp/pdf/householdradon.pdf>

Fig 73: Percent of Homes Tested by Radon Level Ranges, Washoe County, 1989-2015 Aggregate Data



Note: data are based on independently tested homes in Washoe County from 1989 through June 30, 2015 and are not a scientific sample.

- The majority of homes tested for radon in Washoe County (78%) have indoor radon levels below the recommended EPA action level of 4 pCi/l or higher.
- Slightly more than one in five (22%) homes tested for radon in Washoe County have an indoor radon level above the recommended action level of 4 pCi/l or higher.

Water

Water treated for public utilization is not typically a major concern among developed nations. However, without regular monitoring, sources of pollution or naturally occurring substances may be present in high levels, which when exposed to over a long enough period of time, could result in negative health effects. Waterborne infectious diseases are primarily due to exposures during recreation on lakes or rivers or when a person consumes untreated water.

Water Systems in Compliance

A public or community water system is any system that provides water for human consumption with at least 15 service connections or that serves an average of 25 persons for at least 60 days out of the year.⁶⁴ There are over 100 community water systems in Washoe County and all are expected to maintain compliance with the regulations set forth in the Safe Drinking Water Act. Water systems are regularly tested for water contaminants including microorganisms, disinfectant residuals, disinfectant byproducts, radionuclides, as well as organic and inorganic chemicals. If a water sample test indicates a contaminate is above the EPA maximum contaminant level (MCL) the sample has to be retested and the contaminate must fall back under the MCL within a set period

⁶⁴ Environmental Protection Agency. Public Water Systems. Accessed <https://www.epa.gov/dwreginfo/information-about-public-water-systems>

of time or else the water system is designated as out of compliance. Once a water system is out of compliance the local health authority ensures the water system will distribute guidelines to either boil water from the tap or switch to bottled water depending on the type of contaminate in violation.

Truckee Meadows Water Authority (TMWA) oversees the city water supply for the majority of the Reno-Sparks population (77%). More than 85% of the drinking water delivered by TMWA originates from Lake Tahoe, which is primarily fed by snow melt and rain throughout the Tahoe basin. The remaining 15% of drinking water comes from more than 90 wells drilled in deep-water aquifers located within TMWA’s service area.⁶⁵

Find your water system consumer confidence report by accessing this interactive website

https://ofmpub.epa.gov/apex/safewater/f?p=ccr_wyl:102

Table 33: Community Water Systems (CWS) & Population Served by CWS without MCL Violations by Year, Washoe County, 2011-2016

Indicator	2011	2012	2013	2014	2015	2016
Percent of CWS with no violations	89.66%	89.66%	96.55%	96.55%	89.66%	89.66%
Total number of people served by all CWS	352,158	352,158	352,158	352,158	352,158	352,158
Percent of population served with no violation	99.96%	99.95%	99.98%	99.98%	99.93%	99.94%

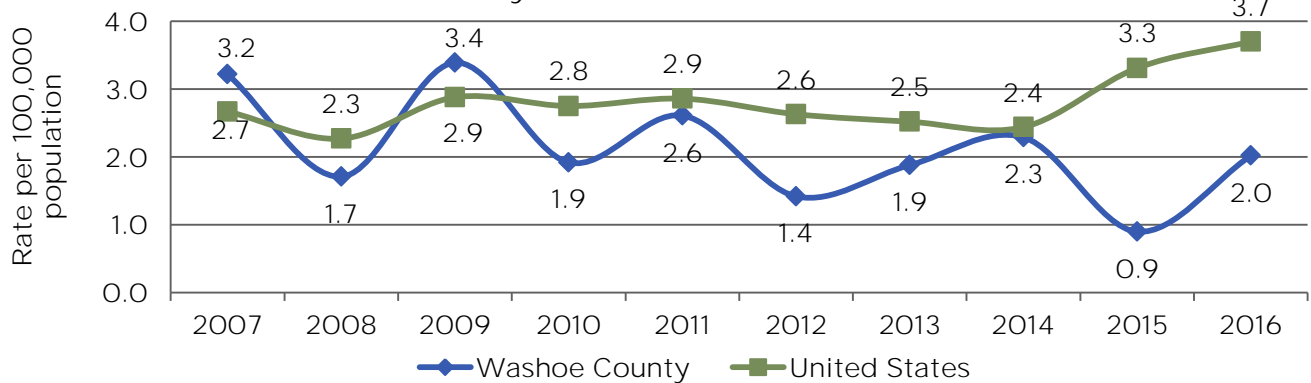
- The majority of community drinking water systems in Washoe County did not have any violations from 2011 through 2016.
- The majority of people served through community water systems were not impacted by MCL violations in any given year from 2011 through 2016.

⁶⁵ Truckee Meadows Water Authority. Accessed <http://tmwa.com/your-water/topics-facts/water-quality/>

Cryptosporidiosis

Cryptosporidium parvum is a parasite which causes Cryptosporidiosis, a diarrheal disease which can be transmitted through the fecal/oral route. Cryptosporidiosis is one of the most common waterborne diseases in the United States and is often spread by a person coming into contact with water contaminated by stool from humans or animals, although can also be spread through contaminated or uncooked food. Symptoms usually begin within two to 10 days of infection, can last up to two weeks, and include watery diarrhea, stomach cramps, nausea, vomiting, fever, and weight loss.⁶⁶

Fig 74: Rates of Reported Cases of Cryptosporidiosis, Washoe County & the United States, 2007-2016



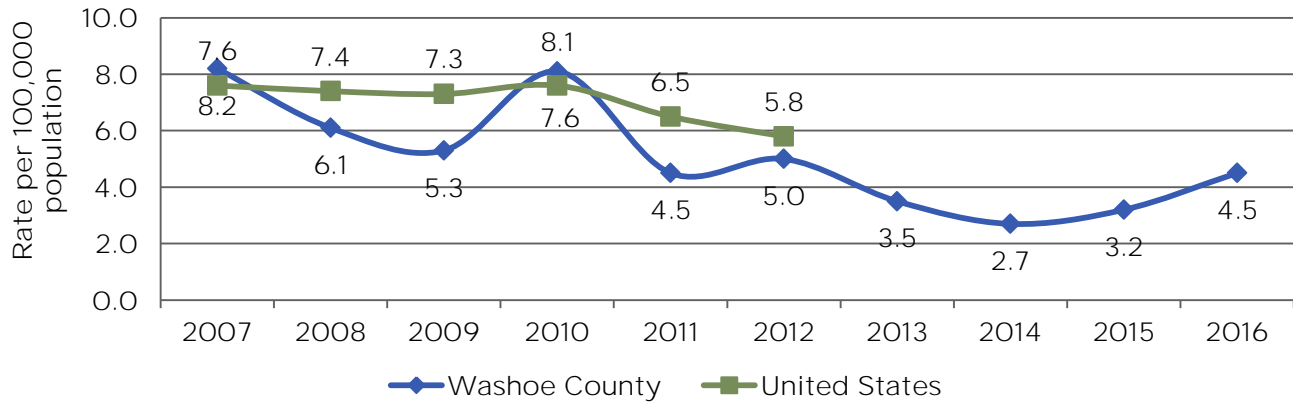
- The rate of reported cryptosporidiosis in Washoe County fluctuated from a low in 2015 (0.9 per 100,000 population) to a high in 2009 (3.4 per 100,000 population).
- From 2010 through 2016, the rate of reported cases of cryptosporidiosis in Washoe County has remained lower than the rate in the United States.

⁶⁶ Centers for Disease Control and Prevention. Parasites-Cryptosporidium (also known as “Crypto”). Accessed https://www.cdc.gov/parasites/crypto/gen_info/infect.html

Giardiasis

Giardia lamblia is a parasite which causes Giardiasis, a diarrheal disease which can be transmitted through the fecal/oral route. *Giardia* is spread by a person coming into contact with water contaminated by stool from humans or animals, contaminated, uncooked food and can be transmitted from person-to-person contact with someone who is ill. Symptoms usually begin within 1-3 weeks of infection, can last up to six weeks, and include diarrhea, gas/flatulence, greasy stool, nausea, and dehydration.⁶⁷

Fig 75: Rates of Reported Cases of Giardia, Washoe County & the United States, 2007-2016



Note: United States data unavailable from 2013 through 2016

- The rate of reported cases of giardia in Washoe County decreased from 2007 (7.6 per 100,000 population) to 2016 (4.5 per 100,000 population). However, the reported rates of giardia have increased in recent years (2015-2016).

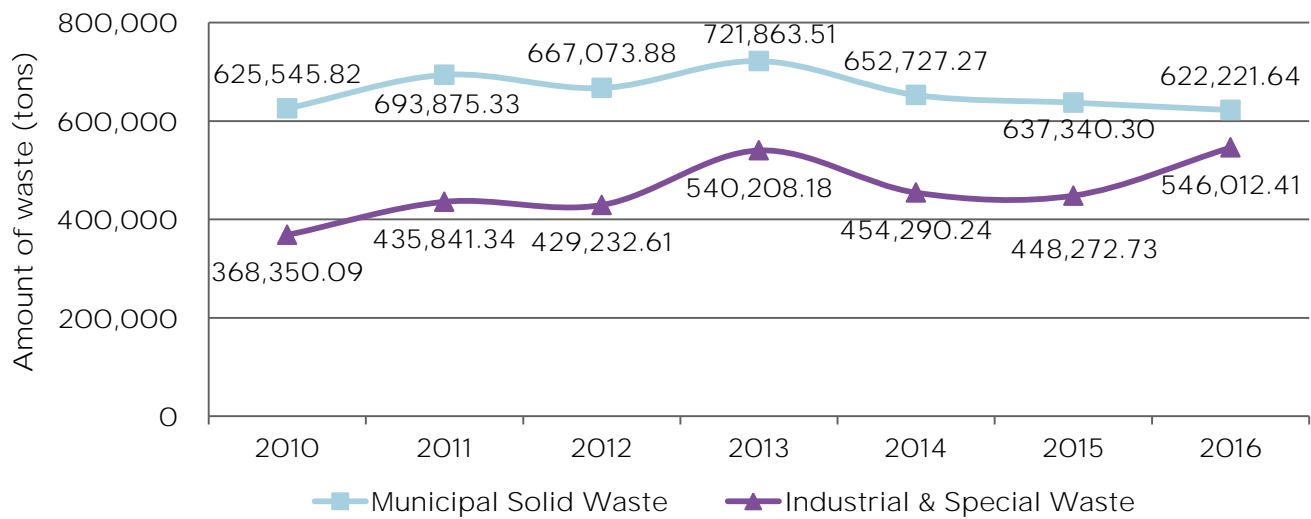
⁶⁷ Centers for Disease Control and Prevention. Parasites-Giardia. Accessed <https://www.cdc.gov/parasites/giardia/general-info.html>

Waste Management

Municipal solid waste (MSW) is the trash or garbage from homes, schools, and businesses. According to the EPA in 2013, Americans generated 254 million tons of trash and composted or recycled approximately 34.3% of the trash generated. The EPA encourages preventing waste by using products designed with less packaging, recycling materials such as glass, paper, plastics, and metals, and composting organic waste in order to reduce the impact of garbage on the environment.⁶⁸

Waste Generated & Disposed

Fig 76: Amount of Waste by Source*, Washoe County, 2010-2016



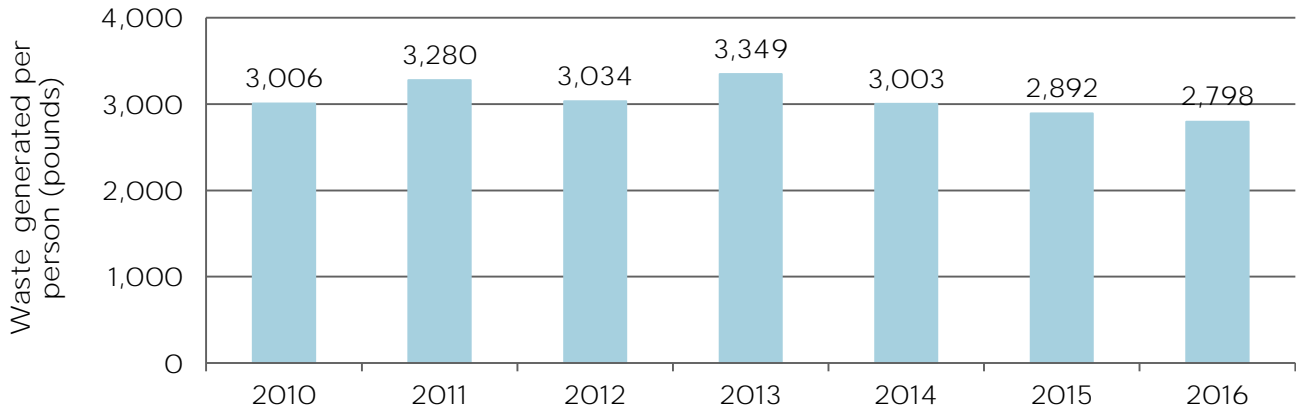
*Waste refers to total amounts disposed plus total amounts recycled in Washoe County.

Note: Nevada solid waste regulations do not require disposal facilities to report the county of origin for Industrial & Special Waste only the county of disposal. Industrial & Special Waste includes debris generated by Construction & Demolition.

- From 2010 through 2016 the majority of waste generated in Washoe County was municipal solid waste.
- The amount of industrial and special waste (in tons) being disposed of in Washoe County increased from 2015 to 2016.

⁶⁸ United States Environmental Protection Agency. Municipal Solid Waste. Accessed <https://archive.epa.gov/epawaste/nonhaz/municipal/web/html/>

Fig 77: Pounds of Municipal Solid Waste Generated per Person, Washoe County, 2010-2016



- The amount of solid waste generated per person in Washoe County decreased from 2010 (3,006 lbs/person) to 2016 (2,798 lbs/person).

Recycling

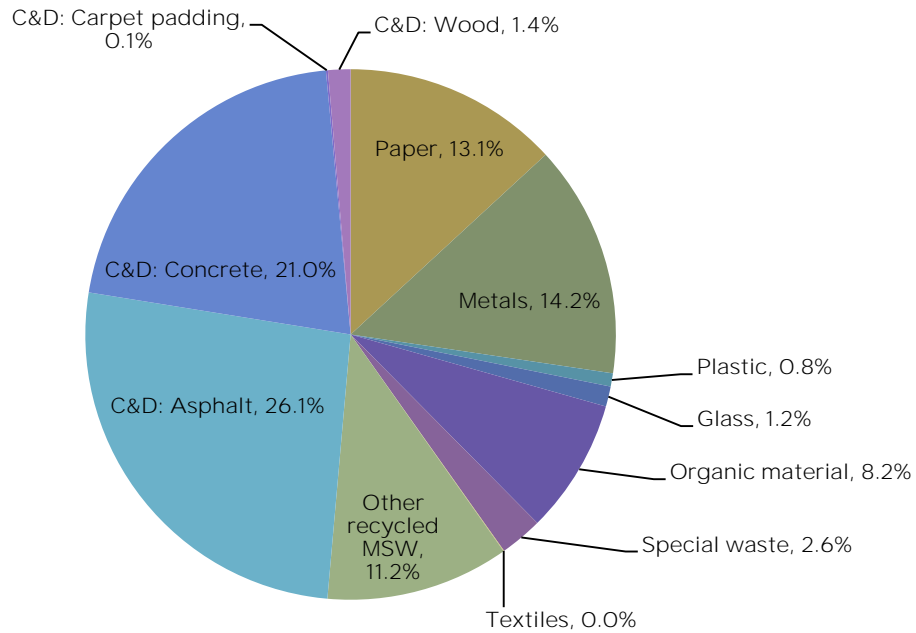
In 2016 a combined total of 383,663 tons of MSW and construction and demolition debris was recycled in Washoe County. Figure 78 shows the percentage of municipal solid waste recycled compared to total waste recycled. Total waste includes MSW and construction and demolition debris combined. Figure 79 illustrates the percentage, by weight in tons, of material recycled in 2016.

Fig 78: Percent of MSW & Total Waste Recycled, Washoe County, 2010-2016



- The percent of municipal solid waste (MSW) that was recycled in Washoe County increased from 2010 (27.1%) to 2016 (31.7%). However, since reaching a high of 36.6% in 2013, the proportion of MSW waste that has been recycled has decreased.
- From 2010 to 2016 the overall percent of waste recycled was higher than the proportion of MSW waste recycled. The total waste accounts for debris generated by Construction and Demolition as well as Special Waste.

Fig 79: Percent of Recycled Material by Type as Measured by Weight in Tons, Washoe County, 2016



- In 2016, slightly over half (51.4%) of waste generated in Washoe County are municipal solid wastes, largely composed of metal (14.2%) and paper (13.1%).
- The proportion of recycled material in Washoe County classified as debris from Construction and Demolition (48.6%) was largely due to asphalt (26.1%) and concrete (21.0%) in 2016.

Summary of Environmental Health

Overall air quality as measured by the NAAQS and annual exceedances has remained relatively stable over the past 10 years (2007-2016) in Washoe County, with a few higher number of exceedances during the 2012-2014 time period. Seasonal exceedances are often due to smoke from wildfires in the summer months and strong inversions which are more likely to occur during the winter months. Indoor air quality is often impacted by smoking tobacco products indoors, however naturally occurring radon is a phenomenon Washoe County residents should be aware of and test for in their homes.

The majority of community water systems in Washoe County have remained in compliance with the EPA defined MCLs from 2011-2016. Reported cases of water borne illness, such as cryptosporidiosis and giardia which are cause by drinking untreated water, or eating food contaminated by untreated water, have both declined from 2007 through 2016.

The amount of municipal solid waste disposed of or recycled in Washoe County has remained stable from 2010 through 2016, however industrial and special waste has increased. Overall, nearly one third of waste is recycled.

The state and local health authorities work diligently to ensure the county meets air quality standards, residents have access to safe and clean drinking water, and that waste is properly managed.

For detailed documents related to environmental health in Washoe County refer to:

Washoe County Health District's Air Quality Management Division's reports

<https://www.washoecounty.us/health/programs-and-services/air-quality/air-quality-reports-and-data.php>

Washoe County Health District's Environmental Health Division's food safety inspections, waste management plan and other helpful information <https://www.washoecounty.us/health/programs-and-services/environmental-health/index.php>

Environmental Health Sources

Image 7; Fig 70-Fig 72 Same Source

Image 7: Washoe County Ambient Air Monitoring Sites 2017

Fig 70: Air Quality Index Summary, Washoe County, 2007-2016

Fig 71: Air Quality Index Summary, Washoe County, 2007-2016 with NAAQS as of 12/31/2016 Applied Across all Years

Fig 72: Number of Air Quality Pollutant Exceedances by Criteria Pollutant Type, Washoe County, 2007-2016

Washoe County Health District, Air Quality Management Division. Data provided upon request. Reno, NV.

Fig 73: Percent of Homes Tested by Radon Level Ranges, Washoe County, 1989-2015 Aggregate Data

University of Nevada, Reno, Cooperative Extension, Nevada Radon Education Program. Accessed

<http://www.unce.unr.edu/programs/sites/radon/files/pdf/WashoeAverage2015.pdf>

Table 33: Community Water Systems (CWS) & Population Served by CWS without MCL Violations by Year, Washoe County, 2011-2016

Nevada Division of Environmental Protection, Bureau of Safe Drinking Water. Data provided up on request. Carson City, NV.

Fig 74: Rates of Reported Cases of Cryptosporidiosis, Washoe County & the United States, 2007-2016

Washoe County: Washoe County Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

United States 2007-2015: Centers for Disease Control and Prevention, FoodNet. Table 2b. Incidence of infection by Pathogen all sites, 2004-2015. Accessed <https://www.cdc.gov/foodnet/reports/data/infections.html>

United States 2016: Marder E.P., Cieslak P.R., Cronquist A.B., et al. (2017). Incidence and Trends of Infections with Pathogens Transmitted Commonly Through Food and the Effect of Increasing Use of Culture-Independent Diagnostic Tests on Surveillance - Foodborne Diseases Active Surveillance Network, 10 U.S. Sites, 2013–2016. *MMWR Morbidity and Mortality Weekly Report*; 66:397–403.

Fig 75: Rates of Reported Cases of Giardia, Washoe County & the United States, 2007-2016

Washoe County: Washoe County Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

United States 2011-201: Centers for Disease Control and Prevention, *MMWR*. (2015). Giardiasis Surveillance-United States, 2011-2012. 64(SS03);15-25.

United States 2009-2010: Centers for Disease Control and Prevention, *MMWR*. (2012). Giardiasis Surveillance-United States, 2009-2010. 61(SS05);13-23.

United States 2006-2008: Centers for Disease Control and Prevention, *MMWR*. (2010). Giardiasis Surveillance-United States, 2006-2008. 59(SS06); 15-25.

Fig 76-Fig 79 Same Source

Fig 76: Amount of Waste by Source*, Washoe County, 2010-2016

Fig 77: Pounds of Municipal Solid Waste Generated per Person, Washoe County, 2010-2016

Fig 78: Percent of MSW & Total Waste Recycled, Washoe County, 2010-2016

Fig 79: Percent of Recycled Material by Type as Measured by Weight in Tons, Washoe County, 2016

Washoe County Health District, Environmental Health Division. Data provided upon request. Reno, NV.

1.6 UNINTENTIONAL INJURIES & DEATHS

Unintentional Injuries & Deaths

There are three categories of injury and deaths caused by injuries; intentional, unintentional and undetermined. This section contains only injuries and deaths resulting from injuries, which were classified as unintentional, or accidental. The Crime & Violent-related Behaviors section contains data related to intentional injuries and fatalities.

In 2014, the fourth highest cause of death was unintentional injuries, accounting for 59% of all deaths among persons 1 to 44 years of age in the United States. Poisonings, motor vehicle accidents, and falls account for the majority of unintentional deaths, while motor vehicle accidents and falls attribute to the largest proportion of non-fatal traumatic injuries. In 2013, injury and violence resulted in a \$671 billion cost due to medical expenditures and work loss related-costs.⁶⁹ The consequences of injury can have long-lasting impacts. Taking proper safety precautions and being aware of potential hazards at all times can prevent and reduce the burden of unintentional injuries.

Indicator	Trend	Most Recent Year
Unintentional Injuries		
Unintentional death rate	Increasing	48.7 per 100,000 (2015)
Cause of unintentional death ranked by rate	~	various
Number of deaths by cause of death	Increasing	various
Unintentional traumatic injury, by mechanism of injury	~	various
Traffic Safety		
Helmet use among adolescents	~	24.4% wore helmet (2015)
Seat belt use among adolescents	~	93.7% wore seat belt (2015)
Texting while driving among adolescents	~	35.3% (2015)
Riding with driver under the influence among adolescents	~	22.1% (2015)
Driving while under the influence among adolescents	~	8.2% (2015)
Motor vehicle fatality rates	STABLE	8.4 per 100,000 (2015)
Pedestrian fatality rates	STABLE	1.3 per 100,000 (2015)
Percent of fatal traffic accidents with BAC .08+	Increasing	38.0% (2015)
Falls		
Deaths due to falls	Increasing	12.2 per 100,000 (2015)
~not able to assess for trend		

Unintentional Death Rates

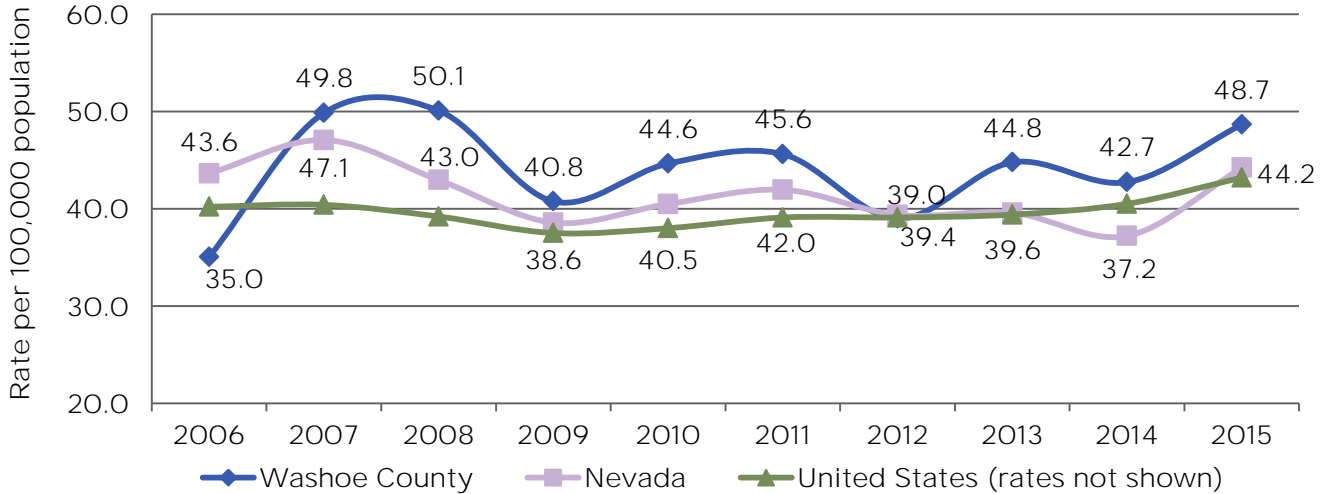
The rates of death due to unintentional poisonings have drastically increased over the past few decades. Data specific to deaths due to poisonings are presented in the Substance Use section. The United States age-

⁶⁹ Centers for Disease Control and Prevention. Injury Prevention & Control. Key Injury and Violence Data. Accessed https://www.cdc.gov/injury/wisqars/overview/key_data.html

1.6 UNINTENTIONAL INJURIES & DEATHS

adjusted death rate due to unintentional poisonings in 1999 was 4.4 per 100,000 compared to the 2015 rate of 14.8 per 100,000. Washoe County unintentional poisoning death rates mirror this trend from 1999 to 2015.⁷⁰

Fig 80: Age-adjusted Unintentional Death Rate, Washoe County, Nevada, & the United States, 2006-2015



- The age-adjusted rate of unintended deaths in Washoe County increased from 2006 (35.0 per 100,000) to 2016 (48.7 per 100,000).
- As of 2016, the age-adjusted rate of unintended deaths in Washoe County (48.7 per 100,000) was higher than Nevada (44.2 per 100,000) and the United States (43.2 per 100,000).

Cause of Unintentional Deaths

Rank	Cause	Washoe County	Nevada	United States
1	Poisoning	18.3	17.5	14.8
2	Motor vehicle accidents	12.1	11.9	10.9
3	Falls	12.2	8.4	9.0
4	Other non-transport accidents	4.1	3.9	~
5	Drowning and submersion	0.8	1.4	1.1

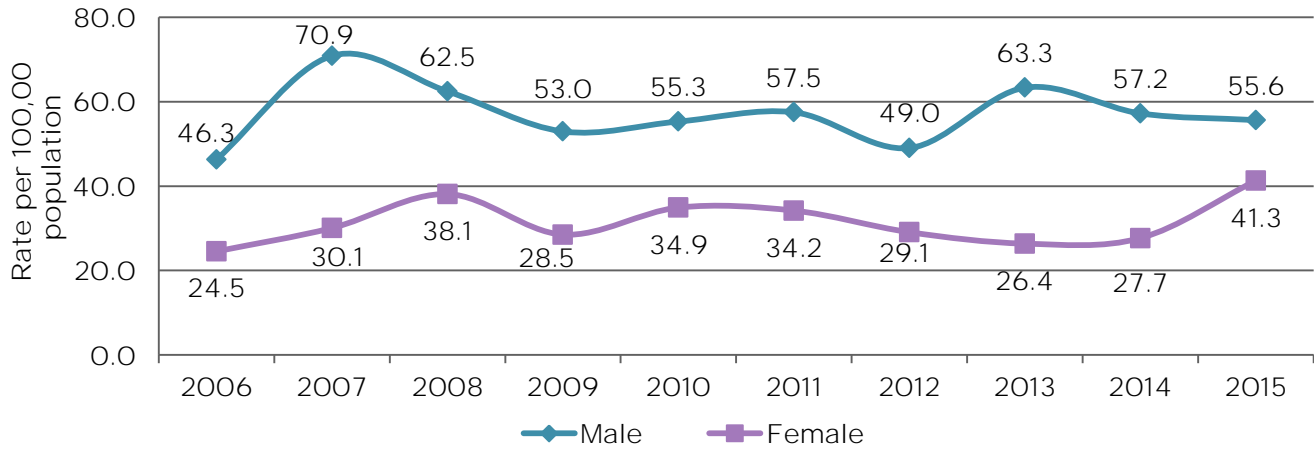
~data not available

- In 2015, poisonings, motor vehicle accidents, and falls were the top three causes of unintentional deaths across Washoe County, Nevada, and the United States.
- As of 2015, the rate of unintended death in Washoe County was higher than Nevada and the United States for all three top causes of death.

⁷⁰ Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed <http://wonder.cdc.gov/ucd-icd10.html>

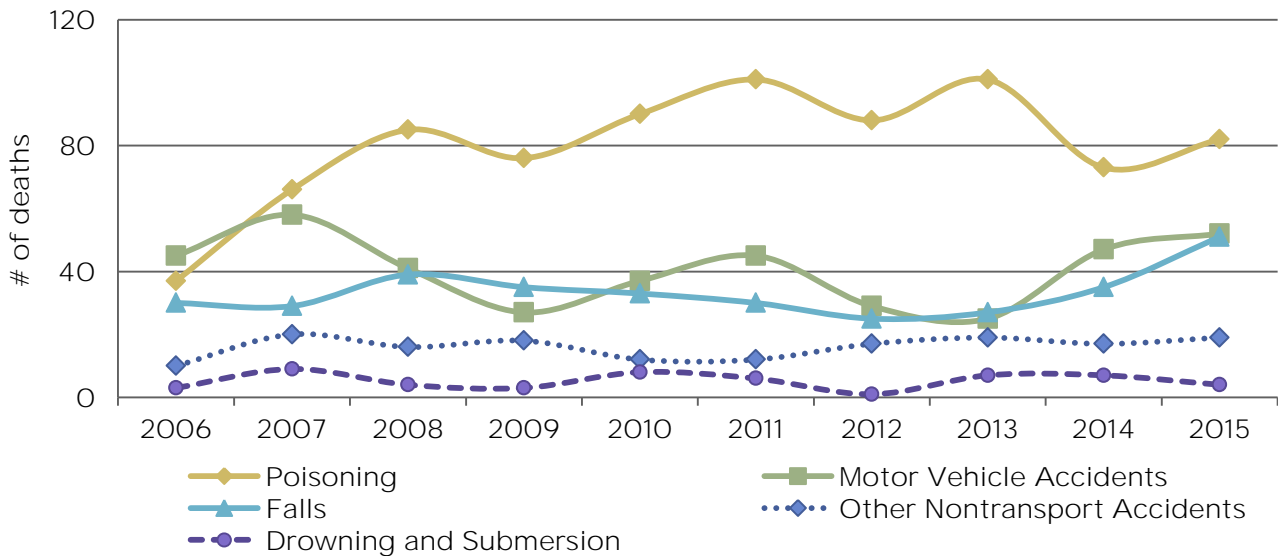
1.6 UNINTENTIONAL INJURIES & DEATHS

Fig 81: Age-adjusted Unintentional Death Rate by Sex, Washoe County, 2006-2015



- The rate of unintended death was higher among males in Washoe County compared to females from 2006 through 2015.
- The rate of unintended deaths among males has increased from 2006 (46.3 per 100,000) to 2015 (55.6 per 100,000). However, the rate of unintended deaths among females have increased more from 2006 (24.5 per 100,000) to 2015 (41.3 per 100,000).

Fig 82: Number of Deaths Due to Unintentional Injury by Type, Washoe County, 2006-2015



- The number of deaths due to poisonings increased from 2006 through 2015. Since 2008, the number of deaths due to poisoning has been nearly twice as high as the second highest cause of death, motor vehicle accidents.
- Deaths due to motor vehicle accidents, other transport accidents, and drowning/submersion have remained fairly stable from 2006 through 2015.
- Deaths due to falls have increased since 2013 and continue to rise.

1.6 UNINTENTIONAL INJURIES & DEATHS

Unintentional Traumatic Injury

The majority of traumatic injuries do not result in death; however, non-fatal injuries often result in long-term impacts including mental, physical, and financial complications. For every fatality due to injury and violence, there are 13 people hospitalized, and another 135 people treated in an emergency room in the United States.⁷¹

Table 35: Unintentional Traumatic Incidents by Mechanism of Injury, Washoe County, 2016

Mechanism of Injury	Number of Incidents	Percent of Incidents
Cut/Pierce	10	0.5%
Fall	840	44.8%
Fire/Burn	11	0.6%
Firearm	13	0.7%
Machinery	8	0.4%
Motor vehicle	602	32.1%
Natural/Environmental factors	12	0.6%
Other specified, classifiable	7	0.4%
Other specified, not elsewhere classifiable	1	0.1%
Overexertion	1	0.1%
Pedal Cyclist, other	61	3.3%
Pedestrian, other	7	0.4%
Struck by/Against	89	4.8%
Transport-other	212	11.3%
Unspecified	1	0.1%

- In 2016, the largest proportion of unintended traumatic injuries in Washoe County were due to falls (44.8%), followed by motor vehicle accidents (32.1%), and other transport mechanisms (11.3%).

Traffic Safety

Motor vehicle accidents continue to be one of the leading causes in the United States and when not fatal, contribute to traumatic injury and long-term disability. Driving under the influence is a major contributor, as approximately one in three fatal traffic accidents from 2006 through 2015 involved a driver with a blood-alcohol content (BAC) equal to or over the legal limit of .08 in the United States.⁷² In 2015, Nevada ranked as the 5th highest state (out of 51-including the District of Columbia) in the United States for pedestrian fatalities at 2.28 per 100,000 population. The national rate was 1.67 per 100,000 population, ranging from a high of 3.70 per 100,000 population in Delaware, to a low of 0.48 pedestrian fatalities per 100,000 population in Idaho.⁷³

⁷¹ Centers for Disease Control and Prevention. Injury Prevention & Control. Key Injury and Violence Data. Accessed https://www.cdc.gov/injury/wisqars/overview/key_data.html

⁷² National Highway Traffic Safety Administration, Fatality Analysis Reporting System. Accessed <https://www-fars.nhtsa.dot.gov/Trends/TrendsGeneral.aspx>

⁷³ U.S. Department of Transportation, National Highway Traffic Safety Administration. (2016). Traffic Safety Facts 2015: A Compilation of Motor Vehicle Crash Data from the Fatality Analysis Reporting System and the General Estimates System. Washington, D.C.

1.6 UNINTENTIONAL INJURIES & DEATHS

Additionally, motor vehicle accidents accounted for nearly one in three trauma patients in Washoe County during 2015 and 2016.⁷⁴

Table 36: Percent of High School Students who Rarely/Never Wore Bicycle Helmet, 2013 & 2015

Location	2013	2015
Washoe County	80.4%	75.6%
Nevada	87.3%	85.0%
United States	87.9%	81.4%

*among those that had ridden a bicycle during the 12 months before the survey

- The percentage of Washoe County high school students who reported they rarely/never wear a helmet while riding a bicycle decreased from 2013 (80.4%) to 2015 (75.6%).
- The percentage of high school students in Washoe County reporting rarely/never wearing a helmet while riding a bicycle has been lower than Nevada and the United States in both 2013 and 2015.

Table 37: Percent of High School Students who Rarely/Never Wore Seat Belt, 2013 & 2015

Location	2013	2015
Washoe County	8.4%	6.3%
Nevada	5.8%	6.2%
United States	7.6%	6.1%

*when riding in a car driven by someone else

- The percentage of Washoe County high school students who reported they rarely/never wear a seatbelt decreased from 2013 (8.4%) to 2015 (6.3%).
- The percentage of high school students in Washoe County reporting rarely/never wear a seatbelt has been higher than Nevada and the United States during 2013 and 2015.

Table 38: Percent of High School Students who Texted/Emailed while Driving a Car or Other Vehicle, 2013 & 2015

Location	2013	2015
Washoe County	36.9%	35.3%
Nevada	35.6%	37.7%
United States	41.4%	41.5%

*on at least 1 day during the 30 days before the survey; among those that had driven

- The percentage of Washoe County high school students who reported they texted/emailed while driving decreased from 2013 (36.9%) to 2015 (35.3%).
- The percentage of high school students in Washoe County reporting they texted/emailed while driving was lower in 2015 (35.3%) compared to Nevada (37.7%) and the United States (41.5%).

Table 39: Percent of High School Students who Rode with a Driver that had Been Drinking Alcohol, 2013 & 2015

Location	2013	2015
Washoe County	24.7%	22.1%
Nevada	21.4%	21.4%
United States	21.9%	20.0%

*in a car or other vehicle on at least 1 day during the 30 days before the survey

⁷⁴ Nevada Trauma Registry Data. 2015 and 2016 Washoe County Trauma data provided upon request. Carson City, NV.

1.6 UNINTENTIONAL INJURIES & DEATHS

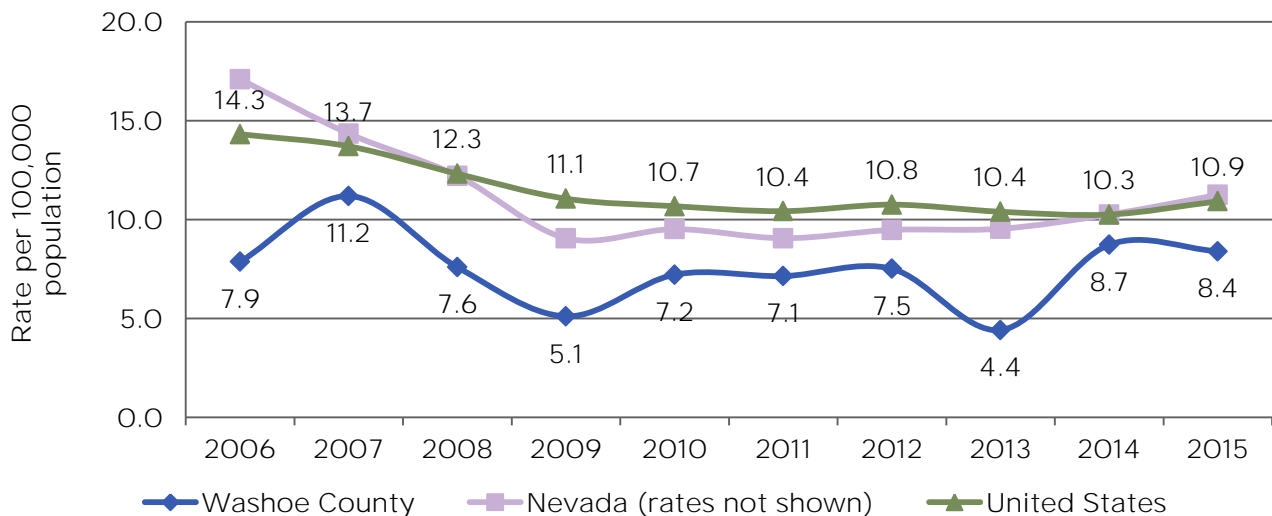
- The percentage of Washoe County high school students who reported they rode in a vehicle with a driver that had been drinking decreased from 2013 (24.7%) to 2015 (22.1%).
- The percentage of high school students in Washoe County reporting they rode in a vehicle with a driver that had been drinking has been higher than Nevada and the United States in 2013 and 2015.

Location	2013	2015
Washoe County	11.7%	8.2%
Nevada	7.0%	6.9%
United States	10.0%	7.8%

*on at least 1 day during the 30 days before the survey; among those that had driven

- The percentage of Washoe County high school students who reported they drove when they had been drinking alcohol decreased from 2013 (11.7%) to 2015 (8.2%).
- The percentage of high school students in Washoe County reporting they drove when they had been drinking alcohol was higher in 2015 (8.2%) compared to Nevada (6.9%) and the United States (7.8%).

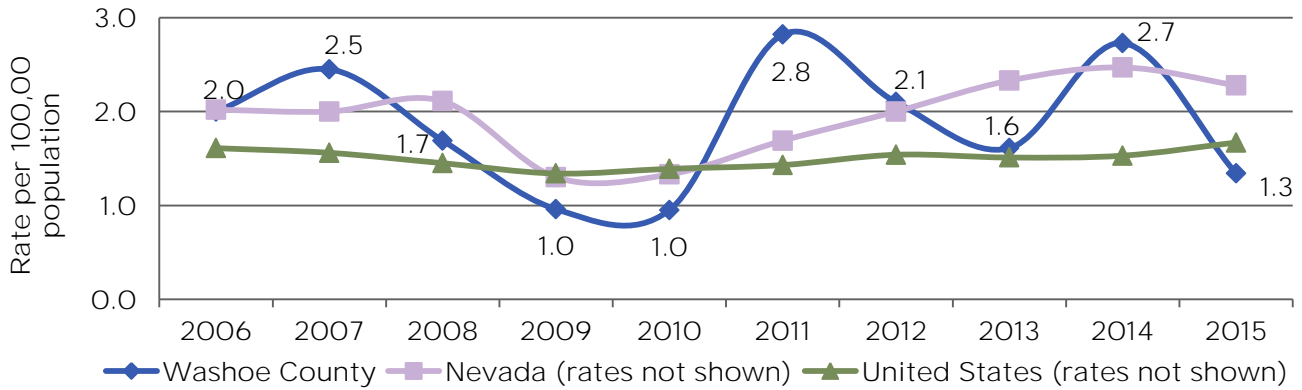
Fig 83: Rate of Death Due to Motor Vehicles, Washoe County, Nevada, & the United States, 2006-2015



- The rate of death due to motor vehicles in Washoe County increased from 2006 (7.9 per 100,000) to 2015 (8.4 per 100,000). However, rates fluctuated from a low in 2013 (4.4 per 100,000) to a high in 2007 (11.2 per 100,000).
- The rate of motor vehicle fatalities (per 100,000 population) in Washoe County was lower than Nevada and the United States from 2006 through 2015.

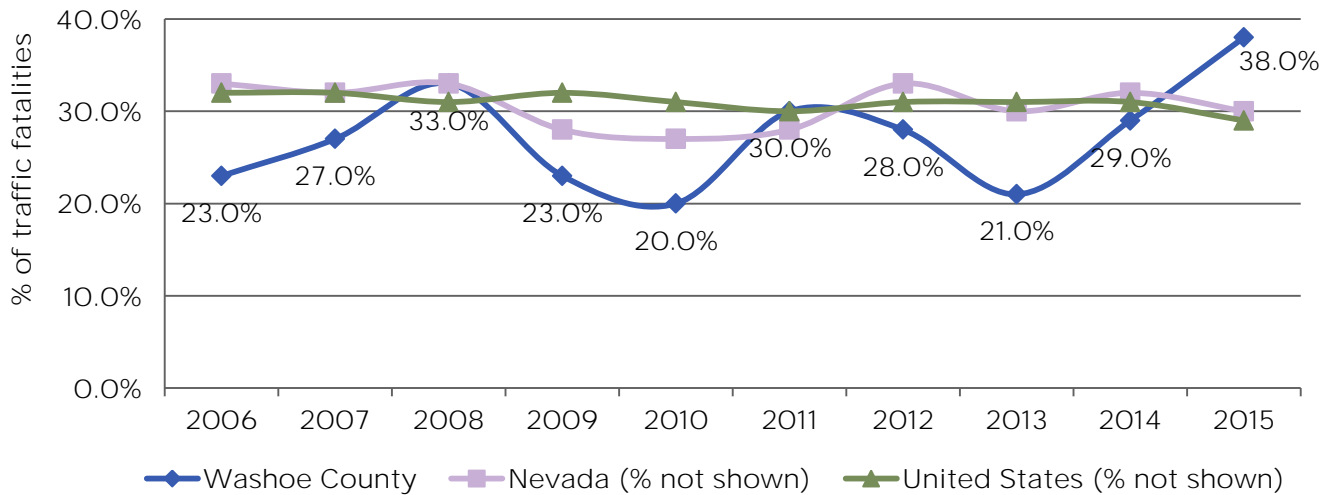
1.6 UNINTENTIONAL INJURIES & DEATHS

Fig 84: Pedestrian Fatality Rate, Washoe County, Nevada, & the United States, 2006-2015



- Overall the rate of pedestrian fatalities in Washoe County decreased slightly from 2006 (2.0 per 100,000) to 2015 (1.3 per 100,000). However, rates fluctuated from a low in 2009 and 2010 (1.0 per 100,000) to a high in 2011 (2.8 per 100,000).
- The rate of pedestrian fatalities per 100,000 population increased in Nevada and the United States from 2011 through 2015.

Fig 85: Percent of Traffic Fatalities with Highest Driver Blood Alcohol Content $\geq .08$ (BAC = .08 or Greater), Washoe County, Nevada, & the United States, 2006-2015



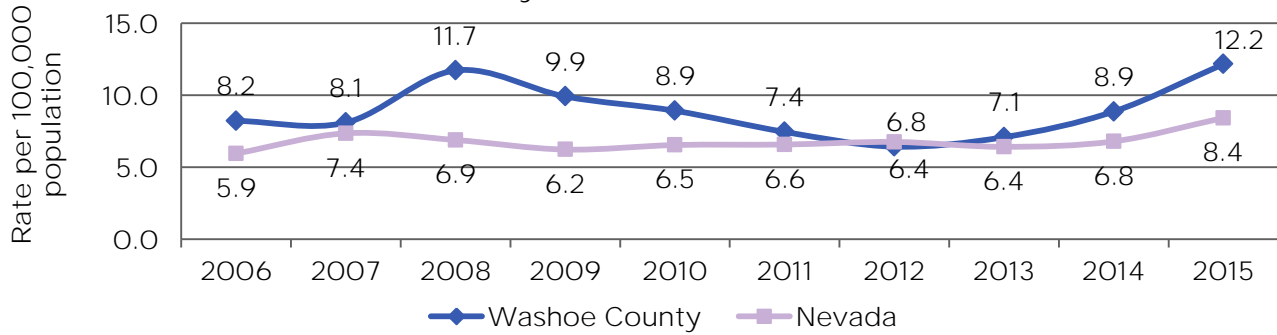
- From 2006 through 2014 approximately one in five traffic fatalities in Washoe County involved a driver with a blood alcohol content (BAC) equal to or higher than the legal limit (.08).
- In 2015, a record high of 38.0% of fatalities involved a driver with blood alcohol content at or higher than the legal limit.

1.6 UNINTENTIONAL INJURIES & DEATHS

Falls

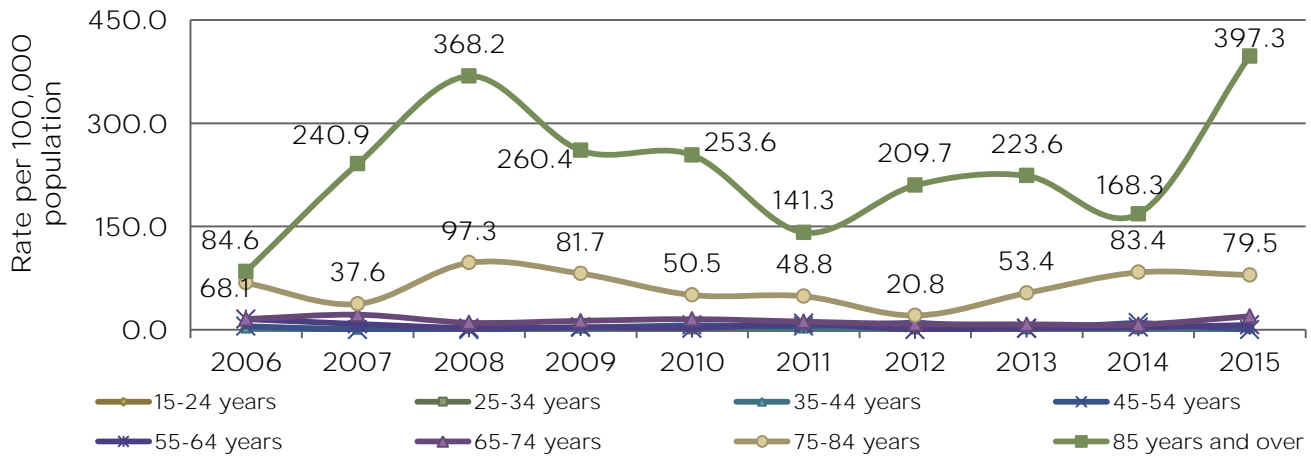
The death rate due to falls has increased in recent years, nationally and in Washoe County. This trend is expected to continue to rise with the aging of the Baby Boomer generation. When not fatal, falls cause serious injury such as broken bones and head injury. In 2015, the cost for falls to Medicare totaled over \$31 billion.⁷⁵

Fig 86: Age-Adjusted Rate of Death Due to Falls, Washoe County & Nevada, 2006-2015



- The death rate due to falls in Washoe County has increased from 2006 (8.2 per 100,000 population) to 2015 (12.2 per 100,000).
- The death rate due to falls in Washoe County remained higher than Nevada from 2006 through 2015, with the exception of 2012.

Fig 87: Rate of Death Due to Falls, by Age Group, Washoe County, 2006-2015



- The death rate due to falls in Washoe County among those older than 75 years was higher than all other age groups less than 75 years.

⁷⁵ Vellas B.J., Wayne S.J., Romero L.J., Baumgartner R.N., & Garry P.J.(1997). Fear of falling and restriction of mobility in elderly fallers. *Age and Ageing*. 26:189-193.

Summary of Unintentional Injuries & Deaths

Many of those who survive injuries may suffer from long-term consequences leading to high health-care costs and reduced quality of life. From 2007 through 2016, the rates of unintentional deaths in Washoe County have been higher than Nevada and the United States. Since 2006, poisonings, motor vehicle accidents, and falls were the top three causes of unintended deaths in Washoe County, Nevada, and the United States. Washoe County's rates of death for the three top causes of unintentional death were also higher than Nevada and the United States. Rates of unintended deaths are higher among males, although the rates among females have been increasing in recent years in Washoe County.

Falls, motor vehicle accidents, and other transport accidents were responsible for a large proportion of traumatic injury in Washoe County during 2016. The rate of deaths due to falls increased in recent years and was higher in Washoe County compared to Nevada. Falls are especially frequent among elderly populations and when they are not fatal, often result in debilitating injury including pelvic and back fractures and head injuries. As Washoe County's elderly population continues to experience a higher rate growth, this is a topic to continue to monitor.

In 2015, over one in five high school students in Washoe County (22.1%) reported having ridden in a car with a driver who had been drinking alcohol and 8.2% reported they had drove when drinking alcohol. Additionally in 2015, a record high of 38% of motor vehicle fatalities in Washoe County involved a driver with blood alcohol content at or above the legal limit (BAC 0.08). Injury and deaths due to people driving under the influence are 100% preventable, there is no excuse for driving while intoxicated. The increasing numbers of unintentional injury and unintended deaths warrant attention to improve and expand on preventive efforts to reduce fatal and non-fatal injuries.

For detailed documents related to unintentional injuries in Washoe County refer to:

2015 and 2016 Washoe County Trauma Report https://www.washoecounty.us/health/files/emergency-medical-services/NVTR_1516_FINAL.pdf

Unintentional Injury Sources

Fig 80: Age-adjusted Unintentional Death Rate, Washoe County, Nevada, & the United States, 2006-2015

Washoe County & Nevada: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Jul 21, 2017 4:09:00 PM

Table 34: Age-adjusted Rate of Unintentional Deaths by Cause & Rank, 2015

Washoe County & Nevada: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

1.6 UNINTENTIONAL INJURIES & DEATHS

United States: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html>

Fig 81-Fig 82 Same Source

Fig 81: Age-adjusted Unintentional Death Rate by Sex, Washoe County, 2006-2015

Fig 82: Number of Deaths Due to Unintentional Injury by Type, Washoe County, 2006-2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Table 35: Unintentional Traumatic Incidents by Mechanism of Injury, Washoe County, 2016

Nevada Division of Public and Behavioral Health. 2016 Nevada Trauma Registry. Data provided up on request.

Table 36-Table 40 Same Source

Table 36: Percent of High School Students who Rarely/Never Wore Bicycle Helmet, 2013 & 2015

Table 37: Percent of High School Students who Rarely/Never Wore Seat Belt, 2013 & 2015

Table 38: Percent of High School Students who Texted/Emailed while Driving a Car or Other Vehicle, 2013 & 2015

Table 39: Percent of High School Students who Rode with a Driver that had Been Drinking Alcohol, 2013 & 2015

Table 40: Percent of High School Students that Drove when Drinking Alcohol, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Fig 83-Fig 85 Same Source

Fig 83: Rate of Death Due to Motor Vehicles, Washoe County, Nevada, & the United States, 2006-2015

Fig 84: Pedestrian Fatality Rate, Washoe County, Nevada, & the United States, 2006-2015

Fig 85: Percent of Traffic Fatalities with Highest Driver Blood Alcohol Content $\geq .08$ (BAC = .08 or Greater), Washoe County, Nevada, & the United States, 2006-2015

National Highway Traffic Safety Administration, Fatality Analysis Reporting System. Accessed <https://www-fars.nhtsa.dot.gov/States>

Fig 86-Fig 87 Same Source

Fig 86: Age-Adjusted Rate of Death Due to Falls, Washoe County & Nevada, 2006-2015

Fig 87: Rate of Death Due to Falls, by Age Group, Washoe County, 2006-2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Crime & Violent-Related Behaviors

Exposure to violence and being a victim of crime or violence is detrimental to health, and effects often last beyond the initial threat or incident. Other than direct bodily harm, the lasting health impacts include psychological and behavioral changes such as chronic stress, depression, anxiety, sleep disturbances, and may result in unhealthy coping mechanisms such as increased substance use. Persons exposed to violence and violent behaviors are more likely to be a victim of violence and commit violence acts against others in the future.⁷⁶

Indicator	Trend	Most Recent Year
Violent crime, <i>by type</i>	STABLE	514.5 per 100,000 (2016)
Property crime, <i>by type</i>	Decreasing	2,593.3 per 100,000 (2016)
Washoe County School District K-12 bullying	STABLE	16% reported incidents substantiated 2016-2017
Washoe County School District K-12 cyber bullying	Increasing	41% of reported incidents substantiated 2016-2017
<i>Violent Behaviors & Victims of Violence (Adolescents)</i>		
Carried a weapon	~	19.7% (2015)
In a physical fight	~	22.2% (2015)
Electronically bullied	~	16.8% (2015)
Bullied on school property	~	20.8% (2015)
Missed school because feel unsafe at/on their way to and from school	~	9.0% (2015)
Threatened/injured on school property	~	8.1% (2015)
Experienced physical dating violence	~	10.8% (2015)
Experienced sexual dating violence	~	12.1% (2015)
Forced to have sexual intercourse	~	9.1% (2015)
Been physically hurt by an adult	~	17.7% (2015)
Have seen adults in their home be physically violent to one another	~	16.6% (2015)
Death due to homicide/assault	STABLE	6.0 per 100,000 (2015)
~ unable to assess for trend		

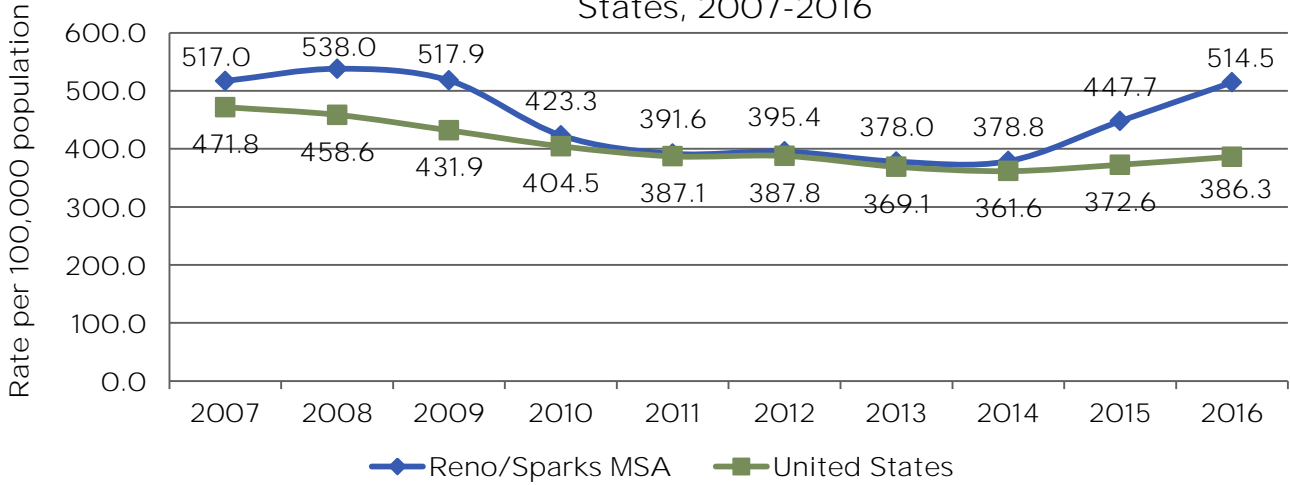
⁷⁶ Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Atlanta, Georgia: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Oakland, California: Prevention Institute.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Violent Crime

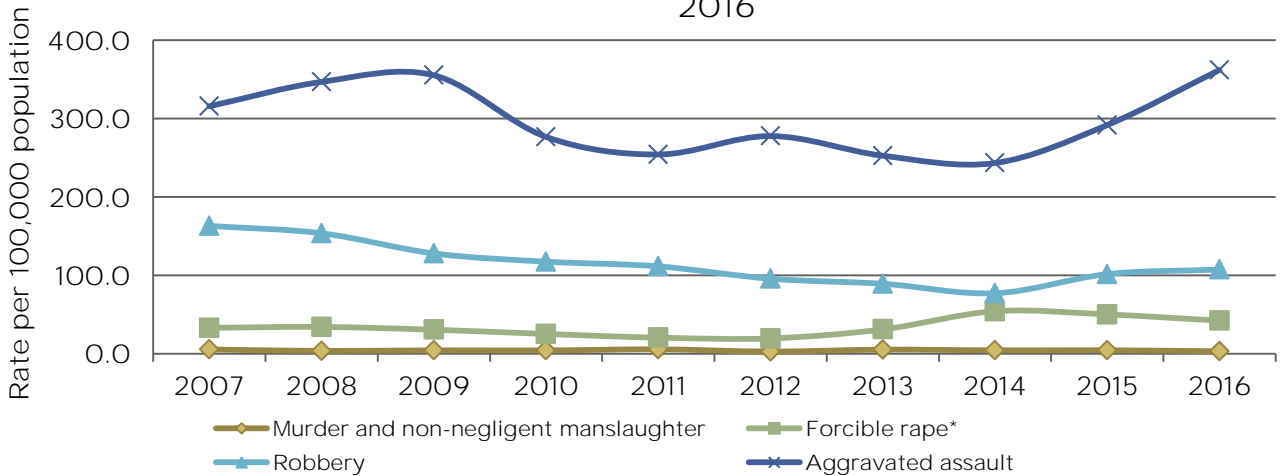
Violent crimes involve force or threats of force and include aggravated assault, robbery, forcible rape, murder, and non-negligent manslaughter.

Fig 88: Violent Crime Rate, Reno/Sparks MSA & the United States, 2007-2016



- The violent crime rate per 100,000 population in the Reno/Sparks metropolitan statistical area (MSA) has been higher than the rate in the U.S. every year from 2007 through 2016.
- From 2010 through 2013 the violent crime rate in the Reno/Sparks MSA was only slightly higher than the U.S. rate, however in 2014 Washoe County’s rate began to increase and in 2016 was higher than the United States.

Fig 89: Violent Crime Rate by Type, Reno/Sparks MSA, 2007-2016



Note: Legacy definition of rape (prior to 2013), included forcibly and against will. In 2013 the term forcible was removed and the revised definition of rape includes “Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim. Attempts or assaults to commit rape are also included; however, statutory rape and incest are excluded.”

- Aggravated assault crimes have been the largest contributor to the violent crime rate in the Reno/Sparks MSA from 2007 through 2016 and have been increasing since 2014.
- The rate of robberies per 100,000 population fell from 2007 to 2014, however began to increase in 2014.

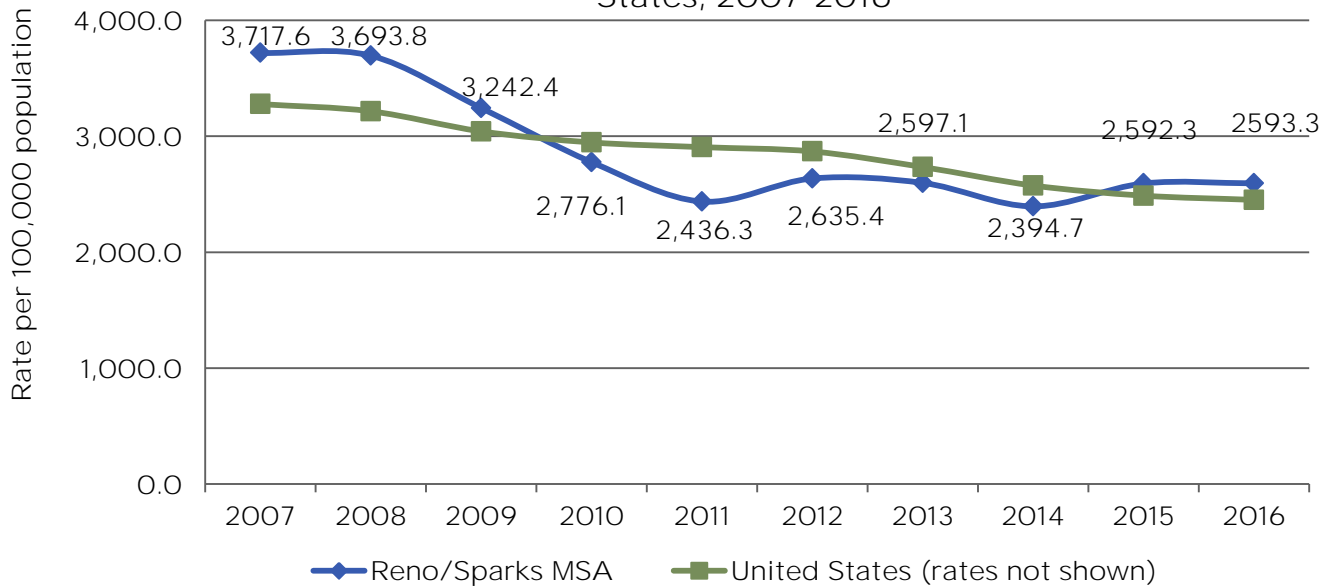
1.7 CRIME & VIOLENT-RELATED BEHAVIORS

- Due to the change in definition of rape, the rate of forcible rape appears to have increased since 2013; however this may be a reflection of the change in definition and not a true increase of rape—see note under Figure 89.
- The rate of murder and non-negligent manslaughter has remained less than 6.0 per 100,000 population from 2007 through 2016.

Property Crime

Property crimes do not involve force or threat to the victims of crime and include burglary, larceny-theft, motor vehicle theft, and arson.⁷⁷

Fig 90: Property Crime Rate, Reno/Sparks MSA & the United States, 2007-2016

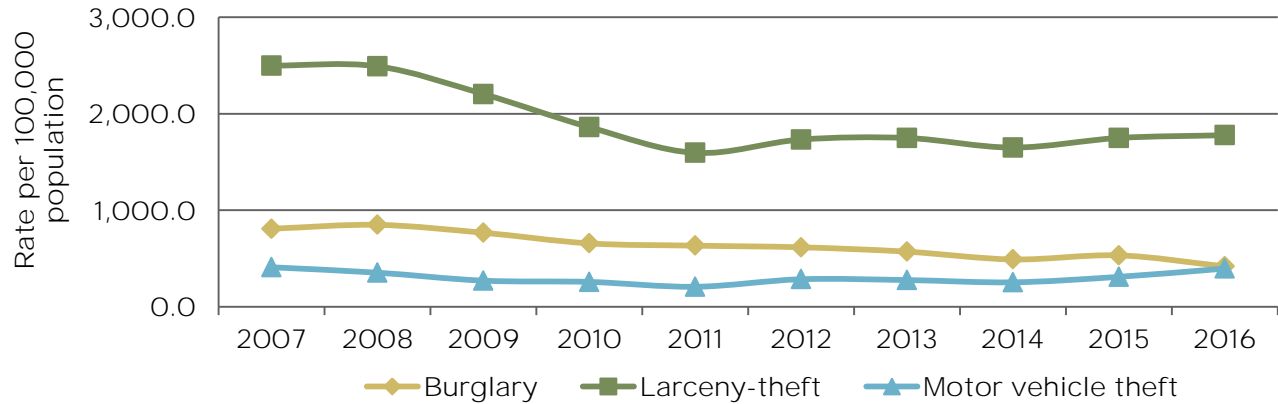


- As of 2010, the rate of property crime per 100,000 population was lower in the Reno/Sparks MSA compared to the U.S. rates, however in 2016 the Reno/Sparks MSA property crime rate increased (2,593.3 per 100,000) and was higher than the U.S. rates (2,450.7 per 100,000).

⁷⁷ Note: Due to varying collection procedures by local law enforcement agencies, limited data are available for arson and are not included in the data for violent crimes.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Fig 91: Property Crime Rate by Type, Reno/Sparks MSA, 2007-2016



- Larceny-theft has been the largest contributor to overall property crimes in the Reno/Sparks MSA from 2007 through 2016.
- The rate of burglary per 100,000 population in the Reno/Sparks MSA decreased from 2007 through 2014, and reached a new low in 2016.
- Motor vehicle theft per 100,000 population in the Reno/Sparks MSA decreased from 2007 through 2011, however has increased since then.

Bullying-Washoe County School District Grades K-12

Table 41: Bullying Incidents in Washoe County School District, Reported, Determined to be so, & Resulting in Suspension/Expulsion, 2013-2014 through 2015-2016

School year	# Reported	Found to be Bullying % (#)	Resulting in Suspension or Expulsion % (#)
2013-2014	899	66% (n=595)	22% (n=200)
2014-2015	681	64% (n=436)	21% (n=147)
2015-2016	853	57% (n=489)	18% (n=156)
2016-2017	870	57% (n=496)	16% (n=142)

- The raw number of bullying events reported in Washoe County School District (grades K-12) decreased slightly from the 2013-2014 (n=899) school year to 2016-2017 school year (n=870).
- Over half of all reported and investigated events of bullying were substantiated, while around 1 in 5 resulted in suspension or expulsion.

Table 42: Cyber Bullying Incidents in Washoe County School District, Reported, Determined to be so, & Resulting in Suspension/Expulsion, 2013-2014 through 2015-2016

School year	# Reported	Found to be Bullying % (#)	Resulting in Suspension or Expulsion % (#)
2013-2014	26	100% (n=26)	38% (n=10)
2014-2015	14	100% (n=14)	28% (n=4)
2015-2016	26	100% (n=26)	46% (n=12)
2016-2017	29	100% (n=29)	41% (n=12)

- 100% of reported and investigated cyber bullying incidents were substantiated, and in 2016-2017, 41% resulted in suspension or expulsion.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Violent Behaviors & Victims of Violence

Table 43: Percent of High School Students who carried a Weapon*, 2013 & 2015

Location	2013	2015
Washoe County	20.3%	19.7%
Nevada	15.8%	16.9%
United States	17.9%	16.2%

*such as a gun, knife, or club on at least 1 day during the 30 days before the survey

- A higher percentage of high school students in Washoe County reported they have carried a weapon at least once in the past 30 days (prior to the survey), compared to Nevada and the U.S. in both 2013 and 2015.
- The percentage of high school students in Washoe County reported having carried a weapon slightly decreased from 2013 (20.3%) to 2015 (19.7%).

Table 44: Percent of High School Students who were in a Physical Fight*, 2013 & 2015

Location	2013	2015
Washoe County	28.8%	22.2%
Nevada	23.5%	19.3%
United States	24.7%	22.6%

*one or more times during the 12 months before the survey

- A higher percentage of high school students in Washoe County reported they were in a physical fight in the past 12 months (prior to the survey), compared to Nevada in both 2013 and 2015.
- The percentage of high school students who reported they were in a physical fight was lower in Washoe County and Nevada compared to the U.S. in 2015.
- The percentage of high school students in Washoe County reporting they were in a physical fight decreased from 2013 (28.8%) to 2015 (22.2%).

Table 45: Percent of High School Students who were Electronically Bullied*, 2013 & 2015

Location	2013	2015
Washoe County	16.9%	16.8%
Nevada	15.1%	13.8%
United States	14.8%	15.5%

*including being bullied through email, chat rooms, instant messaging, websites, or texting during the 12 months before the survey

- A higher percentage of high school students in Washoe County reported they were electronically bullied in the past 12 months (prior to the survey), compared to Nevada and the U.S. in both 2013 and 2015.
- The percentage of high school students in Washoe County reporting they were electronically bullied remained relatively unchanged from 2013 (16.9%) to 2015 (16.8%).

Table 46: Percent of High School Students who were Bullied on School Property*, 2013 & 2015

Location	2013	2015
Washoe County	21.7%	20.8%
Nevada	19.6%	18.5%
United States	19.6%	20.2%

*during the 12 months before the survey

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

- A higher percentage of high school students in Washoe County reported they were bullied on school property in the past 12 months (prior to the survey), compared to Nevada and the U.S. in both 2013 and 2015.
- The percentage of high school students in Washoe County reporting they were bullied on school property slightly decreased from 2013 (21.7%) to 2015 (20.8%).

Table 47: Percent of High School Students who did not go to School Because they feel Unsafe at School or on their way to and from School*, 2013 & 2015

Location	2013	2015
Washoe County	14.9%	9.0%
Nevada	11.1%	7.6%
United States	7.1%	5.6%

*on at least 1 day during the 30 days before the survey

- A higher percentage of high school students in Washoe County reported they did not go to school because they feel unsafe, compared to Nevada and the U.S. in both 2013 and 2015.
- The percentage of high school students in Washoe County reporting they did not go to school because they feel unsafe, decreased from 2013 (14.9%) to 2015 (9.0%).

Table 48: Percent of High School Students who were Threatened or Injured with a Weapon on School Property*, 2013 & 2015

Location	2013	2015
Washoe County	8.7%	8.1%
Nevada	6.5%	6.7%
United States	6.9%	6.0%

*such as a gun, knife, or club one or more times during the 12 months before the survey

- A higher percentage of high school students in Washoe County reported they were threatened or injured with a weapon on school property, compared to Nevada and the U.S. in both 2013 and 2015.
- The percentage of high school students in Washoe County reporting they were threatened or injured with a weapon on school property, slightly decreased from 2013 (8.7%) to 2015 (8.1%).

Table 49: Percent of High School Students who Experienced Physical Dating Violence*, 2013 & 2015

Location	2013	2015
Washoe County	12.8%	10.8%
Nevada	10.4%	9.9%
United States	10.3%	9.6%

*one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with a weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey

- A higher percentage of high school students in Washoe County reported they had experienced physical dating violence in the past 12 months (prior to the survey), compared to Nevada and the U.S. in both 2013 and 2015.
- Among high school students in Washoe County who reported they had been going out with or dating someone in the past 12 months, the percentage who had experienced physical dating violence, decreased from 2013 (12.8%) to 2015 (10.8%).

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Table 50: Percent of High School Students who Experienced Sexual Dating Violence*, 2013 & 2015

Location	2013	2015
Washoe County	13.3%	12.1%
Nevada	13.0%	11.2%
United States	10.4%	10.6%

*one or more times during the 12 months before the survey, including kissing, touching, or being physically forced to have sexual intercourse when they did not want to by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey

- A higher percentage of high school students in Washoe County reported they had experienced sexual dating violence in the past 12 months (prior to the survey), compared to Nevada and the U.S. in both 2013 and 2015.
- Among high school students in Washoe County who reported they had been going out with or dating someone in the past 12 months, the percentage who had experienced sexual dating violence, decreased from 2013 (13.3%) to 2015 (12.1%).

Table 51: Percent of High School Students who were ever Physically Forced to have Sexual Intercourse*, 2013 & 2015

Location	2013	2015
Washoe County	10.8%	9.1%
Nevada	11.4%	9.0%
United States	7.3%	6.7%

*when they did not want to

- A higher percentage of high school students in Washoe County (9.1%) reported they had ever been physically forced to have sexual intercourse, compared to Nevada (9.0%) and the U.S. (6.7%) in 2015.
- High school students in Washoe County who reported they had ever been physically forced to have sexual intercourse, decreased from 2013 (10.8%) to 2015 (9.1%).

Table 52: Percent of High School Students who have ever been Hit, Beaten, Kicked or Physically Hurt in Anyway by an Adult*, 2015

Location	2015
Washoe County	17.7%
Nevada	15.8%

*not including spanking for bad behavior

- A higher percentage of high school students in Washoe County (17.7%) reported they had ever been physically hurt by an adult, compared to Nevada (15.8%) in 2015.

Table 53: Percent of High School Students who have ever seen Adults in their Home Slap, Hit, Kick, Punch, or Beat each Other Up, 2015

Location	2015
Washoe County	16.6%
Nevada	16.4%

- A slightly higher percentage of high school students in Washoe County (16.6%) reported they had ever seen adults in their home be physically violent, compared to Nevada (16.4%) in 2015.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Child Abuse

When a child in Washoe County discloses sexual abuse or extreme physical abuse the case is referred by social services or law enforcement personnel to the Washoe County Children’s Advocacy Center. A multidisciplinary team determines if a medical exam is warranted and which additional follow up services should be offered to the child. Child Wellness Exams are conducted on each child placed into social services custody to ensure medical needs are being met. A researched-based Forensic Interview is conducted for all children 17 years and younger to obtain information from a child regarding abuse allegations. A Child Abuse Response and Evaluations (CARES) exam is provided to those children 12 years and older who has experienced suspected age-inappropriate sexual activity. A Sexual Assault Response Team (SART) is the term used to describe an evidentiary medical exam, which provides sensitive and thorough medical care and collects evidence that may be necessary to prosecute the case. The SART exam is only conducted on those children 13 years and older.

Table 54: Number of Services Provided by Washoe County Children's Advocacy Center by Type, 2014-2016

Type of Service	2014	2015	2016
Forensic Interviews	259	329	429
CARES	80	61	76
SART	217	181	186
Counseling	~	339	614
~Counseling services not provided in 2014			

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Table 55: Number & Percent of Alleged Child Abuse Victims by Demographic Characteristics, Washoe County, 2016

Sex (n=596)	% of Alleged Clients/Victims
Unknown sex	3%
Female	77%
Male	21%
Age Group (n=602)	
Unknown age	5%
0-6 years	26%
7-12 years	36%
13-17 years	33%
Race/Ethnicity (n=596)	
Unknown	29%
American Indian/Alaska Native	2%
Asian/Pacific Islander	2%
Black/African American	5%
Hispanic/Latino	15%
Indian	0%
Other	1%
White	47%

- In 2016, the majority of alleged victims of child abuse in Washoe County were female (77%).
- Approximately one in three alleged victims of child abuse were between the ages of 7-12 years (36%), one in three were between the ages of 13-17 years (33%), and one in four were 0-6 years (26%).
- Nearly half of alleged victims of child abuse were white (47%), while race/ethnicity was unknown for 29% of alleged victims, another 15% were Hispanic.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Table 56: Number & Percent of Alleged Child Abuse Offenders by Demographic Characteristics, Washoe County, 2016

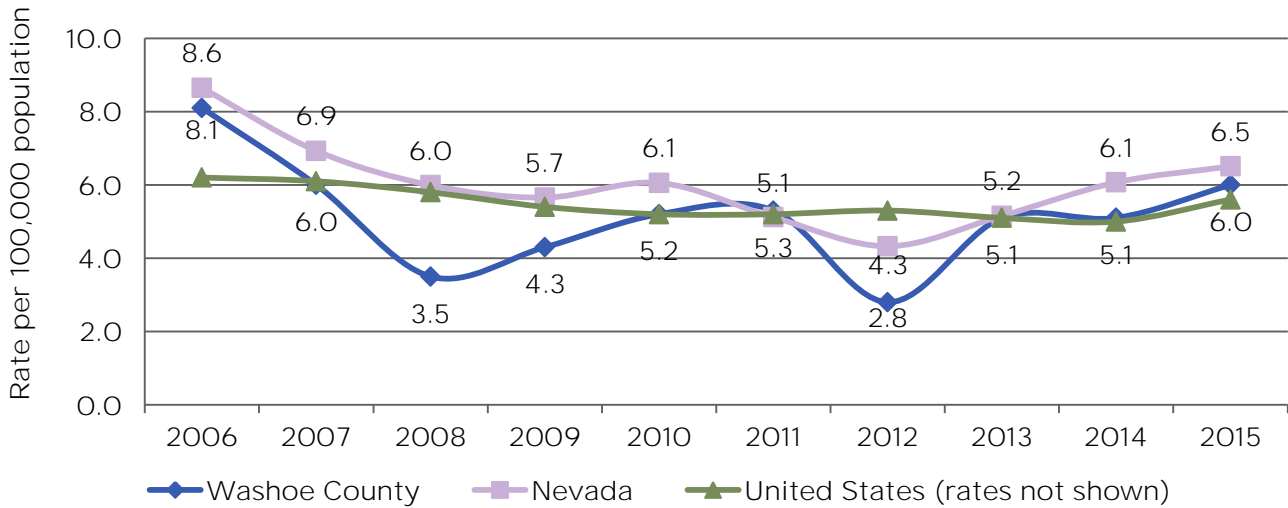
Sex (n=431)	% of Alleged Offenders
Unknown sex	1%
Female	14%
Male	85%
Age Group (n=437)	
Unknown age	13%
0-17 years	18%
18-35 years	34%
36-53 years	27%
54-65 years	5%
66-100 years	3%
Race/Ethnicity (n=431)	
Unknown race/ethnicity	35%
American Indian/Alaska Native	0%
Asian/Pacific Islander	1%
Black/African American	5%
Hispanic/Latino	14%
Indian	0%
Other	0%
White	44%
Relationship to Alleged Victim/Client (n=448)	
Other known person	27%
Other Relative	19%
Parent	28%
Parent's boy/girlfriend	7%
Stepparent	5%
Unknown relationship to victim/client	14%

- In 2016, the majority of alleged child abuse offenders in Washoe County were male (85%).
- Approximately one in three alleged child abuse offenders were between the ages of 18-35 years (34%).
- Although race/ethnicity was unknown for 35% of alleged child abuse offenders, 44% were white and 14% were Hispanic.
- Approximately one in four alleged child abuse offenders were parents of the purportedly abused child (28%), another one in four were some other known person but not directly related (27%), and other relatives were the third highest group (19%) of alleged child abuse offenders in regard to the relationship to the victim.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Deaths Due to Homicide/Assault

Fig 92: Age-adjusted Rate of Death Due to Homicide/Assault, Washoe County, Nevada, & the United States, 2006-2015



- The rate of death due to homicide/assault in Washoe County decreased from 2006 (8.1 per 100,000) to 2015 (6.0 per 100,000); however this rate has been increasing since 2012.
- The rate of deaths due to homicide/assault in Washoe County has been lower than the rate for Nevada from 2006 through 2010 and again from 2012 through 2016.

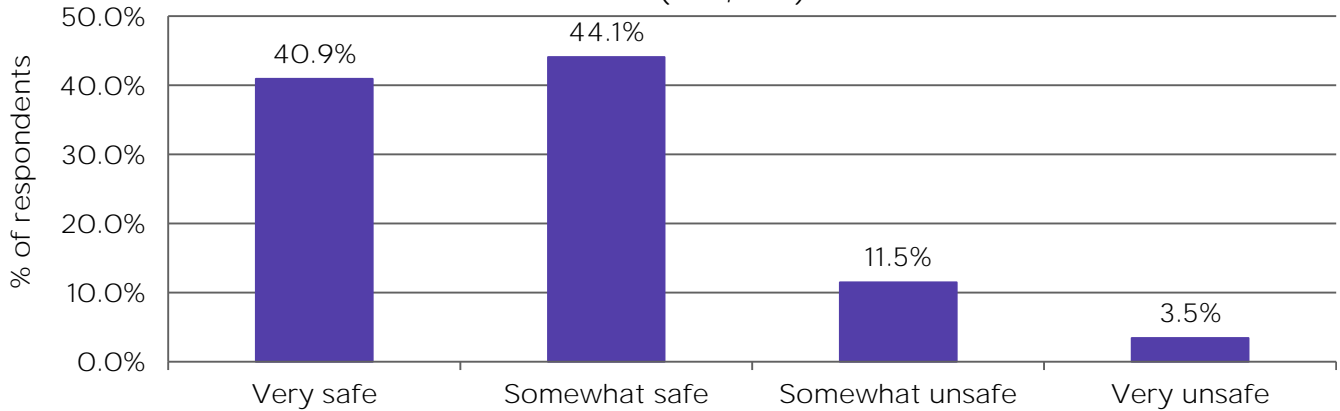
Primary Data Related to Crime & Violence

Primary data were collected via an online community survey from over 1,400 survey participants. The survey included 44 questions and analyses for questions related to Crime and Violent-Related Behaviors are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community Survey Demographics section.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Question: “How safe do you feel your neighborhood is from crime?”

Fig 93: How safe do you Feel Your Neighborhood is From Crime?
(n=1,358)

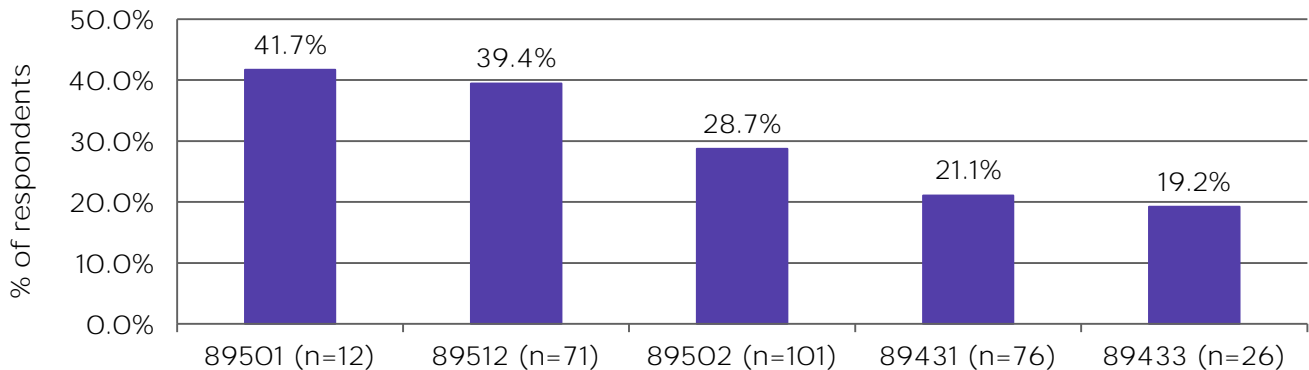


- The majority of survey respondents indicated they feel their neighborhood is very safe (40.9%) or somewhat safe (44.1%) from crime.
- Approximately one in ten (11.5%) respondents indicated they feel their neighborhood is somewhat unsafe and another 3.5% feel their neighborhood is very unsafe from crime.

Neighborhood Safety by ZIP Code

Responses to the neighborhood safety question were grouped into Safe (Very safe and Somewhat safe) and Unsafe (Somewhat unsafe and Very unsafe) and broken down by ZIP code. Figure 94 illustrates the ZIP codes with the highest proportion of respondents indicating they felt their neighborhood was unsafe.

Fig 94: Percent of Respondents that Feel Their Neighborhood is Somewhat Unsafe or Very Unsafe From Crime, Top 5 ZIP Codes



- Among the 12 respondents that lived in 89501, the downtown Reno area, 41.7% indicated they feel the neighborhood is unsafe.
- Among the 71 respondents that lived in 89512, the northeast Reno area, 39.4% indicated they feel the neighborhood is unsafe.
- Among the 101 respondents that lived in 89502, the southeast Reno area, 28.7% indicated they feel the neighborhood is unsafe.
- Among the 76 respondents that lived in 89431, the central Sparks area, 21.1% indicated they feel the neighborhood is unsafe.

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

- Among the 26 respondents that lived in 89433, the central Sparks area, 19.2% indicated they feel the neighborhood is unsafe.
- These five ZIP codes were also the five highest needs ZIP codes as identified by the Community Needs Index (CNI) scores, more details are provided in the CNI Section.

Summary of Crime & Violent-Related Behaviors

The Reno/Sparks MSA has historically seen higher rates of violent crime and property crimes compared to the United States (2007-2016). Although rates of crime appeared to have decreased since 2007 and remained relatively stable from 2010 to 2014, the rates of both violent and property crime increased in 2015.

Additionally, most of the select violent-related behaviors reported among high school students in Washoe County were higher than Nevada and United States rates during both 2013 and 2015.

The majority of survey respondents indicated they feel their neighborhood is very or somewhat safe from crime. However, when broken out by ZIP code, the ZIP codes with the highest proportion of residents indicating they felt their neighborhood is somewhat or very unsafe are the same five ZIP codes with the highest Community Needs Index (CNI) scores.

Having been a victim or witness of violence results in negative impacts across several aspects of health and carries consequences far beyond the initial incident; reducing a person's exposure to all forms of violence, both in and outside of the home, play a major part in increasing the health and safety of a community.

Crime & Violent-Related Behaviors Sources

Fig 88: Violent Crime Rate, Reno/Sparks MSA & the United States, 2007-2016

Washoe County: U.S. Department of Justice, Federal Bureau of Investigation: Uniform Crime Rates. Table 6 Crime in the United States, by Metropolitan Statistical Area, 2007-2016. www.ucr.fbi.gov

United States: U.S. Department of Justice, Federal Bureau of Investigation: Uniform Crime Rates. Table 1 Crime in the United States, by Volume and Rate per 100,000 Inhabitants, 1996-2016. www.ucr.fbi.gov

Fig 89: Violent Crime Rate by Type, Reno/Sparks MSA, 2007-2016

U.S. Department of Justice, Federal Bureau of Investigation: Uniform Crime Rates. Table 6 Crime in the United States, by Metropolitan Statistical Area, 2007-2016. www.ucr.fbi.gov

Fig 90: Property Crime Rate, Reno/Sparks MSA & the United States, 2007-2016

Washoe County: U.S. Department of Justice, Federal Bureau of Investigation: Uniform Crime Rates. Table 6 Crime in the United States, by Metropolitan Statistical Area, 2007-2016. www.ucr.fbi.gov

United States: U.S. Department of Justice, Federal Bureau of Investigation: Uniform Crime Rates. Table 1 Crime in the United States, by Volume and Rate per 100,000 Inhabitants, 1996-2016. www.ucr.fbi.gov

Fig 91: Property Crime Rate by Type, Reno/Sparks MSA, 2007-2016

U.S. Department of Justice, Federal Bureau of Investigation: Uniform Crime Rates. Table 6 Crime in the United States, by Metropolitan Statistical Area, 2007-2015. www.ucr.fbi.gov

Table 41-table 42 Same Source

Table 41: Bullying Incidents in Washoe County School District, Reported, Determined to be so, & Resulting in Suspension/Expulsion, 2013-2014 through 2015-2016

Table 42: Cyber Bullying Incidents in Washoe County School District, Reported, Determined to be so, & Resulting in Suspension/Expulsion, 2013-2014 through 2015-2016

Nevada Department of Education. Nevada Report Card. Accessed <http://nevadareportcard.com/di/>

1.7 CRIME & VIOLENT-RELATED BEHAVIORS

Table 43-Table 53 Same Source

Table 43: Percent of High School Students who carried a Weapon, 2013 & 2015

Table 44: Percent of High School Students who were in a Physical Fight, 2013 & 2015

Table 45: Percent of High School Students who were Electronically Bullied, 2013 & 2015

Table 46: Percent of High School Students who were Bullied on School Property, 2013 & 2015

Table 47: Percent of High School Students who did not go to School Because they feel Unsafe at School or on their way to and from School, 2013 & 2015

Table 48: Percent of High School Students who were Threatened or Injured with a Weapon on School Property, 2013 & 2015

Table 49: Percent of High School Students who Experienced Physical Dating Violence, 2013 & 2015

Table 50: Percent of High School Students who Experienced Sexual Dating Violence, 2013 & 2015

Table 51: Percent of High School Students who were ever Physically Forced to have Sexual Intercourse, 2013 & 2015

Table 52: Percent of High School Students who have ever been Hit, Beaten, Kicked or Physically Hurt in Anyway by an Adult, 2015

Table 53: Percent of High School Students who have ever seen Adults in their Home Slap, Hit, Kick, Punch, or Beat each Other Up, 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 54 –Table 56 Same Source

Table 54: Number of Services Provided by Washoe County Children's Advocacy Center by Type, 2014-2016

Table 55: Number & Percent of Alleged Child Abuse Victims by Demographic Characteristics, Washoe County, 2016

Table 56: Number & Percent of Alleged Child Abuse Offenders by Demographic Characteristics, Washoe County, 2016
Washoe County Children's Advocacy Center. Data provided upon request. Reno, NV.

Fig 92: Age-adjusted Rate of Death Due to Homicide/Assault, Washoe County, Nevada, & the United States, 2006-2015

Washoe County & Nevada: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Jul 7, 2017 3:19:14 PM

Following Figures from the Online Community Survey

Fig 93: How safe do you Feel Your Neighborhood is From Crime? (n=1,358)

Fig 94: Percent of Respondents that Feel Their Neighborhood is Somewhat Unsafe or Very Unsafe From Crime, Top 5 ZIP Codes

Nutrition & Physical Activity

Eating a healthy diet and engaging in adequate amounts of physical activity are among the most effective prevention activities to reduce or slow weight gain. A lifestyle that incorporates healthy eating and physical activity decreases the risk for many of the leading causes of death including cardiovascular disease, heart disease, stroke, and diabetes.⁷⁸

Indicator	Most Recent Year	HP 2020 Objective
Nutrition		
Fruit consumption among adolescents	32.2% 2+ times/day (2015)	NA
Vegetable consumption among adolescents	27.2% 2+ times/day (2015)	NA
Soda consumption among adolescents	13.4% 1+ soda/day (2015)	NA
Milk consumption among adolescents	37.0% 1+ glass/day (2015)	NA
Breakfast consumption among adolescents	14.7% did not eat breakfast (2015)	NA
Fruit consumption among adults	65.7% 1+ servings/day (2015)	NA
Vegetable consumption among adults	80.8% 1+ servings/day (2015)	NA
Physical Activity		
Physical activity among adolescents	27.0% (2015) 7+ days/week	31.6%
Physical education among adolescents	22.5% (2015) 5 days/week	36.6%
Adolescents that played on sports team	50.8% (2015)	NA
Adults that met the aerobic guidelines	32.5% (2015)	NA
Adults that met the strength guidelines	7.9% (2015)	24.1%
Adults that met the aerobic & strength guidelines	28.5% met both (2015)	20.1% met both
Sedentary Behavior		
Adolescents that watched 3+ hrs of television	20.9% (2015)	NA
Adolescents that played videogames or used the computer 3+ hrs	33.6% (2015)	NA
All indicators contain only data from 2013 & 2015, therefore indicators were unable to be assessed for trend and the column was not included for this section.; NA=identical HP 2020 objectives not available		

Nutrition

According to the 2015-2020 Dietary Guidelines for the United States, a healthful diet includes a variety of vegetables and fruits, whole grains, fat-free or low-fat dairy, and a variety of proteins such as seafood, lean meats, beans, nuts, and seeds.⁷⁹ Additionally, the Centers for Disease Control and Prevention (CDC) developed documentation on strategies to increase and promote the consumption of fruits and vegetables reinforcing their importance in the prevention of obesity and related chronic diseases.

⁷⁸ Centers for Disease Control and Prevention. (2009). The Power of Prevention: Chronic Disease the Challenge of the 21st Century.

⁷⁹ United States Department of Health and Human Services and United States Department of Agriculture. (2015). 2015-2020 Dietary Guidelines for Americans 8th Edition. Washington, DC.

1.8 NUTRITION & PHYSICAL ACTIVITY

Fruit Consumption - Adolescents

Table 57: Percent of High School Students who did not Eat Fruit/Drink 100% Fruit Juice*, 2013 & 2015

Location	2013	2015
Washoe County	5.2%	4.3%
Nevada	5.6%	5.0%
United States	5.0%	5.2%

*during the 7 days before the survey

- Slightly lower percentage of Washoe County high school students reported not eating fruit or drinking fruit juice in 2015 (4.3%) compared to 2013 (5.2%).
- In 2015, the percentage of Washoe County high school students reporting not eating fruit or drinking fruit juice (4.3%) was lower than Nevada (5.0%) and the United States (5.2%).

Table 58: Percent of High School Students who ate Fruit/Drank 100% Fruit Juice 1 or more Times per Day*, 2013 & 2015

Location	2013	2015
Washoe County	62.3%	61.5%
Nevada	57.9%	58.4%
United States	62.6%	63.3%

*during the 7 days before the survey

Table 59: Percent of High School Students who ate Fruit/Drank 100% Fruit Juice 2 or more Times per Day*, 2013 & 2015

Location	2013	2015
Washoe County	30.7%	32.2%
Nevada	29.7%	28.3%
United States	33.2%	31.5%

*during the 7 days before the survey

Table 60: Percent of High School Students who ate Fruit/Drank 100% Fruit Juice 3 or more Times per Day*, 2013 & 2015

Location	2013	2015
Washoe County	18.4%	19.6%
Nevada	17.9%	17.3%
United States	21.9%	20.0%

*during the 7 days before the survey

Vegetable Consumption - Adolescents

Table 61: Percent of High School Students who did not eat Vegetables*, 2013 & 2015

Location	2013	2015
Washoe County	6.1%	5.5%
Nevada	6.5%	6.7%
United States	6.6%	6.7%

*green salad, potatoes (excluding French fries, fried potatoes, or potato chips), carrots, or other vegetables during the 7 days before the survey

- Slightly lower percentage of Washoe County high school students reported not eating vegetables in 2015 (5.5%) compared to 2013 (6.1%).

1.8 NUTRITION & PHYSICAL ACTIVITY

- In 2015, the percentage of Washoe County high school students that reported not eating vegetables (5.5%) was lower than Nevada (6.7%) and the United States (6.7%).

Table 62: Percent of High School Students who ate Vegetables 1 or more Times per Day*, 2013 & 2015

Location	2013	2015
Washoe County	82.3%	60.4%
Nevada	57.9%	56.9%
United States	61.5%	61.0%

*green salad, potatoes (excluding French fries, fried potatoes, or potato chips), carrots, or other vegetables during the 7 days before the survey

- There was a large decrease in the percentage of Washoe County high school students reporting they ate vegetables at least once a day from 2013 (82.3%) to 2015 (60.4%).

Table 63: Percent of High School Students that ate Vegetables 2 or more Times per Day*, 2013 & 2015

Location	2013	2015
Washoe County	26.4%	27.2%
Nevada	24.2%	23.2%
United States	28.4%	28.0%

*green salad, potatoes (excluding French fries, fried potatoes, or potato chips), carrots, or other vegetables during the 7 days before the survey

Table 64: Percent of High School Students who ate Vegetables 3 or more Times per Day*, 2013 & 2015

Location	2013	2015
Washoe County	12.9%	14.6%
Nevada	12.1%	11.5%
United States	15.7%	14.8%

*green salad, potatoes (excluding French fries, fried potatoes, or potato chips), carrots, or other vegetables during the 7 days before the survey

Soda Consumption -Adolescents

Table 65: Percent of High School Students who did not Drink soda or pop*, 2013 & 2015

Location	2013	2015
Washoe County	24.7%	31.2%
Nevada	28.5%	29.4%
United States	22.3%	26.2%

*can, bottle, or glass of soda (not including diet-soda or diet-pop) during the 7 days before the survey

- Slightly higher percentage of Washoe County high school students reported not drinking soda in 2015 (31.2%) compared to 2013 (24.7%).
- In 2015, the percentage of Washoe County high school students reporting not drinking soda (31.2%) was higher than Nevada (29.4%) and the United States (26.2%).

1.8 NUTRITION & PHYSICAL ACTIVITY

Table 66: Percent of High School Students who Drank Soda 1 or more Times per Day*, 2013 & 2015

Location	2013	2015
Washoe County	17.9%	13.4%
Nevada	16.3%	14.5%
United States	27.0%	20.4%

*can, bottle, or glass of soda (not including diet-soda or diet-pop) during the 7 days before the survey

- A lower percentage of Washoe County high school students reported drinking soda one or more times per day in 2015 (13.4%) compared to 2013 (17.9%).
- In 2015, the percentage of Washoe County high school students reporting drinking soda one or more times a day (13.4%) was lower than Nevada (14.5%) and the United States (20.4%).

Milk Consumption - Adolescents

Table 67: Percent of High School Students who did not Drink Milk*, 2013 & 2015

Location	2013	2015
Washoe County	17.0%	19.5%
Nevada	21.8%	22.7%
United States	19.4%	21.5%

*during the 7 days before the survey

- Slightly higher percentage of Washoe County high school students reported not drinking milk in 2015 (19.5%) compared to 2013 (17.0%).
- In 2015, the percentage of Washoe County high school students reporting not drinking milk (19.5%) was lower than Nevada (22.7%) and the United States (21.5%).

Table 68: Percent of High School Students who Drank 1 or more Glasses of Milk per Day*, 2013 & 2015

Location	2013	2015
Washoe County	38.1%	37.0%
Nevada	33.8%	31.6%
United States	40.3%	37.5%

*during the 7 days before the survey

- A slightly lower percentage of Washoe County high school students reported drinking milk one or more times per day in 2015 (37.0%) compared to 2013 (38.1%).
- In 2015, the percentage of Washoe County high school students reporting drinking milk one or more times a day (37.0%) was higher than Nevada (31.6%) and relatively similar to the United States (37.5%).

Breakfast Consumption - Adolescents

Table 69: Percent of High School Students who did not eat Breakfast*, 2013 & 2015

Location	2013	2015
Washoe County	13.6%	14.7%
Nevada	17.3%	16.7%
United States	13.7%	13.8%

*during the 7 days before the survey

- Slightly higher percentage of Washoe County high school students reported not eating breakfast in 2015 (14.7%) compared to 2013 (13.6%).
- In 2015, the percentage of Washoe County high school students reporting not eating breakfast (14.7%) was lower than Nevada (16.7%), however was higher than the United States (13.8%).

1.8 NUTRITION & PHYSICAL ACTIVITY

Table 70: Percent of High School Students who ate Breakfast on all 7 Days*, 2013 & 2015

Location	2013	2015
Washoe County	36.8%	38.9%
Nevada	34.5%	34.1%
United States	38.1%	36.3%

*during the 7 days before the survey

- A higher percentage of Washoe County high school students reported eating breakfast on all seven days prior to the survey in 2015 (38.9%) compared to 2013 (36.8%).
- In 2015, the percentage of Washoe County high school students reporting eating breakfast (38.9%) was higher than Nevada (34.1%) and the United States (36.3%).

Fruit Consumption - Adults

Table 71: Percent of Adults who had at least 1 Serving of Fruit per Day, 2013 & 2015

Location	2013	2015
Washoe County	66.9%	65.7%
Nevada	64.4%	63.1%
United States	60.8%	60.3%

- The percentage of adults in Washoe County that reported having at least one serving of fruit per day decreased slightly from 2013 (66.9%) to 2015 (65.7%).
- In 2015, the percentage of adults in Washoe County that reported having at least one serving of fruit per day (65.7%) was higher than Nevada (63.1%) and the United States (60.3%).

Vegetable Consumption -Adults

Table 72: Percent of Adults who had at least 1 Serving of Vegetables per Day, 2013 & 2015

Location	2013	2015
Washoe County	83.3%	80.8%
Nevada	79.1%	80.8%
United States	77.1%	77.9%

- The percentage of adults in Washoe County that reported having at least one serving of vegetables per day decreased from 2013 (83.3%) to 2015 (80.8%).
- In 2015, the percentage of adults in Washoe County that reported having at least one serving of vegetables per day (80.8%) was equal to Nevada and higher than the United States (77.9%).

Physical Activity

The 2008 Physical Activity Guidelines for children and adolescents recommend 60 or more minutes of physical activity each day with a combination of aerobic activity (at least three days a week), as well as muscle and bone-strengthening activities (at least three days a week). The recommendations for adults are 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity aerobic activity per week, with two or more days of muscle-strengthening activities for all major muscle groups.⁸⁰

⁸⁰ United States Department of Health and Human services. (2008). 2008 Physical Activity Guidelines for Americans. ODPHP Publication No. U0036. Washington, DC.

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Physical Activity -Adolescents

Table 73: Percent of High School Students who did not Participate in Physical Activity for at least 60 Minutes on 1 day*, 2013 & 2015

Location	2013	2015
Washoe County	15.1%	11.2%
Nevada	16.4%	13.9%
United States	15.2%	14.3%

*doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey

- A higher percentage of Washoe County high school students reported they did not participate in physical activity in 2013 (15.1%) compared to 2015 (11.2%).
- In 2015, a lower percentage of Washoe County high school students reported they did not participate in physical activity (11.2%) compared to Nevada (13.9%) and the United States (14.3%).

Table 74: Percent of High School Students who were Physically Active for 60 or more Minutes on 7 or more Days*, 2013 & 2015

Location	2013	2015
Washoe County	23.9%	27.0%
Nevada	23.3%	27.6%
United States	27.1%	27.1%

*doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey

- A higher percentage of Washoe County high school students reported they were physically active on each of the seven days prior to the survey in 2015 (27.0%) compared to 2013 (23.9%).
- In 2015, a relatively similar percentage of Washoe County high school students reported they were physically active on the seven days preceding the survey (27.0%) compared to Nevada (27.6%) and the United States (27.1%).

Table 75: Percent of High School Students who Attended Physical Education Classes on all 5 Days*, 2013 & 2015

Location	2013	2015
Washoe County	18.8%	22.5%
Nevada	24.8%	27.8%
United States	29.4%	29.8%

*in an average week when they were in school

- A higher percentage of high school students in Washoe County reported they attended P.E. classes on five or more days in 2015 (22.5%) compared to 2013 (18.8%).
- In 2015, a much lower percentage of Washoe County high school students reported they attended P.E. classes on five or more days (22.5%) compared to Nevada (27.8%) and the United States (29.8%).

Table 76: Percent of High School Students who Played on at least 1 Sports Team*, 2013 & 2015

Location	2013	2015
Washoe County	51.8%	50.8%
Nevada	49.2%	50.1%
United States	54.0%	57.6%

*run by their school or community group during the 12 months before the survey

- A slightly lower percentage of high school students in Washoe County reported having played on a sports team in 2015 (50.8%) compared to 2013 (51.8%).

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- In 2015, the percentage of Washoe County high school students reporting having played on a sports team (50.8%) was relatively similar to Nevada (50.1%), and both were much lower than the United States (57.6%).

Physical Activity - Adults

Table 77: Percent of Adults who met the Aerobic & Strength Guidelines, Washoe County, 2013 & 2015

Guideline met	2013	2015
Met aerobic	32.7%	32.5%
Met strength	7.0%	7.9%
Met both aerobic and strength	28.0%	28.5%
Met neither	32.3%	31.0%

- The percentage of adults in Washoe County that met the aerobic guidelines remained stable from 2013 (32.7%) to 2015 (32.5%)
- The percentage of adults that met the strength guidelines also remained relatively stable from 2013 (7.0%) to 2015 (7.9%).
- In 2015, 28.5% of adults in Washoe County met both the aerobic and strength guidelines, which was higher than Nevada (24.9%)-Table 78, and the United States (20.3%)-Table 79; however, in 2015 31.0% of adults in Washoe County met neither the aerobic nor the strengthening guidelines.

Table 78: Percent of Adults who met the Aerobic & Strength Guidelines, Nevada, 2013 & 2015

Guideline met	2013	2015
Met aerobic	29.5%	29.7%
Met strength	9.3%	9.7%
Met both aerobic and strength	22.8%	24.9%
Met neither	38.5%	35.7%

Table 79: Percent of Adults who met the Aerobic & Strength Guidelines, United States, 2013 & 2015

Guideline met	2013	2015
Met both aerobic and strength	20.5%	20.3%

Sedentary Behavior- Adolescents

Table 80: Percent of High School Students who Watched Television 3 or more Hours a Day*, 2013 & 2015

Location	2013	2015
Washoe County	28.8%	20.9%
Nevada	30.2%	22.9%
United States	32.5%	24.7%

*on an average school day

- A much lower percentage of Washoe County high school students reported having watched three or more hours of T.V. each day in 2015 (20.9%) compared to 2013 (28.8%).
- In 2015, the percentage of Washoe County high school students reporting having watched three or more hours of T.V. each day (20.9%) was lower than Nevada (22.9%) and the United States (24.7%).

Table 81: Percent of High School Students who Played Video or Computer Games or used a Computer 3 or more hours per day*, 2013 & 2015

Location	2013	2015
Washoe County	36.2%	33.6%
Nevada	38.0%	38.3%
United States	41.3%	41.7%

*used a computer that was not for school work, on an average school day

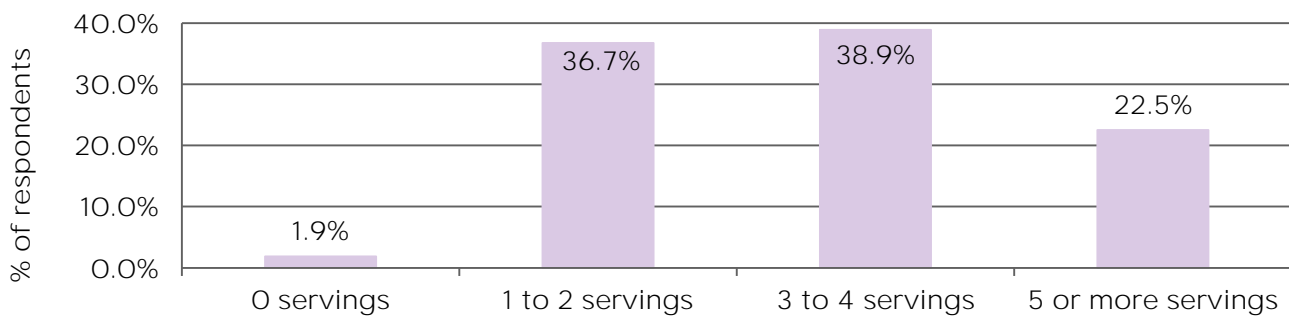
- A lower percentage of Washoe County high school students reported having played videogames or using the computer (not for school work) for three or more hours per day in 2015 (33.6%) compared to 2013 (36.2%).
- In 2015, the percentage of Washoe County high school students reporting having played videogames or using the computer (not for school work) for three or more hours per day (33.6%) was much lower than Nevada (38.3%) and the United States (41.7%).

Primary Data Related to Nutrition & Physical Activity

Primary data were collected via an online community survey from over 1,400 survey participants. The survey included 44 questions and analyses for questions related to nutrition and physical activity are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community survey Demographics section.

Question: “During the past week, about how many servings of fruit and vegetables (combined) did you eat each day? Include fresh, frozen or cooked fruits and vegetables. DO NOT COUNT items such as fruit drinks, French fries, or potato chips.”

Fig 95: Fruit & Vegetable Consumption per Day in Past Week (n=1,399)

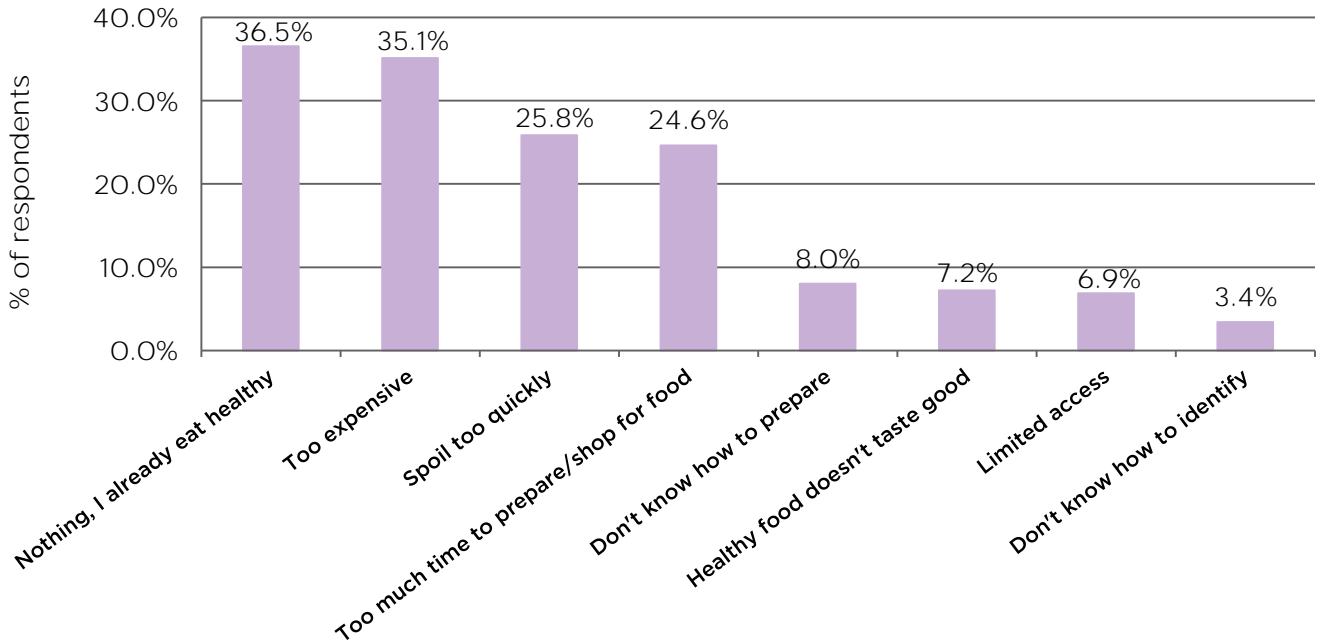


- Over one in three respondents (36.7%) ate between 1 to 2 servings of fruit and vegetables combined, while another third (38.9%) ate 3 to 4 servings of fruit and vegetables combined each day in the past week.
- Over one in five respondents (22.5%) indicated they ate 5 or more servings of fruits and vegetables each day in the past week.

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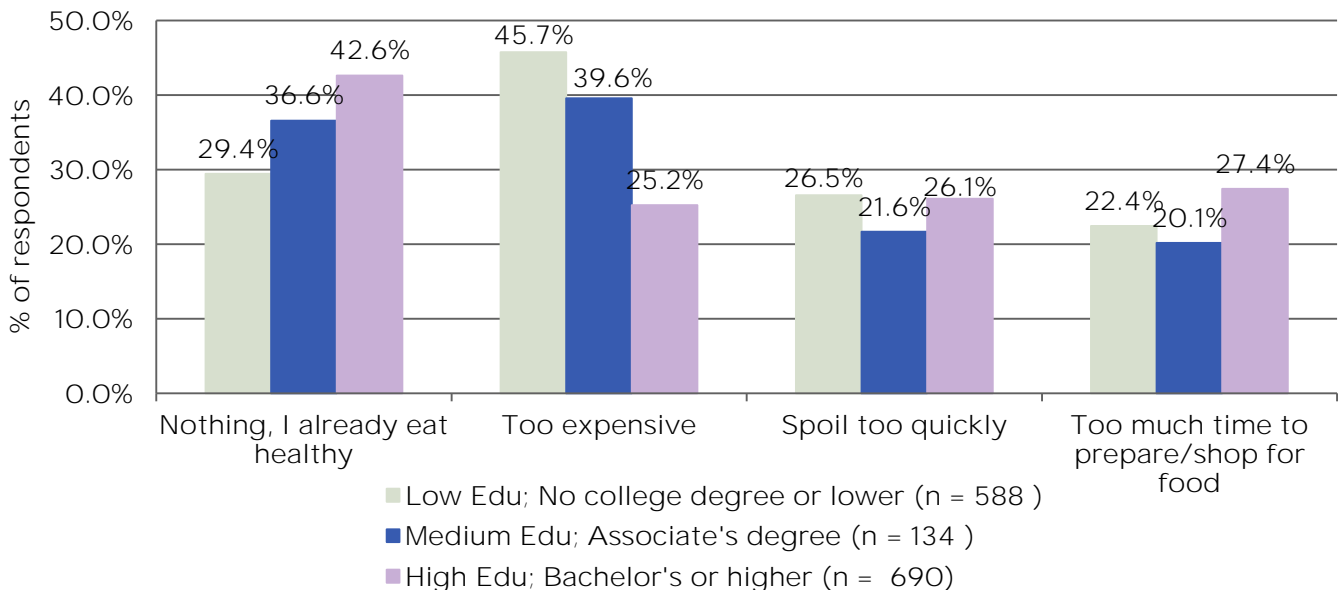
Question: “Which of the following are the largest barriers to you eating healthy food more often? Select up to three.”

Fig 96: Barriers to Eating Healthy Food More Often (n=1,412)



- One in three respondents indicated they already eat enough healthy foods (36.5%).
- Healthy food is too expensive (35.1%), spoils too quickly (25.8%), and takes too much time to shop for and/or prepare (24.6%) were the top three barriers identified by respondents.
- Less than 10% of respondents indicated lack of knowledge on food preparation (8.0%), not liking the taste of healthy food (7.2%), limited access (6.9%), and lack of ability to identify healthy foods (3.4%) as barriers to eating healthy food more often.

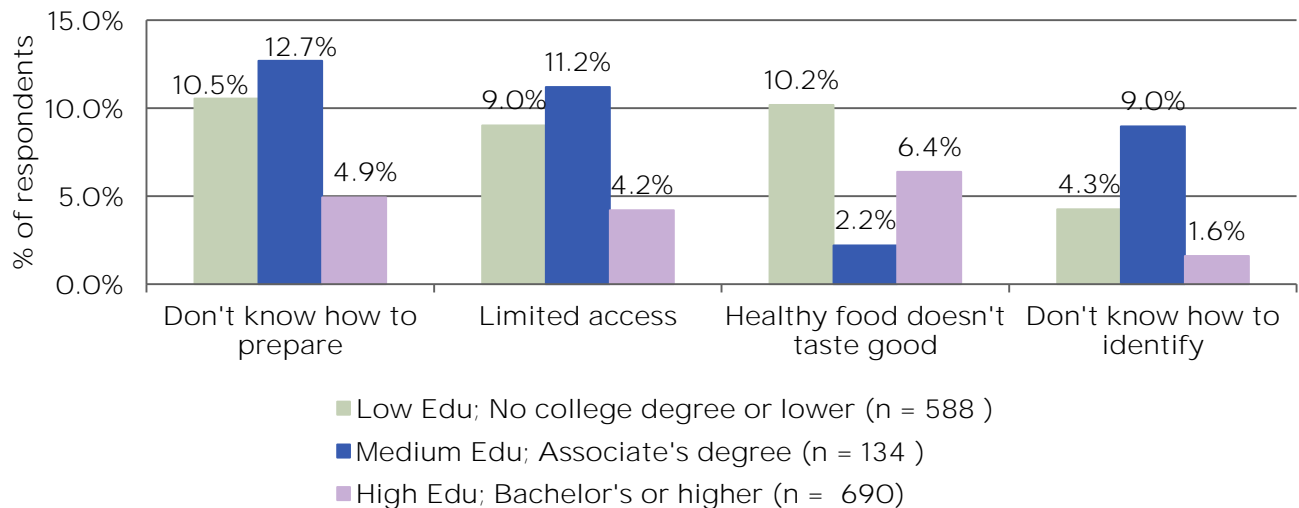
Fig 97: Top Three Barriers to Eating Healthy Food More Often by Educational Attainment



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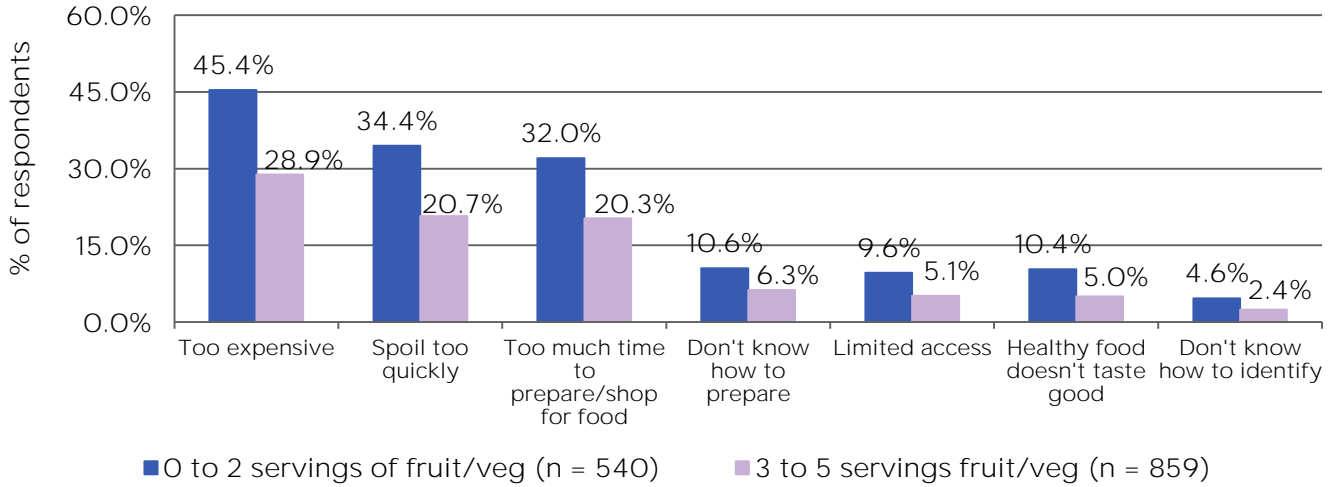
- As educational attainment increased, so did the proportion of respondents who indicated they already eat enough healthy foods.
- Among those with a lower education level (no college degree or lower), nearly half (45.7%) indicated healthy food is too expensive, 26.5% indicated healthy food spoils too quickly, and 22.4% of respondents with a lower educational attainment indicated healthy food takes too much time to prepare or shop for.
- Among those with a medium education level (associate's degree), 39.6% indicated healthy food is too expensive, 21.6% indicated healthy food spoils too quickly, and 20.1% of respondents with a medium educational attainment indicated healthy food takes too much time to prepare or shop for.
- Among those with a high education level (bachelor's degree or higher), 25.2% indicated healthy food is too expensive, 26.1% indicated healthy food spoils too quickly, and 27.4% of respondents with a medium educational attainment indicated healthy food takes too much time to prepare or shop for.

Fig 98: Other Identified Barriers to Eating Healthy Food More Often by Educational Attainment



- The least often identified barriers to eating healthy food more often were lack of knowledge of how to prepare healthy foods, having limited access to healthy foods, believing healthy foods do not taste good, and lack of knowledge how to identify healthy food.

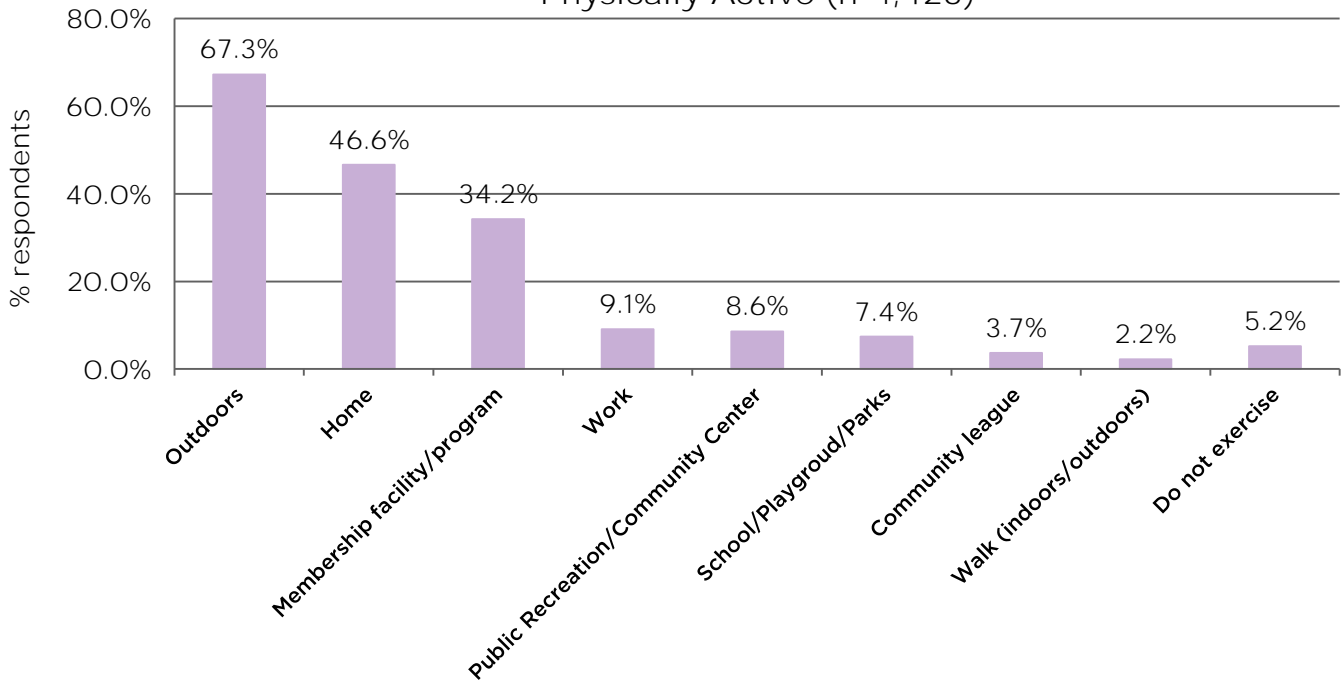
Fig 99: Barriers to Eating Healthy More Often by Fruit & Vegetable Consumption



- Respondents who reported consuming a lower number of servings of fruit and vegetables (0 to 2 servings) each day within the previous week reported each of the barriers to eating more healthy more often than respondents that reported a higher number (3 to 5 servings) of servings of fruit and vegetables each day.

Question: “Where do you currently go most often to be physically active? Select all that apply.”

Fig 100: Places Survey Respondents Go Most Often to be Physically Active (n=1,423)



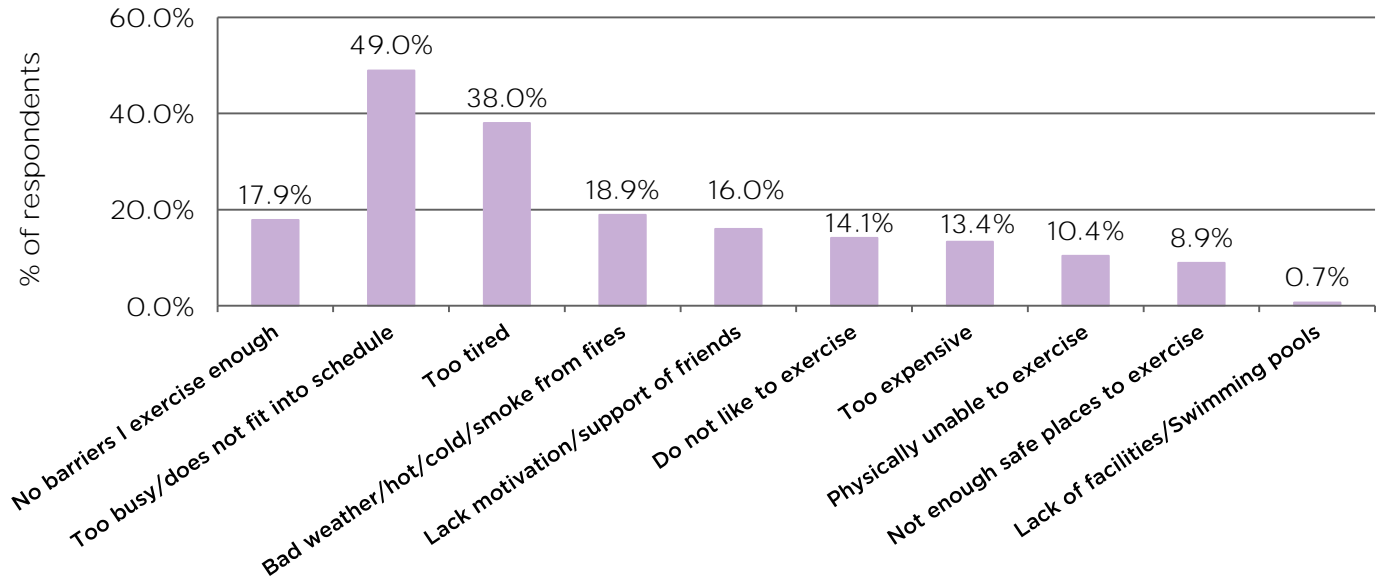
- The majority of respondents reported they go outdoors to be physically active (67.3%), followed by the home (46.6%), and a membership facility or paid class (34.2%).

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- Less than one in ten participants indicated they go to work (9.1%), a public recreation or community center (8.6%), schools, playgrounds, parks (7.4%), community league (3.7%), or they just walk (2.2%) (i.e. shopping, walking at the mall).
- Approximately 5.2% of survey respondents indicate they do not exercise.

Question: “Which of the following are the largest barriers to you being more physically active? Select up to three.”

Fig 101: Barriers to Being More Physically Active (n=1,438)

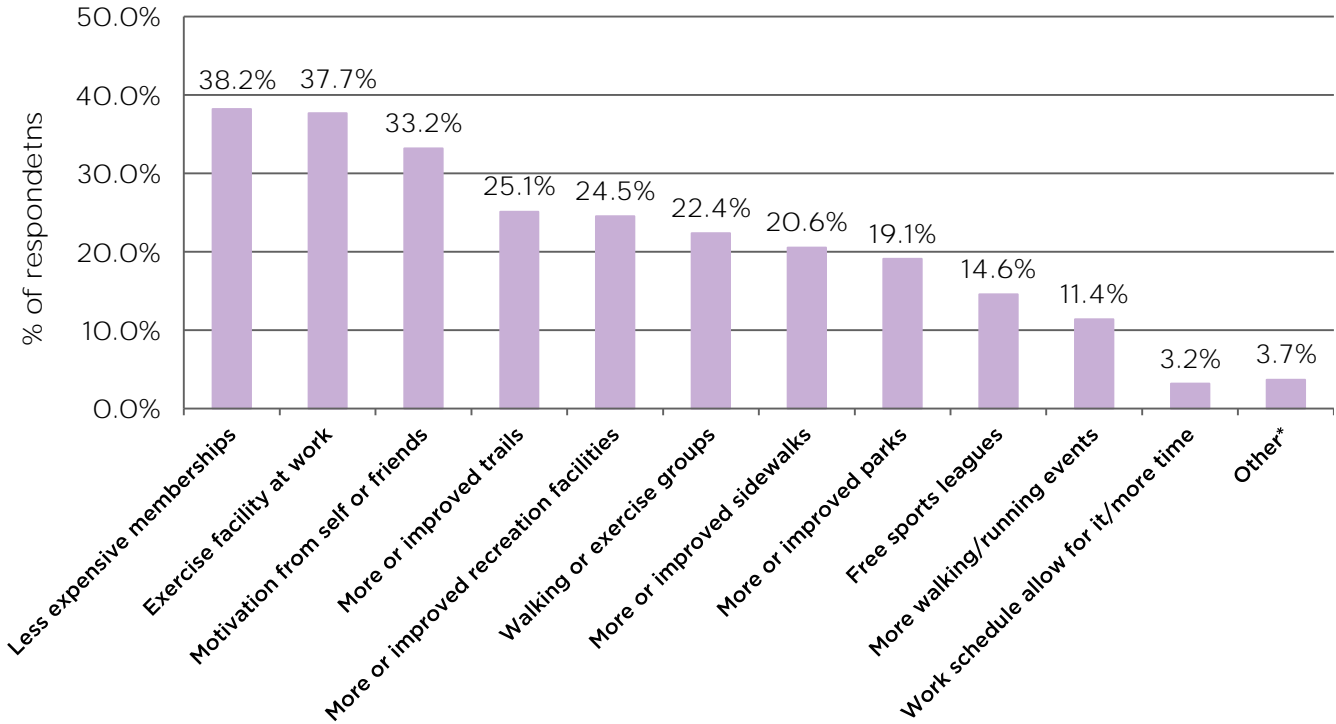


- Only 17.9% of respondents indicated they believe they exercise enough.
- Nearly half of the respondents (49.0%) indicated they are too busy/exercise does not fit into their current schedule, the second most commonly cited barrier to being more physically active was being too tired (38.0%), followed by bad weather, either too hot too cold or having poor air quality from fires (18.9%).
- Lack of facilities/swimming pools was not one of the options provided, however these were frequently cited in the comments sections and were grouped into one category.

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Question: “Which of the following would help you to increase your physical activity levels? Select all that apply.”

Fig 102: What Would Help to Increase Physical Activity Levels
(n=1,377)



Note: Other includes having more public pools, access to transportation, child care options, and safer areas to engage in exercise.

- Survey respondents most frequently identified having less expensive memberships (38.2%), having an exercise facility at work (37.7%) and having motivation either self motivation or from friends (33.2%) as methods to increase physical activity levels.
- One in four respondents indicated the desire to have more or improved trails (25.1%) for biking, walking, running, and more or improving existing recreation facilities (24.5%) as some respondents stated they did not have a facility close to where they lived. More walking/exercise groups (22.4%) and more or improved sidewalks (20.6%) were especially noted among elderly adults 65 years and older.
- Free sport leagues (14.6%) and more walking and running events (11.4%) were among the least frequently cited options for increasing physical activity, although still relatively common.
- Having a work schedule that allows for flexibility to incorporate physical activity (3.2%) was not among the options provided, but listed so frequently in the comments it was given its own category.

Summary of Nutrition & Physical Activity

According to the 2013 and 2015 Youth Risk Behavior Survey (YRBS) data, fruit and vegetable consumption reported by Washoe County high school students was relatively similar to the United States. Soda consumption among Washoe County high school students was lower than the United States and reported milk consumption among Washoe County high school students was relatively similar to the United States. In 2015,

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reported fruit and vegetable consumption among Washoe County adults was slightly higher than adults nationwide.

In 2015, less than one-third (27.0%) of Washoe County high school students met the recommended physical activity guidelines for adolescents (physically active for 60 minutes daily). Additionally, less than one-third (28.5%) of adults in Washoe County were reported to have met both the aerobic and strengthening guidelines. In 2015, one in five (20.9%) Washoe County high school students reported watching television for three or more hours each day and one in three (33.6%) reported playing videogames or using a computer (not for schoolwork) for three or more hours each day. While these appear high, Washoe County's rates were lower than the rest of the United States.

Analyses of the community survey responses indicate just over one in five respondents (22.5%) were close to consuming the daily recommended amount of fruit and vegetables. The largest reported barriers to eating healthy food more often were "healthy food is too expensive" (35.1%), "spoils too quickly" (25.8%), and "takes too much time to shop and prepare healthy food" (24.6%). Lack of knowledge on how to prepare healthy food (8.0%), not liking the taste of healthy food (7.2%), having limited access (6.9%), and the lack of ability to identify healthy foods (3.4%) were among the least frequently cited barriers. Respondents that reported eating a higher number of servings of fruits and vegetables (3 to 5 servings) were less likely to identify any of the above reasons as barriers to healthy eating.

The majority of survey respondents indicated they engage in physical activity outdoors (67.3%) or at home (46.6%). The most frequently cited barriers to being more physically active were "being too busy" (49.0%), "too tired" (38.0%), or "bad weather" including too hot, too cold, and smoke from wild fires (18.9%). Over one in three respondents indicated having less expensive memberships (38.2%), exercise facilities at work (37.7%), and self-motivation or motivation/support from friends (33.2%) would help to increase physical activity levels.

People can significantly reduce their risk for the most prevalent chronic conditions and seven of the top 10 leading causes of death by eating a healthy diet consisting of nutrient-dense foods from each food group and limiting saturated fats, sugars, and sodium, as well as engaging in regular and adequate physical activity to help maintain a healthy weight.

Nutrition & Physical Activity Sources

Table 57-Table 70; SAME SOURCE

Table 57: Percent of High School Students who did not Eat Fruit/Drink 100% Fruit Juice, 2013 & 2015

Table 58: Percent of High School Students who ate Fruit/Drank 100% Fruit Juice 1 or more Times per Day*, 2013 & 2015

Table 59: Percent of High School Students who ate Fruit/Drank 100% Fruit Juice 2 or more Times per Day*, 2013 & 2015

Table 60: Percent of High School Students who ate Fruit/Drank 100% Fruit Juice 3 or more Times per Day*, 2013 & 2015

Table 61: Percent of High School Students who did not eat Vegetables*, 2013 & 2015

Table 62: Percent of High School Students that ate Vegetables 1 or more Times per Day*, 2013 & 2015

Table 63: Percent of High School Students that ate Vegetables 2 or more Times per Day*, 2013 & 2015

Table 64: Percent of High School Students that ate Vegetables 3 or more Times per Day*, 2013 & 2015

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Table 65: Percent of High School Students who did not Drink soda or pop*, 2013 & 2015

Table 66: Percent of High School Students who Drank Soda 1 or more Times per Day*, 2013 & 2015

Table 67: Percent of High School Students who did not Drink Milk*, 2013 & 2015

Table 68: Percent of High School Students that Drank 1 or more Glasses of Milk per Day*, 2013 & 2015

Table 69: Percent of High School Students who did not eat Breakfast*, 2013 & 2015

Table 70: Percent of High School Students who ate Breakfast on all 7 Days*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 71-Table 72 Same Source

Table 71: Percent of Adults who had at least 1 Serving of Fruit per Day, 2013 & 2015

Table 72: Percent of Adults who had at least 1 Serving of Vegetables per Day, 2013 & 2015

Nevada and Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Nevada Behavioral Risk Factor Surveillance Survey (BRFSS). Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Table 73-Table 76 Same Source

Table 73: Percent of High School Students who did not Participate in Physical Activity for at least 60 Minutes on 1 day*, 2013 & 2015

Table 74: Percent of High School Students who were Physically Active for 60 or more Minutes on 7 or more Days*, 2013 & 2015

Table 75: Percent of High School students who Attended Physical Education Classes on all 5 Days*, 2013 & 2015

Table 76: Percent of High School Students who Played on at least 1 Sports Team*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 77-79 Same Source

Table 77: Percent of Adults who met the Aerobic & Strength Guidelines, Washoe County, 2013 & 2015

Table 78: Percent of Adults who met the Aerobic & Strength Guidelines, Nevada, 2013 & 2015

Table 79: Percent of Adults who met the Aerobic & Strength Guidelines, United States, 2013 & 2015

Nevada and Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Nevada Behavioral Risk Factor Surveillance Survey (BRFSS). Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Table 80-Table 81 Same Source

Table 80: Percent of High School Students who Watched Television 3 or more Hours a Day*, 2013 & 2015

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Table 81: Percent of High School Students who Played Video or Computer Games or used a Computer 3 or more hours per day*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Following Figures from the Online Community Survey

Fig 95: Fruit & Vegetable Consumption per Day in Past Week (n=1,399)

Fig 96: Barriers to Eating Healthy Food More Often (n=1,412)

Fig 97: Top Three Barriers to Eating Healthy Food More Often by Educational Attainment

Fig 98: Other Identified Barriers to Eating Healthy Food More Often by Educational Attainment

Fig 99: Barriers to Eating Healthy More Often by Fruit & Vegetable Consumption

Fig 100: Places Survey Respondents Go Most Often to be Physically Active (n=1,423)

Fig 101: Barriers to Being More Physically Active (n=1,438)

Fig 102: What Would Help to Increase Physical Activity Levels (n=1,377)

General Health

Health behaviors, education, socioeconomic, and environmental conditions not only impact health and health outcomes, but also influence an individual's perceived importance of health and ability to overcome health issues. Perceived self-reported health status is a validated proxy indicator for assessing population health. The categories of self-reported health status range from "excellent" to "poor". These categories are a predictor of morbidity and mortality and correlate with socioeconomic indicators such as educational attainment and income.^{81,82} Weight status is included within the General Health section since being overweight or obese increases the risk for the majority of the leading causes of death in the United States. Becoming overweight or obese is a result of a variety of factors including diet, exercise, genetic predisposition, and even medication use. However, in 1960, only 13.4% of Americans were obese, compared to 37.9% of adults as of 2013-2014.⁸³ In 2015, two in every three adults and one in every three adolescents in the United States were overweight or obese.^{84,85}

Obesity may be the single largest threat, to not only public health, but the economy as well.⁸⁶ A study utilizing data from 2000-2005 estimated the annual cost of obesity in the United States was \$209.7 billion (2008 dollars).⁸⁷ Obese individuals spend approximately 36% more on healthcare related costs compared to the general population and spend 21% more than daily smokers and 14% more than heavy drinkers on general health services.⁸⁸

⁸¹ Milunpalo S., Vuori I., Oja P., Pasanen M., & Urponen H. (1997). Self-Rated Health Status as a Health Measure: The Predictive Value of Self-Reported Health Status on the Use of Physician Services and on Mortality in the Working-Age Population. *Journal of Clinical Epidemiology*. 50(5); 517-528.

⁸² Goldberg, P., Gueguen, A., Schumas, A., Nakacha, J.P., & Goldberg, M. (2001). Longitudinal Study of Associations between Perceived Health Status and Self-Reported Diseases in the French Gazel Cohort. *Journal of Epidemiology and Community Health*. 55; 233-238.

⁸³ Fryar C.D., Carroll M.D., & Ogden C.L. (2016). Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults Aged 20 and Over: United States, 1960-1962 through 2013-2014. Atlanta, GA.

⁸⁴ 2015 Behavioral Risk Factor Surveillance System data for the United States. Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

⁸⁵ Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. *MMWR*, 65(6) 1-174.

⁸⁶ Trust for America's Health and the Robert Wood Johnson Foundation. (2013). *F as in Fat: How Obesity Threatens America's Future*, 2013. Accessed <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407528>

⁸⁷ Cawley, J. & Meyerhoefer, C. (2012). The medical care costs of obesity: An instrumental variables approach. *Journal of Health Economics*. 31; 219-230.

⁸⁸ Sturm R., & Wells K.B. The Health Risks of Obesity: Worse than Smoking, Drinking or Poverty. *RAND Health*. Accessed https://www.rand.org/pubs/research_briefs/RB4549.readonline.html

1.9 GENERAL HEALTH

Indicator	Trend	Most Recent Year
Perceived Health Status		
Perceived health status among adults 18+ years	Increasing (fair/poor)	18.7% fair/poor (2016)
Perceived health status among adults 65+ years	Increasing (fair/poor)	24.0% fair/poor (2016)
Weight Status		
Weight status among 4 th graders	Decreasing (overweight/obese)	15.6% overweight; 15.6% obese (2015-2016 school year)
Weight status among 7 th graders	Increasing (overweight/obese)	17.4% overweight; 20.8% obese (2015-2016 school year)
Weight status among 10 th graders	STABLE (overweight/obese)	17.2% overweight; 17.7% obese (2015-2016 school year)
Percent of adolescents overweight	~	13.9% (2015)
Percent of adolescents obese	~	9.9% (2015)
Weight status among adults	Increasing (overweight/obese)	36.4% overweight; 26.4% obese (2016)
~not able to assess for trend		

Perceived Health Status

Table 82: Percent of Adults 18+ years who Report their Health Status as Fair or Poor, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	16.5%	18.0%	17.1%	15.7%	18.7%
Nevada	18.5%	17.3%	18.9%	17.6%	20.9%
United States	16.9%	16.7%	16.8%	16.4%	17.9%

- The percent of adults in Washoe County who reported they perceive their personal health status to be fair or poor increased from 2012 (16.5%) to 2016 (18.7%).
- As of 2016, the percentage of adults in Washoe County who reported their perceived health status to be fair or poor (18.7%) was lower than Nevada (20.9%), but higher than the United States (17.9%).

Table 83: Percent of Adults 65+ years who Report Health status as Fair or Poor, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	22.3%	22.9%	24.3%	19.7%	24.0%
Nevada	22.9%	21.8%	26.4%	21.8%	26.8%

- The percent of adults 65 years and older in Washoe County who reported they perceive their personal health status to be fair or poor increased from 2012 (22.3%) to 2016 (24.0%).
- As of 2016, the percentage of adults 65 years and older in Washoe County who reported their perceived health status to be fair or poor (24.0%) was lower than Nevada (26.8%).

Weight Status

This section provides weight status among various groups, as measured by body mass index (BMI). Body mass index is a calculation of a person's weight in kilograms divided by square height in meters. The resulting number is used to classify and screen for overweight and obesity. Although BMI is moderately correlated with body fat, it does not measure body fat directly nor does it necessarily determine an individual's health status.

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BMI is however, strongly correlated with a variety of adverse health outcomes that are associated with being overweight or obese.⁸⁹

Data caveat: The data provided in Table 84, Table 85, and Table 86 illustrate weight classification based on BMI calculated from student’s height and weight as measured by school nurses. This source of data collection differs from Youth Risk Behavior Survey (YRBS) data presented in Table 87 and Table 88. For the YRBS, BMI is calculated from the student’s self-reported height and weight.

Weight Status - 4th, 7th & 10th Grade Students

Table 84: Weight Classification of 4th graders, Washoe County, 2011-2012 through 2015-2016

Weight Classification	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Underweight	3.0%	3.7%	4.7%	4.9%	6.1%
Healthy weight	62.7%	61.2%	62.2%	61.8%	62.7%
Overweight	16.0%	15.4%	16.1%	15.3%	15.6%
Obese	18.4%	19.7%	17.0%	18.0%	15.6%

- The percentage of fourth grade students in Washoe County classified as underweight increased from 2011-2012 (3.0%) to 2015-2016 (6.1%).
- The percentage of fourth grade students classified as healthy weight remained stable from 2011-2012 (62.7%) to 2015-2016 (62.7%).
- The percentage of fourth grade students classified as overweight decreased slightly from 2011-2012 (16.0%) to 2015-2016 (15.6%).
- The percentage of fourth grade students in Washoe County classified as obese decreased from 2011-2012 (18.4%) to 2015-2016 (15.6%).

Table 85: Weight Classification of 7th graders, Washoe County, 2011-2012 through 2015-2016

Weight Classification	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Underweight	3.1%	4.1%	4.5%	3.0%	4.3%
Healthy weight	62.5%	60.7%	62.9%	61.1%	57.6%
Overweight	17.0%	18.0%	17.3%	17.3%	17.4%
Obese	17.4%	17.2%	15.3%	18.5%	20.8%

- The percentage of seventh grade students in Washoe County classified as underweight increased from 2011-2012 (3.1%) to 2015-2016 (4.3%).
- The percentage of seventh grade students classified as healthy weight decreased from 2011-2012 (62.5%) to 2015-2016 (57.6%).
- The percentage of seventh grade students classified as overweight increased slightly from 2011-2012 (17.0%) to 2015-2016 (17.4%).
- The percentage of seventh grade students in Washoe County classified as obese increased from 2011-2012 (17.4%) to 2015-2016 (20.8%).

⁸⁹ Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. About Adult BMI. Accessed https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/

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Table 86: Weight Classification of 10th graders, Washoe County, 2011-2012 through 2015-2016

Weight Classification	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Underweight	2.4%	1.7%	3.1%	2.8%	3.2%
Healthy weight	62.9%	62.8%	61.7%	62.4%	61.8%
Overweight	18.5%	16.8%	18.1%	17.3%	17.2%
Obese	16.2%	18.7%	17.1%	17.5%	17.7%

- The percentage of tenth grade students in Washoe County classified as underweight increased from 2011-2012 (2.4%) to 2015-2016 (3.2%).
- The percentage of tenth grade students classified as healthy weight decreased slightly from 2011-2012 (62.9%) to 2015-2016 (61.8%).
- The percentage of tenth grade students classified as overweight decreased slightly from 2011-2012 (18.5%) to 2015-2016 (17.2%).
- The percentage of tenth grade students in Washoe County classified as obese increased slightly from 2011-2012 (16.2%) to 2015-2016 (17.7%).

Weight Status - Adolescents

Table 87: Percent of High School Students who were Overweight*, 2013 & 2015

Location	2013	2015
Washoe County	14.9%	13.9%
Nevada	14.9%	15.8%
United States	16.6%	16.0%

*Students who were ≥85th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts

- The percentage of high school students in Washoe County classified as overweight decreased slightly from 2013 (14.9%) to 2015 (13.9%) and remained lower than the United States in both 2013 and 2015.

Table 88: Percent of High School Students who were Obese*, 2013 & 2015

Location	2013	2015
Washoe County	8.7%	9.9%
Nevada	11.5%	11.4%
United States	13.7%	13.9%

*Students who were ≥95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts

- The percentage of high school students in Washoe County classified as obese increased slightly from 2013 (8.7%) to 2015 (9.9%), however remained lower than Nevada and the United States in both 2013 and 2015.

Weight Status – Adults

Table 89: Weight Classification of Adults, Washoe County, 2012-2016

Weight Classification	2012	2013	2014	2015	2016
Underweight	3.3%	1.9%	2.0%	1.6%	2.7%
Healthy weight	39.3%	38.5%	38.6%	40.4%	34.6%
Overweight	35.3%	35.7%	39.8%	37.1%	36.4%
Obese	22.1%	23.9%	19.6%	20.9%	26.4%
Total overweight/obese	57.4%	59.6%	59.4%	58.0%	62.8%

- The percentage of adults in Washoe County classified as either overweight or obese increased from 2012 (57.4%) to 2016 (62.8%), however was lower than Nevada until 2016 [Table 90].

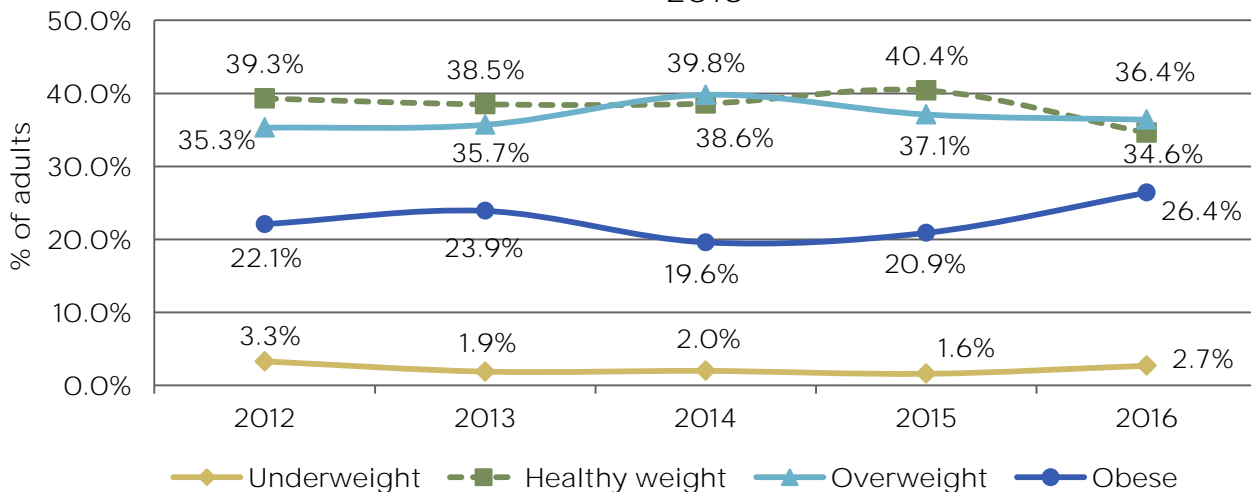
1.9 GENERAL HEALTH

- The percentage of adults classified as overweight or obese in Washoe County remained lower than the United States from 2012 through 2016 [Table 91].

Weight Classification	2012	2013	2014	2015	2016
Underweight	2.6%	1.7%	2.4%	1.8%	1.8%
Healthy weight	34.8%	33.4%	34.1%	33.6%	35.9%
Overweight	36.3%	38.7%	35.9%	37.9%	36.5%
Obese	26.2%	26.2%	27.6%	26.7%	25.8%
Total overweight/obese	62.5%	64.9%	63.5%	64.6%	62.3%

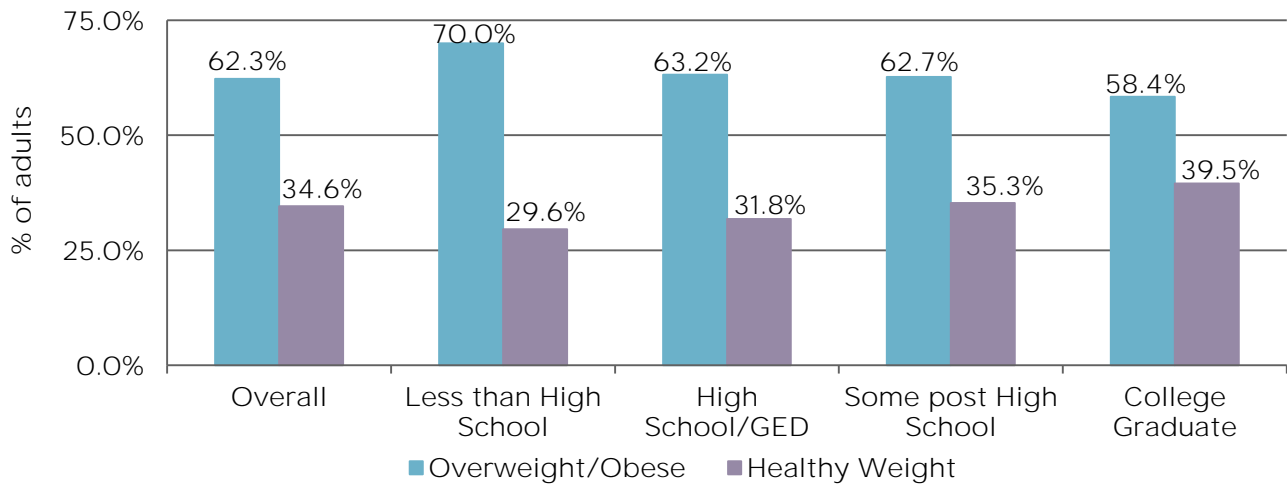
Weight Classification	2012	2013	2014	2015	2016
Underweight	1.8%	1.8%	1.8%	1.8%	2.0%
Healthy weight	34.2%	33.4%	33.4%	32.7%	33.2%
Overweight	35.8%	35.4%	35.4%	35.5%	35.2%
Obese	27.6%	29.4%	29.6%	29.8%	29.6%
Total overweight/obese	63.4%	64.8%	65.0%	65.3%	64.8%

Fig 103: Weight Status among Adults, Washoe County, 2012-2016



- The proportion of adults in Washoe County classified as healthy weight, decreased from 2012 (39.3%) to 2016 (34.6%).
- The proportion of adults in Washoe County classified as overweight, increased from 2012 (35.3%) to 2016 (36.4%).
- The proportion of adults in Washoe County classified as obese, increased from 2012 (22.1%) to 2016 (26.4%).
- In 2016, 62.8% of adults in Washoe County were classified as either overweight or obese.

Fig 104: Percentage of Population Classified as Healthy Weight Compared to Overweight & Obese (combined) by Educational Attainment, Washoe County, 2016



- In 2016, nearly two out of every three (62.3%) adults in Washoe County were either overweight or obese. However, an estimated 70.0% of adults in Washoe County with less than a high school education were classified as either overweight or obese, compared to 58.4% of adults who were college graduates.
- In 2016, only one in three adults (34.6%) in Washoe County were classified as a healthy weight. While 29.6% of adults with less than a high school education were a healthy weight, 39.5% of college graduates were classified as a healthy weight.

Summary of General Health

The proportion of adults 18 years and older and adults 65 years in Washoe County that perceive their health status to be fair or poor increased from 2012 to 2016, indicating the perceived quality of life may be declining among Washoe County residents. The trends in weight status among 4th, 7th and 10th graders vary, however the proportion of students classified as a “healthy weight” has remained stable (4th graders) or declined (7th and 10th graders) among all three groups. The proportion of adults classified as a “healthy weight” also declined, while the percentage of adults classified as overweight or obese increased from 2012 to 2016.

The trends in perceived self-reported health status and weight status among youth and adults in Washoe County are concerning. Both of these indicators are associated with a wide range of poor health outcomes and are influenced by a multitude of factors. Perceived health status is an indicator not just of physical health, but also of other forms of health including mental and spiritual. Preventing or reducing obesity by increasing physical activity levels and improving dietary quality should be a top priority for everybody.

General Health Sources

Table 82-Table 83 Same Source

Table 82: Percent of Adults 18+ years who Report their Health Status as Fair or Poor, 2012-2016

Table 83: Percent of Adults 65+ years who Report Health status as Fair or Poor, 2012-2016

Nevada and Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Nevada Behavioral Risk Factor Surveillance Survey (BRFSS). Data provided upon request. Carson City, NV.

1.9 GENERAL HEALTH

United States: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Table 84-Table 86 Same Source

Table 84: Weight Classification of 4th graders, Washoe County, 2011-2012 through 2015-2016

Table 85: Weight Classification of 7th graders, Washoe County, 2011-2012 through 2015-2016

Table 86: Weight Classification of 10th graders, Washoe County, 2011-2012 through 2015-2016

Nevada BMI Reports. Washoe County Health District. Data provided up on request. Reno, NV.

Table 87-Table 88 Same Source

Table 87: Percent of High School Students who were Overweight*, 2013 & 2015

Table 88: Percent of High School Students who were Obese*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, NV.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, NV.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, NV.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, NV.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 89-Table 91; Fig 103-Fig 104 Same Source

Table 89: Weight Classification of Adults, Washoe County, 2012-2016

Table 90: Weight classification of Adults, Nevada, 2012-2016

Table 91: Weight Classification of Adults, United States, 2012-2016

Fig 103: Weight Status Among Adults, Washoe County, 2012-2016

Fig 104: Percentage of Population Classified as Healthy Weight Compared to Overweight & Obese (combined) by Educational Attainment, Washoe County, 2016

Nevada and Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Nevada Behavioral Risk Factor Surveillance Survey (BRFSS). Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Substance Use

Substance use is the ingestion of any substance, which has the ability to alter a person’s mental or physical status. Some substances, even when taken in small doses, can be immediately intoxicating and may lead to chemical dependency, while others only prove to be harmful when an excessive amount is consumed. Substances, both legal and illegal, may be ingested to provide relief or reprieve from a range of negative stimuli from daily stress to chronic pain. When substances are used in excess or in a manner other than intended, causing harm to the user or others around them, it is classified as substance misuse or abuse.⁹⁰

Combined, alcohol misuse, illicit drug use, misuse of medications, and substance use disorders are estimated to cost the United States over \$400 billion in workplace productivity, health care expenses, motor vehicle crashes, law enforcement, and criminal justice costs.^{91, 92} The effects of substance use and misuse often extend beyond the health of the individual user. Additional impacts include increased violence, sexual assault, and loss of employment, housing, and other financial assets.

Indicator	Trend	Most Recent Year
Tobacco Use		
Ever smoked cigarettes-Adolescents	~	36.2% (2015)
Currently smoke cigarettes-Adolescents, Adults	~ Decreasing-Adults	10.3% (2015-Adolescents) 15.3% (2016-Adults)
Ever used electronic vapor products - Adolescents, Adults	~ Decreasing -Adults	53.5% (2015-Adolescents) 6.3% (2016-Adults)
Currently use electronic vapor products- Adolescents, Adults	~ Decreasing-Adults	30.1% (2015-Adolescents) 6.3% (2016-Adults)
Currently use tobacco of any kind -Adolescents	~	14.4% (2015-Adolescents)
Alcohol Use		
Ever drank alcohol -Adolescents	~	65.6% (2015)
Currently drink alcohol -Adolescents, College Students	~ Decreasing -College Students	35.5% (2015-Adolescents) 59.9% (2016-College Students)
Drove after drinking -College Students	Decreasing	14.7% (2016-College Students)
Average number of drinks -College Students	Decreasing	2.8 (2016-College Students)
Binge drank -College Students, Adults	Increasing -College Students Increasing -Adults	29.7% (2016-College Students) 18.7% (2016-Adults)
Heavy drinkers - Adults	Increasing	8.0% (2016-Adults)
Marijuana Use		
Lifetime use marijuana -Adolescents	~	45.2% (2015)
Currently use marijuana -Adolescents, College Students, Adults	~ Increasing-College Students Increasing-Adults	24.6% (2015-Adolescents) 20.0% (2016-College Students) 11.6% (2016-Adults)

⁹⁰ U.S. Department of Health and Human Services, Office of the Surgeon General. (2016). Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health. Washington, DC.

⁹¹ Sacks, J. J., Gonzales, K. R., Bouchery, E. E., Tomedi, L. E., & Brewer, R. D. (2015). 2010 National and State Costs of Excessive Alcohol Consumption. American Journal of Preventive Medicine, 49(5), e73-e79.

⁹² U.S. Department of Justice, National Drug Intelligence Center. (2011). National Drug Threat Assessment. Washington, DC.

1.10 SUBSTANCE USE

Indicator	Trend	Most Recent Year
Prescription Drug Use		
Lifetime use of any prescription drug-Adolescents	~	18.3% (2015)
Pain killers used in past year - College Students	Decreasing	5.6% (2016)
Sedatives used in past year - College Students	Decreasing	2.9% (2016)
Stimulants used in past year - College Students	Increasing	6.1% (2016)
Use of Other Drugs -Adolescents		
Lifetime use of synthetic marijuana, cocaine, heroin, ecstasy, methamphetamines, & inhalants	~	Range 3.5% to 11.1% (2015)
Treatment, Hospitalizations, & Deaths Due to Substance Use		
Needing but not receiving treatment for alcohol	~	7.61% (2012-2014 data combined)
Needing but not receiving treatment for illicit drugs	~	2.54% (2012-2014 data combined)
Hospitalizations due to opiates	Increasing	39.0 per 100,000 (2015)
Alcohol-related death rate	Increasing	39.6 per 100,000 (2015)
Prescription drug-related death rate	Increasing	16.3 per 100,000 (2015)
Illicit drug-related death rate	Increasing	17.4 per 100,000 (2015)
~not able to assess for trend		

Tobacco Use

Use of tobacco products accounts for one in every five deaths each year and is among the leading causes of preventable deaths in the United States. While legal, there is no determined “safe” limit for the consumption of tobacco due to the added chemicals which are ingested when these products are used. Cigarette smokers have been long studied and are proven to have a higher risk for developing lung cancer, liver cancer, colorectal cancer, chronic obstructive pulmonary disease (COPD), stroke, pneumonia, diabetes, heart disease, congenital birth defects, and many other negative health outcomes. Not only does smoking affect nearly every organ in the body, it also causes inflammation and reduces the immune system’s ability to function properly. A national economic analysis for 2009-2012 found the annual cost of direct medical care for conditions related to smoking is estimated to be over \$130 billion in the United States.⁹³

Tobacco Use - Adolescents

Location	2013	2015
Washoe County	40.8%	36.2%
Nevada	38.8%	32.4%
United States	41.1%	32.3%
*even one or two puffs		

- The percentage of high school students in Washoe County who reported they had ever tried smoking cigarettes decreased from 2013 (40.8%) to 2015 (36.2%).

⁹³ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. (2014). The Health Consequences of Smoking-50 Years of Progress, a Report of the Surgeon General. Atlanta, GA.

1.10 SUBSTANCE USE

- In 2015, the percentage of high school students in Washoe County who reported having ever tried smoking cigarettes was higher (36.2%) than Nevada (32.4%) and the United States (32.3%).

Table 93: Percent of High School Students who Currently Smoke Cigarettes*, 2013 & 2015

Location	2013	2015
Washoe County	14.3%	10.3%
Nevada	10.2%	7.2%
United States	15.7%	10.8%

*on at least 1 day during the 30 days before the survey

- The percentage of high school students in Washoe County who reported they currently smoked cigarettes decreased from 2013 (14.3%) to 2015 (10.3%).
- In 2015, the percentage of high school students in Washoe County who reported they currently smoked cigarettes was higher (10.3%) than Nevada (7.2%), however was lower than the United States (10.8%).

Table 94: Percent of High School Students who ever Used Electronic Vapor Products*, 2013 & 2015

Location	2015
Washoe County	53.5%
Nevada	50.9%
United States	44.9%

*including e-cigarettes, e-pipes, vape pipes, vape pens, e-hookahs, and hookah pens

- In 2015 over half (53.5%) of high school students in Washoe County reported they ever used electronic vapor products.
- In 2015, the percentage of high school students in Washoe County who reported they ever used electronic vapor products was higher (53.5%) than Nevada (50.9%) and the United States (44.9%).

Table 95: Percent of High School Students who Currently use Electronic Vapor Products*, 2013 & 2015

Location	2015
Washoe County	30.1%
Nevada	26.1%
United States	24.1%

*including e-cigarettes, e-pipes, vape pipes, vape pens, e-hookahs, and hookah pens

- In 2015, 30.1% of high school students in Washoe County reported they currently used electronic vapor products.
- In 2015, the percentage of high school students in Washoe County who reported they currently used electronic vapor products was higher (30.1%) than Nevada (26.1%) and the United States (24.1%).

Table 96: Percent of High School Students who Currently use Tobacco*, 2013 & 2015

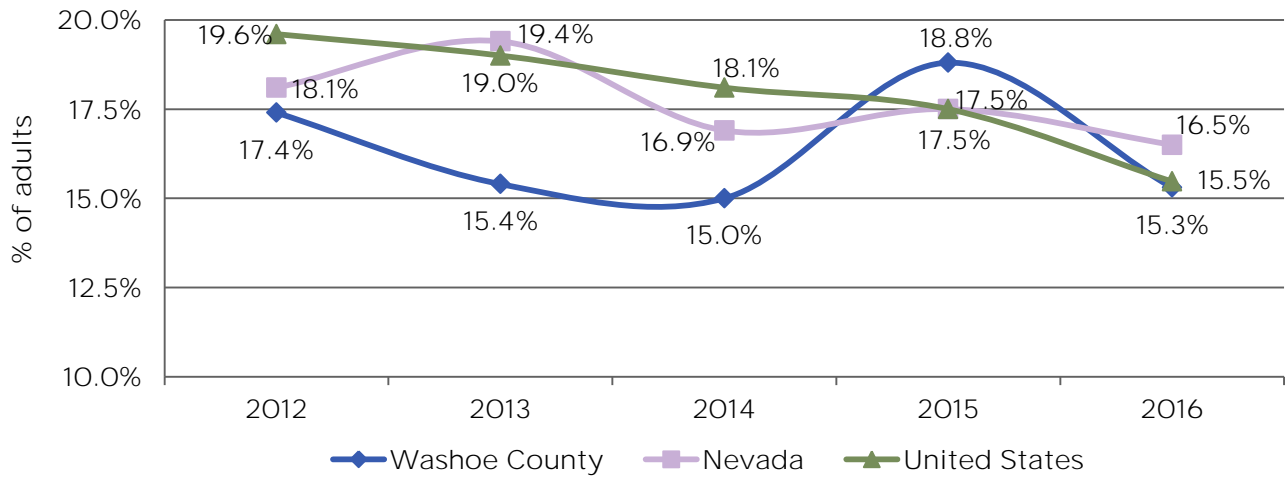
Location	2013	2015
Washoe County	18.3%	14.4%
Nevada	14.3%	11.4%
United States	22.4%	18.5%

*including cigars, cigarillos, or smokeless tobacco on at least 1 day during the 30 days before the survey

- The percentage of high school students in Washoe County who reported they currently used tobacco (any form) decreased from 2013 (18.3%) to 2015 (14.4%).
- In 2015, the percentage of high school students in Washoe County who reported they currently used tobacco (any form) was higher (14.4%) than Nevada (11.4%), however was lower than the United States (18.5%).

Tobacco Use - Adults

Fig 105: Percent of Adults that Currently Smoke Cigarettes, Washoe County, Nevada, & the United States, 2012-2016



- The percentage of adults in Washoe County who reported they currently smoked decreased from 2012 (17.4%) to 2016 (15.3%).
- In 2016 the percent of adults in Washoe County who reported they currently smoke was lower (15.3%) than Nevada (16.5%) and slightly lower than the United States (15.5%).

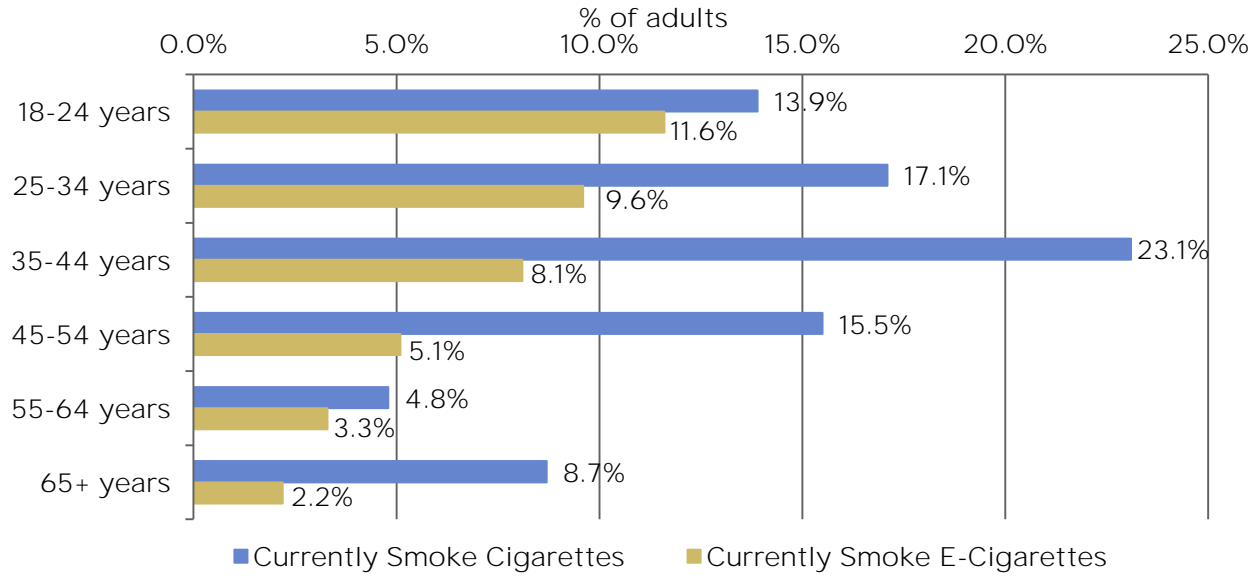
Table 97: Percent of Adults that Currently Smoke E-Cigarettes*, 2014-2016

Location	2014	2015	2016
Washoe County	7.6%	5.0%	6.3%
Nevada	6.9%	5.8%	6.0%
United States	~	~	4.3%
*smoked e-cigarettes last 30 days; ~ data not available			

- The percentage of adults in Washoe County who reported they currently smoked e-cigarettes decreased from 2012 (7.6%) to 2016 (6.3%).
- In 2016, the percent of adults in Washoe County who reported they currently smoked e-cigarettes was higher (6.3%) than Nevada (6.0%) and the United States (4.3%).

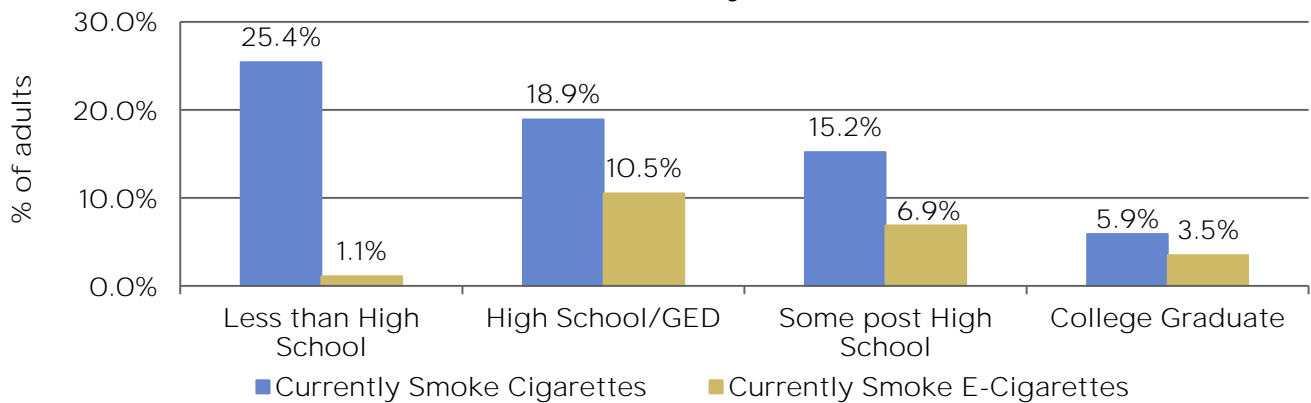
Adult Cigarette & E-Cigarette Use by Age Group & Educational Attainment

Fig 106: Percentage of Adults Reporting they Currently Smoke Cigarettes or E-Cigarettes by Age Group, Washoe County, 2016



- In 2016, cigarette smoking was highest among those aged 35 to 44 years (23.1%), with those aged 25 to 34 years ranked second highest (17.1%) among adults in Washoe County.
- The reported current use of e-cigarettes decreased as age increased as 11.6% of those aged 18 to 24 years reporting current use of e-cigarettes, compared to only 2.2% of those aged 65 years or older.

Fig 107: Percentage of Adults Reporting they Currently Smoke Cigarettes or E-Cigarettes by Educational Attainment, Washoe County, 2016



- The reported current use of cigarettes decreased as educational attainment increased as 25.4% of those with less than a high school education reported they currently smoke cigarettes, compared to only 3.5% of those who are college graduates.
- In 2016, reported use of e-cigarettes were highest among Washoe County adults with a high school education/GED equivalent (10.5%), while those with less than a high school education were lowest as 1.1% reported currently using e-cigarettes.

Alcohol Use

There are both immediate and long-term negative health effects related to alcohol consumption. The short-term effects of alcohol consumption include, impaired brain function, coordination and memory resulting in delayed reaction times and change in moods or behaviors. Consumption of alcohol also results in decreased immune system function, reducing the body’s ability to fight off infection, even 24 hours after intoxication.

Long-term health effects of alcohol consumption include increased stroke risk, high blood pressure, fatty liver, cirrhosis, risk of certain cancers, including cancer of the mouth, throat, liver, and breast, as well as an increased potential for chemical dependence.⁹⁴ Additionally, fetal alcohol syndrome (FAS) and other fetal malformations or fetal death can occur if a woman consumes alcohol while pregnant.⁹⁵ Additionally, one in every three motor vehicle fatalities in Nevada from 2011 through 2016 involved a driver over the legal limit for blood alcohol level (blood alcohol equal to or higher than 0.08).⁹⁶

Alcohol Use - Adolescents

Table 98: Percent of High School Students who ever Drank Alcohol*, 2013 & 2015

Location	2013	2015
Washoe County	70.1%	65.6%
Nevada	67.4%	64.0%
United States	66.2%	63.2%

*at least 1 drink of alcohol on at least 1 day during their life

- The percentage of high school students in Washoe County who reported they ever drank alcohol decreased from 2013 (70.1%) to 2015 (65.6%).
- In 2015, the percentage of high school students in Washoe County who reported they ever drank alcohol was higher (65.6%) than Nevada (64.0%) and the United States (63.2%).

Table 99: Percent of High School Students who Currently Drink Alcohol*, 2013 & 2015

Location	2013	2015
Washoe County	36.5%	35.5%
Nevada	33.3%	30.6%
United States	34.9%	32.8%

*at least 1 drink of alcohol on at least 1 day during the 30 days before the survey

- The percentage of high school students in Washoe County who reported they currently drink alcohol decreased slightly from 2013 (36.5%) to 2015 (35.5%).
- In 2015, the percentage of high school students in Washoe County who reported they currently drink alcohol was higher (35.5%) than Nevada (30.6%) and the United States (32.8%).

⁹⁴ National Institute on Alcohol Abuse and Alcoholism. Alcohol’s Effects on the Body. Accessed <http://www.niaaa.nih.gov/alcohol-health/alcohols-effects-body>

⁹⁵ National Institute on Alcohol Abuse and Alcoholism. Fetal Alcohol Spectrum Disorders. Last updated March, 2013. Accessed <http://report.nih.gov/nihfactsheets/viewfactsheet.aspx?csid=27>

⁹⁶ U.S. Department of Transportation, National Highway Traffic Safety Administration. (2016). Traffic Safety Facts Nevada 2011-2015. Washington, DC.

Alcohol Use - College Students

Table 100: Percent of College Students who Currently Drink Alcohol*, 2010, 2012, 2014, & 2016

Location	2010	2012	2014	2016
Washoe County (UNR)	66.6%	65.2%	63.7%	59.9%
United States	65.1%	65.8%	66.8%	63.6%

*at least once in the past 30 days

- The percentage of UNR students who reported they currently drink alcohol decreased from 2010 (66.6%) to 2016 (59.9%) and has remained below the national percentage for 2012, 2014 and 2016.

Table 101: Percent of College Students who Drove after Drinking any Alcohol at all*, 2010, 2012, 2014, & 2016

Location	2010	2012	2014	2016
Washoe County (UNR)	23.6%	20.2%	19.0%	14.7%
United States	17.9%	15.7%	14.0%	12.6%

*in the past 30 days

- The percentage of UNR students who reported they drove after drinking alcohol decreased from 2010 (23.6%) to 2016 (14.7%).
- In 2016, the percentage of UNR students who reported they drove after drinking alcohol (14.7%) was higher than the national percentage (12.6%).

Table 102: College Students Average Number of Drinks, 2010, 2012, 2014, & 2016

Location	2010	2012	2014	2016
Washoe County (UNR)	3.4	3.3	3.0	2.8
United States	3.7	3.6	3.6	3.1

*last time "partied"/socialized

- The average number of drinks consumed by UNR students decreased from 3.4 drinks in 2010 to 2.8 drinks in 2016.
- In 2016, the average number of drinks consumed by UNR students was slightly lower at 2.8 drinks, compared to college students across the United States at an average of 3.1 drinks.

Table 103: Percent of College Students who are Binge Drinkers*, 2010, 2012, 2014, & 2016

Location	2010	2012	2014	2016
Washoe County (UNR)	27.2%	32.1%	26.8%	29.7%
United States	35.0%	34.1%	34.7%	31.2%

*5 or more drinks of alcohol at a sitting, past 2 weeks

- Approximately one in three UNR students reported binge drinking in the past two weeks from 2010 through 2016, ranging from a low of 26.8% in 2014 to a high of 32.1% in 2012.
- In 2016, the percentage of UNR students who reported binge drinking in the past two weeks (29.7%) was lower than the national percentage (31.2%).

Alcohol Use - Adults

Location	2012	2013	2014	2015	2016
Washoe County	17.7%	19.4%	20.7%	16.2%	18.7%
Nevada	15.1%	15.2%	15.9%	14.2%	15.8%
United States	16.9%	16.8%	16.0%	16.3%	15.6%

*for men-having 5 or more drinks on one occasion; for women-having 4 or more drinks on one occasion

- The percentage of adults classified as binge drinkers in Washoe County increased from 2012 (17.7%) to 2016 (18.7%).
- The percentage of adults in Washoe County classified as binge drinkers remained higher than Nevada and the United States from 2012 through 2016.
- In 2016, the percentage of adults in Washoe County classified as binge drinkers was 18.7%, which was higher than in Nevada (15.8%) and the United States (15.6%).

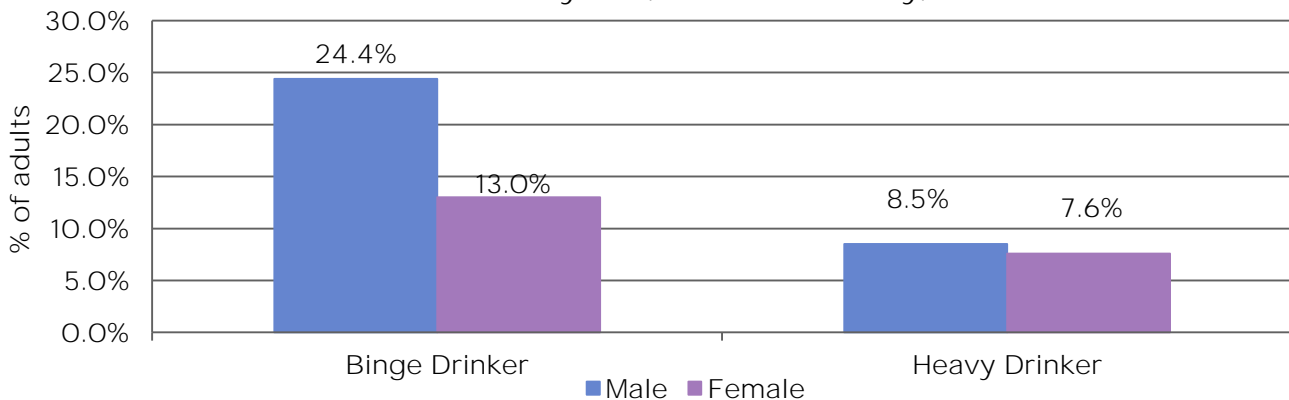
Location	2012*	2013*	2014*	2015**	2016**
Washoe County	7.4%	7.5%	9.7%	8.2%	8.0%
Nevada	6.5%	7.0%	6.9%	6.2%	6.3%
United States	6.1%	6.2%	5.9%	5.9%	5.9%

*for men-having more than 2 drinks per day; for women-having more than 1 drink per day
 **for men-having more than 14 drinks per week; for women-having more than 7 drinks per week

- The percentage of adults who were classified as heavy drinkers in Washoe County increased from 2012 (7.4%) to 2016 (8.0%).
- The percentage of adults in Washoe County classified as heavy drinkers remained higher than in Nevada and the United States from 2012 through 2016.
- In 2016, the percentage of adults in Washoe County classified as heavy drinkers was higher (8.0%) than in Nevada (6.3%) and the United States (5.9%).

Adult Binge & Heavy Drinking by Select Demographics

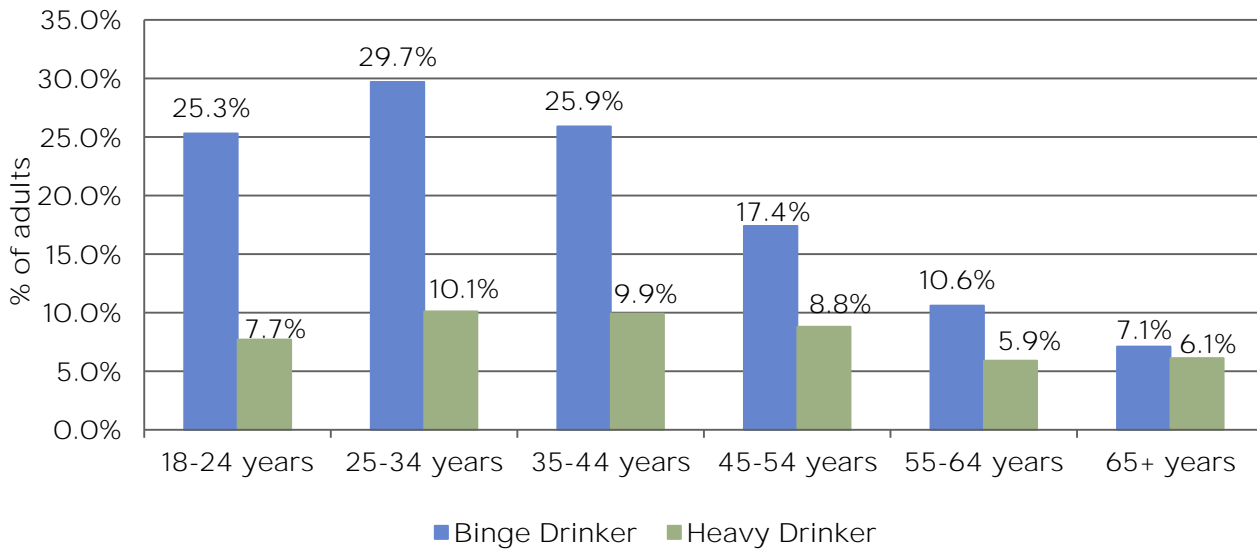
Fig 108: Percentage of Adults Classified as a Binge or Heavy Drinker by Sex, Washoe County, 2016



Note: Binge drinking for men having 5 or more drinks on one occasion; for women-having 4 or more drinks on one occasion
 Note: Heavy drinking classified for men-having more than 14 drinks per week; for women-having more than 7 drinks per week

- Adult males in Washoe County had a higher prevalence of both binge and heavy drinking compared to females in 2016.

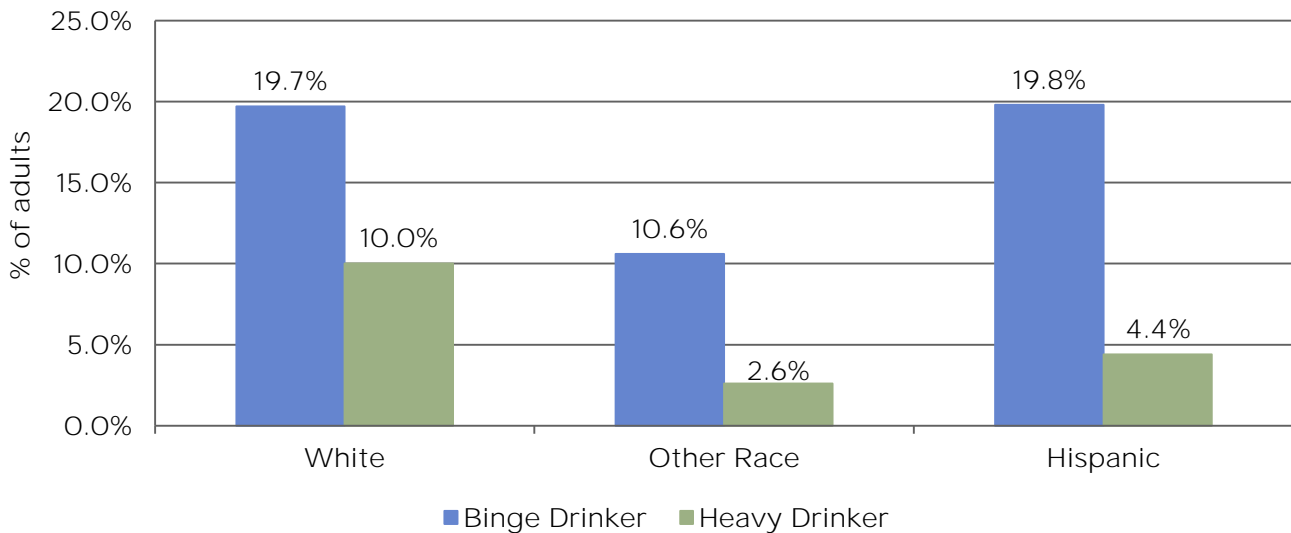
Fig 109: Percentage of Adults Classified as a Binge or Heavy Drinker by Age Group, Washoe County, 2016



Note: Binge drinking for men having 5 or more drinks on one occasion; for women-having 4 or more drinks on one occasion
 Note: Heavy drinking classified for men-having more than 14 drinks per week; for women-having more than 7 drinks per week

- Heavy and binge drinking was most prevalent among adults aged 25 to 34 years in Washoe County and the prevalence of binge and heavy drinking declined as age increased, with the exception of those aged 18 to 24 year and heavy drinking for those over age 65 years.

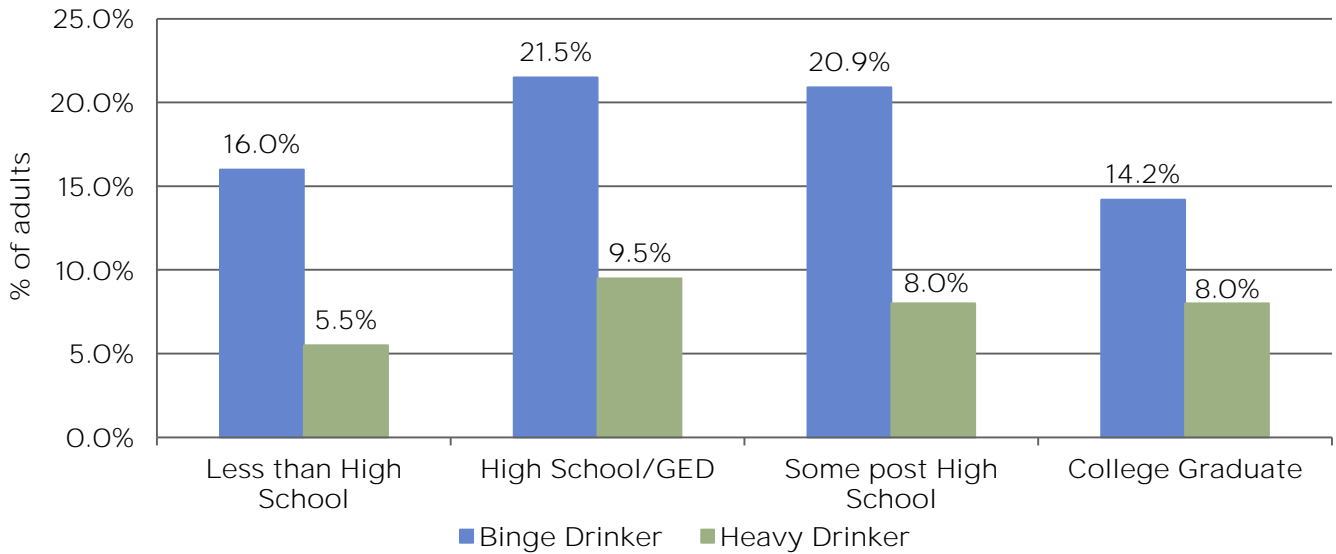
Fig 110: Percentage of Adults Classified as a Binge or Heavy Drinker by Race & Ethnicity, Washoe County, 2016



Note: Binge drinking for men having 5 or more drinks on one occasion; for women-having 4 or more drinks on one occasion
 Note: Heavy drinking classified for men-having more than 14 drinks per week; for women-having more than 7 drinks per week

- Binge drinking was highest among white (19.7%) and Hispanic (19.8%) adults in Washoe County.
- The percentage of white adults classified as a heavy drinker (10.0%) was double the percentage of Hispanic adults (4.4%) and nearly five times higher than adults of an “other race” (2.6%).

Fig 111: Percentage of Adults Classified as a Binge or Heavy Drinker by Educational Attainment, Washoe County, 2016



Note: Binge drinking for men having 5 or more drinks on one occasion; for women-having 4 or more drinks on one occasion
 Note: Heavy drinking classified for men-having more than 14 drinks per week; for women-having more than 7 drinks per week

- Adults with a high school education/GED equivalent had the highest prevalence of binge drinking (21.5%), followed closely by those with some education post high school (20.9%).
- Adults with a high school education/GED equivalent also had the highest prevalence of heavy drinking (9.5%), although heavy drinking was similar among those with some education post high school (8.0%), as well as college graduates (8.0%).

Marijuana Use

Marijuana is the most commonly used illicit drug and in 2015, 22.2 million persons across the United States 12 years and older reported having used it within the past month.⁹⁷ In 2016, Nevada residents voted to legalize recreational marijuana joining six other states and the District of Columbia; however it is federally classified as a Schedule I illicit drug. The perceived risk of marijuana use has declined in recent years, while rates of use have increased among adolescents and adults in Washoe County.⁹⁸

Marijuana Use - Adolescents

Location	2013	2015
Washoe County	49.1%	45.2%
Nevada	39.9%	39.4%
United States	40.7%	38.6%

*one or more times during their life

- The percentage of high school students in Washoe County who reported ever using marijuana decreased from 2013 (49.1%) to 2015 (45.2%).

⁹⁷ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2016). Results from the 2015 National Survey on Drug Use and Health: Detailed tables. Rockville, MD.

⁹⁸ Join Together Northern Nevada. (2017). 2016 Comprehensive Community Prevention Plan. Reno, NV.

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- In 2015, the percentage of high school students in Washoe County who reported ever using marijuana was higher (45.2%) than in Nevada (39.4%) and the United States (38.6%).

Table 107: Percent of High School Students who Currently use Marijuana*, 2013 & 2015

Location	2013	2015
Washoe County	28.2%	24.6%
Nevada	18.5%	19.6%
United States	23.4%	21.7%

*one or more times during the 30 days before the survey

- The percentage of high school students in Washoe County who reported they currently use marijuana decreased from 2013 (28.2%) to 2015 (24.6%).
- In 2015, the percentage of high school students in Washoe County who reported they currently use marijuana was higher (24.6%) than in Nevada (19.6%) and the United States (21.7%).

Marijuana Use - College Students

Table 108: Percent of College Students who Currently use Marijuana*, 2010, 2012, 2014, & 2016

Location	2010	2012	2014	2016
Washoe County (UNR)	16.7%	18.3%	18.1%	20.0%
United States	16.9%	15.9%	18.4%	18.7%

*at least once in the past 30 days

- The percentage of UNR students who reported they currently use marijuana has increased from 2010 (16.7%) to 2016 (20.0%).
- In 2016, the percentage of UNR students who reported they currently use marijuana (20.0%) was higher than the national percentage (18.7%).

Marijuana Use - Adults

Table 109: Percent of Adults who Currently Smoke Marijuana or Hash*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	6.2%	~	8.8%	9.5%	11.6%
Nevada	5.4%	~	6.1%	7.3%	8.4%

*smoked marijuana or hash in last 30 days

~Not asked in 2013

- The percentage of adults in Washoe County who reported they currently use marijuana increased from 2012 (6.2%) to 2016 (11.6%).
- In 2016, the percentage of adults in Washoe County who reported they currently use marijuana was higher (11.6%) than in Nevada (8.4%).

Prescription Drug Use

The use of prescription drugs in the United States has increased over the past 30 years, in both the overall percentage of the population taking prescription drugs, as well as the number of prescription drugs each person is taking.⁹⁹ In 2015, approximately \$324.6 billion was spent on the purchase of prescription drugs in the United States, a 9% increase from the previous year.¹⁰⁰

Prescription drugs, specifically opioids, have been the driving factor in the 15-year increase in drug overdose deaths. In 2015, over half of all drug overdose deaths involved an opioid and among those deaths, nearly half were due to a prescription opioid, accounting for over 15,000 overdose deaths in the United States.¹⁰¹ Recent research has shown that the majority of heroin overdoses occur among those who had a history of using prescription opiates prior to using heroin.¹⁰² In 2016, the Centers for Disease Control and Prevention (CDC) released guidelines for prescribing opioids for chronic pain; these guidelines emphasize the risks associated with and recommendations for- the appropriate uses of long-term opioid therapy.¹⁰³

Prescription Drug Use - Adolescents

Table 110: Percent of High School Students who ever took Prescription Drugs without a Doctor's Prescription*, 2013 & 2015

Location	2013	2015
Washoe County	22.0%	18.3%
Nevada	18.4%	17.0%
United States	17.8%	16.8%

*such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life

- The percentage of high school students in Washoe County who reported they took prescription drugs without a doctor’s permission decreased from 2013 (22.0%) to 2015 (18.3%).
- In 2015, the percentage of high school students in Washoe County who reported they took prescription drugs without a doctor’s permission was higher (18.3%) than Nevada (17.0%) and the United States (16.8%).

⁹⁹ National Center for Health Statistics. (2014). Health, United States, 2013: With Special Feature on Prescription Drugs. Hyattsville, MD.

¹⁰⁰ National Center for Health Statistics. (2017). Health, United States, 2016: With Chartbook on Long-term Trends in Health. Hyattsville, MD.

¹⁰¹ Centers for Disease Control and Prevention. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Accessed <http://wonder.cdc.gov>

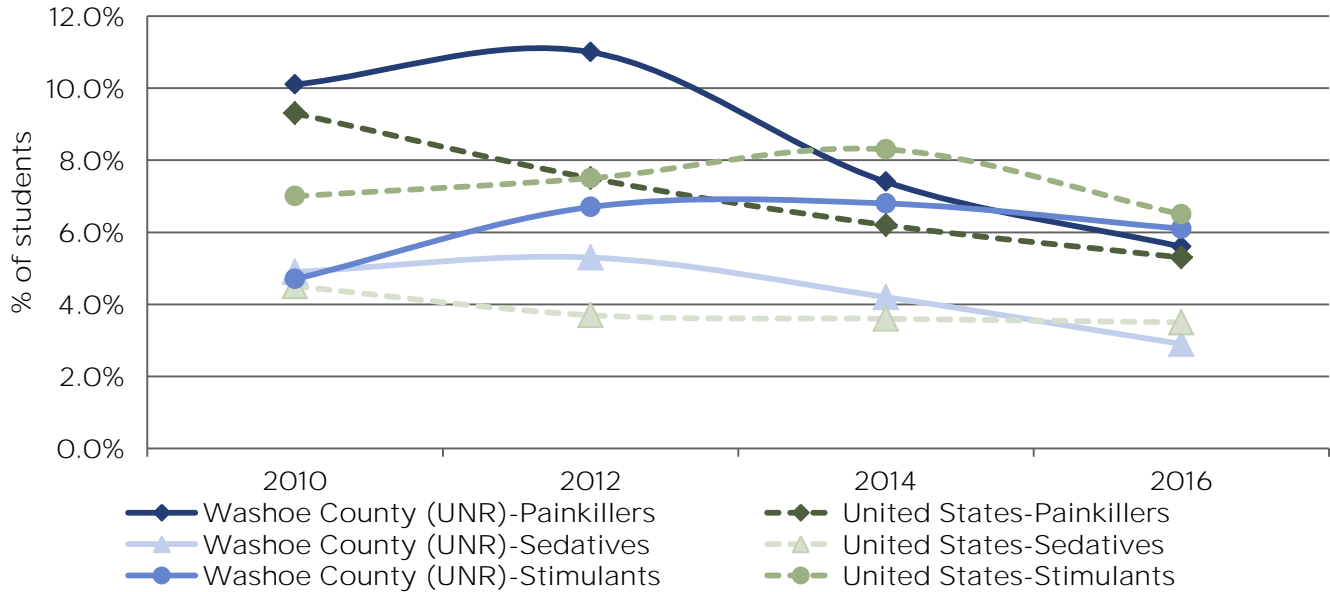
¹⁰² National Institute on Drug Abuse. Prescription Opioid and Heroin. Prescription opioid use is a risk factor for heroin use. Accessed <https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use>

¹⁰³ Dowell, D., Haegerish, T.T., Chou, R.. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain-United States 2016. MMWR; No. RR-1 (65), 1-49.

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Prescription Drug Use - College Students

Fig 112: Use of Prescription Drugs in the Past Year* Among College Students, Washoe County & the United States, 2010, 2012, 2014, & 2016



Note: Painkillers such as OxyContin, Vicodin, and Codeine not prescribed to them; Sedatives such as Xanax, Valium not prescribed to them; Stimulants such as Ritalin, Adderall not prescribed to them

- The use of painkillers (such as OxyContin, Vicodin, and Codeine) among UNR students has decreased from 2010 (10.1%) to 2016 (5.6%); however in 2016, was higher at UNR (5.6%) than the United States (5.3%).
- The use of sedatives (such as Xanax, Valium) among UNR students has decreased from 2010 (4.9%) to 2016 (2.9%) and in 2016, was lower at UNR (2.9%) than the United States (3.5%).
- The use of stimulants (such as Ritalin, Adderall) among UNR students has increased from 2010 (4.7%) to 2016 (6.1%) and in 2016, was lower at UNR (6.1%) than the United States (6.5%).

Use of Other Drugs

Use of Other Drugs - Adolescents

All data in Table 111 through Table 116 for Washoe County high school indicate a decrease in the percentage of students reporting having ever used these drugs from 2013 to 2015. However, during 2015 the percentage of Washoe County high school students reported having ever used each of these drugs was higher than high school students in both Nevada and the United States.

Table 111: Percent of High School Students who ever used Synthetic Marijuana*, 2013 & 2015

Location	2013	2015
Washoe County	21.6%	11.1%
Nevada	17.4%	10.9%
United States	~	9.2%

*also called K2, Spice, fake weed, King Kong, Yucatan Fire, Skunk, or Moon Rocks, one or more times during their life
~data unavailable

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Table 112: Percent of High School Students who ever used Ecstasy*, 2013 & 2015

Location	2013	2015
Washoe County	16.2%	10.5%
Nevada	10.8%	7.0%
United States	6.6%	5.0%

*also called MDMA, one or more times during their life

Table 113: Percent of High School Students who ever used Cocaine*, 2013 & 2015

Location	2013	2015
Washoe County	11.3%	9.2%
Nevada	7.9%	6.1%
United States	5.5%	5.2%

*such as powder, crack, or freebase, one or more times during their life

Table 114: Percent of High School Students who ever used Inhalants*, 2013 & 2015

Location	2013	2015
Washoe County	11.6%	8.0%
Nevada	9.8%	6.9%
United States	8.9%	7.0%

*sniffed glue, breathed the contents of aerosol cans, or inhaled any paints or sprays to get high, one or more times during their life

Table 115: Percent of High School Students who ever used Methamphetamines*, 2013 & 2015

Location	2013	2015
Washoe County	6.7%	4.8%
Nevada	5.0%	3.4%
United States	3.2%	3.0%

*also called speed, crystal, crank, or ice, one or more times during their life

Table 116: Percent of High School Students who ever used Heroin*, 2013 & 2015

Location	2013	2015
Washoe County	4.6%	3.5%
Nevada	3.3%	2.5%
United States	2.2%	2.1%

*also called smack, junk, or China white, one or more times during their life

Treatment, Hospitalizations, & Deaths Due to Substance Use

Substance use disorders typically develop during adolescence and may continue to progress with age. Treatment for substance use is an ongoing process involving the identification of triggers for using substances, behavior modification, and reducing risk of relapse. Historically, substance use was viewed as a social problem, often handled through arrests and subsequent criminal justice interventions. Since the 1970's there has been movement to treat the underlying conditions and view substance use as a diagnosable medical issue with an increase in adoption of behavior changes to address use and abuse. Although there have been marked changes

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in dealing with substance use treatment, mainstream health care still does not often address the identification, prevention, and effective treatment for substance use. Full integration of the continuum of substance use disorder services into health care allows for improved health outcomes, reduced health care costs, and increased likelihood of recovery.¹⁰⁴

Treatment

Table 117: Needing but Not Receiving Treatment* Among Persons 12 Years & Older, Annual Average 2012, 2013, 2014 Combined

Substance	Washoe County	Nevada	United States
Alcohol use	7.61%	7.13%	6.29%
Illicit drug use	2.54%	2.37%	2.40%

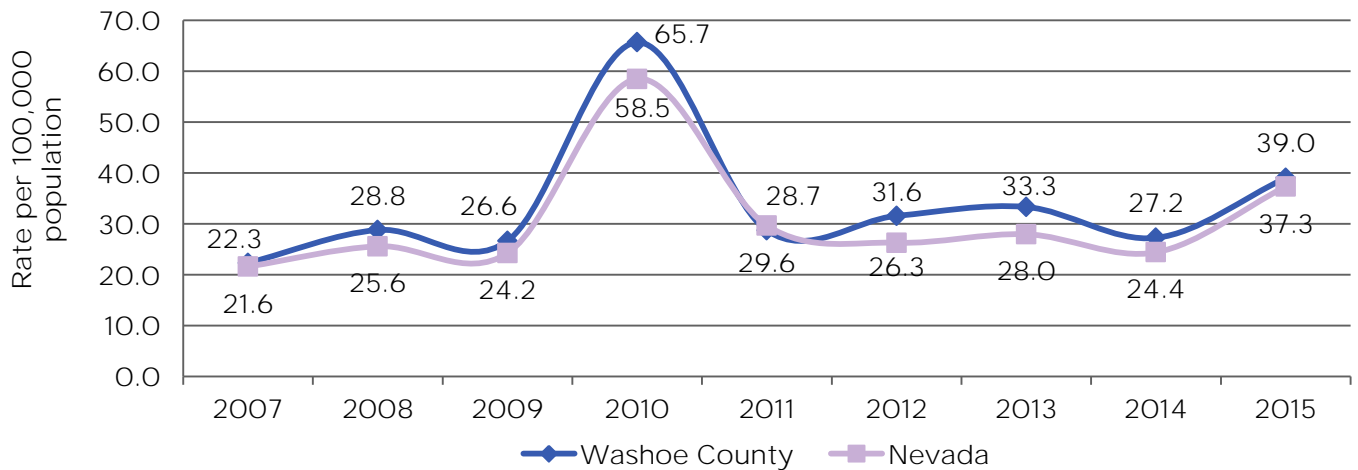
*in the past year

Note: Needing but not receiving treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], or mental health centers).

- Persons needing but not able to receive treatment for alcohol use in Washoe County was higher (7.61%) than Nevada (7.13%) and the United States (6.29%).
- Persons needing but not able to receive treatment for illicit drug use in Washoe County was higher (2.54%) than Nevada (2.37%) and the United States (2.40%).

Hospitalizations

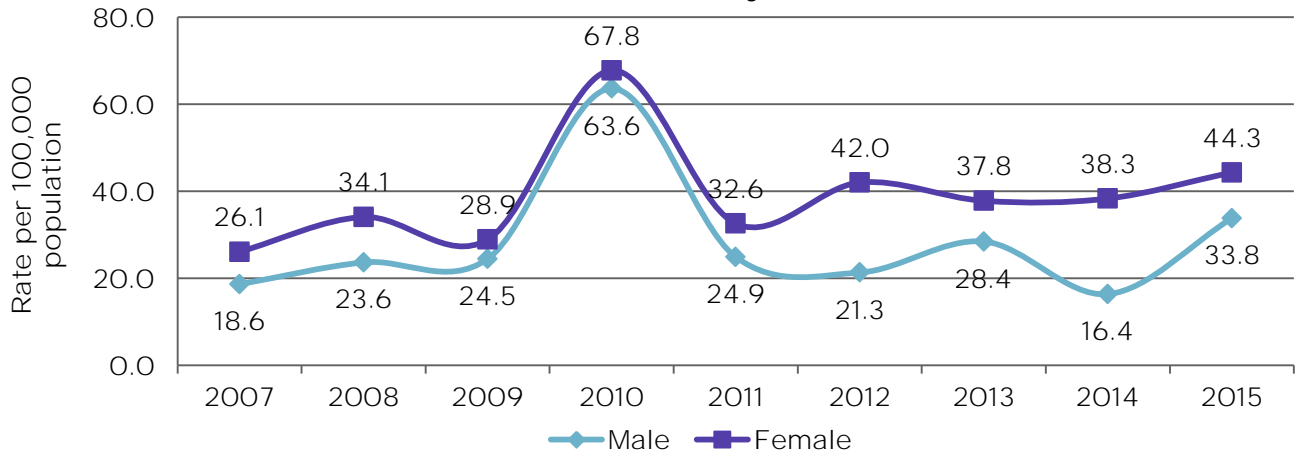
Fig 113: Hospitalization Rate Due to Opioid Poisoning, Washoe County & Nevada, 2007-2015



- The rate of hospitalizations due to opioid poisoning in Washoe County increased from 2007 (22.3 per 100,000) to 2015 (39.0 per 100,000).
- From 2007 through 2015 the rate of hospitalizations due to opioid poisoning was higher in Washoe County compared to Nevada.

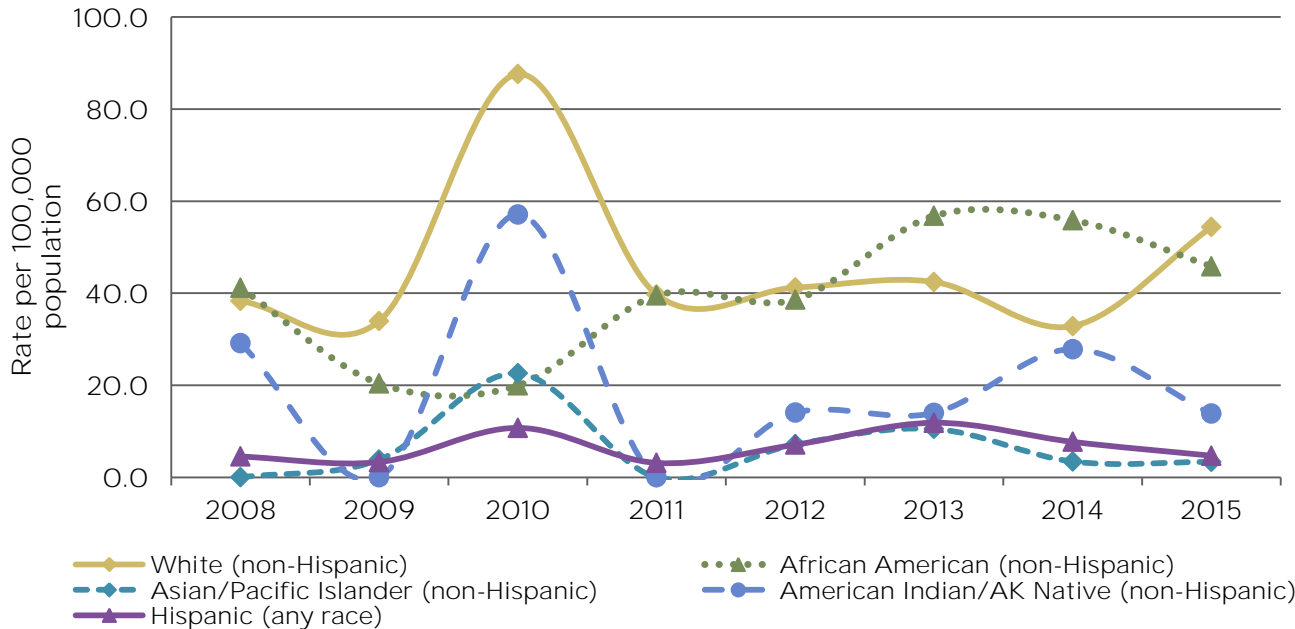
¹⁰⁴ United States of Health and Human Service, Office of the Surgeon General. (2016). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC.

Fig 114: Hospitalization Rate Due to Opioid Poisoning by Sex, Washoe County, 2007-2015



- The rate of hospitalizations due to opioid poisoning in Washoe County was higher among females compared to males every year from 2007 through 2015.
- The hospitalization rate due to opioid poisoning among female residents of Washoe County increased, nearly doubling, from 2007 (26.1 per 100,000) to 2015 (44.3 per 100,000).
- The hospitalization rate due to opioid poisoning among male residents of Washoe County increased, nearly doubling, from 2007 (18.6 per 100,000) to 2015 (33.8 per 100,000).

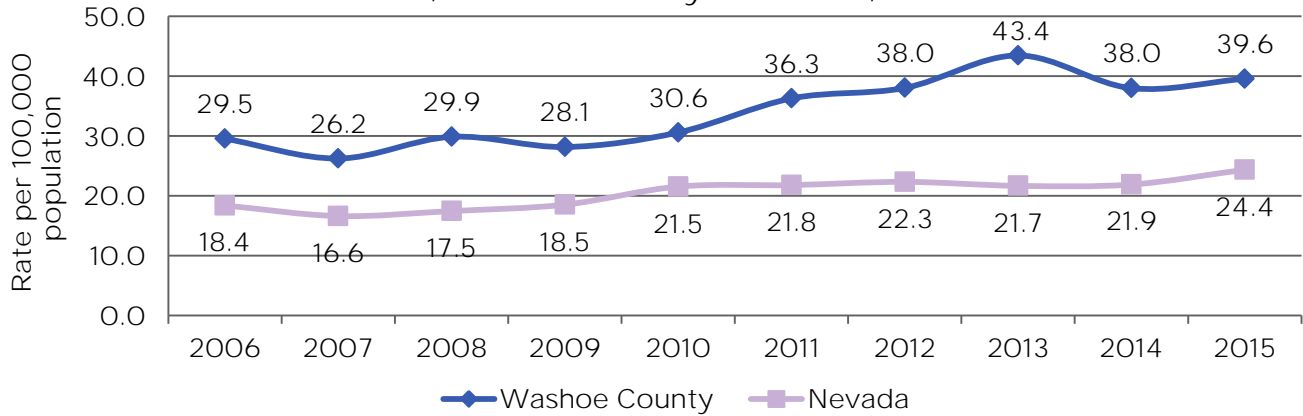
Fig 115: Hospitalization Rate Due to Opioid Poisoning by Race/Ethnicity, Washoe County, 2008-2015



- The rate of hospitalization in Washoe County due to opioid poisoning was highest among non-Hispanic whites and non-Hispanic African Americans from 2008 through 2015.
- The rate of hospitalization in Washoe County due to opioid poisoning among American Indian/Alaskan Natives fluctuated from 2008 through 2015.
- The rate of hospitalization in Washoe County due to opioid poisoning was lowest among non-Hispanic Asian/Pacific Islanders and Hispanics (any race) from 2008 through 2015.

Mortality

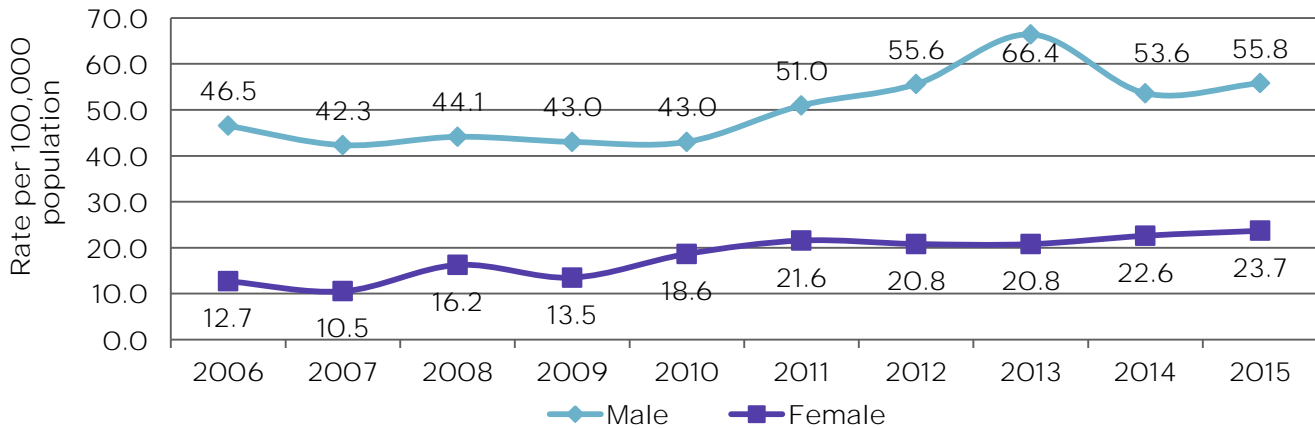
Fig 116: Age-adjusted Rate of Death Due to Alcohol-related Causes, Washoe County & Nevada, 2006-2015



Note: Includes mental and behavioral disorders due to use of alcohol, degenerative nervous system illnesses, gastrointestinal system illness, damage to fetus from alcohol, toxic effect of alcohol, accidental, undetermined, and intentional poisoning due to exposure to alcohol.

- The rate of deaths due to alcohol-related causes among Washoe County residents has increased from 2006 (29.5 per 100,000) to 2015 (39.6 per 100,000).
- The rate of deaths due to alcohol-related causes among Washoe County residents has remained higher than Nevada from 2006 through 2015.

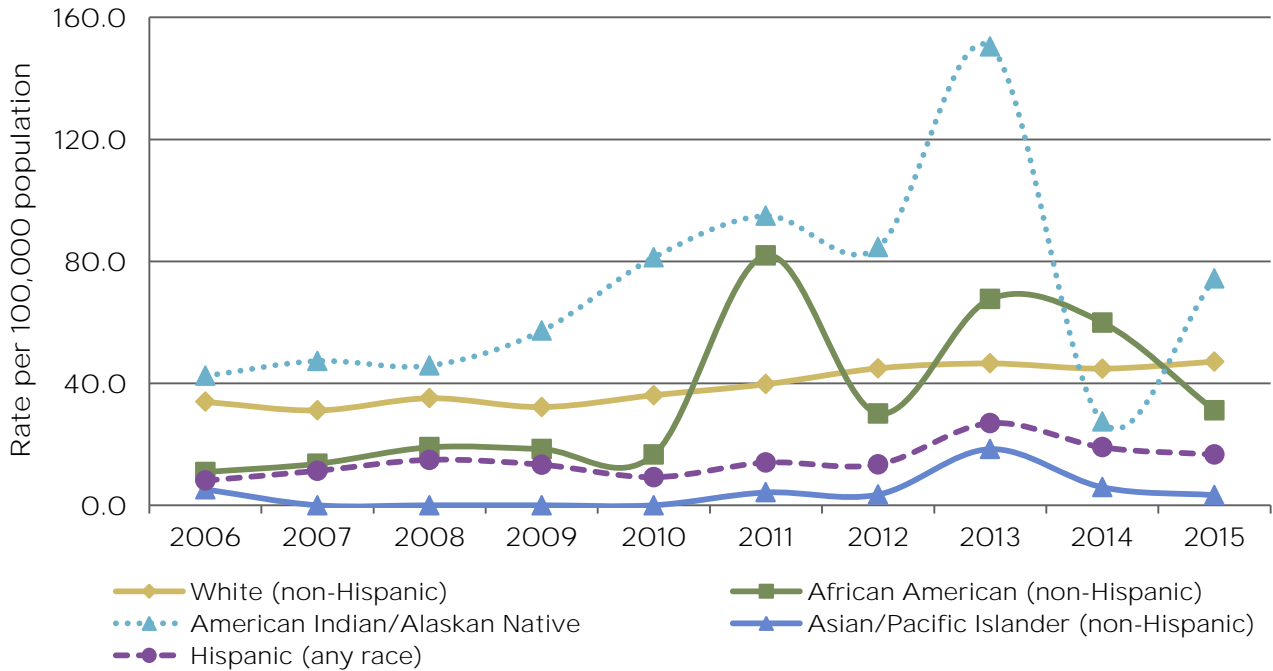
Fig 117: Age-adjusted Rate of Death Due to Alcohol-related Causes by Sex, Washoe County, 2006-2015



Note: Includes mental and behavioral disorders due to use of alcohol, degenerative nervous system illnesses, gastrointestinal system illness, damage to fetus from alcohol, toxic effect of alcohol, accidental, undetermined, and intentional poisoning due to exposure to alcohol.

- The rate of deaths due to alcohol-related causes among males in Washoe County has been much higher than the rate among females from 2006 through 2015.
- The rate of alcohol-related deaths among females has nearly doubled from 2006 (12.7 per 100,000 population) to 2015 (23.7 per 100,000 population).

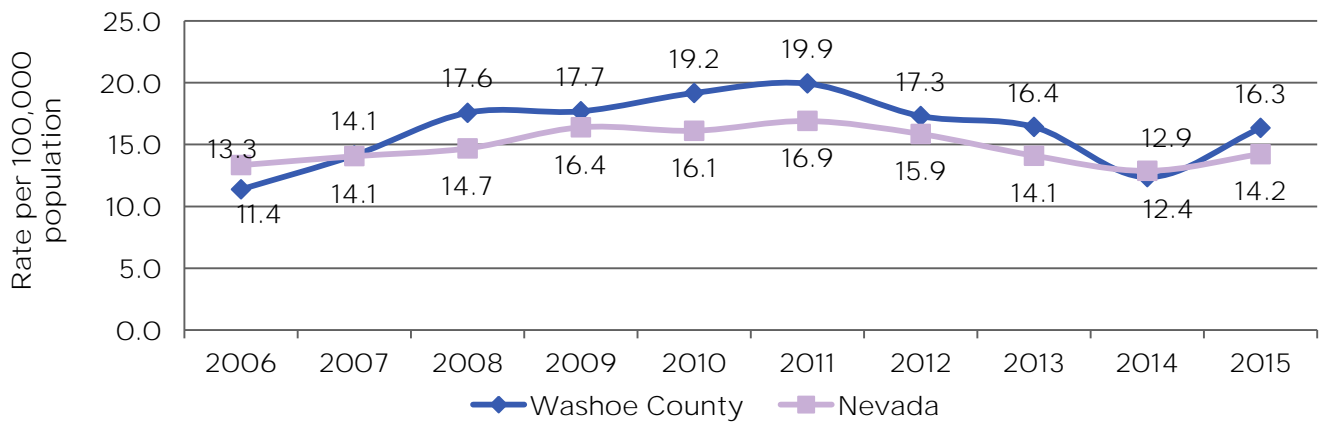
Fig 118: Age-adjusted Rate of Death Due to Alcohol-related Causes by Race/Ethnicity, Washoe County, 2006-2015



Note: Includes mental and behavioral disorders due to use of alcohol, degenerative nervous system illnesses, gastrointestinal system illness, damage to fetus from alcohol, toxic effect of alcohol, accidental, undetermined, and intentional poisoning due to exposure to alcohol.

- The rate of deaths due to alcohol-related causes among residents of Washoe County among all races and ethnicities, except for Hispanics (any race) has increased from 2006 to 2015, the largest increase has been among American Indian/Alaska Native, followed by African Americans.
- The death rate due to alcohol-related causes was highest among non-Hispanic whites for all years from 2006 through 2015, with the exception of 2014.

Fig 119: Age-adjusted Rate of Death Due to Prescription Drugs, Washoe County & Nevada, 2006-2015

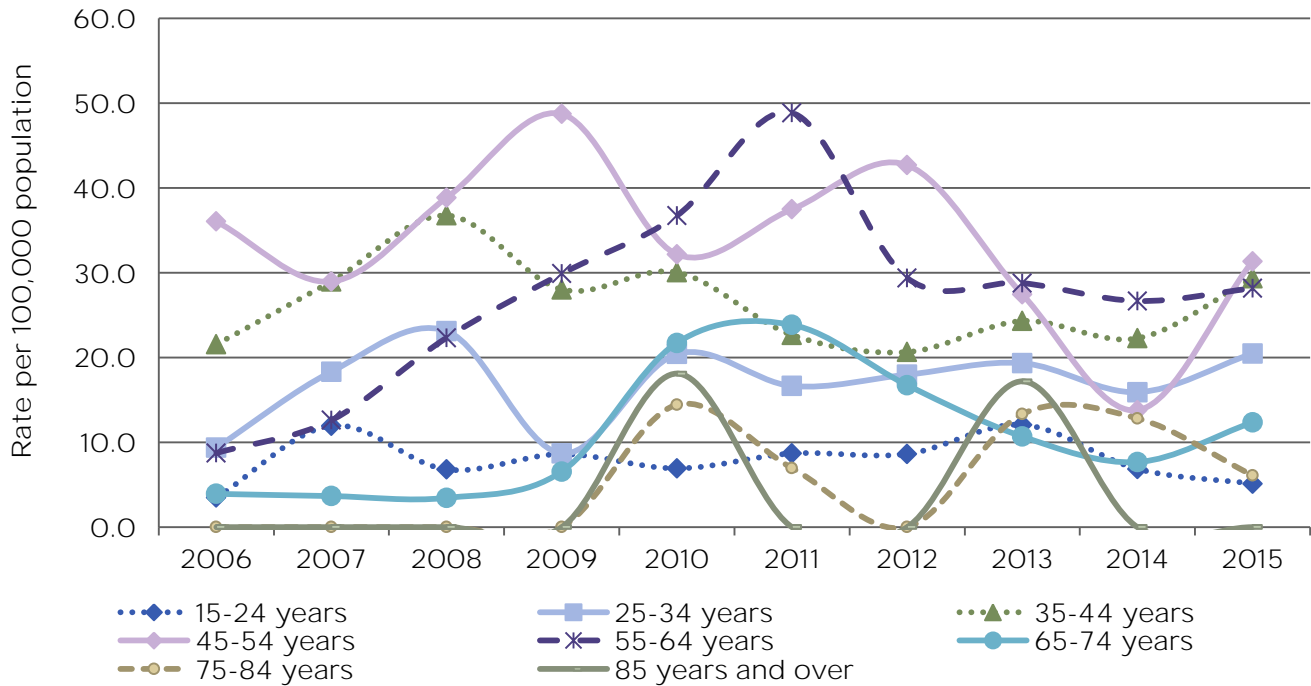


Note: Includes accidental, intentional, and undetermined poisonings by any class of non-illicit drug, may include deaths where a person was using a prescription drug in an illegal manner.

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- The rate of death due to prescription drugs among Washoe County residents has increased from 2006 (13.3 per 100,000) to 2015 (16.3 per 100,000).
- The rate of death due to prescription drugs among Washoe County residents has remained higher than the rate for Nevada from 2007 through 2013. As of 2015, Washoe County rates again rose above Nevada.

Fig 120: Age-adjusted Rate of Death Due to Prescription Drugs by Age Group, Washoe County, 2006-2015

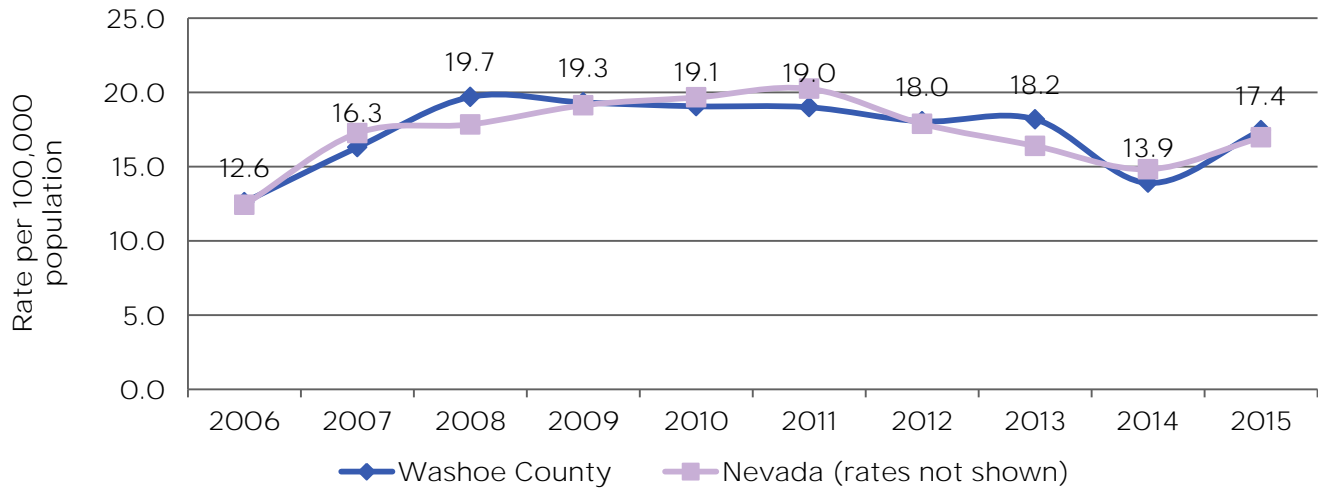


Note: Includes accidental, intentional, and undetermined poisonings by any class of non-illicit drug, may include deaths where a person was using a prescription drug in an illegal manner.

- The rate of death due to prescription drugs was highest among Washoe County residents aged 45-54 years and 55-64 years from 2006-2015.
- The rate of death due to prescription drugs among Washoe County residents increased from 2006 to 2015 among all age groups except for those aged 45-54 years.

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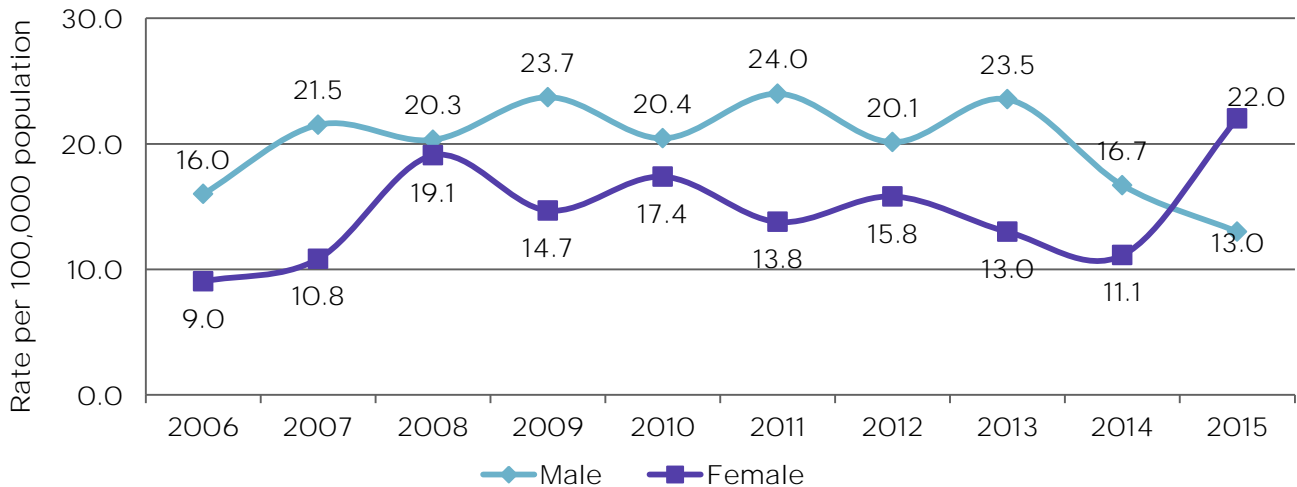
Fig 121: Age-adjusted Rate of Death Due to Illicit Drugs, Washoe County & Nevada, 2006-2015



Note: Includes mental and behavioral disorders due to use of opioids, cannabinoids, sedatives or hypnotics, cocaine, hallucinogens, psychodysleptics, and neonatal withdrawal from maternal use of drugs.

- The rate of death due to illicit drugs among Washoe County residents increased from 2006 (12.6 per 100,000) to 2015 (17.4 per 100,000).
- The rate of death due to illicit drugs among Washoe County residents has remained relatively similar to the rate for Nevada from 2006 through 2015.

Fig 122: Age-adjusted Rate of Death Due to Illicit Drugs by Sex, Washoe County, 2006-2015



Note: Includes mental and behavioral disorders due to use of opioids, cannabinoids, sedatives or hypnotics, cocaine, hallucinogens, psychodysleptics, and neonatal withdrawal from maternal use of drugs.

- The rate of death due to illicit drugs has been higher among males compared to females in Washoe County from 2006 through 2014. However, in 2015 the rate of death due to illicit drugs among females (22.0 per 100,000) doubled from the previous year and was higher than males (13.0 per 100,000).

Summary of Substance Use

In 2015, more than one in three (36.2%) Washoe County high school students reported they had ever smoked a cigarette and over half (53.5%) reported they had ever tried electronic vapor products. Additionally, two in three (65.6%) high school students in Washoe County reported having ever drunk alcohol and slightly more than one in three (35.5%) reported they currently drink alcohol; both rates are higher than Nevada and the United States. About two out of three UNR (college) students reported they currently drink alcohol and nearly one in three (29.7%) reported binge drinking in the two weeks prior. From 2012 through 2016, the percentage of adults in Washoe County classified as a heavy or binge drinker was higher than both Nevada and the United States. According to National Highway and Traffic Association, 38% of motor vehicle fatalities in Washoe County in 2015 involved a driver over the legal limit for alcohol (BAC > 0.08). Mortality rates for alcohol-related causes of death have increased county-wide and have remained higher than Nevada from 2006 through 2015.

The rates of current marijuana use among adolescents and college students have increased from previous years, are higher than rates for the United States, and are expected to continue to increase due to legalization of recreational use in Nevada. Although reported misuse of prescription drugs among adolescents and college students decreased from previous years, the rate of hospitalization for opioid poisonings in Washoe County have increased from 2007 through 2015 and have remained higher than Nevada.

Continued integration of substance use prevention, screening, and treatment into the traditional health care settings can decrease stigma and the burden on standalone treatment facilities, as well as increase opportunities for reducing poor health outcomes and improving quality of life.

For detailed documents related to substance use in Washoe County refer to:

Join Together Northern Nevada's Community Prevention Plans <http://www.jtnn.org/community-resources/community-assessment/>

Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Service's Washoe County Behavioral Health Summary
<http://dphh.nv.gov/uploadedFiles/dphhnavgov/content/Programs/OPHIE/dta/Publications/Washoe%20County%20BH%20Report%2008.16.pdf>

Substance Use Sources

Table 92-Table 96 Same Source

Table 92: Percent of High School Students who ever Tried Cigarette Smoking*, 2013 & 2015

Table 93: Percent of High School Students who Currently Smoke Cigarettes*, 2013 & 2015

Table 94: Percent of High School Students who ever Used Electronic Vapor Products*, 2013 & 2015

Table 95: Percent of High School Students who Currently use Electronic Vapor Products*, 2013 & 2015

Table 96: Percent of High School Students who Currently use Tobacco*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

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Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Fig 105; Table 97; Fig 106-Fig 107 Same Source

Fig 105: Percent of Adults that Currently Smoke Cigarettes, Washoe County, Nevada, & the United States, 2012-2016

Table 97: Percent of Adults that Currently Smoke E-Cigarettes*, 2014-2016

Fig 106: Percentage of Adults Reporting they Currently Smoke Cigarettes or E-Cigarettes by Age Group, Washoe County, 2016

Fig 107: Percentage of Adults Reporting they Currently Smoke Cigarettes or E-Cigarettes by Educational Attainment, Washoe County, 2016

Nevada and Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Nevada Behavioral Risk Factor Surveillance Survey (BRFSS). Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Table 98-Table 99 Same Source

Table 98: Percent of High School Students who ever Drank Alcohol*, 2013 & 2015

Table 99: Percent of High School Students who Currently Drink Alcohol*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 100-Table 103 Same Source

Table 100: Percent of College Students who Currently Drink Alcohol*, 2010, 2012, 2014, & 2016

Table 101: Percent of College Students who Drove after Drinking any Alcohol at all*, 2010, 2012, 2014, & 2016

Table 102: College Students Average Number of Drinks, 2010, 2012, 2014, & 2016

Table 103: Percent of College Students who are Binge Drinkers*, 2010, 2012, 2014, & 2016

Washoe County (UNR): American College Health Assessment-National College Health Assessment II data for Spring of 2010, 2012, 2014, and 2016. Unpublished data provided upon request. Reno, NV.

United States: American College Health Assessment-National College Health Assessment II Reference Group reports for Spring of 2010, 2012, 2014, and 2016. Accessed http://www.acha-ncha.org/pubs_rpts.html

Table 104-Table 105; Fig 108-Fig 111 Same Source

Table 104: Percent of Adults who are Binge Drinkers*, 2012-2016

Table 105: Percent of Adults who are Heavy Drinkers, 2012-2016

Fig 108: Percentage of Adults Classified as a Binge or Heavy Drinker by Sex, Washoe County, 2016

Fig 109: Percentage of Adults Classified as a Binge or Heavy Drinker by Age Group, Washoe County, 2016

Fig 110: Percentage of Adults Classified as a Binge or Heavy Drinker by Race & Ethnicity, Washoe County, 2016

Fig 111: Percentage of Adults Classified as a Binge or Heavy Drinker by Educational Attainment, Washoe County, 2016

1.10 SUBSTANCE USE

Nevada and Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Nevada Behavioral Risk Factor Surveillance Survey (BRFSS). Data provided upon request. Carson City, NV.
United States: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Table 106-Table 107 Same Source

Table 106: Percent of High School Students who ever used Marijuana*, 2013 & 2015

Table 107: Percent of High School Students who Currently use Marijuana*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 108: Percent of College Students who Currently use Marijuana*, 2010, 2012, 2014, & 2016

Washoe County (UNR): American College Health Assessment-National College Health Assessment II data for Spring of 2010, 2012, 2014, and 2016. Unpublished data provided upon request. Reno, NV.

United States: American College Health Assessment-National College Health Assessment II Reference Group reports for Spring of 2010, 2012, 2014, and 2016. Accessed http://www.acha-ncha.org/pubs_rpts.html

Table 109: Percent of Adults who Currently Smoke Marijuana or Hash*, 2012-2016

Nevada and Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Nevada Behavioral Risk Factor Surveillance Survey (BRFSS). Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Table 110: Percent of High School Students who ever took Prescription Drugs without a Doctor's Prescription*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Fig 112: Use of Prescription Drugs in the Past Year* Among College Students, Washoe County & the United States, 2010, 2012, 2014, & 2016

Washoe County (UNR): American College Health Assessment-National College Health Assessment II data for Spring of 2010, 2012, 2014, and 2016. Unpublished data provided upon request. Reno, NV.

United States: American College Health Assessment-National College Health Assessment II Reference Group reports for Spring of 2010, 2012, 2014, and 2016. Accessed http://www.acha-ncha.org/pubs_rpts.html

Table 111-Table 116 Same Source

Table 111: Percent of High School Students who ever used Synthetic Marijuana*, 2013 & 2015

1.10 SUBSTANCE USE

Table 112: Percent of High School Students who ever used Ecstasy*, 2013 & 2015

Table 113: Percent of High School Students who ever used Cocaine*, 2013 & 2015

Table 114: Percent of High School Students who ever used Inhalants*, 2013 & 2015

Table 115: Percent of High School Students who ever used Methamphetamines*, 2013 & 2015

Table 116: Percent of High School Students who ever used Heroin*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 117: Needing but Not Receiving Treatment* Among Persons 12 Years & Older, Annual Average 2012, 2013, 2014 Combined
Substance Abuse and Mental Health Services administration. Population Data/NSDUH. Substate/Metro 2012-2014 NSDUH Substate Region Estimates –Excel Tables and CSV Files. Accessed <https://www.samhsa.gov/data/population-data-nsduh/reports>

Fig 113-Fig 122 Same Source

Fig 113: Hospitalization Rate Due to Opioid Poisoning, Washoe County & Nevada, 2007-2015

Fig 114: Hospitalization Rate Due to Opioid Poisoning by Sex, Washoe County, 2007-2015

Fig 115: Hospitalization Rate Due to Opioid Poisoning by Race/Ethnicity, Washoe County, 2008-2015

Fig 116: Age-adjusted Rate of Death Due to Alcohol-related Causes, Washoe County & Nevada, 2006-2015

Fig 117: Age-adjusted Rate of Death Due to Alcohol-related Causes by Sex, Washoe County, 2006-2015

Fig 118: Age-adjusted Rate of Death Due to Alcohol-related Causes by Race/Ethnicity, Washoe County, 2006-2015

Fig 119: Age-adjusted Rate of Death Due to Prescription Drugs, Washoe County & Nevada, 2006-2015

Fig 120: Age-adjusted Rate of Death Due to Prescription Drugs by Age Group, Washoe County, 2006-2015

Fig 121: Age-adjusted Rate of Death Due to Illicit Drugs, Washoe County & Nevada, 2006-2015

Fig 122: Age-adjusted Rate of Death Due to Illicit Drugs by Sex, Washoe County, 2006-2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Mental Health

Mental health involves a person’s physical, emotional, and psychological well-being, and encompasses how a person copes with stress, how they respond towards unexpected events in their life, and how they engage socially with others. Mental health can impact physical health in various ways; stress and related anxiety for example, can cause stomachaches, headaches, lack of appetite, trouble sleeping, as well as unexplained increases or decreases in energy levels.¹⁰⁵ Chronic stress elevates cortisol levels in the blood stream which increases blood sugar, and inhibits memory and immune system function.¹⁰⁶ Additionally, chronic stress and cumulative stress has been shown to be associated with diagnosable mental illnesses such as depression and other psychiatric disorders.¹⁰⁷

Some types of mental illness may not produce symptoms such as fevers, or other visible physical signs, but instead are subjective and measured only by the person experiencing the condition. Any type of mental illness can be challenging to recognize, especially for someone not familiar with a person’s normal behavior.

The comorbidity of substance use disorders and mental illness are collectively referred to as behavioral health. This assessment contains a separate Substance Use section therefore this section encompasses only those indicators related to mental health and mental illness. Conditions involving mental impairment, such as developmental or intellectual disabilities, were not included.

Indicator	Trend	Most Recent Year
Depression & Mental Illness		
Adolescents that felt sad or hopeless	~	33.5% (2015)
Poor mental health among adults 18+ years	Increasing	14.1% 14+ poor mental health days (2016)
Depression among adults 18+ years	Decreasing	15.1% (2016)
Any mental illness among adults 18+ years	~	18.66% (2012-2014 aggregate data)
Serious mental illness among adults 18+ years	~	4.52% (2012-2014 aggregate data)
Major depressive episodes among adults 18+ years	~	6.36% (2012-2014 aggregate data)
Adolescents that lived with someone with depression, mentally ill, or suicidal	~	32.8% (2015)
Suicide		
Adolescents that seriously considered suicide	~	18.8% (2015)
Adolescents that attempted suicide	~	11.7% (2015)
Mortality rate due to suicide	STABLE	22.5 per 100,000 (2015)
~ not able to assess for trend		

¹⁰⁵ National Alliance on Mental Illness. Know the Warning Signs. Accessed <https://www.nami.org/Learn-More/Know-the-Warning-Signs>

¹⁰⁶ Kiecolt-Glaser, J.K., McGuire, L., Robles, T.F., and Glaser, R. (2002). Psychoneuroimmunology: Psychological influences on Immune Function and Health. *Journal of Consulting and Clinical Psychology*, 70(3), 537-47.

¹⁰⁷ Thoits, P.A. (2010). Stress and Health: Major findings and policy implications. *Journal of Health and Social Behavior*, 51(S) S41-S53.

1.11 MENTAL HEALTH

Depression & Mental Illness

Table 118: Percent of High School Students who felt Sad or Hopeless*, 2013 & 2015

Location	2013	2015
Washoe County	34.0%	33.5%
Nevada	31.7%	34.5%
United States	29.9%	29.9%

*almost every day for 2 or more weeks in a row so they stopped doing usual activities during the 12 months before the survey

- The percentage of high school students in Washoe County that reported having felt sad or hopeless for 2+ weeks in the past year slightly decreased from 2013 (34.0%) to 2015 (33.5%).
- In 2015, the percentage of high school students in Washoe County that reported having felt sad or hopeless for 2+ weeks in the past year (33.5%), was higher than Nevada (34.5%) and the United States (29.9%).

Table 119: Poor Mental Health days* among Adults in Washoe County, 2012-2016

Number of poor mental health days	2012	2013	2014	2015	2016
None	61.3%	61.0%	60.9%	59.0%	60.1%
1-13 days	25.6%	25.6%	26.5%	27.0%	25.8%
14 or more	13.1%	13.4%	12.7%	14.0%	14.1%

*in the past 30 days

Table 120: Poor Mental Health days* among Adults in Nevada, 2012-2016

Number of poor mental health days	2012	2013	2014	2015	2016
None	62.0%	65.1%	66.4%	64.1%	63.5%
1-13 days	23.5%	22.0%	21.7%	23.1%	22.4%
14 or more	14.5%	12.9%	12.0%	12.8%	14.2%

*in the past 30 days

- The percentage of adults in Washoe County that reported zero poor mental health days in the past month decreased from 2012 (61.3%) to 2016 (60.1%) and in 2016, was lower than Nevada (63.5%)
- The percentage of adults in Washoe County that reported between 1 and 13 days of poor mental health in the past month increased slightly from 2012 (25.6%) in 2012 to in 2016 (25.8%) and in 2016, was higher than Nevada (22.4%).
- The percentage of adults in Washoe County that reported 14 or more poor mental health days in the past month increased from 2012 (13.1%) to 2016 (14.1%) and in 2016, was slightly lower than Nevada (14.2%).

Table 121: Percent of Adults that had ever Been Told they had a Depression Disorder*, 2012-2016

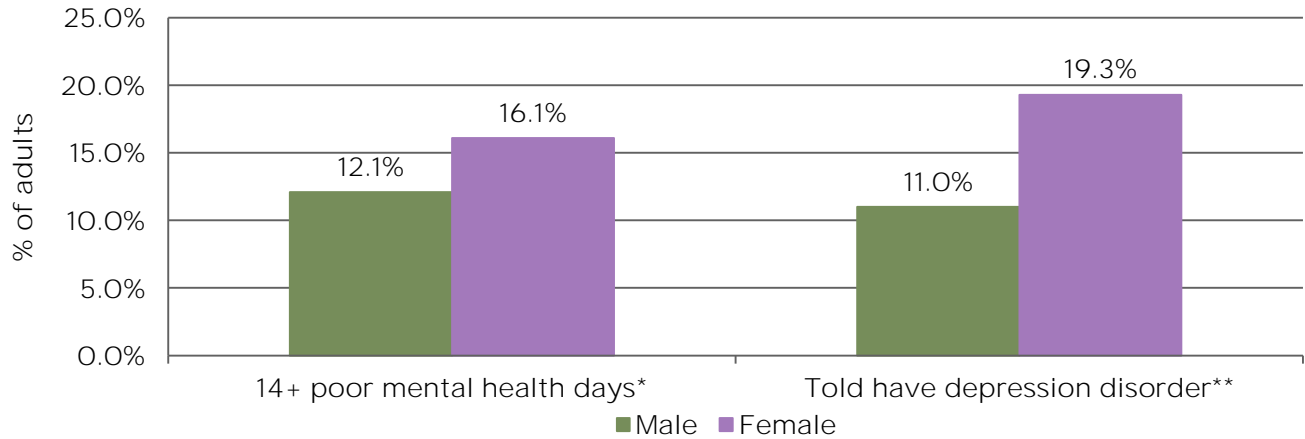
Location	2012	2013	2014	2015	2016
Washoe County	18.8%	16.2%	16.3%	16.6%	15.1%
Nevada	16.3%	17.6%	15.6%	16.6%	17.2%

*including depression, major depression, dysthymia, or minor depression

- The percentage of adults in Washoe County that reported they had ever been told they had a major depression disorder decreased from 2012 (18.8%) to 2016 (15.1%).
- In 2016 the percentage of adults Washoe County that reported they had ever been told they had a major depression disorder (15.1%), was lower for the first time from 2012 through 2015 than Nevada (17.2%).

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Fig 123: Poor Mental Health & Depression among Adults by Sex, Washoe County, 2016

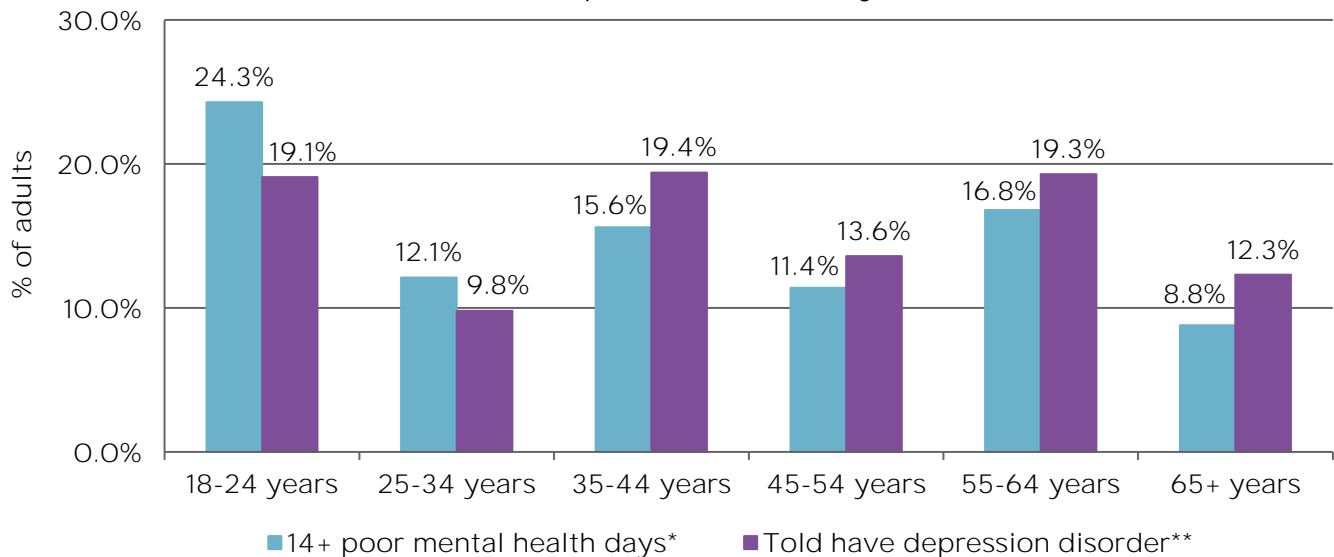


*in the past 30 days

** including depression, major depression, dysthymia, or minor depression

- Females in Washoe County had a higher prevalence of 14 or more poor mental health days in the month prior (16.1%) compared to males (12.1%).
- A higher percentage of females also reported they had been told they have a depression disorder (19.3%) compared to males (11.0%).

Fig 124: Poor Mental Health & Depression among Adults by Age Group, Washoe County, 2016



*in the past 30 days

** including depression, major depression, dysthymia, or minor depression

- Nearly one in four adults 18-24 years of age reported 14 or more poor mental health days (24.3%), while adults 65 years and older had the lowest reported percentage of 14 or more poor mental health days (8.8%) among all age groups.
- In 2016, nearly one in five adults aged 18-24 years (19.1%), adults 35-44 years (19.4%), and adults 55-64 years (19.3%) reported they have a depression disorder.

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Table 122: Prevalence of Mental Illness, Serious Mental Illness, & Major Depressive Episode in the past year among Adults 18+ years, 2012-2014 Aggregate Data

Behavioral Health Issue	Washoe County	Nevada	United States
Any mental illness *	18.66%	18.30%	18.39%
Serious mental illness**	4.52%	4.33%	4.13%
Major depressive episode†	6.36%	6.34%	6.71%

*diagnosable mental, behavioral, or emotional disorder other than a developmental or substance use disorder
 **SMI includes individuals with a diagnosis resulting in a serious functional impairment
 †at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms

- The percentage of adults 18 years and older in Washoe County reported to have had any mental illness in the past year (18.66%) was similar to, but slightly higher than both Nevada (18.30%) and the United States (18.39%).
- The percentage of adults 18 years and older in Washoe County reported to have had a serious mental illness, resulting in a serious functional impairment, in the past year (4.52%) was similar to, but slightly higher than both Nevada (4.33%) and the United States (4.13%).
- The percentage of adults 18 years and older in Washoe County reported to have had a major depressive episode in the past year (6.36%) was similar to Nevada (6.34%) and slightly lower than the United States (6.71%).

Table 123: Percent of High School Students that ever lived with Someone that was Depressed, Mentally ill, or Suicidal, 2015

Location	2015
Washoe County	32.8%
Nevada	30.4%

- In 2015, the percentage of high school students in Washoe County that reported having ever lived with someone that was depressed, mentally ill, or suicidal was higher (32.8%) than Nevada (30.4%).

Suicide

Table 124: Percent of High School Students who Seriously Considered Attempting Suicide*, 2013 & 2015

Location	2013	2015
Washoe County	20.9%	18.8%
Nevada	19.3%	17.7%
United States	17.0%	17.7%

*during the 12 months before the survey

- The percentage of high school students in Washoe County that seriously considered attempting suicide in the past year decreased from 2013 (20.9%) to 2015 (18.8%).
- In 2015, the percentage of high school students in Washoe County that seriously considered attempting suicide in the past year was higher (18.8%) than Nevada (17.7%) and the United States (17.7%).

Table 125: Percent of High School Students who Attempted Suicide*, 2013 & 2015

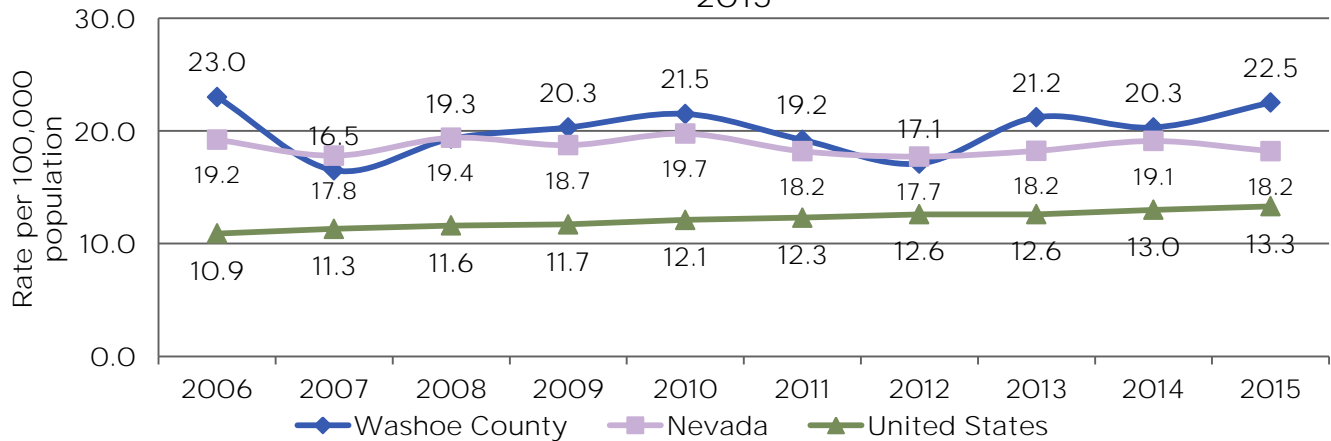
Location	2013	2015
Washoe County	13.7%	11.7%
Nevada	11.8%	9.8%
United States	8.0%	8.6%

*one or more times in the 12 months before the survey

1.11 MENTAL HEALTH

- The percentage of high school students in Washoe County that attempted suicide in the past year decreased from 2013 (13.7%) to 2015 (11.7%).
- In 2015, the percentage of high school students in Washoe County that attempted suicide in the past year was higher (11.7%) than Nevada (9.8%) and the United States (8.6%).

Fig 125: Age-adjusted Rate of Death Due to Suicide/Intentional Self Harm, Washoe County, Nevada, & the United States, 2006-2015



- The rate of suicide among Washoe County residents has remained relatively stable from 2006 (23.0 per 100,000) through 2015 (22.5 per 100,000).
- In 2015, the rate of suicide among Washoe County residents (22.5 per 100,000) was higher than Nevada (18.2 per 100,000) and the United States (13.3 per 100,000).

Primary Survey Data Related to Mental Health

Primary data were collected via an online community survey from over 1,400 survey participants. The survey included 44 questions and analyses for questions related to mental health are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community Survey Demographics section.

Stress involves the brain and body's physical responses to a demand such as work, school, life changes, traumatic events, or even exercise. Stress can be chronic stemming from a routine daily occurrence such as rush hour traffic or a poor relationship with co-workers, friends or family, or stress can be brought on by a sudden event such as bad news, illness, assault, or natural disasters.

Not all types of stress are bad, for example, when faced with a perceived threat, a person's body undergoes physical changes - the pulse quickens delivering more oxygen and blood to the brain and organs and muscles tense up to prepare for action. The body's short-term instinctive responses to stress may be lifesaving

and bodily functions quickly return to normal levels after danger has passed. In modern time, humans are not usually faced with fight or flight conditions, but instead are coping with long-term stressors. Long-term or chronic stress results in impaired immune, cardiovascular, and digestive systems causing an inability to sleep, headaches, prolonged high blood pressure, heart disease, obesity, and diabetes. Stress also drives mental health disorders including depression and anxiety.^{108,109} Stress can be managed to a certain extent through a variety of healthy coping mechanisms including recognizing stressors and preparing, engaging in physical activity, meditation, goal setting, or connecting with close friends or family.

The community survey contained a series of four questions to assess for perceived stress. The respondents were asked the frequency they felt each of the following questions on a scale from “never”, “almost never”, “sometimes”, “fairly often”, to “very often”.

Question 1: “Within the last month, how often have you felt that you were unable to control important things in your life?”

Question 2: “Within the last month, how often have you felt difficulties were piling up so high that you could not overcome them?”

Question 3: “Within the last month, how often have you felt confident about your ability to handle your personal problems?”

Question 4: “Within the last month, how often have you felt that things were going your way?”

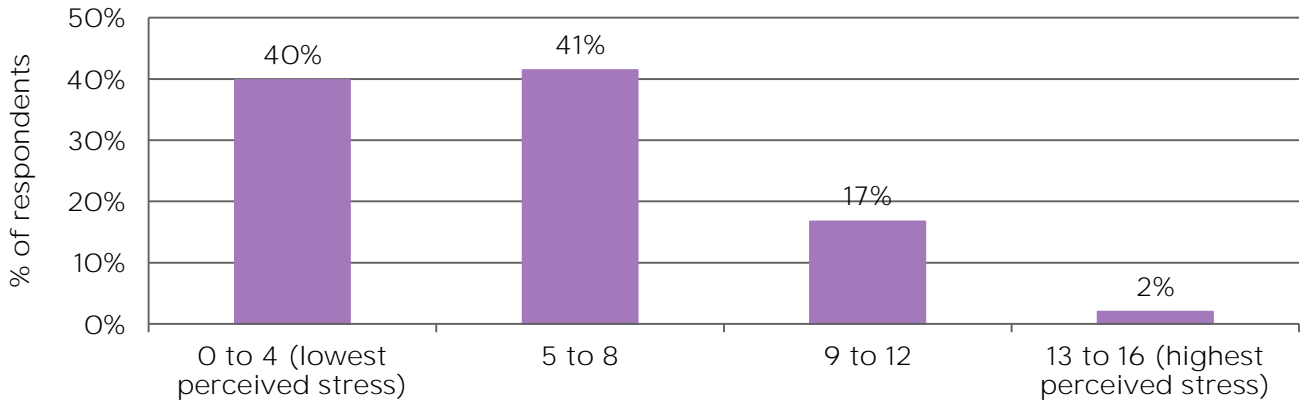
Scoring: The first and second questions were scored in ascending order meaning, “never” scored a “0” and a “very often” response was scored as “5”. The third and fourth questions were scored in descending order meaning, “never” scored a “5” and a “very often” response was scored as “0”. The higher the total score indicates a higher level of perceived stress. Total scores were calculated for only those participants that responded to all four questions in order to assess a true score.

The overall average perceived stress score was a 5.51 among the 1,358 respondents that answered all four questions.

¹⁰⁸ National Institutes of Health. 5 Things You Should Know About Stress. Accessed <https://www.nimh.nih.gov/health/publications/stress/index.shtml>

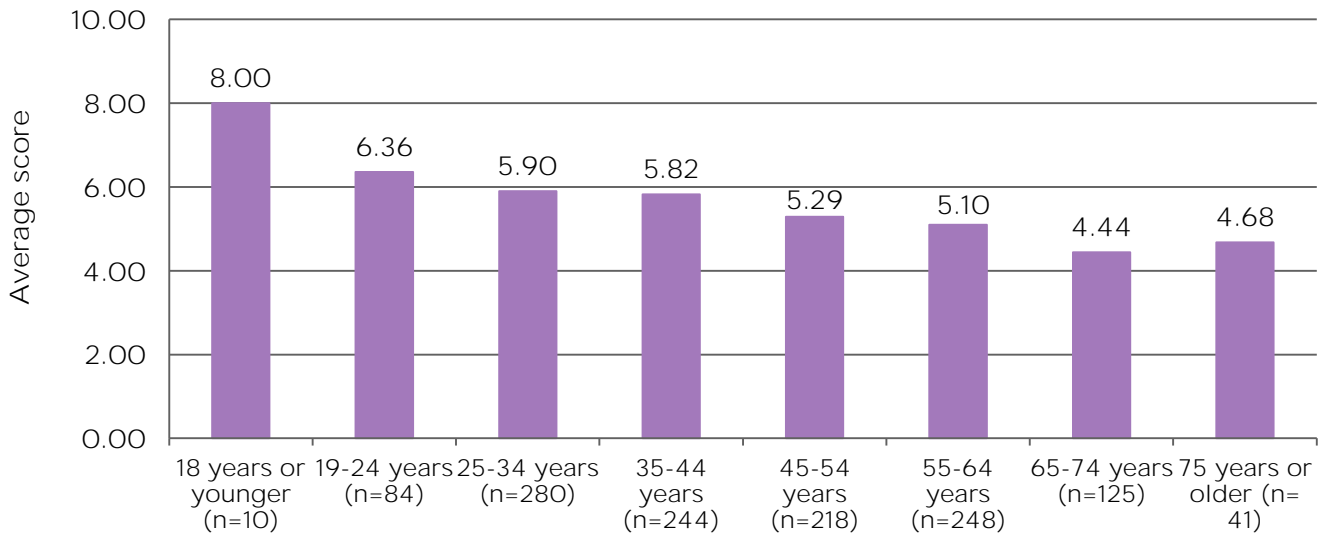
¹⁰⁹ American Institute of Stress. Stress Effects. Accessed <https://www.stress.org/stress-effects/>

Fig 126: Overall Perceived Stress Score Ranges (n=1,358)



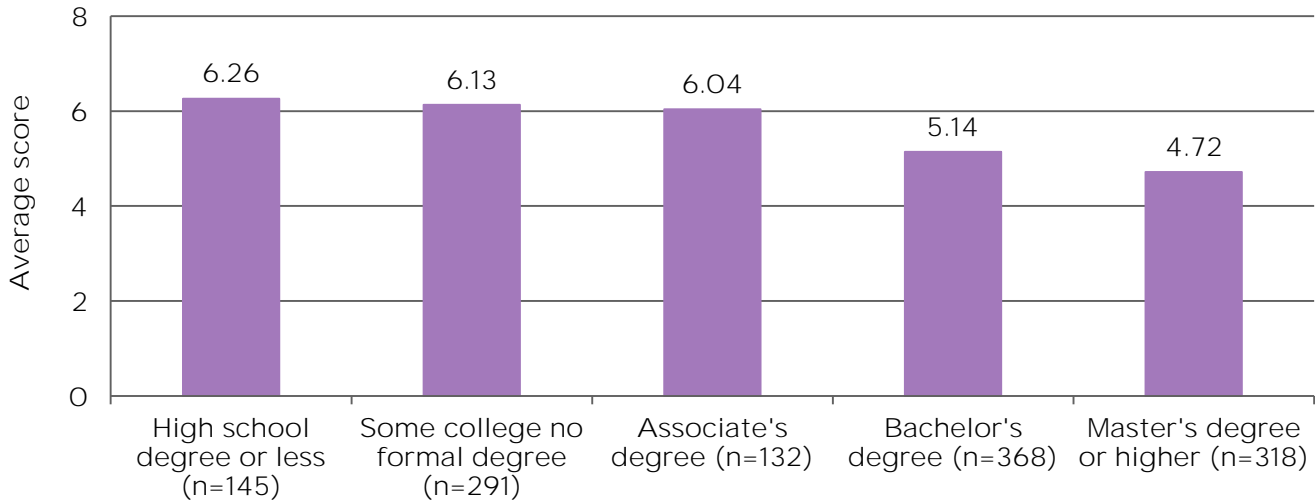
- The majority of the 1,358 respondents were on the lower end of the perceived stress score spectrum with 40% scoring a total from 0 to 4 (lowest perceived stress) and 41% scoring a total between 5 and 8.
- Only 2% of the 1,358 respondents to the four-question scale received a total score between 13 and 16 (highest perceived stress).

Fig 127: Perceived Stress Score by Age Group (n=1,250)



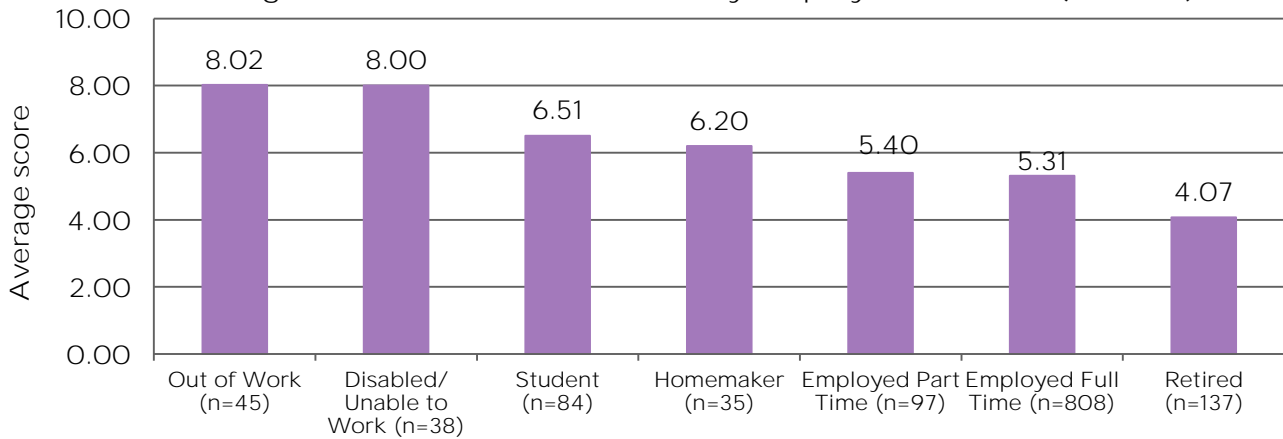
- When the average perceived stress scores were stratified by age group a clear pattern developed. As age increased, the average perceived stress score decreased.
- The mean perceived stress score among respondents 18 years and younger was 8.00, and with each increase in age group, perceived stress scores decreased, with a low score of 4.44 among those 65-74 years of age. There was a slight increase in the average perceived stress score among those 75+ years and older, 4.68.

Fig 128: Perceived Stress Scores by Educational Attainment (n=1,254)



- As educational attainment increased, the average perceived stress score decreased.
- Survey respondents that had a high school degree or less (no high school degree) had an average perceived stress score of 6.26, compared to respondents with a Master’s degree or higher (PhD, medical degree, law degree) with an average perceived stress score of 4.72.

Fig 129: Perceived Stress Score by Employment Status (n=1,244)



- There was a clear pattern in perceived stress when stratified by employment status. Those who were out of work (8.02) or unable to work (8.00) had the highest scores, followed by those who were students (6.51) or homemakers (6.20). Those with part time (5.40) or full time (5.31) employment had the second to lowest scores, while those who were retired (4.07) had the lowest perceived stress.
- This pattern is likely associated with age as well, as younger respondents had higher average perceived stress scores, while those in a retirement age bracket 65+ years had the lowest perceived stress scores.

Summary of Mental Health

In 2015 one in three high school students in Washoe County reported they felt sad or hopeless for two or more weeks (during the past year), a rate higher than Nevada and the United States. In 2016, the percentage of adults in Washoe County reporting poor mental health days was higher than Nevada and has remained relatively stable since 2012. Reportage depression disorders and 14 or more poor mental health days were higher among adult females compared to males in Washoe County. The percent of adults in Washoe County with any mental illness, a serious mental illness or a major depressive episode in the past year was slightly higher compared to Nevada and the United States, for all three conditions.

In 2015, nearly one in three (32.8%) of Washoe County high school students reported they had ever lived with someone that was depressed, mentally ill, or suicidal. In both 2013 and 2015 a higher percentage of Washoe County high school students reported considering attempting suicide and attempting suicide in the past year compared to Nevada and the United States. The mortality rate for suicide and intentional self-harm among adults remained relatively stable in Washoe County. In 2015, the mortality rate was 22.5 deaths per 100,000 population. However, this rate was higher than the overall state rate.

While stressors occur among people of all age groups, perceived stress and rates of depression appear to be more prevalent among younger adults compared to older adults in Washoe County. This may be due to generational differences, or technology such as utilization of social media, or even biological and developmental processes. Additionally chronic stress, including social and environmental stressors, contributes to poor health outcomes even among those who may not present with a clinically diagnosable mental disorder.

For detailed documents related to mental health in Washoe County refer to:

Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Service's Washoe County Behavioral Health Summary
<http://dpbh.nv.gov/uploadedFiles/dpbhnavgov/content/Programs/OPHIE/dta/Publications/Washoe%20County%20BH%20Report%2008.16.pdf>

Mental Health Sources

Table 118: Percent of High School Students who felt Sad or Hopeless*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

1.11 MENTAL HEALTH

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 119-Table 121; Fig 123-Fig 124 Same Source

Table 119: Poor Mental Health days* among Adults in Washoe County, 2012-2016

Table 120: Poor Mental Health days* among Adults in Nevada, 2012-2016

Table 121: Percent of Adults that had ever Been Told they had a Depression Disorder*, 2012-2016

Fig 123: Poor Mental Health & Depression among Adults by Sex, Washoe County, 2016

Fig 124: Poor Mental Health & Depression among Adults by Age Group, Washoe County, 2016

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

Table 122: Prevalence of Mental Illness, Serious Mental Illness, & Major Depressive Episode in the past year among Adults 18+ years, 2012-2014 Aggregate Data

Substance Abuse and Mental Health Services Administration. Population Data/NSDUH. Substate/Metro 2012-2014 NSDUH Substate Region Estimates –Excel Tables and CSV Files. Accessed <https://www.samhsa.gov/data/population-data-nsduh/reports>

Table 123-Table 125 Same Source

Table 123: Percent of High School Students that ever lived with Someone that was Depressed, Mentally ill, or Suicidal, 2015

Table 124: Percent of High School Students who Seriously Considered Attempting Suicide*, 2013 & 2015

Table 125: Percent of High School Students who Attempted Suicide*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 118 –Table 120; Fig 118-Fig 119 SAME SOURCE

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

Fig 125: Age-adjusted Rate of Death Due to Suicide/Intentional Self Harm, Washoe County, Nevada, & the United States, 2006-2015

Nevada & Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Data provided up on request. Carson City, NV.

United States: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html>

Following Figures from the Online Community Survey

Fig 126: Overall Perceived Stress Score Ranges (n=1,358)

Fig 127: Perceived Stress Score by Age Group (n=1,250)

Fig 128: Perceived Stress Scores by Educational Attainment (n=1,254)

Fig 129: Perceived Stress Score by Employment Status (n=1,244)

Sexual Health

Sexual health encompasses physical, mental, emotional, and social well-being in relation to sex and sexuality. Poor sexual health outcomes include discrimination based on gender identity, as well as sexually transmitted infections and diseases, unintended pregnancy, and certain types of cancer. Sexual violence (rape and assault) and physical dating violence are also measures of sexual health; however, those data are presented in the Crime & Violent-Related Behaviors section.

Indicator	Trend	Most Recent Year
<i>Sexually Transmitted Infections & Diseases</i>		
Chlamydia	Increasing	493.0 per 100,000 population (2016)
Gonorrhea	Increasing	13.40 per 100,000 population (2016)
Syphilis, primary & secondary	Increasing	7.3 per 100,000 population (2016)
HIV	STABLE	9.6 per 100,000 population (2016)
<i>Sexual Health Behaviors</i>		
Ever had sexual intercourse-Adolescents	~	40.8% (2015)
Currently sexually active-Adolescents	~	29.8% (2015)
Used condom last time sexually active-Adolescents	~	53.6% (2015)
No method used to prevent pregnancy-Adolescents	~	12.2% (2015)
Teen birth rates among females aged 15-19 years	Decreasing	21.9 per 1,000 females (2016)
~not able to assess for trend		

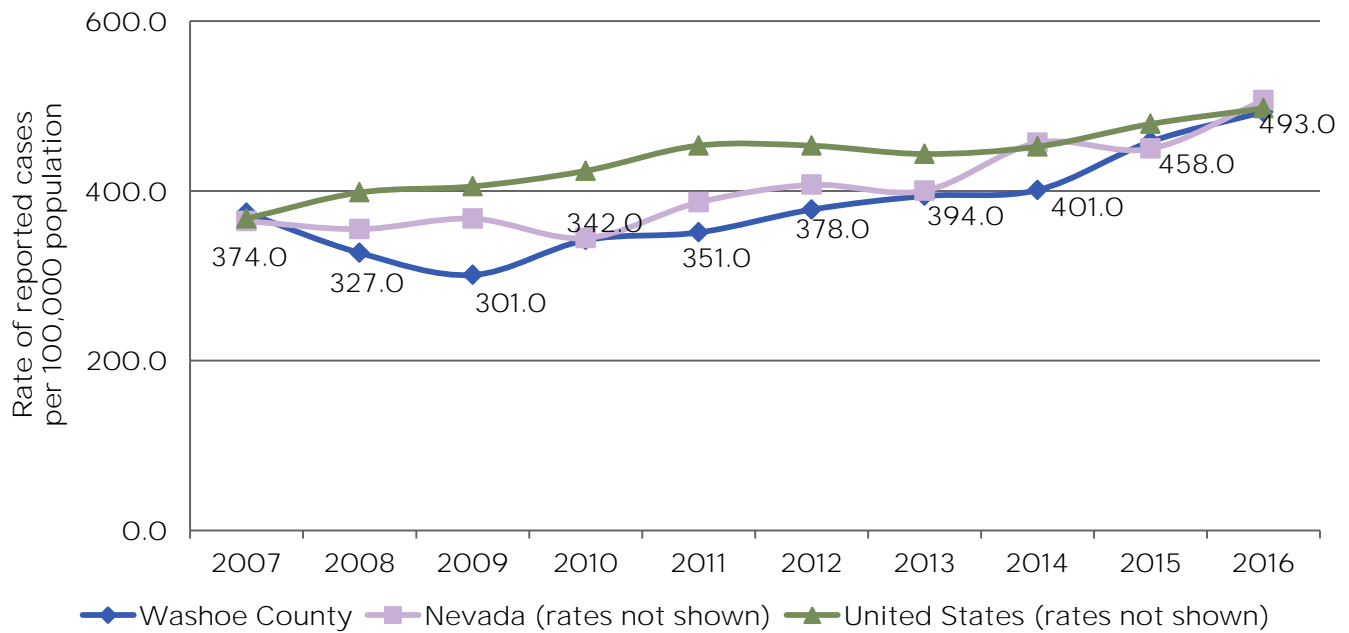
1.12 SEXUAL HEALTH

Sexually Transmitted Infections & Diseases

Chlamydia

Chlamydia trachomatis is the most frequently reported infectious disease in the United States, and is the most common sexually transmitted infections. Chlamydia is transmitted through vaginal, anal, and oral sexual intercourse and can be passed to a fetus during childbirth, which can lead to blindness and pneumonia of the infant. If left untreated, chlamydia can result in pelvic inflammatory disease (PID), a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Chlamydia is treatable with antibiotics; however continued intercourse with a partner who is also infected and not also treated, may result in repeated infections.¹¹⁰

Fig 130: Rate of Reported Cases of Chlamydia, Washoe County, Nevada, & the United States, 2007-2016



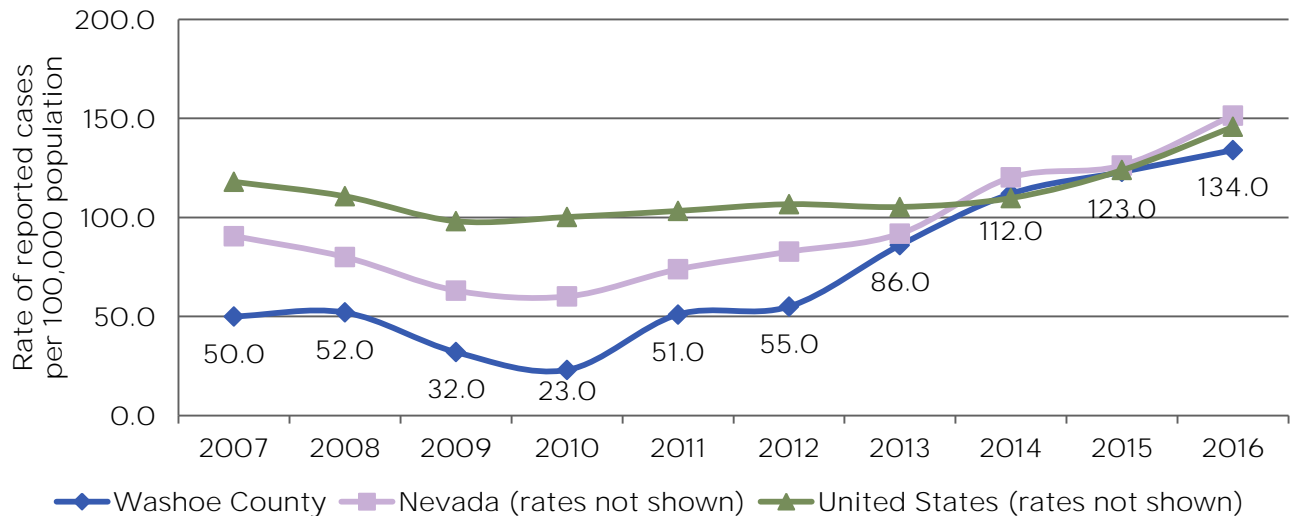
- The rate of reported cases (per 100,000 population) of chlamydia in Washoe County have increased steadily each year from 2009 through 2016.
- In 2016, the rate of reported cases of chlamydia in Washoe County (493.0 per 100,000) was lower than Nevada (506.7 per 100,000) and the United States (497.3 per 100,000).

¹¹⁰ Centers for Disease Control and Prevention. (2014). Chlamydia –CDC Fact Sheet. Accessed <https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm>

Gonorrhea

Gonorrhea is caused by *Neisseria gonorrhoeae*, and is the second most prevalent sexually transmitted disease in the United States. Similar to chlamydia, Gonorrhea is also transmitted through vaginal, anal, and oral sexual intercourse and can be passed to a fetus during childbirth. If left untreated, gonorrhea can result in serious and permanent health issues, including infertility in both men and women. Gonorrhea can spread to the uterus or fallopian tubes causing pelvic inflammatory disease, and can also spread to the blood stream resulting in an infection which can cause arthritis, tenosynovitis, or dermatitis.¹¹¹ Although gonorrhea can be treated, antibiotic-resistant strains have been emerging and gonorrhea is now resistant to penicillin, tetracycline, sulfanilamides, and fluoroquinolones, leaving one effective class of antibiotics (cephalosporins) available.¹¹²

Fig 131: Rate of Reported Cases of Gonorrhea, Washoe County, Nevada, & the United States, 2007-2016



- From 2007 through 2013, the rate of reported cases (per 100,000 population) of gonorrhea in Washoe County was lower than the rates reported in Nevada and the United States.
- The rate of gonorrhea in Washoe County has more than quadrupled since 2011; however, in 2016 was lower (134.0 per 100,000) than Nevada (151.5 per 100,000) and the United States (145.8 per 100,000).

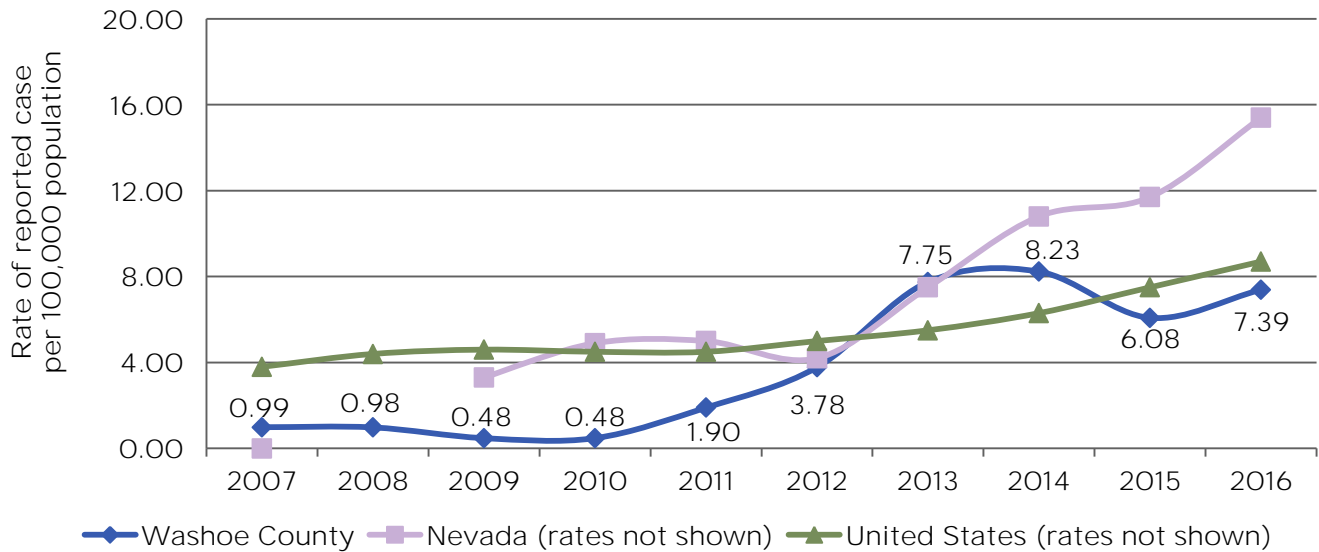
¹¹¹ Centers for Disease Control and Prevention. (2016). Gonorrhea-CDC Fact Sheet (Detailed Version). Accessed <https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea-detailed.htm>

¹¹² Centers for Disease Control and Prevention. (2013). Antibiotic-Resistance Gonorrhea Basic Information. Accessed <https://www.cdc.gov/std/gonorrhea/arg/basic.htm>

Primary & Secondary Syphilis

Syphilis is a complex STD caused by *Treponema palladium*. The primary and secondary stages of Syphilis are both contagious, while late latent stage (infection for more than one year) and tertiary syphilis are not. Symptoms of the primary stage of syphilis include a single chancre which is usually firm, round, small, and painless, typically lasting 3-6 weeks. The secondary stage is marked by a rough, red or reddish-brown rash on the trunk and extremities, swollen lymph nodes, fever, and some may experience patchy hair loss. Both the primary and secondary stages of syphilis may be asymptomatic, however if left untreated can progress to the latent and tertiary stages. Latent syphilis can affect the heart, brain, and other organs. All stages of syphilis can be treated; however treatment cannot reverse any damage to tissues or nerves.¹¹³

Fig 132: Rate of Reported Cases of Primary & Secondary Syphilis, Washoe County, Nevada, & the United States, 2007-2016



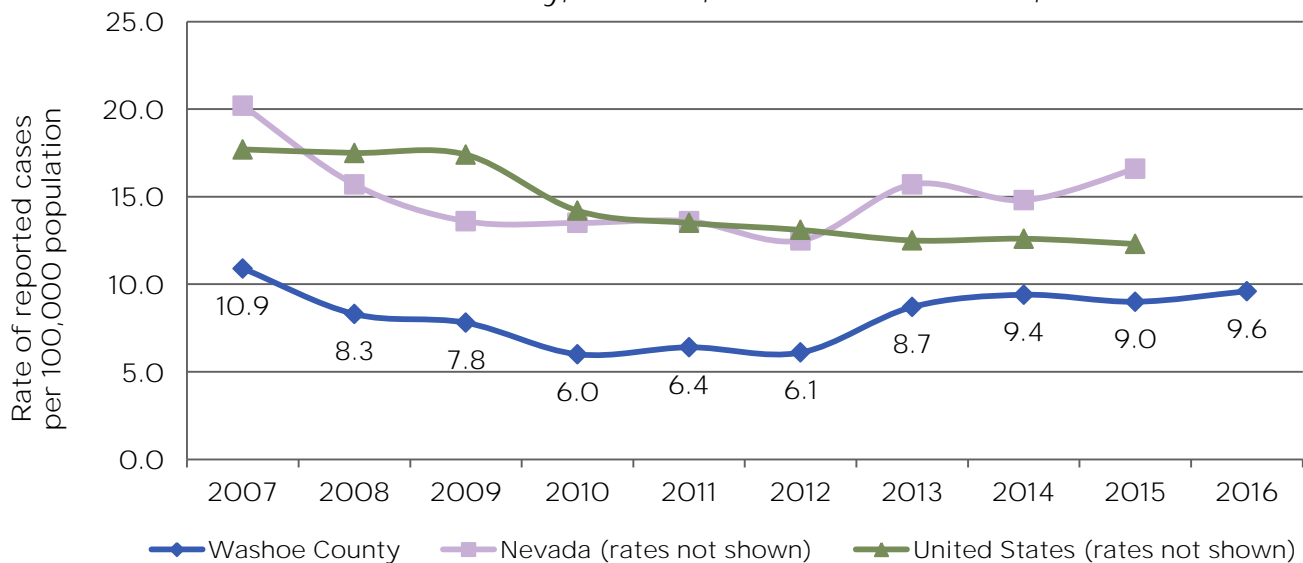
- From 2007 through 2012 the rate of reported cases (per 100,000 population) of primary and secondary syphilis in Washoe County were lower than Nevada and the United States.
- Washoe County experienced nearly double the rate of reported cases of primary and secondary syphilis from 2012 (3.78 per 100,000 population) to 2013 (7.75 per 100,000 population) and rates have remained high.
- In 2016, the rate of reported cases of primary and secondary syphilis in Washoe County (7.39 per 100,000) were lower than Nevada (15.4 per 100,000) and the United States (8.7 per 100,000).

¹¹³ Centers for Disease Control and Prevention. (2017). Syphilis-CDC Fact Sheet. Accessed <https://www.cdc.gov/std/syphilis/stdfact-syphilis.htm>

Human Immunodeficiency Virus (HIV)

Infection of Human Immunodeficiency Virus (HIV) leads to the development of Acquired Immune Deficiency Syndrome (AIDS). HIV is a virus which attacks the body’s immune system, specifically CD4 or T-cells, and overtime results in the body being unable to fight off infections and diseases. A CD4 cell count of 200 cells/mm or less meets the diagnostic criteria for AIDS. Once a person has been diagnosed with AIDS, they are more likely to develop rare diseases and cancers, typically referred to as opportunistic infections. HIV is primarily transmitted through unprotected vaginal or anal intercourse, sharing of needles (including piercing and tattoo equipment), or equipment used to prepare and inject intravenous drugs. HIV can also be transmitted from mothers to infants during pregnancy, birth, or breastfeeding. Although there is no vaccine or cure for HIV, there have been new developments such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), which when taken appropriately may reduce the likelihood of infection after a possible recent exposure (72 hours or less).¹¹⁴

Fig 133: Rate of Reported Newly Diagnosed HIV Infection, Washoe County, Nevada, & the United States, 2007-2016



- The rate of reported cases of newly diagnosed HIV infection in Washoe County decreased from 2007 (10.9 per 100,000) to 2016 (9.6 per 100,000).
- The rate of reported cases of newly diagnosed HIV infection in Washoe County has remained lower than Nevada and the United States from 2007 through 2015.

¹¹⁴ Centers for Disease Control and Prevention. (2017). HIV Basics. Accessed <https://www.cdc.gov/hiv/basics/index.html>

1.12 SEXUAL HEALTH

Sexual Health Behaviors

Table 126: Percent of High School Students who had ever had Sexual Intercourse, 2013 & 2015

Location	2013	2015
Washoe County	47.0%	40.8%
Nevada	43.0%	38.5%
United States	46.8%	41.2%

- The percentage of high school students in Washoe County who reported they had ever had sexual intercourse decreased from 2013 (47.0%) to 2015 (40.8%).
- In 2015, the percentage of high school students in Washoe County who had ever been sexually active was slightly higher than Nevada (38.5%), and slightly lower than the United States (41.2%).

Table 127: Percent of High School Students who are Currently Sexually Active*, 2013 & 2015

Location	2013	2015
Washoe County	29.1%	29.8%
Nevada	28.2%	27.1%
United States	34.0%	30.1%

*sexual intercourse with at least one person during the 3 months before the survey

- The percentage of high school students in Washoe County who reported they currently sexually active remained relatively stable from 2013 (29.1%) to 2015 (29.8%).
- In 2015, the percentage of high school students in Washoe County (29.8%) who reported they were currently sexually active was higher than Nevada (27.1%), and slightly lower than the United States (30.1%).

Table 128: Percent of High School Students who used a Condom*, 2013 & 2015

Location	2013	2015
Washoe County	53.2%	53.6%
Nevada	56.4%	56.9%
United States	59.1%	56.9%

*they or their partner used a condom during last sexual intercourse among those who were currently sexually active

- In 2015, just over half (53.6%) of sexually active high school students reported wearing a condom during last sexual intercourse in Washoe County. This remained relatively stable from 2013 to 2015.
- In 2015, the percentage of high school students in Washoe County (53.6%) who reported wearing a condom during their last sexual intercourse was lower than both Nevada (56.9%) and the United States (56.9%).

Table 129: Percent of High School Students who did not use any Method to Prevent Pregnancy*, 2013 & 2015

Location	2013	2015
Washoe County	18.7%	12.2%
Nevada	18.2%	12.4%
United States	13.7%	13.8%

* during last sexual intercourse among those who were currently sexually active

- In 2015, 12.2% of sexually active high school students reported they did not use any method to prevent pregnancy last sexual intercourse in Washoe County.

1.12 SEXUAL HEALTH

- The percent of high school students in Washoe County who reported they did not use any method to prevent pregnancy during last sexual intercourse decreased from 2013 (18.7%) to 2015 (12.2%).
- In 2015, the percentage of high school students in Washoe County (12.2%) who reported they did not use any method to prevent pregnancy during their last sexual intercourse, was lower than both Nevada (12.4%) and the United States (13.8%).

Teen Birth Rates

Pregnant adolescent females (15 to 19 years) are considered to have higher risks for negative health outcomes related to birth, not only impacting their child's lives, but their own as well. Teen mothers are more likely to end pregnancy in abortion and are less likely to enroll in prenatal care during pregnancy.¹¹⁵

Additionally, women who give birth during their teen years are less likely to finish high school, earn a GED, and are more likely to live in poverty.^{116,117}

Infants of teen mothers have an increased chance of being born prematurely and having a low weight at birth and therefore an increased risk for infant mortality.¹¹⁸ Children of teen mothers have 2-4 times higher mortality rates, higher rates of hospitalizations, and are less likely to finish high school than children born of non-teenaged mothers.¹¹⁹ As adults, those born to teen mothers are more likely to grow up in poverty, give birth as a teenager, have higher unemployment rates and lower rates of income and as a result, experience more health issues through all stages of life.^{120,121}

Table 130: Teen Birth Rate* among Women 15-19 years, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	30.6	28.4	29.0	27.4	21.9
Nevada	31.9	28.7	27.4	26.1	22.6
United States	29.4	26.5	24.2	22.3	~

*Birth rate per 1,000 women; ~ data not available

- The rate of births among teens aged 15-19 years in Washoe County decreased from 2012 (30.6 per 1,000) to 2016 (21.9 per 1,000); however remained higher than the United States from 2012-2015.
- In 2016, the rate of births among teens 15-19 years in Washoe County was slightly lower (21.9 per 1,000) than Nevada (22.6 per 1,000).

¹¹⁵ Nevada Division of Health and Human Service, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

¹¹⁶ Perper K., Peterson K., & Manlove J. (2010). *Diploma Attainment Among Teen Mothers*. Child Trends, Fact Sheet Publication #2010-01: Washington, DC.

¹¹⁷ Hotz V.J., McElroy S.W., & Sanders S.G. *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. Washington, DC: The Urban Institute Press; 1997

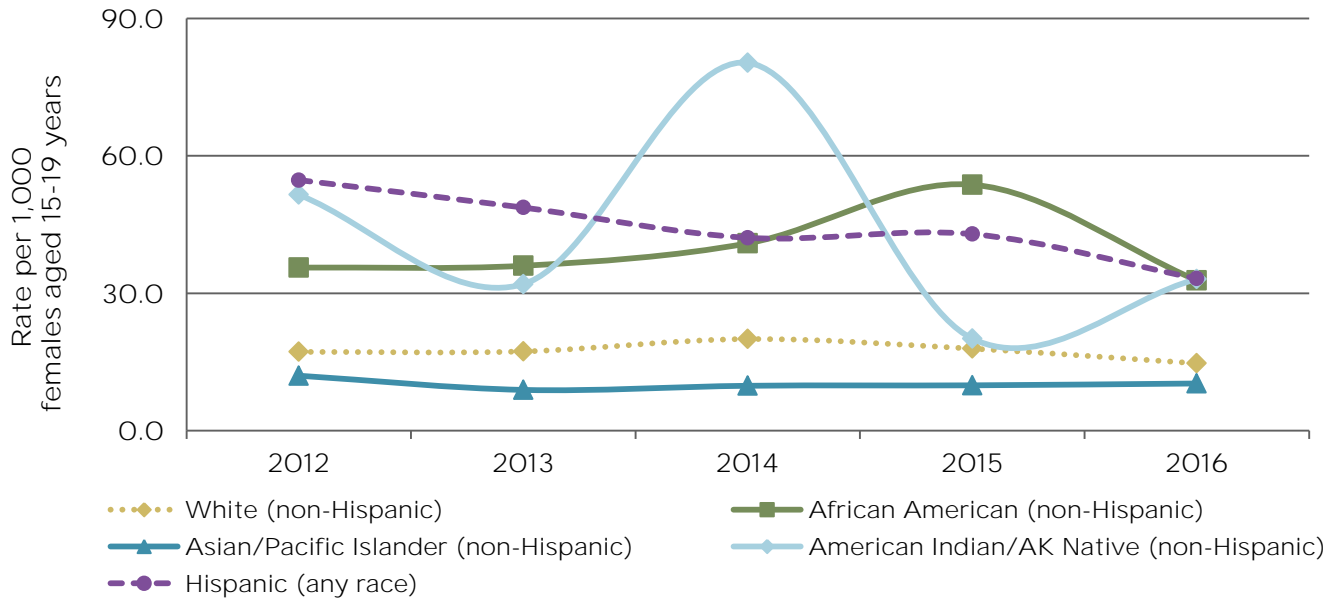
¹¹⁸ Martin J.A., Hamilton B.E., Osterman M.J.K., Curtin S.C., & Mathews T.J.. (2013). Births: Final Data for 2012. Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistic System. *National Vital Statistics Reports*; 62 (3).

¹¹⁹ Jutte, D.P., Roos, N.P., Bownell, M.D., Briggs, G. MacWilliam, L, & Roos, L.L.. (2010). The Ripples of Adolescent Motherhood: Social, Educational and Medical Outcomes for Children of Teen and Prior Teen Mothers. *Academic Pediatrics*. 10(5); 293-301.

¹²⁰ Abma, J.C., Martinez, G.M., & Copen, C.E.. Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, National Survey of Family Growth 2006-2008. National Center for Health Statistics. *Vital Health Statistics* 23(30). 2010.

¹²¹ Jutte, D.P., Roos, N.P., Bownell, M.D., Briggs, G. MacWilliam, L, & Roos, L.L. (2010). The Ripples of Adolescent Motherhood: Social, Educational and Medical Outcomes for Children of Teen and Prior Teen Mothers. *Academic Pediatrics*. 10(5); 293-301.

Fig 134: Teen Birth Rate among Women 15-19 Years by Race & Ethnicity, Washoe County, 2012-2016



- Teen birth rates among females aged 15-19 years in Washoe County were higher among Hispanic and African American populations from 2012 through 2016.
- Teen birth rates among females aged 15-19 years in Washoe County were lowest among Asian/Pacific Islander and white, non-Hispanic populations from 2012 through 2016.

Summary of Sexual Health

Although historically low, the rates of reported cases of *Chlamydia* and gonorrhea in Washoe County have increased and in recent years have been nearing the state and national rates. The rates of reported primary and secondary syphilis have also increased dramatically since 2010.

In 2015, the percentage of high school students in Washoe County who reported they were ever or currently sexually active was relatively similar to the state and nation. Condom use among adolescents in Washoe County was slightly lower in Washoe County than Nevada and the United States. However, the percent of high school students reporting not using any form of birth control during their last sexual intercourse was slightly lower in Washoe County compared to Nevada and the United States. The rate of birth among teenage females in Washoe County decreased from 2012 to 2016, mirroring national trends.

The increased rates of sexually transmitted infections coupled with the low rates of teenage pregnancy may indicate a reduction in the perceived importance of condom use. With the increase in alternative forms of birth control, condom use as a form of birth control may be decreasing, which allows for spread of sexually transmitted infections. Having fewer sexual partners, wearing condoms, and obtaining regular screening and treatment reduces the risk for sexually transmitted infections. In addition to physical health, sexual health also

includes mental and social well-being in relation to sex and sexuality. The data describing sexual assault and physical dating violence are presented in the Crime & Violent-Related Behaviors Section.

Sexual Health Sources

Fig 130-Fig 132 Same Source

Fig 130: Rate of Reported Cases of Chlamydia, Washoe County, Nevada, & the United States, 2007-2016

Fig 131: Rate of Reported Cases of Gonorrhea, Washoe County, Nevada, & the United States, 2007-2016

Fig 132: Rate of Reported Cases of Primary & Secondary Syphilis, Washoe County, Nevada, & the United States, 2007-2016

Washoe County 2007-2015: Washoe County Health District. (2016). 2015 Annual Communicable Disease Summary. Reno, NV.

Washoe County 2016: Washoe County Health District, Epidemiology Program. Data provided upon request. Reno, NV.

Nevada 2007-2015: Nevada Division of Public and Behavioral Health, Office of Public Health Informatics and Epidemiology. (2007-2015). STD Fast Facts. Carson City, NV.

United States 2007-2015: Centers for Disease Control and Prevention. 2015 Sexually Transmitted Diseases Surveillance-Table 1. Sexually Transmitted Diseases-Reported Cases and Rates of Reported Cases per 100,000 Populations, United States, 1941-2015. Accessed <https://www.cdc.gov/std/stats15/tables/1.htm>

Nevada and United States 2016: Centers for Disease Control and Prevention. 2016 Sexually Transmitted Diseases Surveillance. Accessed <https://www.cdc.gov/std/stats16/toc.htm>

Fig 133: Rate of Reported Newly Diagnosed HIV Infection, Washoe County, Nevada, & the United States, 2007-2016

Washoe County 2007-2015: Washoe County Health District. (2016). 2015 Annual Communicable Disease Summary. Reno, NV.

Washoe County 2016: Washoe County Health District, Epidemiology Program. Data provided upon request. Reno, NV.

Nevada: Nevada Division of Public and Behavioral Health, Office of Public Health Informatics and Epidemiology. (All years 2007-2015). HIV/AIDS Fast Facts. Carson City, NV.

United States 2007-2009: Centers for Disease Control and Prevention. (2011). HIV Surveillance Reports, 2009; Vol. 21. Retrieved <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>.

United States 2010-2015: Centers for Disease Control and Prevention. (2016). HIV Surveillance Reports, 2015; Vol. 27. Retrieved <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>.

Table 126-Table 129 Same Source

Table 126: Percent of High School Students who had ever had Sexual Intercourse, 2013 & 2015

Table 127: Percent of High School Students who are Currently Sexually Active*, 2013 & 2015

Table 128: Percent of High School Students who used a Condom*, 2013 & 2015

Table 129: Percent of High School Students who did not use any Method to Prevent Pregnancy*, 2013 & 2015

Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). 2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada.

Nevada 2013: Office of Public Health Informatics and Epidemiology. Division of Public and Behavioral Health. (2014). 2013 Nevada Youth Risk Behavior Survey. Carson City, Nevada.

Nevada 2015: Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2016). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Reno, Nevada.

United States 2013: Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. MMWR, 63(4) 1-168.

United States 2015: Centers for Disease Control and Prevention. (2016). Youth Risk Behavior Surveillance-United States, 2015. MMWR, 65(6) 1-174.

Table 130: Teen Birth Rate* among Women 15-19 years, 2012-2016

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Martin JA, Hamilton BE, Osterman MJK, et al. (2017). Births: Final data for 2015. National Vital Statistics Report; 66 (1). Hyattsville, MD: National Center for Health Statistics.

Fig 134: Teen Birth Rate among Women 15-19 Years by Race & Ethnicity, Washoe County, 2012-2016

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Maternal & Child Health

The health and wellbeing of mothers and their children reflect not only the current health status of the nation, but the health of future generations. Studies have found health at birth is largely influenced by socioeconomic status and not simply genetic traits. Having poor health at birth is associated with a broad range of adverse health effects across the lifespan including, reduction in the child's ability to learn, lower rates of high school graduation, higher rates of hospitalizations, and higher childhood mortality.¹²² Although teen birth rates are an indicator associated with maternal and child health, teen birth rate data are provided within the Sexual Health Section.

Indicator	Trend	Most Recent Year	HP 2020 Objective
Adverse Childhood Experiences (ACEs)	~	various	NA
KIDS COUNT rankings	Decreasing	Nevada 47 th out of 50 (2017)	NA
Children in single-parent households	Decreasing	31.9% (2016)	NA
Birth rates	STABLE	67.5 per 1,000 females 20-44 years (2016)	NA
Abortion rates	Decreasing	7.1 per 1,000 females 15-44 years (2014)	NA
Prenatal care within first trimester	Decreasing	65.8% (among women 15-44 years; 2016)	77.9% (among all pregnant women)
Preterm births	STABLE	9.3% (among women 15-44 years; 2016)	11.4% (among all pregnant women)
Low birth weight births	STABLE	7.6% (among women 15-44 years; 2016)	7.8% (among all pregnant women)
Women, Infants, Children (WIC) Enrollment	Decreasing	n = 15,957 (2016)	NA
Breastfed at 6 months-WIC client data	Increasing	22.9% (2016)	60.6%
Ever breastfed-WIC client data	Increasing	39.8% (2016)	81.9%
Infant & Child Mortality			
Infant mortality rate (<1 year)	Decreasing	5.7 per 1,000 live births (2015)	6.0 per 1,000 live births
Top 3 causes of death among infants < 1 year	~	various	NA
Child mortality rate (1-4 years)	Increasing	18.5 per 100,000 (2015)	26.5 per 100,000
Top 3 causes of death among children 1-4 years	~	various	NA
Child mortality rate (5-14 years)	Increasing	18.2 per 100,000 (2015)	NA
Top 3 causes of death among children 5-14 years	~	various	NA
~not able to assess for trend; NA= identical HP 2020 objective not available			

Adverse Childhood Experiences (ACE)

The Health Maintenance Organization (HMO) Kaiser Permanente conducted the initial Adverse Childhood Experiences (ACE) Study from 1995 to 1997. The study utilized confidential surveys regarding childhood experiences from 9,500 HMO members as well as survey respondent's current health behaviors and

¹²² Johnson R.C & Schoeni R.F. (2007). The Influence of Early-Life Events on Human Capital, Health Status, and Labor Market Outcomes over the Life Course. Institute for Social Research, Population Studies Center Report 07-616.

health status. The ACE Study found a graded dose-response relationship between the number of ACEs experienced and poor health outcomes. An Adverse Childhood Experience, or ACE, is an event which contributes to stress including psychological, physical, or sexual abuse; violence against mother; or living with household members who abused substances, were mentally ill or suicidal, or ever imprisoned.¹²³ As the number of cumulative ACEs increases, so does the risk for infant death, alcoholism/alcohol abuse, chronic obstructive pulmonary disease, depression, liver disease, poor work performance, financial stress, risk for intimate partner violence, sexually transmitted diseases, smoking, attempted suicide, unintended pregnancies, and poor academic achievement, among others.¹²⁴

Nevada ACEs

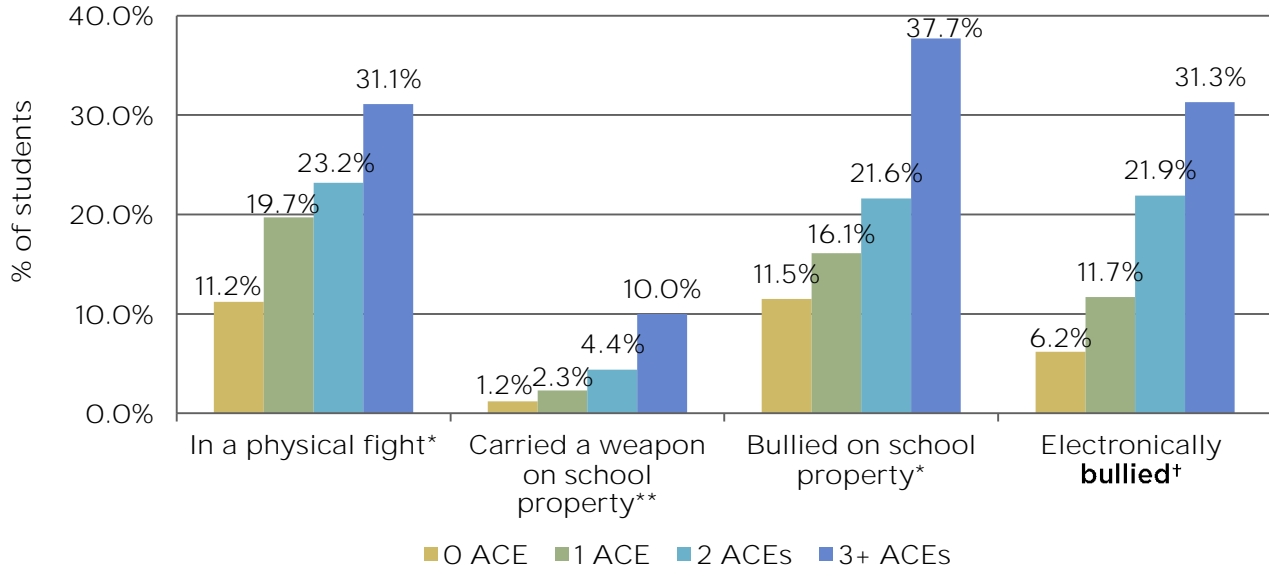
The 2015 Nevada High School YRBS included five state-added ACE questions to assess lifetime prevalence of physical abuse by an adult, forced sex, household domestic violence, household mental illness, and household substance abuse. An analysis of 2015 Nevada High School YRBS respondents found a statistically significant ($p < 0.05$) graded relationship between 73% of risk factors measured by the YRBS as the number of ACEs increased. Statewide, female students, students who qualified for free or reduced lunch, students with parents/other adults in their family serving in the military, students who identified as lesbian, gay, or bisexual, and students who did not receive mostly As or Bs in school had a statistically significant ($p < 0.001$) higher number of ACEs.¹²⁵ The following figures depict the graded relationship between the numbers of cumulative ACEs and select risk factors as measured by the 2015 Nevada High School YRBS.

¹²³ Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*; 14(4):245-258.

¹²⁴ Centers for Disease Control and Prevention. About the CDC-Kaiser ACE Study. Accessed <https://www.cdc.gov/violenceprevention/acestudy/about.html>

¹²⁵ Gay, C., Gao, P., Lensch, T., Zhang, F., Larson, S., Clements-Nolle, K., & Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Adverse Childhood Experiences (ACEs) Analysis.

Fig 135: Prevalence of ACEs & Violence & Victimization among High School Students, Nevada, 2015

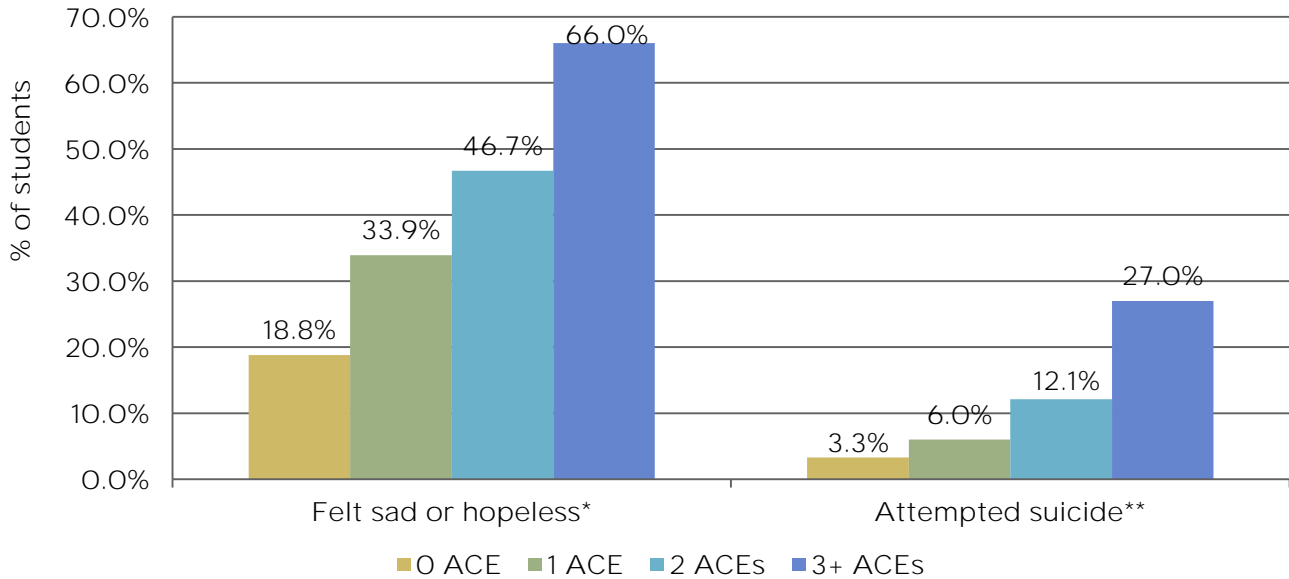


*One or more times during the 12 month before the survey

**Such as a gun, knife, or club on at least 1 day during the 30 days before the survey

†Includes being bullied through email, chat rooms, instant messaging, websites, or texting during the 12 months before the survey

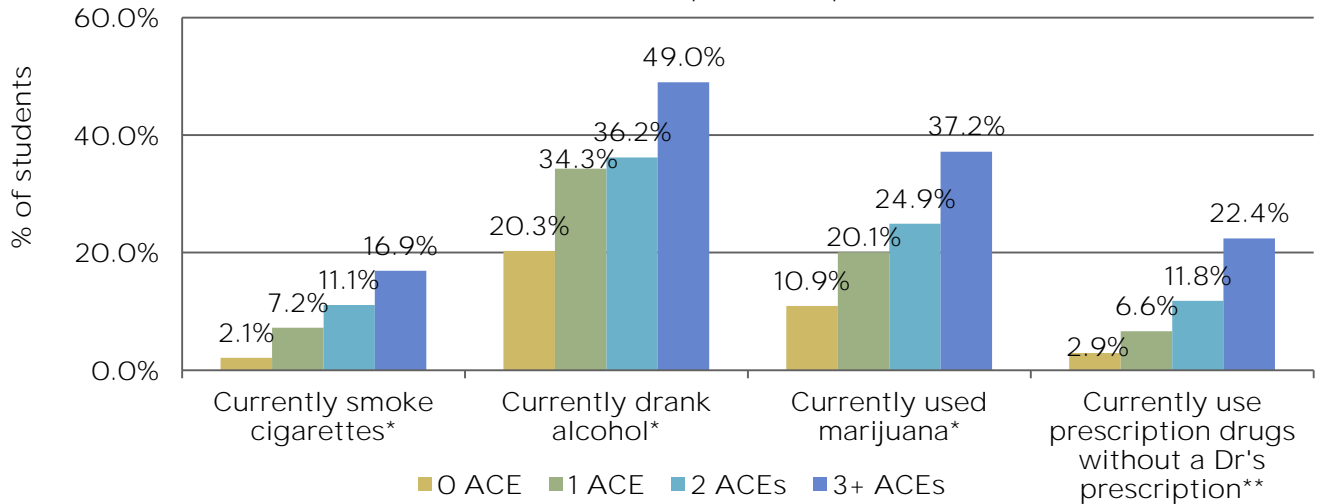
Fig 136: Prevalence of ACEs & Emotional Health among High School Students, Nevada, 2015



*Almost every day for 2 or more weeks in a row so they stopped doing some usual activities during the 12 months before the survey

**One or more times during the 12 months before the survey

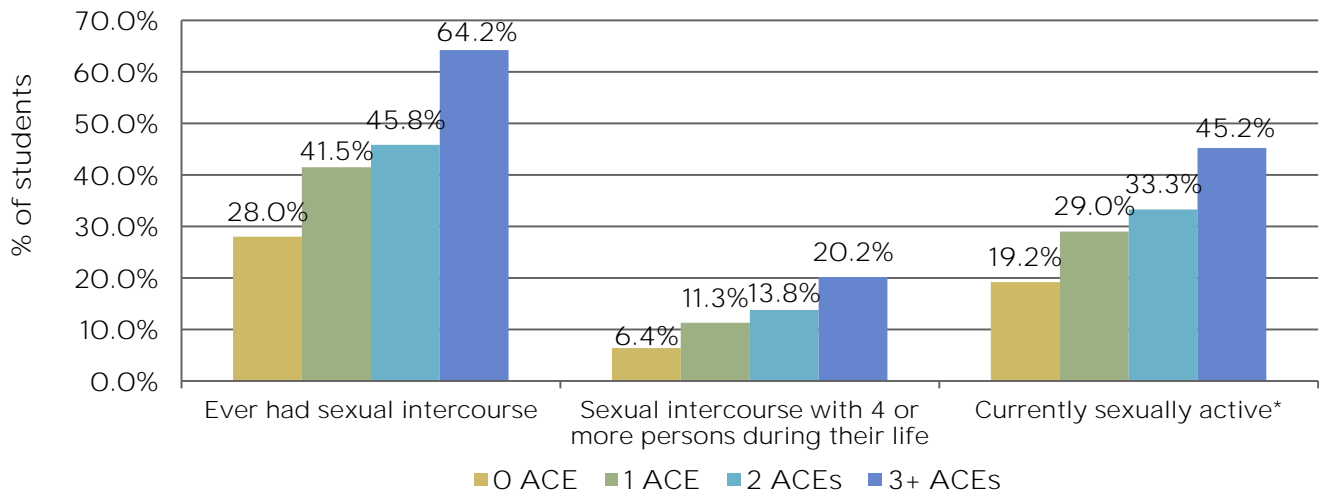
Fig 137: Prevalence of ACEs & Substance Use among High School Students, Nevada, 2015



*on at least 1 days during the 30 days before the survey

**such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during the 30 days before the survey

Fig 138: Prevalence of ACEs & Sexual Health among High School Students, Nevada, 2015



*Sexual intercourse with at least 1 person during the 3 months before the survey

Washoe County ACEs

Although county-level analyses were not yet available regarding the relationship between cumulative number of ACEs among 2015 High School YRBS respondents in Washoe County and associated risk factors, the prevalence of ACEs among Washoe County high school respondents were available and are as follows.¹²⁶

¹²⁶ Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., & Yang, W. University of Nevada, Reno. (n.d.). 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, NV.

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- 9.1% high school students in Washoe County reported they had ever physically forced to have sexual intercourse.
- 17.7% of high school students in Washoe County reported they had ever been hit, beaten, kicked, or physically hurt in anyway by an adult.
- 16.6% of high school students in Washoe County reported they had ever seen adults in their home slap, hit, kick, punch, or beat each other up.
- Nearly one in three (32.8%) high school students in Washoe County reported they ever lived with someone who was depressed, mentally ill, or suicidal.
- One in three (33.8%) high school students in Washoe County reported they had ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs.

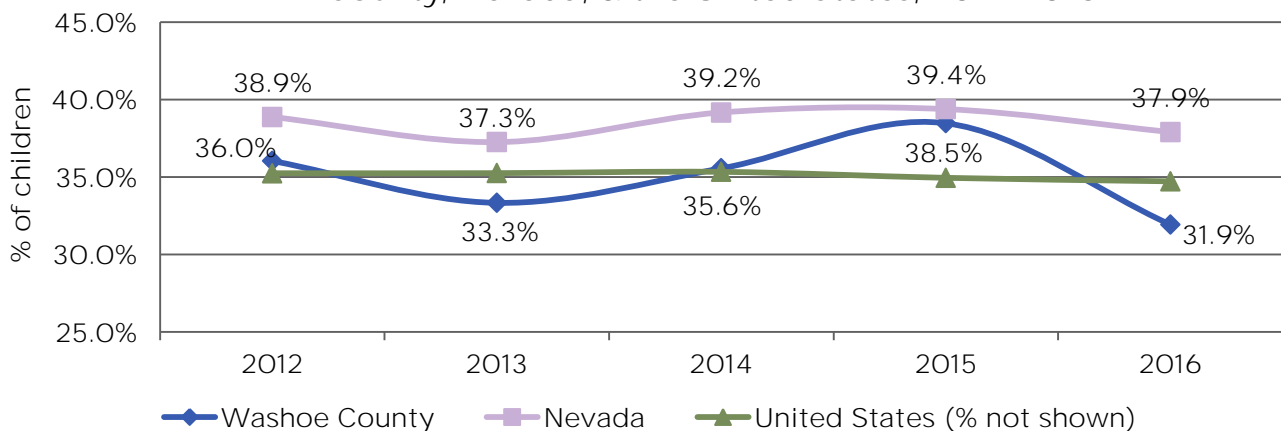
Household and family environment impacts and often predicts health outcomes decades in advance; increasing stability and protective factors among all families, but especially those children who may be high-risk, is instrumental to improving the health and quality of life for future generations.

KIDS COUNT Rankings

The Annie E. Casey Foundation works with all 50 states to increase child advocacy by promoting effective policy and tracking the well-being of children across the nation. Each year since 1990, the Foundation has released the KIDS COUNT data book that highlights state-by-state data and statistics to measure child health. Since 2010, Nevada's rank decreased from 36th to the bottom 40s each year since 2011 and was ranked 47th in 2017. The 2017 KIDS COUNT report measured 16 indicators to determine each state's rank for economic well-being (ranked 40th), education (ranked 49th), health (ranked 45th), family and community (ranked 45th) as it relates to child health.¹²⁷

Single-parent Households

Fig 139: Percent of Children Living with One Parent, Washoe County, Nevada, & the United States, 2012-2016



¹²⁷ The Annie E. Casey Foundation. 2017 KIDS COUNT Data Book, State trends in Child Well-Being.

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- The percent of children living with one parent in Washoe County decreased from 2012 (36.0%) to 2016 (31.9%).
- In 2016, the percentage of children living with one parent in Washoe County (31.9%) was lower than Nevada (37.9%), and the United States (34.7%).

Birth Rates

An estimated 50% of all pregnancies in the United States are unplanned, therefore one in every two children conceived are potentially at risk for various complications later in life due to the parents not being prepared mentally, physical, social, or financially to care for and raise a child.^{128,129}

A key prevention strategy to reducing poor birth outcomes is to assess the health of the parents prior to conception. The American College of Obstetricians and Gynecologists recommends preconception maternal health screenings include physical screenings, risk screenings, vaccinations, and counseling. Physical screenings may include assessing maternal health factors such as obesity, substance use, and genetic carrier traits which could lead to birth defects, genetic disorders, and other health complications. Additional screening includes HIV and other sexually transmitted infections (STIs) to prevent passing those diseases onto the fetus.¹³⁰ Half of pregnant women in the United States are overweight or obese which can lead to complications including, but not limited to, gestational diabetes, hypertension, and postpartum weight retention. Maternal obesity can result in birth complications including shorter gestation or premature birth, stillbirth, congenital abnormalities, and childhood obesity.¹³¹

Table 131: Birth Rate among Women 20-44 years, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	67.9	68.0	68.5	69.3	67.5
Nevada	68.1	67.4	69.0	69.3	69.1

Rate per 1,000 females aged 20-44 years

- The rate of live births among women 20-44 years in Washoe County have remained relatively stable from 2012 (67.9 per 1,000 females 20-44 years) to 2016 (67.5 per 1,000 females 20-44 years).
- The rate of live births among women 20-44 years in Washoe County was slightly lower than the birth rate among women 20-44 years in Nevada in 2012, 2014, and 2016.

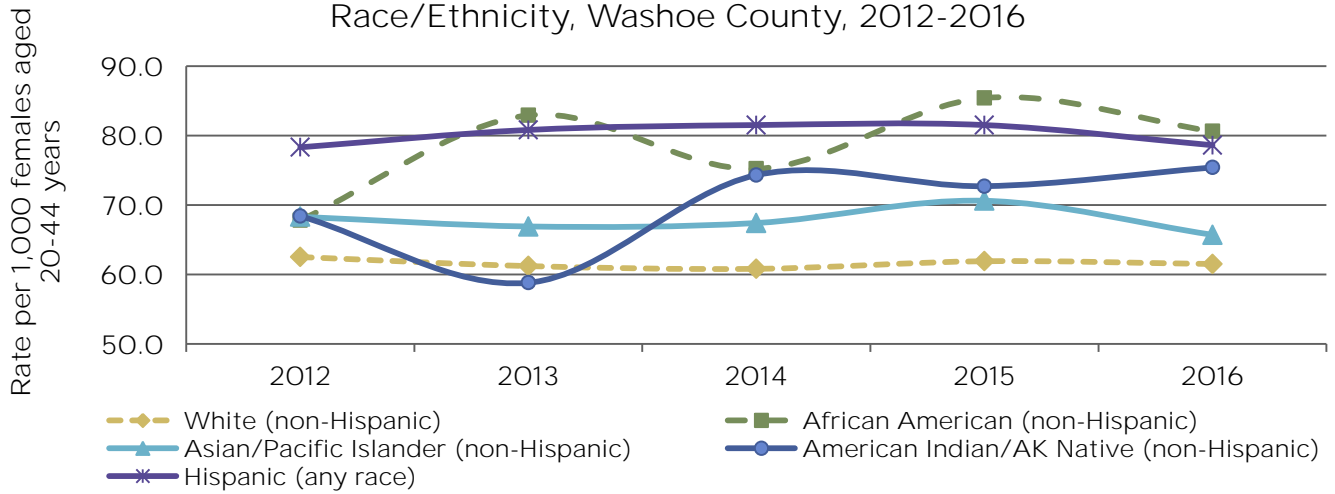
¹²⁸ Finer L.B. & Zolna M.R. (2014). Shifts in Intended and Unintended Pregnancies in the United States, 2001-2008. *American Journal of Public Health*. 104:S43-48.

¹²⁹ Robbins, C.L., Zapta, L.B., & Farr, S.L. et al. (2014). Core State Preconception Health Indicators-Pregnancy Risk Assessment Monitoring System and Behavioral Risk Factor Surveillance System, 2009. *MMWR*; 63(No 3). Centers for Disease Control and Prevention (CDC), Division of Reproductive Health. Atlanta, GA.

¹³⁰ Centers for Disease Control and Prevention. Recommendations to improve preconception health and health care—United States. *MMWR Recommendations and Reports*. 2006;55(RR-06):1–23.

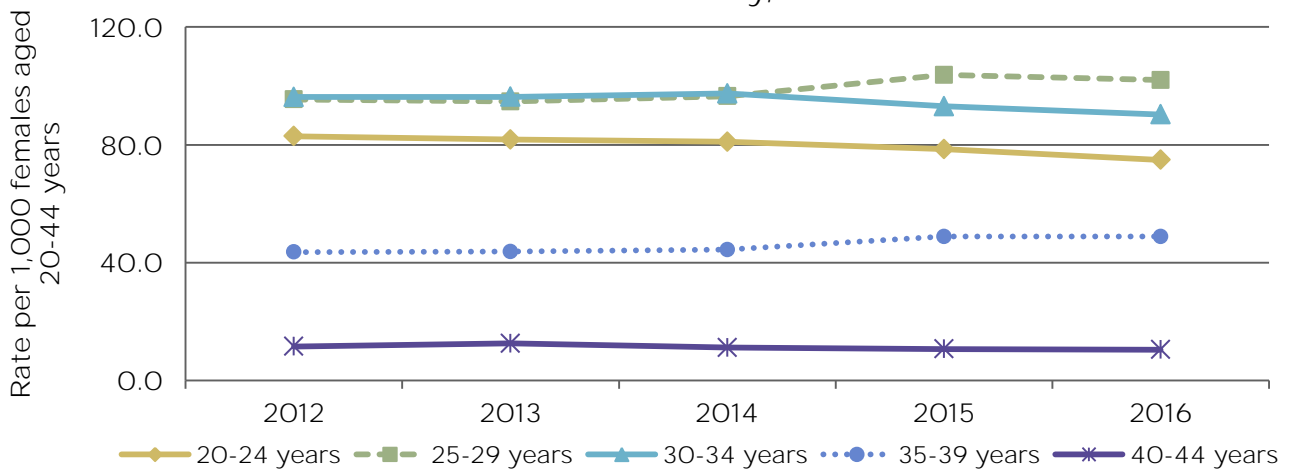
¹³¹ American College of Obstetricians and Gynecologists. (2013). Committee opinion: Obesity in Pregnancy. Opinion No 549. Washington, DC.

Fig 140: Birth Rate among Women 20-44 Years by Race/Ethnicity, Washoe County, 2012-2016



- Birth rates in Washoe County have been among the highest for women of Hispanic origin (any race) from 2012 (78.3 per 1,000) to 2016 (78.6 per 1,000).
- Birth rates among African American women in Washoe County increased from 2012 (67.8 per 1,000) to 2016 (80.6 per 1,000).
- Birth rates among American Indian/Alaska Native women increased from 2012 (68.4 per 1,000) to 2016 (75.4 per 1,000).
- Birth rates among Asian/Pacific Islander women in Washoe County remained stable from 2012 (68.3 per 1,000) to 2015 (70.6 per 1,000), however, decreased in 2016 (65.7 per 1,000).
- Birth rates among women identified as white (non-Hispanic) have remained relatively stable from 2012 (62.5 per 1,000) to 2016 (61.5 per 1,000) and were among the lowest of all races and ethnicities from 2012 to 2016 in Washoe County.

Fig 141: Birth Rate among Women 20-44 Years by Age Group, Washoe County, 2012-2016



- Birth rates in Washoe County have been steadily highest among women aged 25-29 years and have increased from 2012 (95.4 per 1,000) to 2016 (102.0 per 1,000).
- Birth rates among women aged 30-34 years have been second highest, however have decreased from 2012 (96.2 per 1,000) to 2016 (90.3 per 1,000).

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- Birth rates among women aged 20-24 years have been third highest and have decreased from 2012 (82.9 per 1,000) to 2016 (74.9 per 1,000).
- Birth rates among women aged 35-39 years have been fourth highest and have increased from 2012 (43.6 per 1,000) to 2015 (48.9 per 1,000).
- Birth rates among women aged 40-44 years have remained relatively stable from 2012 (11.6 per 1,000) to 2016 (10.5 per 1,000) and were among the lowest of all age groups from 2012 to 2016 in Washoe County.

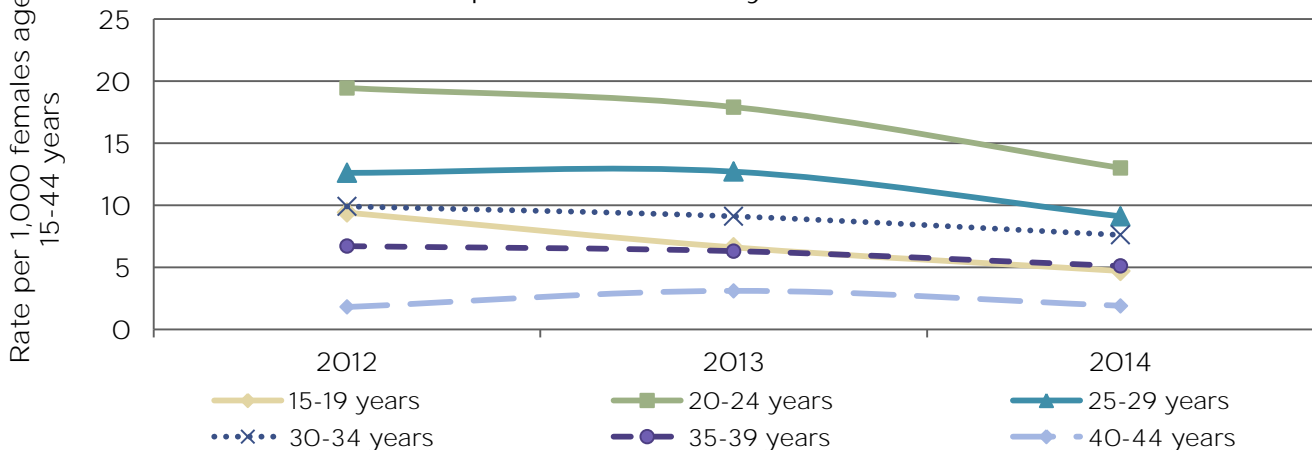
Table 132: Rate of Abortions among Women 15-44 years, 2012-2014

Location	2012	2013	2014
Washoe County	10.2	9.6	7.1
Nevada	12.3	10.4	14.1
United States	13.2	12.5	~

Rate per 1,000 females aged 15-44 years; ~ data not available

- The rate of abortion in Washoe County among women aged 15-44 years decreased from 2012 (10.2 per 1,000) to 2014 (7.1 per 1,000).
- The rate of abortion among women aged 15-44 years (per 1,000 females) in Washoe County was lower than Nevada from 2012 through 2014 and the United States in 2012 and 2013.

Fig 142: Abortion Rate among Women 15-44 Years by Age Group, Washoe County, 2012-2014



- The rate of abortion in Washoe County was highest among women aged 20-24 years, however decreased from 2012 (19.4 per 1,000) to 2014 (13.0 per 1,000).
- The rate of abortion in Washoe County was second highest among women aged 25-29 years and decreased from 2012 (12.6 per 1,000) to 2014 (9.1 per 1,000).
- The rate of abortion in Washoe County was third highest among women aged 30-34 years and decreased from 2012 (9.9 per 1,000) to 2014 (7.6 per 1,000).
- The rate of abortion among women aged 40-44 years remained relatively stable from 2012 (1.8 per 1,000) to 2014 (1.9 per 1,000) and was the lowest among the age groups between 15 and 44 years in Washoe County.

Prenatal Care

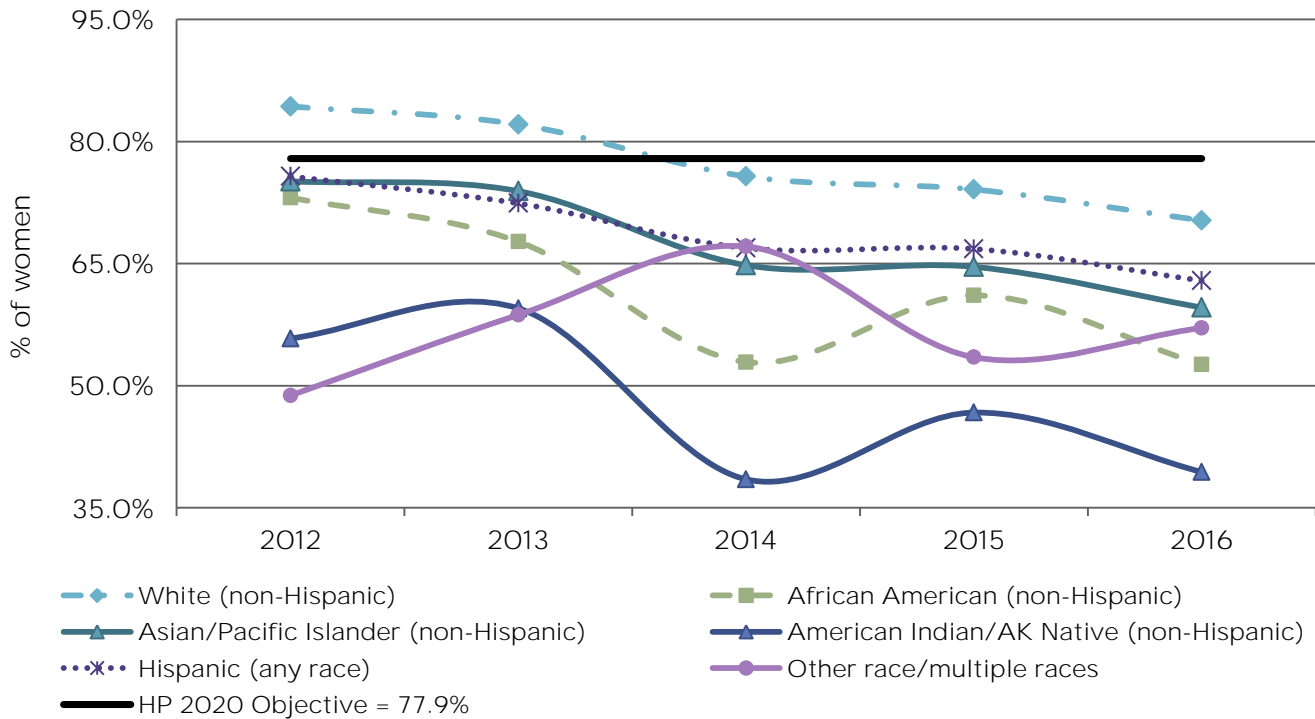
Prenatal care differs from preconception care in that preconception care is conducted prior to conception, while prenatal care occurs once a woman becomes pregnant. There are numerous benefits of receiving early prenatal care, including reduced risk of premature birth, low birth weight, and infant mortality.¹³²

Location	2012	2013	2014	2015	2016
Washoe County	79.7%	77.3%	70.4%	69.8%	65.8%
Nevada	65.4%	66.1%	68.7%	69.6%	68.4%

Among women aged 15-44 years

- The percent of women in Washoe County aged 15-44 years that received prenatal care during their first trimester of pregnancy has decreased from 2012 (79.7%) to 2016 (65.8%).
- For the first time since 2012, the percentage of women in Washoe County that received prenatal care during their first trimester of pregnancy was lower in 2016 (65.8%) than Nevada (68.4%).

Fig 143: Percent of Women that Received Prenatal Care within 1st Trimester among Women 15-44 years, Washoe County, 2012-2016



- The percentage of women in Washoe County that received prenatal care in their first trimester of pregnancy was highest among women identified as white (non-Hispanic), however decreased from 2012 (84.3%) to 2016 (70.3%).
- The percentage of women in Washoe County that received prenatal care in their first trimester of pregnancy was second highest among women identified as Hispanic and decreased from 2012 (75.7%) to 2016 (62.9%).

¹³² Alexander, G.R. & Kotelchuck, M. (2001). Assessing the Role and Effectiveness of Prenatal Care. Public Health Reports. 116; 306-316.

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- The percentage of women in Washoe County that received prenatal care in their first trimester of pregnancy was third highest among women identified as Asian/Pacific Islander and decreased from 2012 (75.1%) to 2016 (59.6%).
- The percentage of women in Washoe County that received prenatal care in their first trimester of pregnancy was lowest among women identified as American Indian/Alaska Native and decreased from 2012 (55.8%) to 2016 (39.4%).

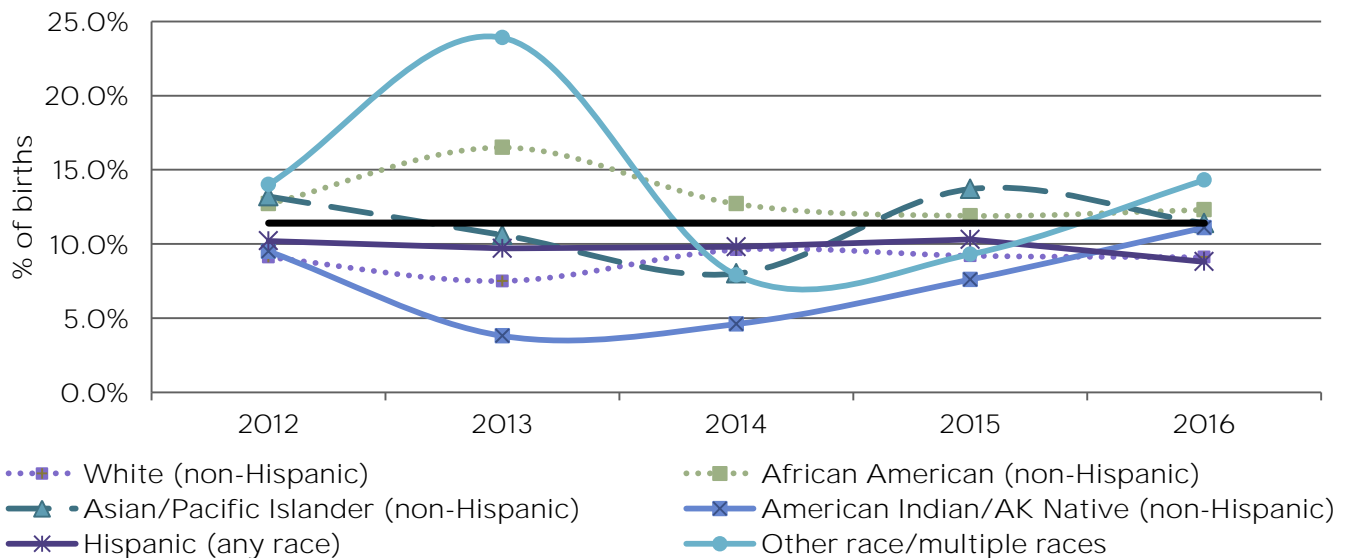
Table 134: Percent of Live Births that were Preterm*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	9.9%	8.8%	9.5%	10.0%	9.3%
Nevada	10.2%	9.7%	10.0%	9.9%	10.3%
United States	9.8%	9.6%	9.6%	9.6%	~

*Preterm less than 37 weeks gestation; ~ data unavailable

- The percentage of live births that were preterm (less than 37 weeks gestation) in Washoe County remained relatively stable from 2012 (9.9%) to 2016 (9.3%).
- In 2016, the percentage of live births that were preterm in Washoe County (9.3%) was lower than Nevada (10.3%).

Fig 144: Percent of Live Births that Were Preterm* among Women 15-44 Years by Race/Ethnicity, Washoe County, 2012-2016



*Preterm is less than 37 weeks gestation

- From 2012 through 2016, the percent of births that were preterm among American Indian/Alaska Native, white (non-Hispanic), and Hispanic (any race) women in Washoe County have met the Healthy People 2020 objective of 11.4%.

Low Birth Weight

Infants born weighing less than 5.5 pounds or 2,500 grams are categorized as low birth weight. Low birth weight infants have an increased risk for several short and long-term consequences including respiratory distress, heart problems, anemia, chronic lung disorders, infections, and infant mortality.¹³³ Being born low birth weight is also linked with developmental delay, lower high school graduation rates, an increased risk of hypertension, diabetes, stroke, heart attack, and heart disease by the age of 50.^{134,135}

Table 135: Percent of Live Births that were Low Birth Weight*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	7.3%	7.4%	7.7%	8.2%	7.6%
Nevada	7.9%	7.9%	8.3%	8.5%	8.4%
United States	8.0%	8.0%	8.0%	8.1%	~

*Low birth weight less than 2,500 grams; ~ data unavailable

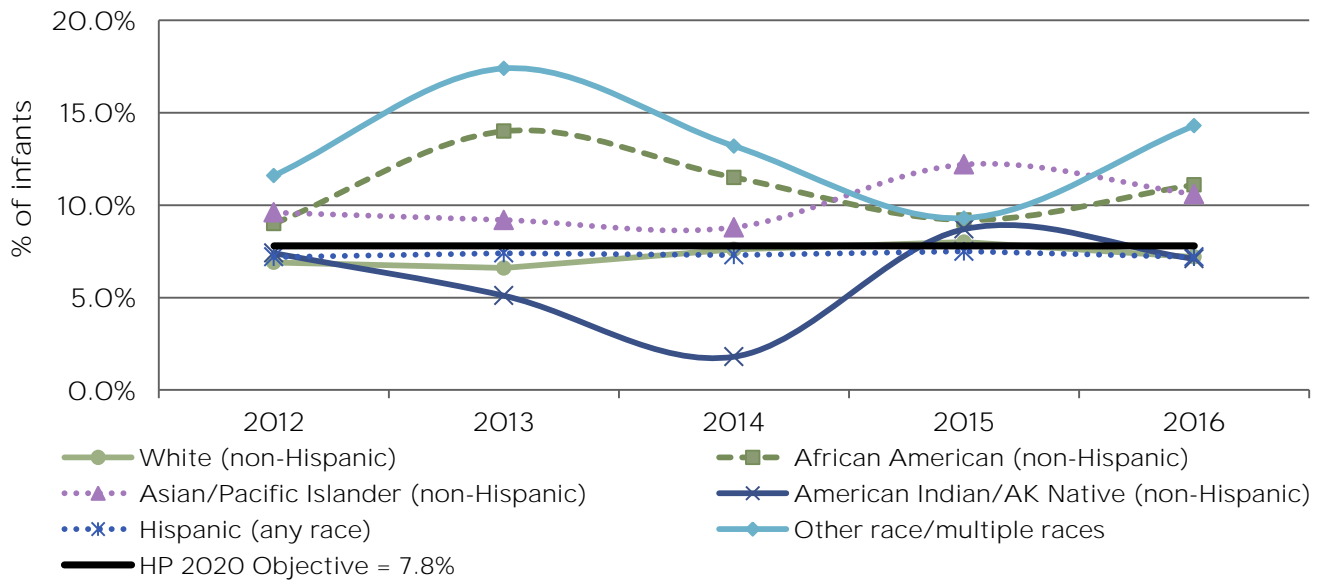
- The percentage of infants born low birth weight in Washoe County has remained relatively stable from 2012 (7.3%) to 2016 (7.6%).
- The percentage of infants born low birth weight in Washoe County has remained lower than Nevada from 2012 through 2016.

¹³³ U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2015). Child Health USA 2014.. Rockville, MD.

¹³⁴ Boardman, J.D., Powers, D.A, Padilla, Y.C., & Hummer, R.A. (2002). Low Birth Weight, Social Factors, and Developmental Outcomes Among Children in the United States. *Demography*. 39(2); 353-368.

¹³⁵ Johnson R.C. & Schoeni, R.F. (2011). Early-Life Origins of Adult Disease: National Longitudinal Population-Based Study of the United States. *American Journal of Public Health*.101.2317-2324.

Fig 145: Percent of Infants Born Low Birth Weight* among Women 15-44 Years by Race/Ethnicity, Washoe County, 2012-2016



*Low birth weight less than 2,500 grams

- The percentage of infants born low birth weight was highest among women identified as an “other/multiple race” from 2012 (11.6%) to 2016 (14.3%).
- The percentage of infants born low birth weight has been lowest among women identified as American Indian/Alaska Native from 2012 (7.4%) to 2016 (7.1%).

Women, Infants & Children (WIC)

Women, Infants and Children (WIC), is a federally funded grant program available in all 50 states, plus Washington D.C., 34 Indian Tribal Organizations, and all five U.S. territories. The WIC program has been shown to increase pregnancy duration, resulting in fewer premature births, decrease infant mortality, increase likelihood of receiving prenatal care, improve diet and related outcomes, and increase breastfeeding duration.¹³⁶

The WIC program’s target population is low-income, nutritionally at-risk pregnant women (through pregnancy up to six weeks after birth), breastfeeding women (up to infant’s first birthday), non-breastfeeding women (up to six months after birth of an infant), infants (up to 1 year) and children up to their fifth birthday. During Fiscal Year 2016, 7.6 million women, infants, and children participated in WIC programs nationwide.¹³⁷

WIC provides supplemental nutritious foods, nutrition education and counseling, and screening and referrals to other health, welfare and social services. To be eligible to participate in WIC, one must be in one of

¹³⁶ Khanani, I., Elam, J., Hearn, R., Jones, C., & Maeru, N. (2010). The Impact of Prenatal WIC Participation on Infant Mortality and Racial Disparities. *American Journal of Public Health*. S1:100(S1); S204-S209.

¹³⁷ United States Department of Agriculture, Food and Nutrition Service. WIC Program Annual State Level Data: FY 2009-2016. Accessed <https://www.fns.usda.gov/pd/wic-program>

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the target population stages, have a gross income below 185% of the Federal Poverty income guidelines, and must meet nutritional risk requirements. Participants receive checks or vouchers to purchase specific foods to supplement their diets and women also may receive educational classes related to nutrition, including breastfeeding promotion and support.¹³⁸

Table 136: Number & Percent of Washoe County WIC Participants by Category, Washoe County, 2007-2016

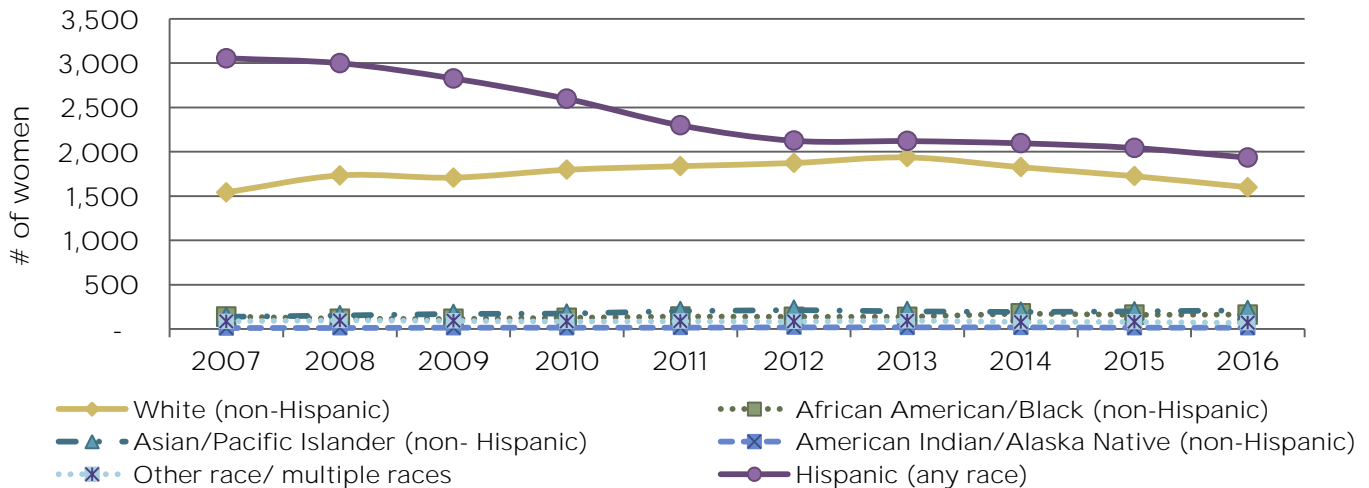
Year	Total Number	% Women	% Infants	% Children
2007	15,566	31.9%	20.6%	47.5%
2008	16,543	30.9%	18.5%	50.6%
2009	16,923	29.1%	16.8%	54.1%
2010	16,885	28.4%	16.7%	54.9%
2011	16,348	28.0%	15.9%	56.1%
2012	15,891	28.0%	15.4%	56.6%
2013	15,699	28.7%	15.6%	55.7%
2014	15,434	28.4%	15.6%	56.0%
2015	14,835	28.4%	15.3%	56.3%
2016	13,941	28.6%	15.8%	55.6%

Does not include Inter-Tribal Council of Nevada (ITCN) WIC participants.

Participants were counted once per year, based on the last date of visit to the clinic regardless if they visited the clinic once or multiple times in a year.

- The total number of clients served by WIC Programs in Washoe County decreased from 2007 (17,573) to 2016 (15,957), after hitting a high in 2009 (18,932).
- The proportion of WIC clients that are women decreased from 2007 (28.3%) to 2016 (25.0%).
- The proportion of WIC clients that are infants decreased from 2007 (18.2%) to 2016 (13.8%).
- The proportion of WIC clients that are children increased from 2007 (42.1%) to 2016 (48.6%).

Fig 146: Number of Women Enrolled in WIC by Race/Ethnicity, Washoe County, 2007-2016



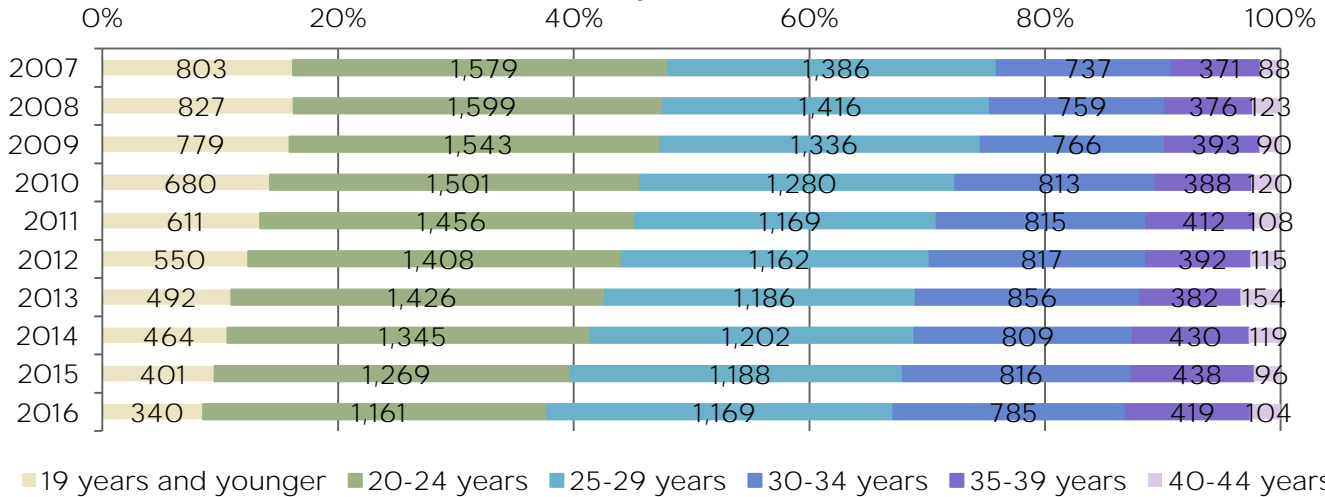
- Women enrolled in Washoe County WIC programs have primarily been Hispanic, although the number decreased from 2007 (3,055) through 2016 (1,933).

¹³⁸ United States Department of Agriculture, Food and Nutrition Service. WIC Program Annual State Level Data: FY 2009-2016. Accessed <https://www.fns.usda.gov/pd/wic-program>

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- The number of women enrolled in WIC in Washoe County identified as white, non-Hispanic increased from 2007 (1,542) to 2013 (1,936) and have since decreased from 2013 to 2016 (1,599).
- The number of African American, Asian/Pacific Islander, American Indian/Alaska Native and women of an “other/multiple races” remained between 350-500 when combined and have been relatively stable from 2007 through 2016.

Fig 147: Number of Women in WIC by Age Group, Washoe County, 2007-2016



- The number of women enrolled in WIC in Washoe County aged 19 years and younger, 20-24 years, and 25-29 years decreased from 2007 to 2016.
- The number of women enrolled in WIC in Washoe County aged 30-34 years, 35-39 years and 40-54 years increased from 2007 to 2016.

Breastfeeding

Research reviews have found the benefits of breastfeeding include reduced neonatal mortality, reduced infection-related infant deaths, decreased diarrhea, and respiratory infections early on in life and can potentially reduce chronic disease onset later in life, including hypertension, diabetes, and cardiovascular diseases.^{139,140}

The World Health Organization, American Academy of Pediatrics, and the Surgeon General all recommend exclusive breastfeeding for infants from birth through the first 6 months of life.

Table 137: Percent of Infants Breastfed among Washoe County WIC Participants, 2012-2016

Breastfed	2012	2013	2014	2015	2016
Breastfed at least 6 Months*	18.6%	19.7%	22.0%	22.7%	22.9%
Ever Breastfed	33.8%	31.1%	32.0%	36.6%	39.8%

* Only includes participants aged 6 to 23 months old

¹³⁹ Kelishadi, R. & Farajian, S. (2014). The Protective Effects of Breastfeeding on Chronic Non-Communicable Diseases in Adulthood: A Review of Evidence. *Advanced Biomedical Research*. 3(13).

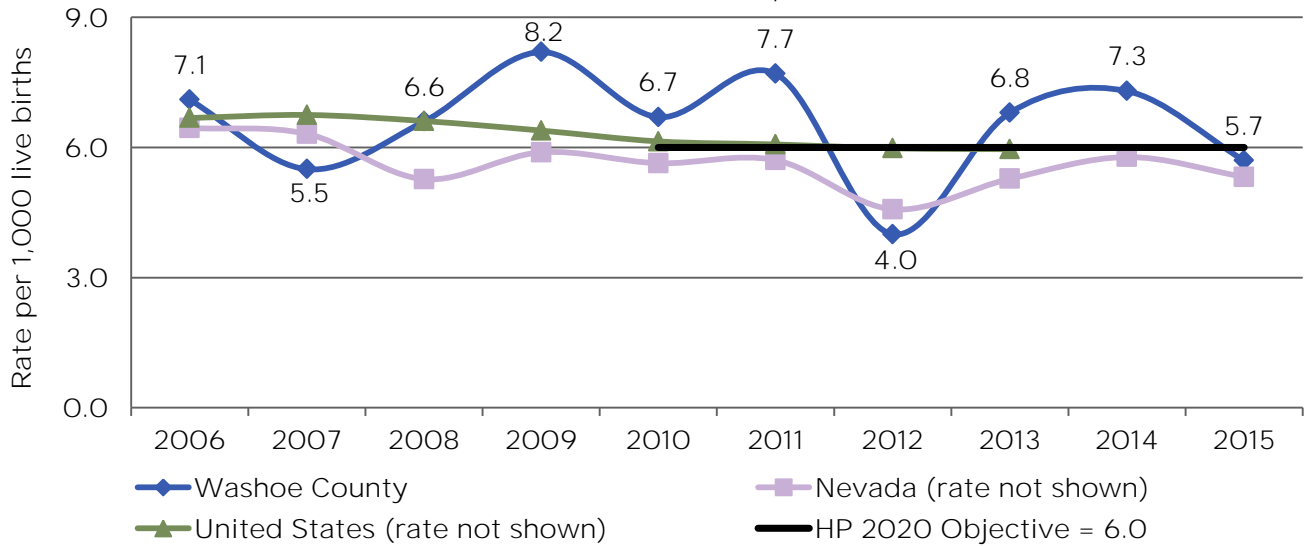
¹⁴⁰ Kahn, J., Vesel, L., Bahl, R. & Martines, J.C. (2015). Timing of Breastfeeding Initiation and Exclusivity of Breastfeeding During the First Month of Life: Effects on Neonatal Mortality and Morbidity: A Systematic Review and Meta-analysis. *Maternal and Child Health Journal*. 19(3), 468-479.

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- The percentage of infants enrolled in WIC that were breastfed at least until 6 months of age increased from 2012 (18.6%) to 2016 (22.9%).
- The percentage of infants enrolled in WIC that were ever breastfed increased from 2012 (33.8%) to 2016 (39.8%).

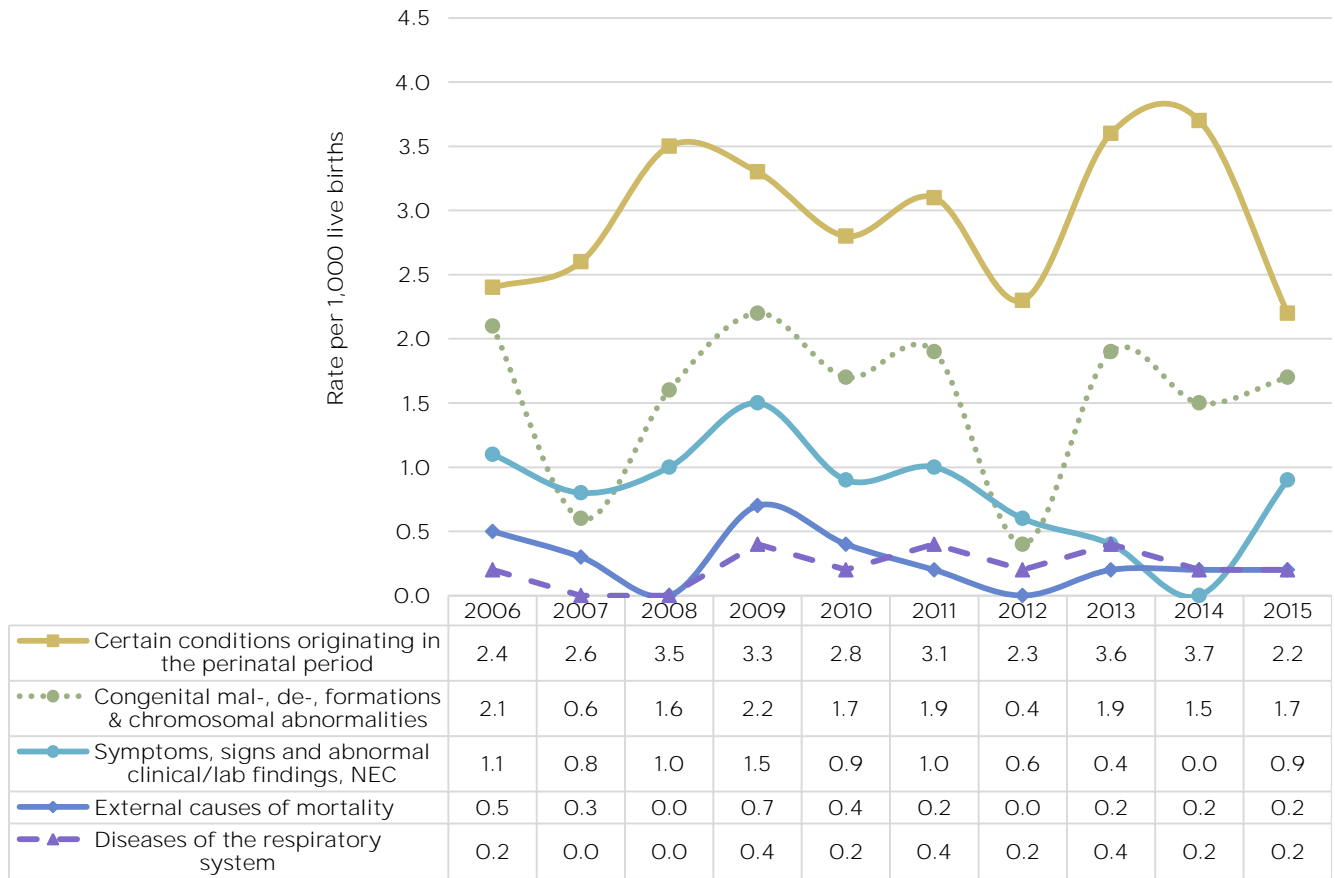
Infant & Child Mortality

Fig 148: Infant (<1 Year) Mortality Rate, Washoe County, Nevada, & the United States, 2006-2015



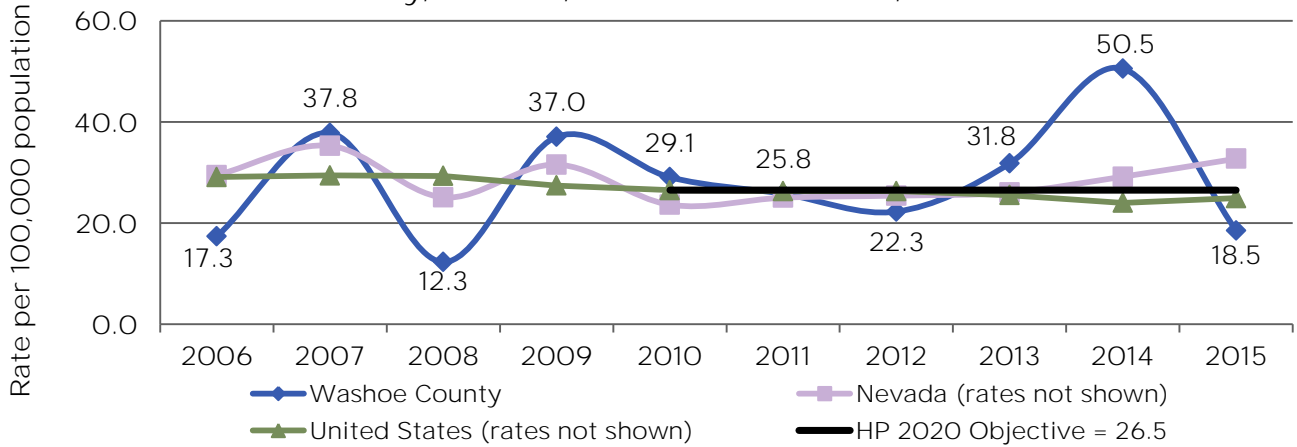
- Although the infant mortality rate fluctuated from 2006-2015, the mortality rate among infants in Washoe County decreased from 2006 (7.1 per 1,000 live births) to 2015 (5.7 per 1,000 live births).
- In 2015, the infant mortality rate in Washoe County (5.7 per 1,000 live births) was higher than Nevada (5.3 per 1,000 live births); however, the rate was lower than Healthy People 2020 objective (6.0 per 1,000 live births).

Fig 149: Top 5 Causes of Death among Infants (<1 Year) by Cause, Washoe County, 2006-2015



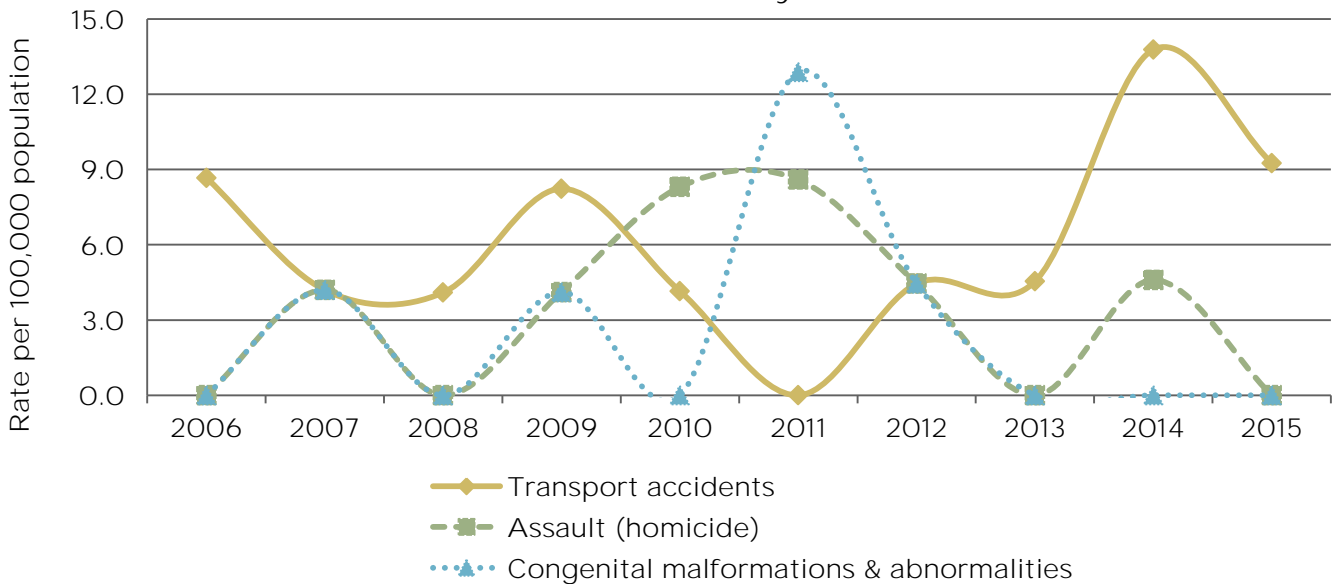
- The number one cause of death among infants aged less than 1 year in Washoe County from 2006 through 2015 has been due to certain condition originating in the perinatal period, followed by congenital malformations, congenital deformations, and chromosomal abnormalities.

Fig 150: Mortality Rate among Children 1-4 Years, Washoe County, Nevada, & the United States, 2006-2015



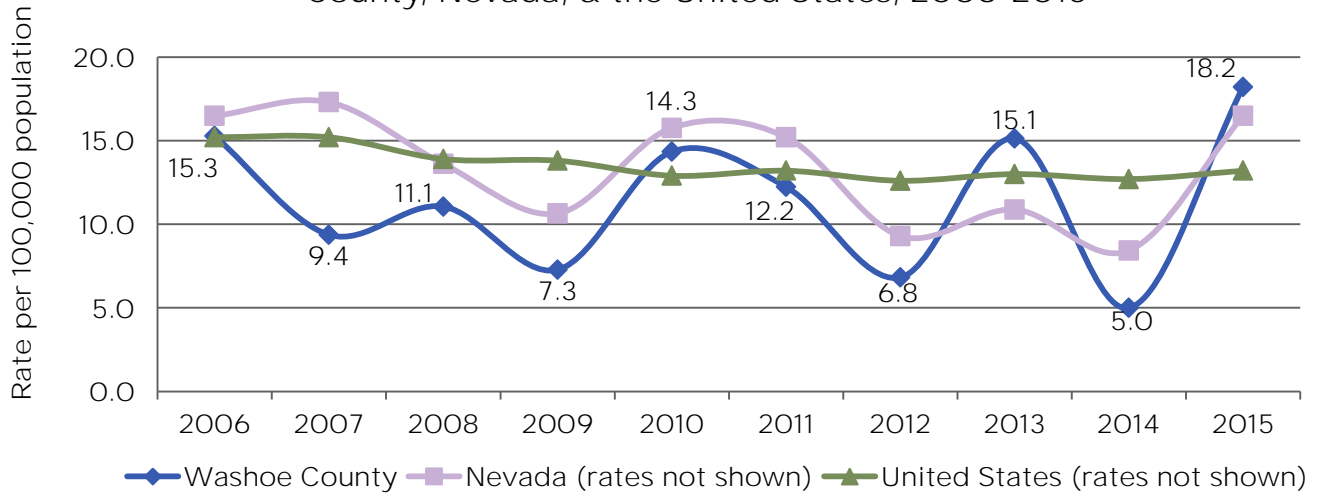
- The rate of death among children aged 1-4 years in Washoe County increased from 2006 (17.3 per 100,000 population) to 2015 (18.5 per 100,000 population).
- There has been a wide fluctuation in the child mortality rate in Washoe county from 2006 to 2015, ranging from a low in 2008 (12.3 per 100,000) to a high in 2014 (50.5 per 100,000 population).
- Although from 2006 through 2015 there have been years when the child (1-4 years) mortality rate in Washoe County has been higher than Nevada, as of 2015 the Washoe County rate (18.5 per 100,000 population) was markedly lower than Nevada (32.7 per 100,000 population) and the United States (24.9 per 100,000).

Fig 151: Top 3 Causes of Death among Children 1-4 years by Cause, Washoe County, 2006-2015



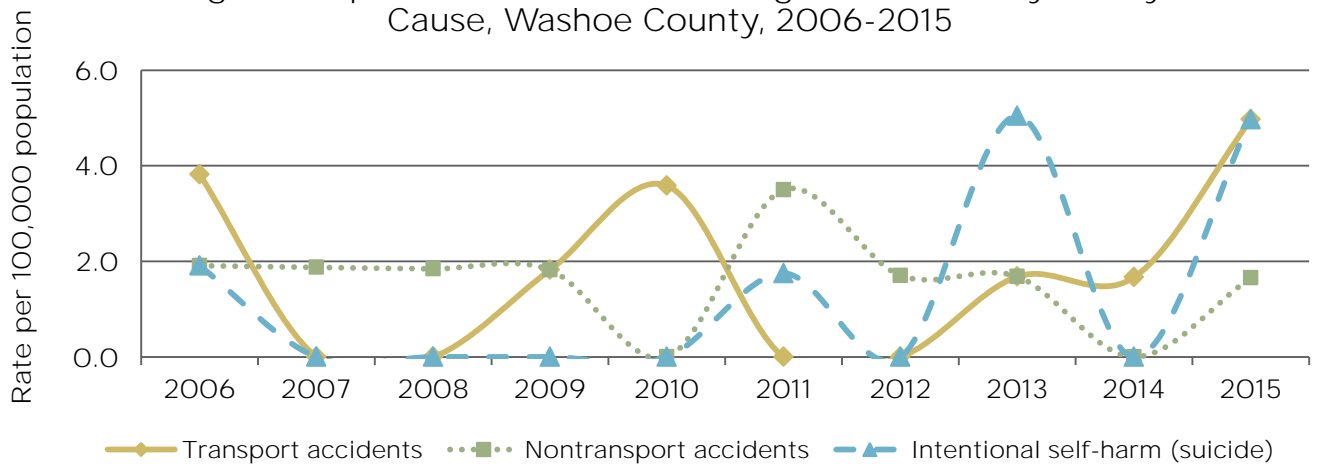
- Overall from 2006 through 2015 (combined) the number one cause of death among children aged 1-4 years, was transport accidents which increased from 2006 (8.7 per 100,000 population) to 2015 (9.3 per 100,000 population).
- Assault (homicide) was the number two cause of death among children (1-4 years) in Washoe County from 2006 through 2015 (combined), followed by congenital malformations and abnormalities.

Fig 152: Mortality Rate among Children 5-14 Years, Washoe County, Nevada, & the United States, 2006-2015



- The mortality rate among children aged 5-14 years in Washoe County increased from 2006 (15.3 per 100,000) to 2015 (18.2 per 100,000).
- In 2015 the child mortality rate among those aged 5-14 years in Washoe County (18.2 per 100,000) was higher than Nevada (16.5 per 100,000), and the United States (13.2 per 100,000).

Fig 153: Top 3 Causes of Death among Children 5-14 years by Cause, Washoe County, 2006-2015



- From 2006 through 2015 (combined) the number one cause of death among children aged 5-14 years, was transport accidents which increased from 2006 (3.8 per 100,000 population) to 2015 (5.0 per 100,000 population).
- Nontransport accidents were the second highest cause of death among children (5-14 years) in Washoe County from 2006 through 2015 (combined), followed by intentional self-harm (suicide), and malignant neoplasms, or cancers (not shown).

Summary of Maternal & Child Health

Adverse childhood experiences (ACEs) analyses have not historically been available at the county-level, therefore the 2015 data will serve as a baseline measure. Reducing the number of ACEs among all children is an important overall goal. According to the Anne E. Casey Foundation 2017 KIDS COUNT data, Nevada was ranked 47th out of 50 states in 2017, with opportunities for improvement across various indicators related to child well-being.

Nationally birth rates among women under 30 have reached an all-time low¹⁴¹; however, the birth rates in Washoe County have remained relatively stable from 2012 through 2016. The percentage of women that receive prenatal care in the first trimester decreased from 2012 to 2016 and was lowest among American Indian/Alaska Native women in Washoe County. In 2016, approximately 9.3% of births were preterm (less than 37 weeks gestation) and 7.6% of births were low birth weight, these rates have remained relatively stable from 2012 through 2016. WIC enrollment in Washoe County has experienced a decline over the past decade (2007-2016). Although below healthy People 2020 target objectives, the proportion of infants reported by WIC programs to have ever been breastfed and breastfed at 6 months has increased from 2012 to 2016. In 2015, mortality rates among infants (<1 year) and children 1-4 years were lower in Washoe County than Nevada, the United States, and Healthy People 2020 objectives; however the mortality rate among children aged 5 to 14 years hit a new high of 18.2 per 100,000 population in 2015. Transport (motor vehicle) accidents were the top cause of death among children ages 1 to 14 years in Washoe County from 2006 through 2015.

Family planning and education are instrumental to help increase the number of women who are better prepared to start a family at a time that is appropriate for them. This increases the chance of enrolling in prenatal care within the first trimester, and establishing a connection with a provider who should closely monitor the growth and health of both the mother and the fetus. These factors all help to reduce the likelihood of preterm births and low birth weight infants, which in turn decreases infant death rates. By fostering a healthy and safe environment for the mother, the baby and the rest of the family, children will have a better chance for success and living a healthy life as they develop.

Maternal Child Health Sources

Fig 135-Fig 138 Same Source

Fig 135: Prevalence of ACEs & Violence & Victimization among High School Students, Nevada, 2015

Fig 136: Prevalence of ACEs & Emotional Health among High School Students, Nevada, 2015

Fig 137: Prevalence of ACEs & Substance Use among High School Students, Nevada, 2015

Fig 138: Prevalence of ACEs & Sexual Health among High School Students, Nevada, 2015

¹⁴¹ Hamilton, B.E., Martin, J.A., Osterman, M.J.K., Driscoll, A.K., & Rossen, L.M. (2017). Vital Statistics Rapid Release, Births: Provisional Data for 2016. National Center for Health Statistics, National Vital Statistics System No. 002. Hyattsville, MD.

Gay, C., Gao, P., Lensch, T., Zhang, F., Larson, S., Clements-Nolle, K., & Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. 2015 Nevada High School Youth Risk Behavior Survey (YRBS): Adverse Childhood Experiences (ACEs) Analysis.

Fig 139: Percent of Children Living with One Parent, Washoe County, Nevada, & the United States, 2012-2016

U.S. Census, American Community Survey -1 year estimates-TABLE C23008 - AGE OF OWN CHILDREN UNDER 18 YEARS IN FAMILIES AND SUBFAMILIES BY LIVING ARRANGEMENTS BY EMPLOYMENT STATUS OF PARENTS

Table 131; Fig 140-Fig 141 Same Source

Table 131: Birth Rate among Women 20-44 years, 2012-2016

Fig 140: Birth Rate among Women 20-44 Years by Race/ Ethnicity, Washoe County, 2012-2016

Fig 141: Birth Rate among Women 20-44 Years by Age Group, Washoe County, 2012-2016

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Table 132: Rate of Abortions among Women 15-44 years, 2012-2014

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Jatlaoui TC, Ewing A, Mandel MG, et al. Abortion Surveillance — United States, 2013. MMWR Surveillance Summary 2016; 65(No. SS-12):1-44.

Fig 142; Table 133; Fig 143 Same Source

Fig 142: Abortion Rate among Women 15-44 Years by Age Group, Washoe County, 2012-2014

Table 133: Percent of Women who Received Prenatal Care within 1st Trimester, 2012-2016

Fig 143: Percent of Women that Received Prenatal Care within 1st Trimester among Women 15-44 years, Washoe County, 2012-2016

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Table 134: Percent of Live Births that were Preterm*, 2012-2016

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Martin JA, Hamilton BE, Osterman MJK, et al. (2017). Births: Final data for 2015. National Vital Statistics Report; 66 (1). Hyattsville, MD: National Center for Health Statistics.

Fig 144: Percent of Live Births that Were Preterm* among Women 15-44 Years by Race/ Ethnicity, Washoe County, 2012-2016

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Table 135: Percent of Live Births that were Low Birth Weight*, 2012-2016

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Martin JA, Hamilton BE, Osterman MJK, et al. (2017). Births: Final data for 2015. National Vital Statistics Report; 66 (1). Hyattsville, MD: National Center for Health Statistics.

Fig 145; Table 136; Fig 146-Fig 147; Table 137 Same Source

Fig 145: Percent of Infants Born Low Birth Weight* among Women 15-44 Years by Race/ Ethnicity, Washoe County, 2012-2016

Table 136: Number & Percent of Washoe County WIC Participants by Category, Washoe County, 2007-2016

Fig 146: Number of Women Enrolled in WIC by Race/Ethnicity, Washoe County, 2007-2016

Fig 147: Number of Women in WIC by Age Group, Washoe County, 2007-2016

Table 137: Percent of Infants Breastfed among Washoe County WIC Participants, 2012-2016

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Fig 148: Infant (<1 Year) Mortality Rate, Washoe County, Nevada, & the United States, 2006-2015

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV

United States: Centers for Disease Control and Prevention. Health, United States, 2015-Child and Adolescent Health. Accessed <https://www.cdc.gov/nchs/hus/child.htm#deaths>

Fig 149: Top 5 Causes of Death among Infants (<1 Year) by Cause, Washoe County, 2006-2015

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV

Fig 150: Mortality Rate among Children 1-4 Years, Washoe County, Nevada, & the United States, 2006-2015

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV

United States: US data Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html>

Fig 151: Top 3 Causes of Death among Children 1-4 years by Cause, Washoe County, 2006-2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Fig 152: Mortality Rate among Children 5-14 Years, Washoe County, Nevada, & the United States, 2006-2015

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV

United States: US data Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html>

Fig 153: Top 3 Causes of Death among Children 5-14 years by Cause, Washoe County, 2006-2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

1.14 IMMUNIZATIONS & SCREENINGS

Immunizations & Screenings

Receiving recommended immunizations and obtaining timely cancer screenings are two preventive mechanisms that reduce disease prevalence and severity. A century ago, people in the United States were primarily dying due to infectious diseases; this is no longer true, due largely in part to antibiotics and widespread vaccination.¹⁴² Having each birth cohort (group of children born during a certain period of time) receiving the proper vaccinations at the proper time is estimated to save 33,000 lives, as well as prevent 14 million cases of disease. In doing so, vaccines are a cost effective prevention measure, estimated to reduce direct health care costs by \$9.9 billion and indirect costs by \$33.4 billion. This cost saving is attributed to the reduction in loss of life and additional cases of disease.¹⁴³

Cancer has been the second leading cause of death in the United States since 1938.¹⁴⁴ Based on data from 2010-2012, nearly 40% of men and women will be diagnosed with cancer at some point during their lifetimes.¹⁴⁵ Medical technological advancements have improved the ability to screen effectively for many types of cancer. These screenings are important for the early detection of potentially life-threatening health conditions. Health costs are reduced, treatments are more successful, and full recovery for certain cancers is more likely when the cancer is caught in an early stage of disease.¹⁴⁶

Indicator	Trend	Most Recent Year	HP 2020 Objective
Immunizations			
Children 19-35 months that received recommended vaccination series	Increasing	79.8% (2016)	80.0%
Young adults <26 years that received all doses of human papillomavirus (HPV) vaccine	Increasing	11.7% (Females-2016) 0.9% (Males -2016)	NA
Children 3 to 18 years that received influenza immunization	Increasing	22.0% (2015-2016)	70.0%
Adults 18-64 years that received annual flu shot	Increasing	31.1% 2016	70.0%
Seniors 65+ years that received annual flu shot	Increasing	52.0% (2016)	70.0%
Seniors 65+ years that ever received pneumonia vaccination	Decreasing	74.8% (2016)	90.0%
Screenings			
Adults 18+ years that had cholesterol checked within past 5 years	~	77.3% (2015)	82.1%
Adults 18+ years that had test for high blood sugar or diabetes within past 3 years	Increasing	56.9% (2015)	NA

¹⁴² Centers for Disease Control and Prevention. Achievements in public health, 1900–1999: Control of infectious diseases. MMWR. 1999 Jul 30;48(29):621-9.

¹⁴³ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Accessed <http://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases>

¹⁴⁴ Centers for Disease Control and Prevention, National Vital Statistic System. Leading Causes of Death, 1990-1998. Accessed https://www.cdc.gov/nchs/nvss/mortality_historical_data.htm

¹⁴⁵ National Cancer Institute. Cancer Statistics. Accessed <https://www.cancer.gov/about-cancer/understanding/statistics>

¹⁴⁶ World Health Organization. Cancer, Early diagnosis. Accessed <http://www.who.int/cancer/prevention/diagnosis-screening/en/>

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Indicator	Trend	Most Recent Year	HP 2020 Objective
Adults 50+ years that received blood stool test within past 2 years	STABLE	11.5% (2015)	NA
Adults 50+ years that received sigmoidoscopy or colonoscopy within past 3 years	Increasing	70.0% (2016)	NA
Adults 50-75 years that met the USPSTF colorectal screening recommendations	~	69.3% (2016)	70.5% (among adults 50 to 75 years)
Females 21-65 years that received pap screening with past 3 years	Decreasing	76.7% (2016)	93.0%
Females 50+ years that received mammogram within past 2 years	Decreasing	69.4% (2016)	73.7% (among females 50 to 74 years)
Males 40+ years that received a prostate-specific antigen (PSA) test within past 2 years	Decreasing	41.2% (2016)	NA
Cancer stage at diagnosis	~	various	NA
~ not able to assess for trend; NA = identical HP 2020 objective not available			

Immunizations

Recommended Vaccination Series (4:3:1:3:3:1:4)*

Immunity against viruses and bacteria is passed to a newborn infant through antibodies from the mother. During the first year of life, infant immunity declines making the infant susceptible to infections, some which cause permanent damage or result in death. Obtaining the recommended vaccination series at the appropriate ages significantly reduces and in most cases, completely prevents infants from getting these diseases. When the majority of a community is vaccinated, they create what is known as “herd immunity” or “community immunity”. Community immunity helps to protect those who are too young to obtain vaccinations or are unable to receive vaccinations due to medical reasons, by limiting the number of individuals with an active infectious disease.¹⁴⁷

Table 138: Percent of Children 19-35 Months that Received Recommended Vaccination Series*, 2009-2016

Location	2009	2010	2011	2012	2013	2014	2015	2016
Washoe County	61.4%	66.4%	70.4%	72.6%	74.5%	75.9%	78.3%	79.8%
Nevada	52.7%	59.5%	63.5%	64.5%	66.1%	68.8%	72.6%	72.4%

*4 doses of DTaP (diphtheria, tetanus, pertussis); 3 doses of polio; 1 dose of MMR (measles, mumps, rubella); 3 doses of Hib; 3 doses of Hepatitis B; 1 dose of varicella; 4 doses of pneumococcal

Note: 2016 data as of 4/2017; 2015 data as of 2/2017

- Immunization rates for the 4:3:1:3:3:1:4 vaccination series (see note), among children 19-35 months in Washoe County increased from 2009 (61.4%) to 2016 (79.8%).
- From 2009 through 2016, the immunization rates among children aged 19-35 months in Washoe County were higher than Nevada.

¹⁴⁷ Centers for Disease Control and Prevention. Why are Childhood Vaccines so Important?. Accessed <https://www.cdc.gov/vaccines/vac-gen/howvpd.htm>

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Human Papillomavirus Vaccination

Human papillomavirus (HPV) is a group of 150+ viruses that are transmitted through intimate skin-to-skin contact and is most often spread through sexual intercourse. HPV is so common that nearly all men and women become infected over the course of their lifetime. Usually HPV resolves without treatment; however in some cases, can cause warts or cancer.¹⁴⁸

Table 139: Percent of Young Adults aged 26 years that Received 3 HPV Doses by Sex, Washoe County, 2012-2016

Sex	2012	2013	2014	2015	2016
Females	3.1%	3.4%	4.5%	8.6%	11.7%
Males	0.2%	0.1%	0.2%	0.6%	0.9%

- The percentage of females aged 26 years in Washoe County that received all 3 doses of HPV vaccine increased from 2012 (3.1%) to 2016 (11.7%).
- The percentage of females aged 26 years that received all 3 doses of HPV vaccine has been higher than the percentage of males in Washoe County from 2012 through 2016.

Influenza Immunization

Influenza is a highly contagious respiratory infection that causes illness for up to two weeks ranging from mild to severe, and in some cases may result in hospitalization or death. Children under the age of 5, adults 65 years and older, pregnant women, and immunocompromised individuals are considered high-risk for serious influenza complications. Obtaining a seasonal flu shot is recommended for all persons 6 months and older, with focus on persons considered to be high-risk, and persons who work with vulnerable high-risk populations.^{149,150}

Table 140: Percent of Children 3 to 18 years that Received Influenza Immunization, 2010-2011 through 2015-2016

Location	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Washoe County	18%	22%	25%	25%	23%	22%
Nevada	15%	16%	18%	19%	19%	18%

- The percentage of children aged 3 to 18 years in Washoe County that received annual influenza immunization increased slightly from 18% in 2010-2011 to 22% in 2015-2016, however did not increase above a high of 25% (2012-2013 and 2013-2014).
- Overall, the annual influenza immunization rate among children in Washoe County increased, however immunization rates remained below the Healthy People 2020 objective of 70.0%.
- The percentage of children aged 3 to 18 years that received annual influenza immunization was higher in Washoe County compared to Nevada overall from the 2010-2011 flu season through 2015-2016 season.

¹⁴⁸ Centers for Disease Control and Prevention. Human papillomavirus (HPV). Accessed <https://www.cdc.gov/hpv/parents/whatishpv.html>

¹⁴⁹ Centers for Disease Control and Prevention. Key Facts about Seasonal Flu Vaccine. Accessed <https://www.cdc.gov/flu/protect/keyfacts.htm>

¹⁵⁰ Centers for Disease Control and Prevention. People at High Risk of Developing Flu-Related Complications. Accessed https://www.cdc.gov/flu/about/disease/high_risk.htm

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Table 141: Percent of Adults 18 to 64 years that Received Annual Flu Shot*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	22.0%	31.3%	33.5%	39.0%	31.1%
Nevada	23.1%	25.8%	28.3%	26.9%	26.9%

*flu shot within past 12 months

- The percentage of adults aged 18 to 64 years in Washoe County that received an annual flu shot increased from 2012 (22.0%) to a high in 2015 (39.0%); however, decreased in 2016 (31.1%). The Healthy People 2020 objective for annual flu shot among adults 65 + years is 70.0%.
- The percentage of adults aged 18 to 64 years that received an annual flu shot increased faster in Washoe County compared to Nevada overall from 2012 through 2016.

Table 142: Percent of Adults 65+ years that Received Annual Flu Shot*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	52.0%	51.7%	53.8%	56.1%	52.0%
Nevada	50.0%	51.6%	52.9%	54.3%	54.1%
United States	60.1%	61.3%	60.8%	62.8%	52.2%

*flu shot within past 12 months

- The percentage of adults aged 65+ years in Washoe County that received an annual flu shot remained the same from 2012 (52.0%) to 2016 (52.0%).
- Despite a decline in 2016, the annual influenza immunization rate among adults 65+ years in Washoe County increased overall, however was lower than the Healthy People 2020 objective (70.0%).
- From 2012 to 2016, the percentage of adults aged 65+ years in Washoe County that received an annual flu shot was higher than Nevada and lower than the United States.

Pneumococcal Vaccination

Streptococcus pneumoniae is the bacteria which causes pneumococcus, or pneumococcal illnesses.

There are more than 90 serotypes of *Streptococcus pneumoniae*. Pneumococcal illnesses include ear infections, sinus infections, meningitis, blood stream infections (bacteremia) and are the most common cause of infection of the lungs, or pneumonia. Pneumococcal diseases are more common among children under the age of two, with increased risk of serious complications occurring among adults 65 years or older and those who have compromised immune systems. Pneumococcal vaccines (Pneumovax 23 and Prevnar 13) protect against many types of pneumococcal bacteria. Vaccination is recommended for children at ages 12 to 15 months, 2, 4, and 6 years, adults over 65 years of age, those with compromised immune systems, and cigarette smokers.¹⁵¹

Table 143: Percent of Adults 65+ years that ever Received Pneumococcal Vaccination, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	78.7%	75.0%	76.1%	76.9%	74.8%
Nevada	64.1%	66.8%	70.9%	70.1%	65.9%
United States	68.8%	69.5%	70.3%	72.7%	62.1%

¹⁵¹ Centers for Disease Control and Prevention. Pneumococcal Vaccination: What Everyone Should Know. Accessed <https://www.cdc.gov/vaccines/vpd/pneumo/public/index.html>

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- The percentage of adults aged 65+ years in Washoe County that have ever received a vaccination for pneumonia decreased from 2012 (78.7%) to 2016 (74.8%). The Healthy People 2020 objective for pneumococcal vaccination among adults 65+ years is 90%.
- The percentage of adults aged 65+ years in Washoe County that have ever received a vaccination for pneumonia has been higher than Nevada, and the United States each year from 2012 to 2016.

Screenings

Cholesterol Screening

Lipid disorders such as high blood cholesterol and high triglyceride levels increase the risk for coronary heart disease, a leading cause of death in the United States. The National Cholesterol Education Program recommends lipoprotein profile (lipid screening) for adults over age 20 every 5 years, while the United States Preventive Services Task Force (USPSTF) recommends screening and treatment for lipid disorders among adults aged 40 to 75 years.¹⁵²

Table 144: Percent of Adults 18+ years that have had Cholesterol Checked within the past 5 years, 2013 & 2015

Location	2013	2015
Washoe County	74.1%	77.3%
Nevada	74.0%	74.7%
United States	76.4%	77.7%

- The percentage of adults aged 18+ years in Washoe County that have had cholesterol checked within the past 5 years increased from 2013 (74.1%) to 2015 (77.3%).
- In 2015, the percentage of adults aged 18+ years in Washoe County that have had cholesterol checked within the past 5 years (77.3%) was higher than Nevada (74.7%), however was slightly lower than the United States (77.7%).

Diabetes/High Blood Sugar Screening

The USPSTF recommends adults aged 40 to 70 years who are overweight or obese be screened for abnormal blood glucose as part of cardiovascular risk assessment.¹⁵³

Table 145: Percent of Adults that have had a test for Blood Sugar or Diabetes within the past 3 years, 2013-2016

Location	2013	2014	2015	2016
Washoe County	53.0%	53.5%	~	56.9%
Nevada	54.6%	55.4%	~	56.1%
~ data not available				

- The percentage of adults in Washoe County that had a test for blood sugar or diabetes within the past 3 years increased between 2013 (53.0%) and 2016 (56.9%).

¹⁵² Gillespie, C.D., Keenan, N.L., Miner, J.B., & Hog, Y. Screening for Lipid Disorders Among Adults-National Health and Nutrition Examination Survey, United States, 2005-2008. MMWR; 61(02); 26-31.

¹⁵³ United States Preventive Services Task Force. (2017). Final Recommendation Summary Abnormal Blood Glucose and Type 2 Diabetes Mellitus: screening. Accessed <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes?ds=1&s=diabetes>.

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- In 2016, the percentage of adults in Washoe County that had a test for blood sugar or diabetes within the past 3 years (56.9%) was relatively similar to Nevada (56.1%).

Cancer Screenings

The number of new cases of cancer and many deaths due to cancer can be reduced with timely cancer screenings or tests. Tests for cervical and colorectal cancers detect precancerous lesions that can be treated prior to becoming cancerous. Regular and timely screenings for cervical, colorectal, prostate, lung, skin, and breast cancers are designed to catch the disease in an early stage. When caught in early stages some types of cancers may be halted or even fully reversed with treatment. If left undiagnosed and untreated, cancer is able to spread to other areas of the body often resulting in a more complex, expensive, and difficult recovery.¹⁵⁴ Cancer screening guidelines are typically based on age, however screenings may be recommended earlier for certain individuals with a family history or other increased risks for specific types of cancers.

Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer starting at age 50 through age 75. Recommendations include receiving an annual fecal immunochemical test (FIT), which identifies blood in stool [Table 146] and obtaining a direct visualization screening or obtaining a sigmoidoscopy or colonoscopy, every 10 years [Table 147].¹⁵⁵ If an irregular test result occurs, a healthcare provider may recommend alternative intervals for screening or additional follow up procedures.

Location	2012	2013	2014	2015
Washoe County	11.6%	8.3%	13.0%	11.5%
Nevada	19.0%	16.2%	16.9%	13.3%
United States	14.2%	~	12.8%	~
~ data not available				

- The percentage of adults aged 50+ years in Washoe County that have had a blood stool test within the past 2 years remained relatively similar between 2012 (11.6%) to 2015 (11.5%), however the percentage fluctuated to a low of 8.3% in 2013 and a high of 13.0% in 2014.
- In 2015, the percentage of adults aged 50+ years in Washoe County that have had a blood stool test within the past 2 years (11.5%) was lower than Nevada (13.3%).

Location	2012	2013	2014	2015	2016
Washoe County	65.2%	67.4%	69.4%	73.5%	70.0%
Nevada	60.5%	60.5%	62.9%	63.9%	64.6%

- The percentage of adults aged 50+ years in Washoe County that have ever had a sigmoidoscopy or colonoscopy has increased from 2012 (65.2%) to 2016 (70.0%).

¹⁵⁴ Centers for Disease Control and Prevention. How to Prevent Cancer or Find It Early. Accessed <https://www.cdc.gov/cancer/dcpc/prevention/index.htm>

¹⁵⁵ United States Preventive Services Task Force. (2017). Final Recommendations Statement Colorectal Cancer: Screening. Accessed <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2>

1.14 IMMUNIZATIONS & SCREENINGS

- In 2016, the percentage of adults aged 50+ years in Washoe County that have ever had a sigmoidoscopy or colonoscopy (70.0%) was higher than Nevada (64.6%).

Table 148: Percent of Adults aged 50-75 who Fully met the USPSTF Colorectal Screening Recommendations, 2016

Location	2016
Washoe County	69.3%
Nevada	62.2%
United States	67.7%

- In 2016, the percentage of adults 50-75 years who met the USPSTF screening recommendations for colorectal cancer was higher (69.3%) than Nevada (62.2%) and the United States (67.7%) however, was still below the Healthy People 2020 objective of 70.5%.

Screening for Cervical Cancer

The USPSTF recommends women be screened for cervical cancer starting at age 21 through age 65. Recommendations include receiving a cervical cytology (pap test) every 3 years or, for women 30 to 65 years, an alternative of every 5 years using high-risk human papillomavirus testing.¹⁵⁶ If an irregular test result occurs, a healthcare provider may recommend alternative intervals for screening or additional follow up procedures.

Table 149: Percent of Females 21-65 years that have had a Pap test within the past 3 years, 2012, 2014, & 2016

Location	2012	2014	2016
Washoe County	78.2%	74.3%	76.7%
Nevada	74.8%	75.3%	74.8%
United States	~	82.6%	80.2%
~ data not available			

- The percentage of females aged 21+ years in Washoe County that have had a pap test within the past 3 years decreased from 2012 (78.2%) to 2016 (76.7%). The Health People 2020 objective for pap test within the past 3 years among females 21-65 years is 93.0%.
- In 2016, the percentage of females aged 21+ years in Washoe County that had a pap test within the past 3 years (76.7%) was higher than Nevada (74.8%), however lower than the United States (80.2%).

Screening for Breast Cancer

The USPSTF recommends mammography screening for breast cancer every 2 years in women age 50 to 74 years. When a woman has a higher than average risk for breast cancer (parent, sibling or child with breast cancer), they may benefit from starting to screen at age 40.¹⁵⁷ If an irregular test result occurs, a healthcare provider may recommend alternative intervals for screening or additional follow up procedures. The American Cancer Society recommends women aged 40 to 44 should have the choice to obtain screening if they select to do so. Women 45 to 54 years of age should obtain an annual screen and those 55 years and older can switch to

¹⁵⁶ United States Preventive Services Task Force. (2017). Draft Recommendations Statement Cervical Cancer: Screening. Accessed <https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/cervical-cancer-screening2>

¹⁵⁷ United States Preventive Services Task Force. (2017). Final Recommendation Statement Breast Cancer: Screening. Accessed <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1>

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every other year.¹⁵⁸ Other professional organizations provide recommendations which vary from those described above. The differences in mammography recommendations may be contributing to the decline in screening rates. The USPSTF recommendations align with the Behavioral Risk Factor Surveillance Survey (BRFSS) data question [Table 150].

Table 150: Percent of Females 50+ years that have had a Mammogram within the past 2 years, 2012, 2014, & 2016

Location	2012	2014	2016
Washoe County	73.5%	69.5%	69.4%
Nevada	73.1%	70.9%	73.3%
United States	77.0%	75.6%	78.4%

- The percent of females aged 50+ years in Washoe County that have had a mammogram within the past 2 years decreased from 2012 (73.5%) to 2016 (69.4%) and is below the Healthy People 2020 objective of 73.7%.
- In 2016, the percentage of females aged 50+ years in Washoe County that had a mammogram within the past 2 years (69.4%) was lower than Nevada (73.3%) and the United States (78.4%).

Screening for Prostate Cancer

The USPSTF current draft for prostate cancer screening recommends clinicians inform patients ages 55 to 69 years of age the potential benefits and harms of prostate-specific antigen (PSA) screening for prostate cancer. The USPSTF recommendation aligns with the American Urological Association recommendations, noting that the screening interval should be every 2 years or more.¹⁵⁹ This differs from the American Cancer Society recommendations which are, men with an average risk of prostate cancer should obtain PSA screenings every 2 years beginning at age 50, and for men with more than one relative with prostate cancer at an early age, screening should be initiated at 40 years.¹⁶⁰

Table 151: Percent of Men 40+ years that have had a PSA test within the past 2 years, 2012, 2014, & 2016

Location	2012	2014	2016
Washoe County	47.7%	43.5%	41.2%
Nevada	48.7%	41.0%	39.5%
United States	45.2%	42.8%	36.5%

- The percent of males aged 40+ years in Washoe County that have had a PSA test within the past 2 years decreased from 2012 (47.7%) to 2016 (41.2%).
- In 2016, the percentage of males aged 40+ years in Washoe County that had a PSA test within the past 2 years (41.2%) was higher than Nevada (39.5%), and the United States (36.5%).

¹⁵⁸ American Cancer Society. Breast Cancer Screening Guidelines. Accessed

<https://www.cancer.org/content/cancer/en/research/infographics-gallery/breast-cancer-screening-guideline.html>

¹⁵⁹ United States Preventive Services Task Force. (2017). Draft Recommendation Statement: Prostate Cancer: Screening. Accessed

<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementDraft/prostate-cancer-screening>

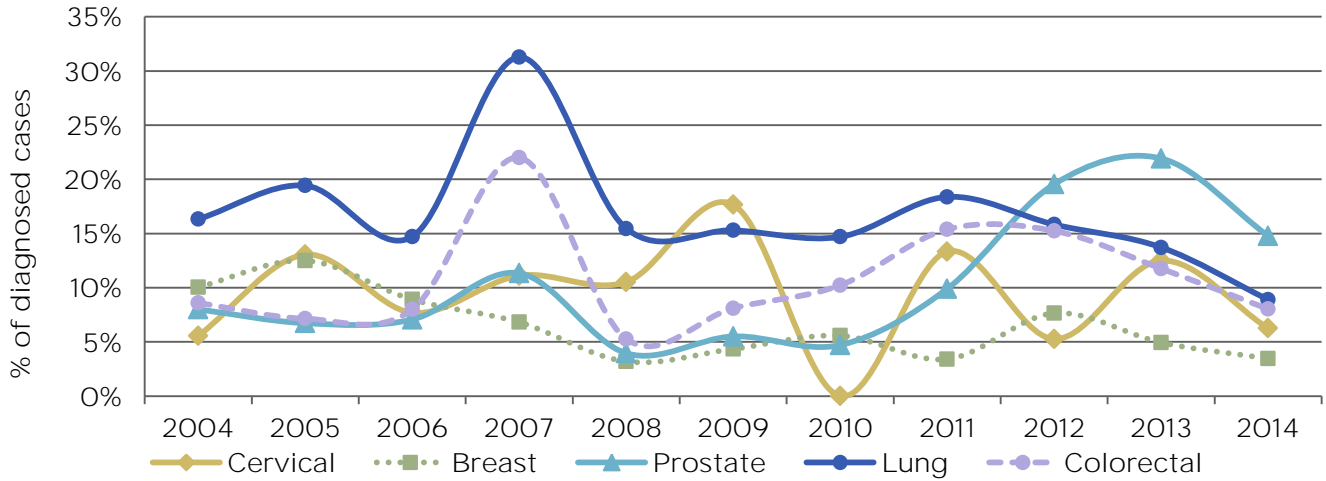
¹⁶⁰ American Cancer Society. American Cancer Society Recommendations for Prostate Cancer Early Detection. Accessed

<https://www.cancer.org/cancer/prostate-cancer/early-detection/acs-recommendations.html>

Cancer Stage at Diagnosis

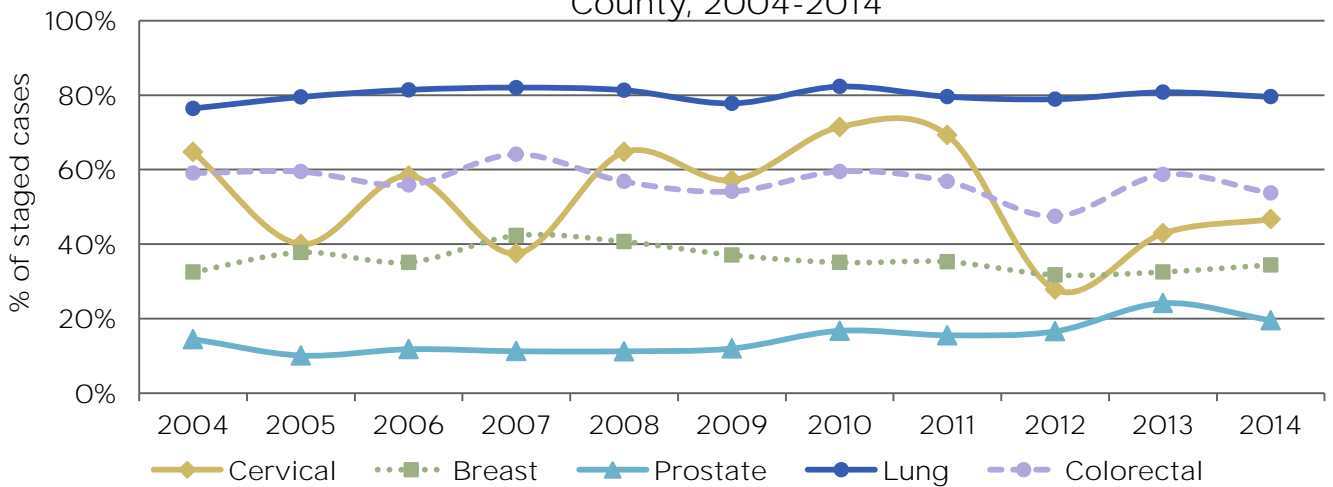
Ideally, screening rates would increase and more cases of cancer would be found in the earlier stages of disease progression. The stage of disease is determined for the majority of cancer cases, but not all cases are staged at time of diagnosis. Figure 149 illustrates cases of cancer that were NOT staged at time of diagnoses, while Figure 150 shows among cases that were staged at time of diagnosis the proportion that were diagnosed in a late stage of disease. Utilize Figure 154 in conjunction with Figure 155.

Fig 154: Percent of Diagnosed Cancer Cases that were Unstaged at time of Diagnosis, Washoe County, 2004-2014



- From 2004 through 2014, the majority of diagnosed cancer cases in Washoe County were staged at time of diagnosis. Lung cancer was most often not staged at time of diagnosis, while breast cancer was most often staged at time of diagnosis over the 10-year period.

Fig 155: Percentage Cancer Cases Staged at Time of Diagnosis Found in the Late Stage of Disease* by Cancer Type, Washoe County, 2004-2014



*Not all cases of diagnosed cancer were staged at time of diagnosis.

Note: Various cancers have different staging mechanisms depending on the type of cancer. Late stage was defined as malignant cancer where the cancer has spread beyond the organ of origin.

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- From 2004 through 2014, over seven in ten cases of lung cancer that were staged at time of diagnosis, were diagnosed as late stage of disease.
- Over half of the cases of colorectal cancer diagnosed and staged, were found in late stage of disease.
- Prostate cancer cases staged at time of diagnoses were most frequently caught in an early stage of disease, as less than 20% of cases were in an advanced stage of disease at time of diagnosis.

Summary of Immunizations & Screenings

The percentage of children receiving the recommended vaccination series in Washoe County has increased from 2010 through 2016, as have the percentage of females (26 years old) that received all three doses of the HPV vaccine. Annual influenza immunization among children has not increased as much as adults 18 to 64 years in Washoe County. The reported percentage of seniors 65 years and older in Washoe County that received their annual influenza immunization has remained stable from 2012 to 2016, while the percentage that have ever received a pneumonia vaccination has decreased over the same time period.

Cholesterol screenings among adults increased from 2013 to 2015, and diabetes (high blood sugar) screenings slightly increased from 2013 to 2016. However, the percentage of adults who obtained blood stool tests, pap tests, mammograms, and PSA tests have remained stable or declined over the past few years.

Washoe County vaccination rates have improved over the course of the past decade, however remain below Healthy People 2020 target objectives. Additionally, while the percentage of adults who report obtaining preventive screenings has improved from 10 years ago, more recent data indicate there may be a plateau in uptake of those recommended preventive services. As the population ages, impacts to relaxed adherence to cancer screenings may result in an influx of late stage cancer diagnoses, resulting in high-cost and extensive treatments. Continued efforts to provide education on the benefits of timely vaccinations and screening, in combination with increased access to primary care providers and low-cost clinics, will be key to maximizing the impact of these preventive measures.

Immunization & Screenings Sources

Table 138-Table 140 Same Source

Table 138: Percent of Children 19-35 Months that Received Recommended Vaccination Series*, 2009-2016

Table 139: Percent of Young Adults aged 26 years that Received 3 HPV Doses by Sex, Washoe County, 2012-2016

Table 140: Percent of Children 3 to 18 years that Received Influenza Immunization, 2010-2011 through 2015-2016

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. WebIZ data as of 3/2017. Provided upon request. Carson City, NV.

Table 141-Table 151 Same Source

Table 141: Percent of Adults 18 to 64 years that Received Annual Flu Shot*, 2012-2016

Table 142: Percent of Adults 65+ years that Received Annual Flu Shot*, 2012-2016

Table 143: Percent of Adults 65+ years that ever Received Pneumococcal Vaccination, 2012-2016

Table 144: Percent of Adults 18+ years that have had Cholesterol Checked within the past 5 years, 2013 & 2015

Table 145: Percent of Adults that have had a test for Blood Sugar or Diabetes within the past 3 years, 2013-2016

Table 146: Percent of Adults 50+ years that have had a Blood Stool test within the past 2 years, 2012-2015

Table 147: Percent of Adults 50+ years that have ever had a Sigmoidoscopy or Colonoscopy, 2012-2016

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Table 148: Percent of Adults aged 50-75 who Fully met the USPSTF Colorectal Screening Recommendations, 2016

Table 149: Percent of Females 21-65 years that have had a Pap test within the past 3 years, 2012, 2014, & 2016

Table 150: Percent of Females 50+ years that have had a Mammogram within the past 2 years, 2012, 2014, & 2016

Table 151: Percent of Men 40+ years that have had a PSA test within the past 2 years, 2012, 2014, & 2016

Washoe County & Nevada: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

United States BRFSS data: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Fig 154-Fig 155 Same Source

Fig 154: Percent of Diagnosed Cancer Cases that were Unstaged at time of Diagnosis, Washoe County, 2004-2014

Fig 155: Percentage Cancer Cases Staged at Time of Diagnosis Found in the Late Stage of Disease* by Cancer Type, Washoe County, 2004-2014

Nevada Division of Public and Behavioral Health, Nevada Cancer Registry. Data provided upon request. Carson City, NV.

Communicable Diseases

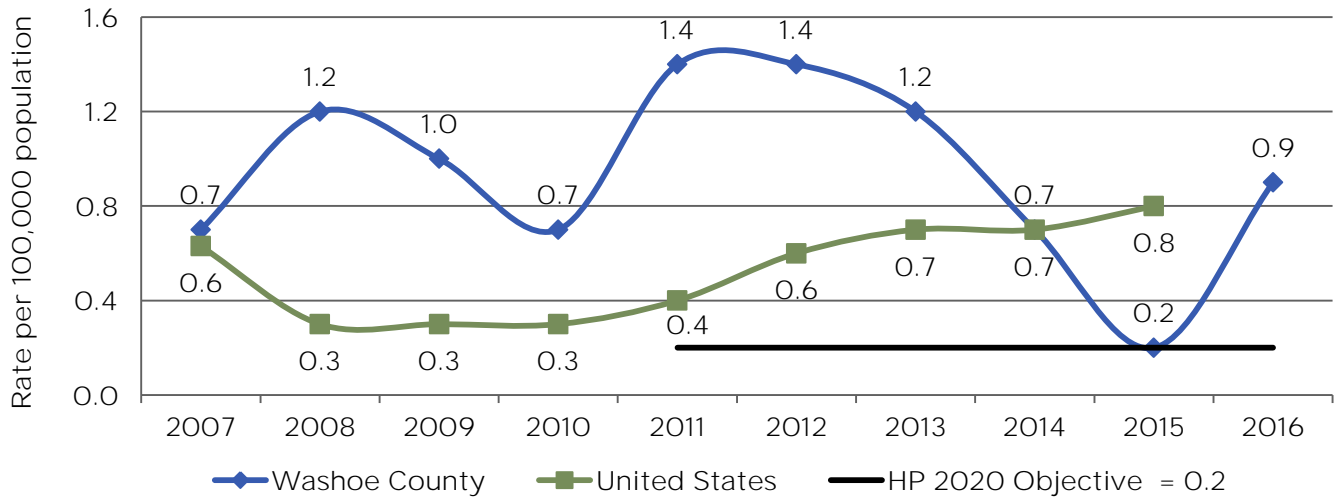
Communicable (infectious) diseases affect people regardless of gender, age, race or ethnicity, or income. These diseases can cause acute illness, develop into chronic conditions and in some cases result in death. Communicable diseases are closely monitored by hospitals, infection prevention teams, laboratories, and governmental health agencies in order to stop or mitigate potential disease outbreaks. The communicable disease indicators presented in this section include blood borne, airborne, select vaccine-preventable diseases, and foodborne illnesses. Data for sexually transmitted infections are presented in the Sexual Health section, while data for water borne infectious diseases are presented in the Environmental Health section.

Indicator	Trend	Most Recent Year	HP 2020 Objective
Acute Hepatitis C	~	0.9 per 100,000 (2016)	0.2 per 100,000
Tuberculosis	Decreasing	1.3 per 100,000 (2016)	1.0 per 100,000
Pertussis	~	0.45 per 100,000 (2016)	NA
Select vaccine-preventable diseases: diphtheria, measles, mumps, polio, rubella, and tetanus	STABLE	various	NA
Invasive pneumococcal disease	Increasing	13.8 per 100,000 (2016)	NA
Rotavirus	Decreasing	3.6 per 100,000 (2016)	NA
Influenza	Increasing	669.9 per 100,000 (2016)	NA
Foodborne illness complaints	Decreasing	35.3 per 100,000 (2016)	NA
Campylobacteriosis	Decreasing	10.5 per 100,000 (2016)	8.5 per 100,000
<i>Escherichia coli</i> STEC O157	Increasing	0.7 per 100,000 (2016)	0.6 per 100,000
Salmonellosis	Decreasing	6.9 per 100,000 (2016)	11.4 per 100,000
~not able to assess for trend; NA = identical HP 2020 objective not available			

Viral Hepatitis C

Hepatitis C virus (HCV) is the most common chronic blood borne infection in the United States. As of 2016 an estimated 2.7 to 3.2 million people were living with a chronic HCV infection. Risk factors for HCV include having had a blood transfusion or a solid organ transplant prior to July 1992, intravenous drug use, children born to mothers who were positive for HCV, and chronic hemodialysis patients. An acute HCV infection may resolve without treatment in about 15% to 25% of patients, however for those who remain undiagnosed and untreated, an acute HCV infection can become chronic.¹⁶¹ There is no vaccine for HCV, however effective treatment regimens became available late 2013.

Fig 156: Rate of Acute Hepatitis C, Washoe County & the United States, 2007-2016



Note: From May 1, 2002 through December 31, 2012 WCHD conducted enhanced HCV surveillance. As of 2013, HCV surveillance in Washoe County was limited to laboratory test registry and WCHD chart review was discontinued.

- In 2016 the acute HCV incidence rate in Washoe County was 0.9 per 100,000 population, which was above the Healthy People 2020 objective 0.2 per 100,000 population.

Tuberculosis

Tuberculosis (TB) is caused by the bacterium, *Mycobacterium tuberculosis*. An estimated one-third of the world’s population is infected with TB, and in 2015 was responsible for 1.8 million deaths (worldwide). TB in the United States is not nearly as common as it once was, as the case rate per 100,000 population has dropped from 18.1 in 1970, to 10.3 in 1990, and 1.3 in 2016.^{162,163}

¹⁶¹ Centers for Disease Control and Prevention. Viral Hepatitis-Hepatitis C Information. Accessed <https://www.cdc.gov/hepatitis/hcv>

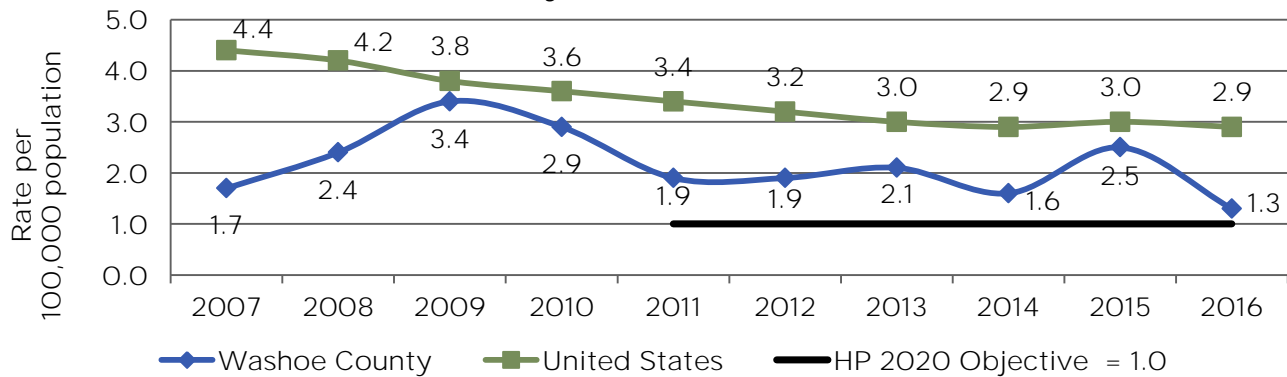
¹⁶² Centers for Disease Control and Prevention. TB Incidence in the United States, 1953-2015. Accessed <https://www.cdc.gov/tb/statistics/tbcases.htm>

¹⁶³ Schmidt, K.M, Wanasaula, Z., Pratt, R., Price, S.F. & Langer, A.J., Tuberculosis-United States, 2016. MMWR Morbidity and Mortality Weekly Report 2017;66:289-294

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Tuberculosis usually affects the lungs, but can impact the kidney, spine, and brain and if not treated properly, can be fatal. TB spreads by an infected person coughing, sneezing, speaking or singing, and non-infected people can inhale the respiratory droplets and become infected. Some people develop active TB within weeks of becoming exposed, some may take years to develop the disease, and others may never develop the active form of TB. Symptoms of TB include a severe cough which lasts more than three weeks, chest pain, coughing up blood or sputum (mucous), weakness, fatigue, weight loss, lack of appetite, chills, fever, and/or night sweats.¹⁶⁴

Fig 157: Rates of Reported Cases of Tuberculosis, Washoe County & the United States, 2007-2016



- The rate of reported cases of tuberculosis in Washoe County decreased from 2007 (1.7 per 100,000) to 2016 (1.3 per 100,000).
- From 2007 through 2016 the rates of reported cases of tuberculosis in Washoe County were lower than the national rates, however have remained above the Healthy People 2020 objective (1.0 per 100,000).

Pertussis

Pertussis, more commonly known as whooping cough, is a very contagious respiratory disease caused by the bacterium *Bordetella pertussis*. Whooping cough infection begins with a mild cough and fever, after a few weeks the cough can become severe and last for weeks or months. The violent coughing can cause apnea (stopped breathing), vomiting, and exhaustion and is characterized by the “whoop” sound of the cough.¹⁶⁵

Pertussis can cause serious respiratory complications in infants and young children, especially those who are unvaccinated or partially vaccinated, including pneumonia, convulsions, slowed or stopped breathing, and possibly death. Fully vaccinated people have been known to be susceptible to infection, however the infection is usually less severe in vaccinated individuals. Being up-to-date on vaccination status is the most effective way to

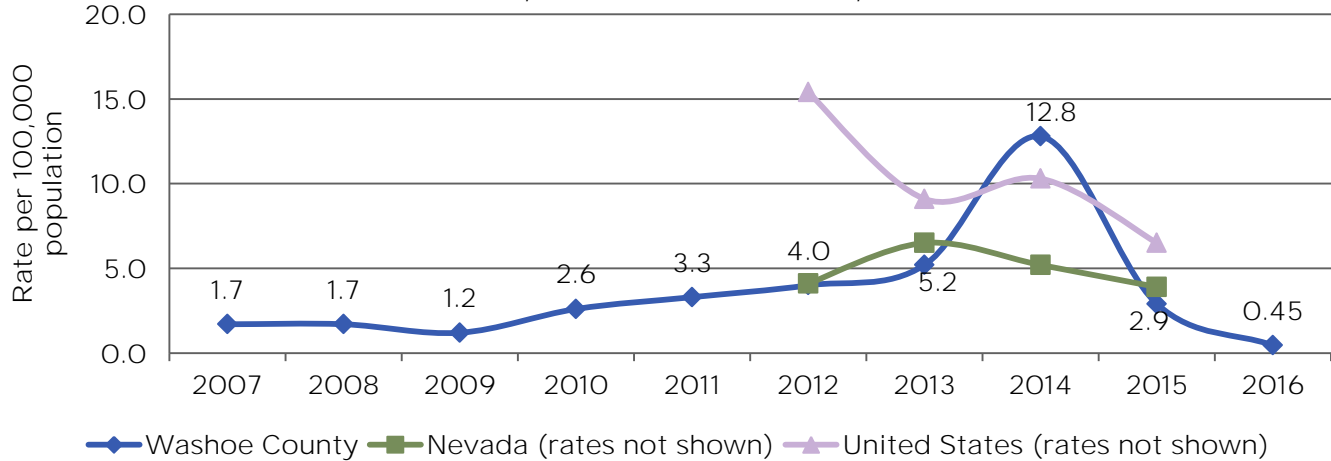
¹⁶⁴ Centers for Disease Control and Prevention. Tuberculosis (TB). Accessed <https://www.cdc.gov/tb/topic/basics/signsandsymptoms.htm>

¹⁶⁵ Centers for Disease Control and Prevention. Pertussis (Whooping Cough)-Signs and Symptoms. Accessed <https://www.cdc.gov/pertussis/about/signs-symptoms.html>

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prevent whooping cough, booster shots are recommended every 10 years for adults, and any woman who is expecting to become pregnant should obtain a booster shot if she is overdue.¹⁶⁶

Fig 158: Rate of Reported Cases of Pertussis, Washoe County, Nevada, & the United States, 2007-2016



- From 2007 to 2016 the rate of reported cases of pertussis in Washoe County have remained relatively stable.
- A spike in reported cases of pertussis occurred in 2014 (12.8 per 100,000) in Washoe County due to outbreaks/clusters, however the rates have since decreased.

Select Vaccine-Preventable Diseases

Table 152 provides the case count for select vaccine-preventable diseases in Washoe County from 2007 through 2016. The vaccinations for diphtheria, measles, mumps, rubella, poliomyelitis (polio), tetanus, and smallpox, are highly effective and are largely responsible for the decline of these illnesses.¹⁶⁷

Table 152: Laboratory-Confirmed Cases of Select Vaccine-Preventable Diseases, Washoe County, 2007-2016

Disease Type	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Diphtheria	0	0	0	0	0	0	0	0	0	0
Measles	0	0	0	0	0	0	0	0	0	0
Mumps	1	0	0	2	1	1	3	4	2	3
Rubella	0	0	0	0	0	0	0	0	0	0
Polio	0	0	0	0	0	0	0	0	0	0
Tetanus	0	0	1	0	0	0	0	0	0	0

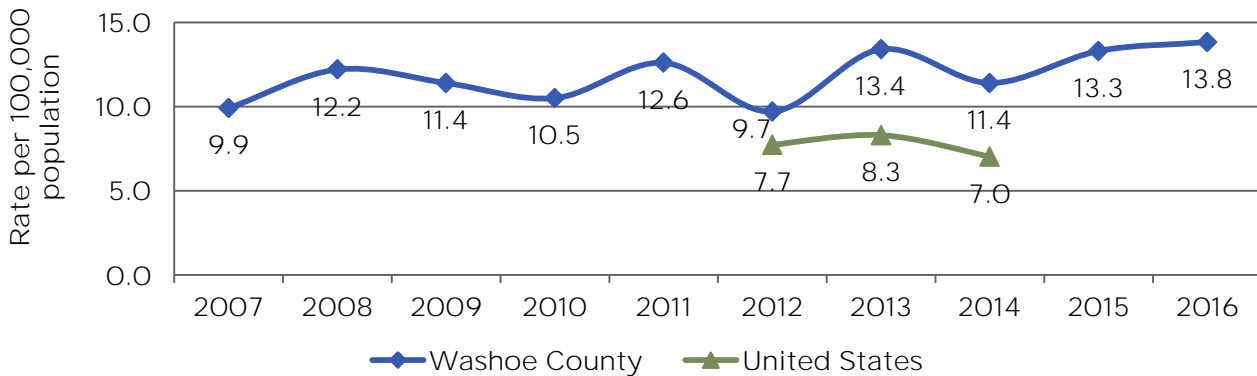
¹⁶⁶ Centers for Disease Control and Prevention. Pertussis (Whooping Cough)-Prevention. Accessed <https://www.cdc.gov/pertussis/about/prevention/index.html>

¹⁶⁷ Centers for Disease Control and Prevention. (1999). Achievements in public health, 1900-1999: Control of infectious diseases. MMWR, 48(29), 621-629.

Invasive Pneumococcal Disease

Streptococcus pneumoniae (pneumococcus) causes ear and sinus infections, bacteremia (blood stream infection), severe pneumonia, and meningitis. Populations at an increased risk for pneumococcal disease include young children, adults over age 65, adults with certain chronic illnesses or compromised immune systems, persons with cochlear implants, and those who smoke cigarettes. Symptoms and complications range and are dependent on the part of the body that is infected.¹⁶⁸

Fig 159: Rate of Reported Cases of Invasive Pneumococcal Disease, Washoe County & the United States, 2007-2016

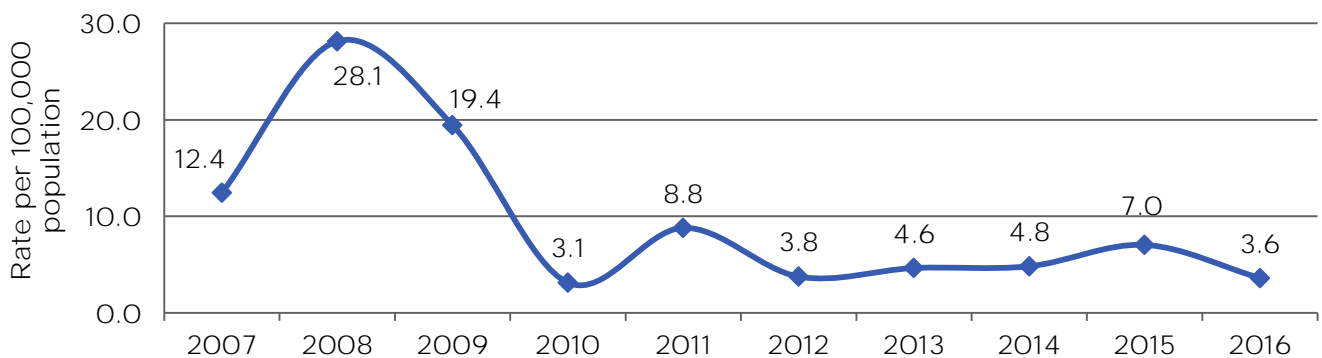


- The rate of reported cases of invasive pneumococcal disease in Washoe County increased from 2007 (9.9 per 100,000) to 2016 (13.8 per 100,000).
- From 2012 through 2014 there were comparable data available for the United States and Washoe County rates of invasive pneumococcal disease were higher than national rates.

Rotavirus

Rotavirus causes severe diarrhea, vomiting, fever, and abdominal pain and is most common among infants and young children. Rotavirus spreads through the oral-fecal route and can be spread by contaminated hands or objects such as toys, food, or water.

Fig 160: Rate of Reported Rotavirus Cases, Washoe County, 2007-2016



¹⁶⁸ Centers for Disease Control and Prevention. Pneumococcal Disease. Accessed <https://www.cdc.gov/pneumococcal/about/index.html>

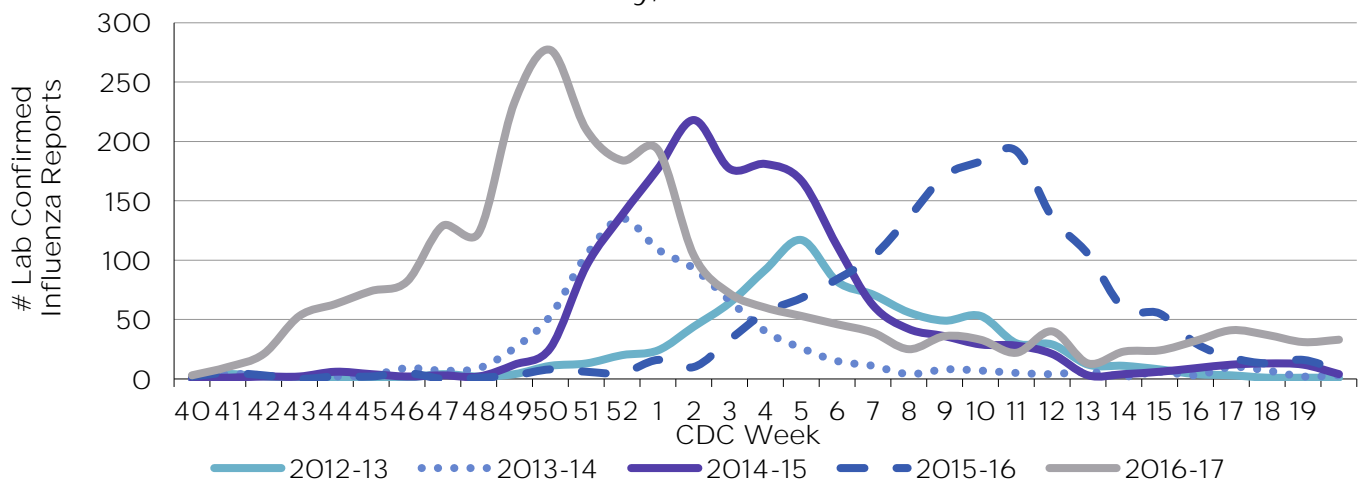
1.15 COMMUNICABLE DISEASES

- The rate of reported rotavirus cases in Washoe County peaked in 2008 at 28.1 per 100,000, however the rate of reported cases was 3.6 per 100,000 population in 2016.
- The significant reduction in incidence was associated with significant increase in vaccination against rotavirus since 2008.

Influenza

Influenza (flu) is a respiratory disease caused by a variety of influenza viruses. The onset of the flu can be rapid and symptoms include fever, cough, sore throat, runny/stuffy nose, body aches, headaches, and fatigue. Vomiting and diarrhea occur more in children than adults. Flu symptoms usually last for a few days to less than two weeks however, serious complications of influenza include hospitalizations or death. Elderly adults, children, and persons with certain health conditions are at high risk for serious complications.¹⁶⁹ Although not shown in Figure 161 the 2016 number of lab confirmed cases in Washoe County was 669.9 per 100,000 population.

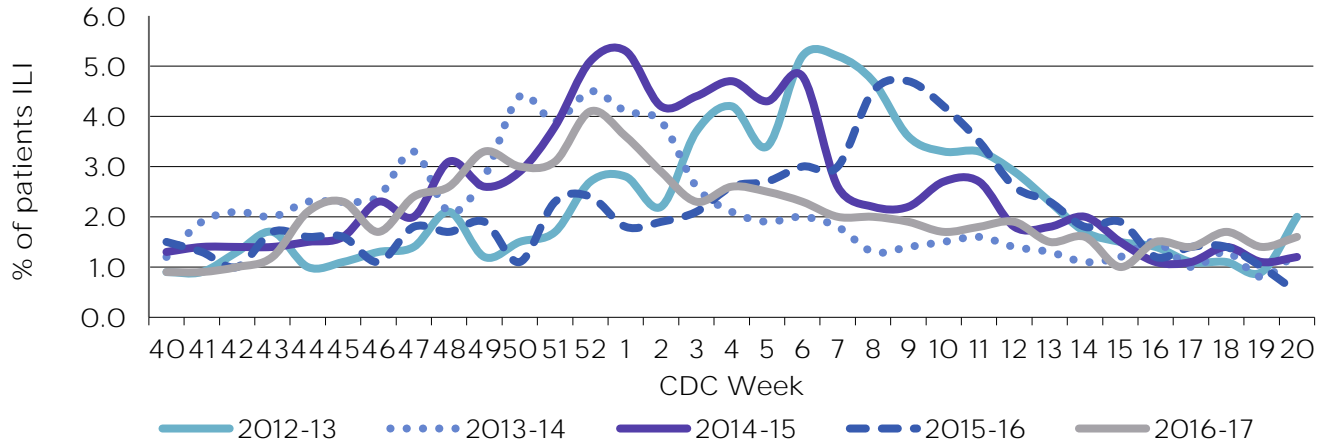
Fig 161: Number of Laboratory Confirmed Influenza Reports, Washoe County, 2012-2017 Influenza Seasons



¹⁶⁹ Centers for Disease Control and Prevention. Influenza (flu). Accessed <https://www.cdc.gov/flu/index.htm>

1.15 COMMUNICABLE DISEASES

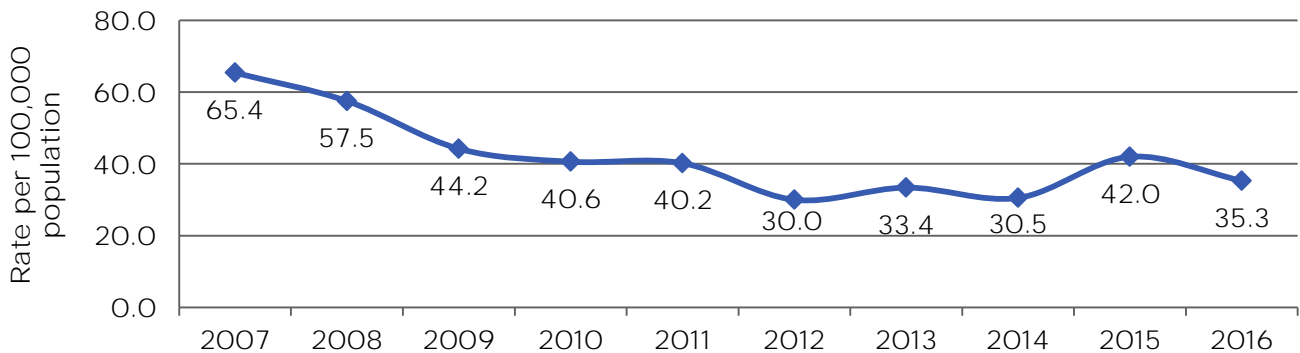
Fig 162: Percent of Patients Visits with Influenza-like Illness as Reported by Sentinel Providers, Washoe County, 2012-2017
Influenza Seasons



Foodborne Illness Complaints

Foodborne illnesses include a range of acute syndromes resulting from the ingestion of contaminated foods. The Washoe County Environmental Health Services Food Safety Program receives complaints related to foodborne illness and conducts investigation to identify the source and halt any potential foodborne illness outbreaks. The rates in Figure 163 reflect the number of complaints per 100,000, however do not reflect confirmed cases or confirmed sources of infection.

Fig 163: Rate of Reported Foodborne Illness Complaints, Washoe County, 2007-2016

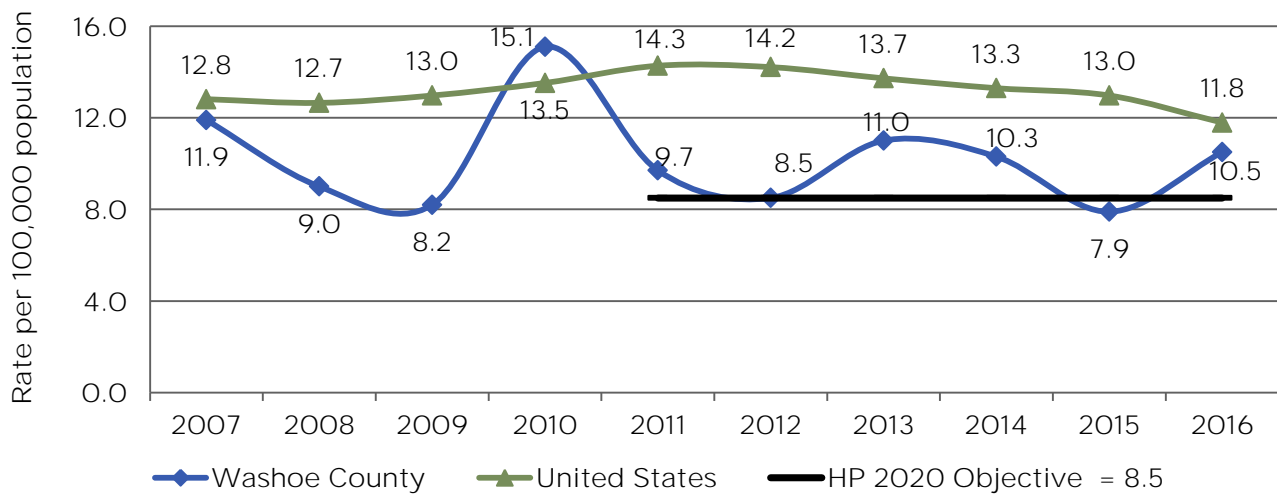


- The rate of reported foodborne illness complaints in Washoe County decreased from 2007 (65.4 per 100,000) to 2016 (35.3 per 100,000).

Campylobacteriosis

Campylobacteriosis is caused by the bacteria (genus) *Campylobacter* and is the most common bacterial diarrheal illness, with an estimated 1.3 million cases in the United States each year. Most cases of campylobacteriosis are caused by eating raw or uncooked poultry meats, or result from cross-contamination of other foods from these items. Symptoms include diarrhea, cramping, abdominal pain, and fever within two to five days of exposure. Illness typically lasts one week, however in immunocompromised individuals *Campylobacter* may spread to the bloodstream and cause a life-threatening infection.¹⁷⁰

Fig 164: Rate of Reported Cases of Campylobacteriosis, Washoe County & the United States*, 2007-2016



*United States data based on surveillance from 10 sites

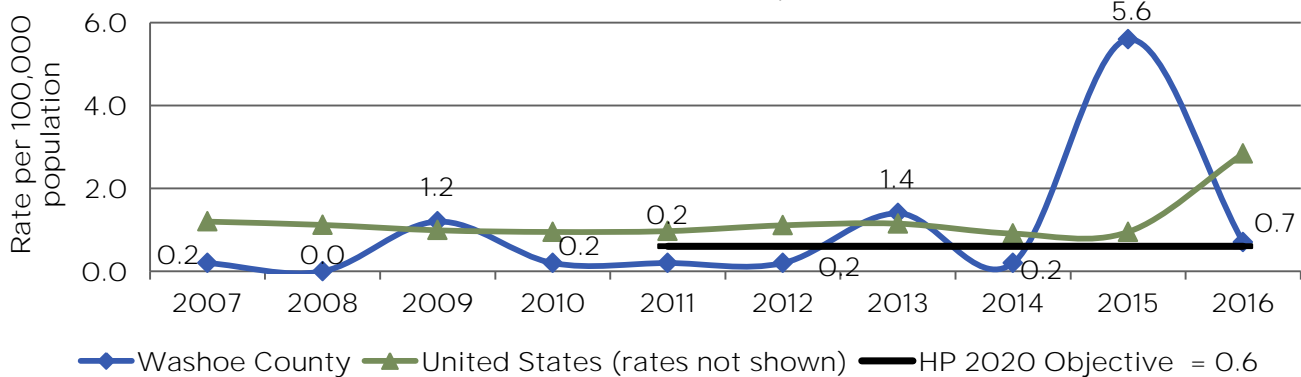
- The rate of reported cases of campylobacteriosis in Washoe County decreased slightly from 2007 (11.9 per 100,000) to 2016 (10.5 per 100,000).
- Rates of reported cases of campylobacteriosis in Washoe County have been lower than national rates from 2007 through 2016, with the exception of 2010 (15.1 per 100,000) when reporting criteria changed to include probable cases.

¹⁷⁰ Centers for Disease Control and Prevention. Food Safety-Campylobacter. Accessed <https://www.cdc.gov/foodsafety/diseases/campylobacter/>

Escherichia coli O157:H7

Escherichia coli (*E. coli*) include a very broad and diverse range of bacteria, and while some are harmless, some have been known to cause death. Types of *E. coli* that can cause disease include ones which produce a toxin known as Shiga toxin *E. coli* or STEC. Most reported outbreaks of *E. coli* are due to STEC O157. Symptoms include stomach cramps, diarrhea (usually bloody), and hemolytic uremic syndrome (HUS). HUS is a condition where red blood cells are destroyed prematurely and clog up the body’s filtration system (kidneys), which can then result in kidney failure. The major source of infection in humans is due to ingestion of undercooked contaminated beef, unpasteurized raw milk, or coming into contact with the feces of an infected human.¹⁷¹

Fig 165: Rate of Reported Cases of STEC O157, Washoe County & the United States*, 2007-2016



*United States data based on surveillance from 10 sites

- The 2015 spike in STEC O157 in Washoe County was due to a foodborne outbreak and resulted in double the national average for that year.
- The 2016 rate of reported STEC O157 cases in Washoe County (0.7 per 100,000) was below the national rate (2.84 per 100,000) and higher than the Healthy People 2020 objective (0.6 per 100,000).

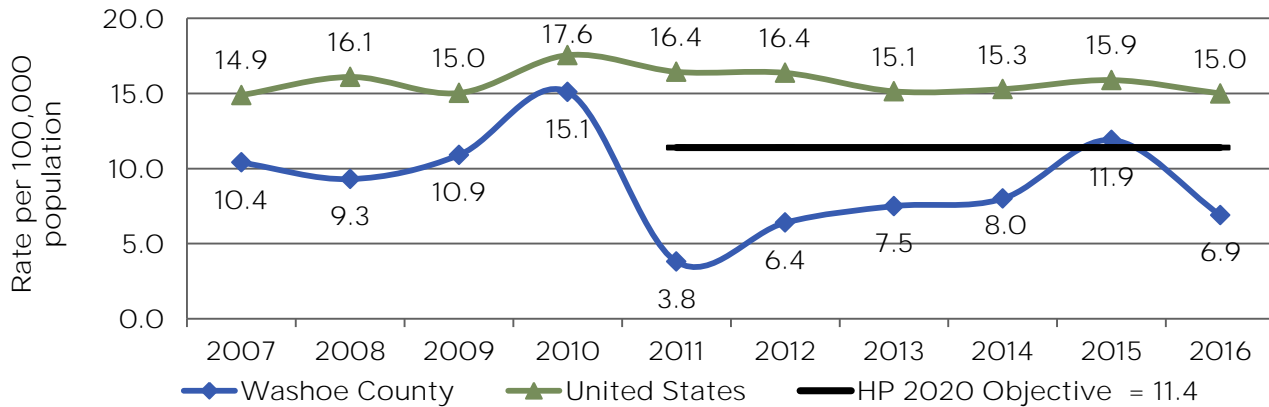
Salmonellosis

Salmonellosis is an infection due caused by the bacterium, *Salmonella*, and is one of the most common types of food-borne infection. Symptoms include diarrhea, fever and abdominal cramps 12 to 72 hours after infection. These symptoms last about a week and most people recover without needing treatment. *Salmonella* lives in the intestinal tracts of humans, and animals, including birds and reptiles. Food contamination usually occurs through fecal contact, however proper food handling reduces risk of cross contamination, and cooking meats thoroughly typically kills *Salmonella*.¹⁷²

¹⁷¹ Centers for Disease Control and Prevention. *E. coli* (Escherichia coli)-General Information. Accessed <https://www.cdc.gov/ecoli/general/index.html>

¹⁷² Centers for Disease Control and Prevention. *Salmonella*. Accessed <https://www.cdc.gov/salmonella/index.html>

Fig 166: Rate of Reported Cases of Salmonellosis, Washoe County & the United States*, 2007-2016



*United States data based on surveillance from 10 sites

- The rate of reported cases of Salmonellosis in Washoe County decreased from 2007 (10.4 per 100,000) to 2016 (6.9 per 100,000).
- The 2016 rate of reported cases of Salmonellosis in Washoe County (6.9 per 100,000) was below the national rate (15.0 per 100,000) and the Healthy People 2020 objective (11.4 per 100,000).

Summary of Communicable Diseases

There are a few communicable diseases presented in this section which have noted peaks, or outbreaks, in recent years. These include pertussis in 2014, slight increase in the number of cases of mumps in 2013, 2014 and 2016, and an outbreak of STEC O157 in 2015. The 2016 rates of reported cases for HCV, tuberculosis, and STEC O157 were above the Healthy People 2020 objectives, while rates for campylobacteriosis and salmonellosis were below the Healthy People 2020 objectives. Regular hand washing and obtaining appropriate vaccinations are two major steps which can be taken to reduce the number of cases of many communicable diseases.

For detailed documents related to communicable diseases in Washoe County refer to:

Washoe County Health District Annual Communicable Disease Summary Reports

www.tinyURL.com/WashoeCDAnnualSummary

Antimicrobial Resistance Surveillance www.tinyURL.com/WashoeAntibiogram

Influenza Surveillance www.tinyURL.com/WashoeFlu

Communicable disease newsletters www.tinyURL.com/WashoeEpiNews

Communicable Disease Sources

Fig 156: Rate of Acute Hepatitis C, Washoe County & the United States, 2007-2016

Washoe County: Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

United States 2007-2009: "Table 4.1 Reported cases of acute, hepatitis C, by state—United States, 2006-2010". Accessed <https://www.cdc.gov/hepatitis/statistics/2010surveillance/table4.1.htm>

United States 2010-2014: "Table 4.1 Reported cases of acute, hepatitis C, by state—United States, 2006-2010". Accessed <https://www.cdc.gov/hepatitis/statistics/2010surveillance/table4.1.htm>

United States: "Table 4.1 Reported cases of acute, hepatitis C, nationally and by state and jurisdiction—United States, 2011-2015". Accessed <https://www.cdc.gov/hepatitis/statistics/2015surveillance/index.htm#tabs-6-1>

1.15 COMMUNICABLE DISEASES

Fig 157: Rates of Reported Cases of Tuberculosis, Washoe County & the United States, 2007-2016

Washoe County: Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

United States 2007-2015: "TB Incidence in the United States, 1953-2015." Accessed <https://www.cdc.gov/tb/statistics/tbcases.htm>

United States 2016: Schmidt, KM., Wanasaula, Z., Pratt, SF, & Langer, AJ. Tuberculosis-United States, 2016. MMWR Morbidity and Mortality Weekly Report 2017; 66:289-294.

Fig 158: Rate of Reported Cases of Pertussis, Washoe County, Nevada, & the United States, 2007-2016

Washoe County: Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

Nevada and United States: "2015 Final Pertussis Surveillance Report". Accessed <https://www.cdc.gov/pertussis/downloads/pertuss-surv-report-2015.pdf>

Table 152: Laboratory-Confirmed Cases of Select Vaccine-Preventable Diseases, Washoe County, 2007-2016

Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

Fig 159: Rate of Reported Cases of Invasive Pneumococcal Disease, Washoe County & the United States, 2007-2016

Washoe County: Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

United States: Centers for Disease Control and Prevention. (2016). Summary of Notifiable Infectious Diseases and Conditions—United States, 2014. MMWR, 63(54), 69.

Fig 160-Fig 163 Same Source

Fig 160: Rate of Reported Rotavirus Cases, Washoe County, 2007-2016

Fig 161: Number of Laboratory Confirmed Influenza Reports, Washoe County, 2012-2017 Influenza Seasons

Fig 162: Percent of Patients Visits with Influenza-like Illness as Reported by Sentinel Providers, Washoe County, 2012-2017 Influenza Seasons

Fig 163: Rate of Reported Foodborne Illness Complaints, Washoe County, 2007-2016

Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

Fig 164-Fig 166 Same Source

Fig 164: Rate of Reported Cases of Campylobacteriosis, Washoe County & the United States*, 2007-2016

Fig 165: Rate of Reported Cases of STEC 0157, Washoe County & the United States*, 2007-2016

Fig 166: Rate of Reported Cases of Salmonellosis, Washoe County & the United States*, 2007-2016

Washoe County: Washoe County Health District, Communicable Disease and Epidemiology Program. Data provided upon request. Reno, NV.

United States 2007-2015: CDC, FoodNet "Table 2b. Incidence of infection by pathogen all sites, 2004-2015". Accessed <https://www.cdc.gov/foodnet/reports/data/infections.html>

United States 2016: Marder, EP, Cieslak, PR, Cronquist, AB et al. Incidence and Trends of Infections with Pathogens Transmitted Commonly Through Food and the Effect of Increasing Use of Culture-Independent Diagnostic Tests on Surveillance-Foodborne Diseases Active Surveillance Network, 10 US Sites, 2013-2016. MMWR Morbidity and Mortality Weekly Report 2017; 66:397-403.

Chronic Diseases

Chronic diseases, such as heart disease, diabetes, arthritis, and obesity, are largely preventable however account for seven out of ten deaths in the United States every year. One in two adults in the United States has a chronic disease, while one in three adults have two or more. The key risk factors for most chronic diseases are tobacco use, poor nutrition and lack of physical activity resulting in obesity, and excessive alcohol use.¹⁷³ In 2010, 86% of healthcare dollars were spent on patients with one or more chronic conditions. The average annual healthcare spending for someone without any chronic conditions in 2010 was \$1,177 compared to \$4,731 for persons with two chronic conditions, and an average of \$15,954 spent on those with five or more chronic conditions. The majority of Medicare (80.0%) enrollees and persons enrolled in both Medicaid and Medicare (78.0%) have multiple chronic conditions.¹⁷⁴

By improving nutrition, increasing physical activity, reducing alcohol consumption and eliminating the use of tobacco products, the United States could significantly reduce total healthcare costs and people would experience an increase in length and quality of life.

Indicator	Trend	Most Recent Year
Arthritis prevalence	Increasing	25.6% (2016)
Asthma prevalence	Increasing	8.5% (2016)
Breast cancer incidence	Increasing	133.5 per 100,000 females (2014)
Cervical cancer incidence	Decreasing	7.4 per 100,000 females (2014)
Prostate cancer incidence	Increasing	91.8 per 100,000 males (2014)
Colorectal cancer incidence	Decreasing	37.2 per 100,000 population (2014)
Lung cancer incidence	Decreasing	54.2 per 100,000 population (2014)
High cholesterol prevalence	Increasing	40.3% (2015)
High blood pressure prevalence	Increasing	32.4% (2015)
Angina or coronary heart disease prevalence	Increasing	4.1% (2016)
Heart attack prevalence	Increasing	4.1% (2016)
Stroke prevalence	Increasing	2.7% (2016)
COPD prevalence	STABLE	5.4% (2016)
Diabetes prevalence	Increasing	10.4% (2016)

Arthritis

Nationwide one in four adults are impacted by arthritis which is considered a leading cause of disability and is one of the most common chronic conditions. Arthritis includes more than 100 types of diseases and conditions that are characterized as inflammation of one or more joints or connective tissues surrounding joints. Some forms of arthritis, such as Lupus or fibromyalgia, may be more widespread impacting the immune system

¹⁷³ Centers for Disease Control and Prevention. Chronic Disease Prevention and Health Promotion. Accessed <https://www.cdc.gov/chronicdisease/about/infographic.htm>

¹⁷⁴ Gerteis, J. Izrael, D., Deitz, D., LeRoy, L. Ricciardi, R., Miller, T., & Basu, J. (2014). Multiple Chronic Conditions Chartbook. AHRQ Publications NO, Q14-0038. Rockville, MD.

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or other internal organs. Symptoms of arthritis typically include pain, aching, stiffness, swelling, redness, and reduced range of motion. Risk factors include age, gender, genetic inheritance, being overweight or obese, joint injuries, infections, and occupations involving repetitive movements or prolonged stress on a joint.¹⁷⁵

Table 153: Percent of Adults who have been told they have Arthritis*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	24.0%	21.2%	24.0%	21.7%	25.6%
Nevada	24.0%	20.9%	23.0%	21.5%	23.7%
United States	25.7%	25.3%	26.0%	25.3%	25.2%

*told they have rheumatoid arthritis, gout, lupus, or fibromyalgia by a doctor, nurse, or other health professional

- The percentage of adults in Washoe County who reported they have been told they have arthritis increased from 2012 (24.0%) to 2016 (25.6%).
- In 2016, the percentage of adults in Washoe County who reported being told they have arthritis was higher (25.6%) than Nevada (23.7%) and slightly higher than the United States (25.2%).

Asthma

Asthma impacts the lungs and is among the most common conditions among children, however adults are also impacted. Asthma is a respiratory disease that causes wheezing, shortness of breath, tightness in the chest, and coughing. Different people may be triggered by a variety of environmental contaminant such as pollution, smoke, dust mites, pet allergens, or mold. When an asthma attack occurs the lungs swell, causing the airways to shrink and may involve all of the previously mentioned symptoms.¹⁷⁶

Table 154: Percent of Adults who currently have Asthma, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	7.8%	7.7%	8.2%	9.5%	8.5%
Nevada	7.4%	7.6%	8.0%	8.1%	7.9%
United States	8.9%	9.0%	8.9%	9.2%	8.9%

- The percentage of adults in Washoe County who reported they currently have asthma increased from 2012 (7.8%) to 2016 (8.5%).
- In 2016, the percentage of adults in Washoe County who reported they currently have asthma, was higher (8.5%) than Nevada (7.9%), however slightly lower than the United States (8.9%).

Cancer

Cancer is a disease where the cells of the body grow out of control, which when left undiagnosed and untreated can spread and impact other organs.¹⁷⁷ The causes of cancer differ from type to type, however there are behavioral factors which increase the risk of many cancers. These include being obese, using tobacco

¹⁷⁵ Centers for Disease Control and Prevention. Arthritis. Accessed <https://www.cdc.gov/arthritis/basics/index.html>

¹⁷⁶ Centers for Disease Control and Prevention. Learn how to Control Asthma. Accessed <https://www.cdc.gov/asthma/faqs.htm>

¹⁷⁷ Centers for Disease Control and Prevention. Cancer Prevention and Control, Statistics for Different Kinds of Cancer. Accessed <https://www.cdc.gov/cancer/dcpc/data/types.htm>

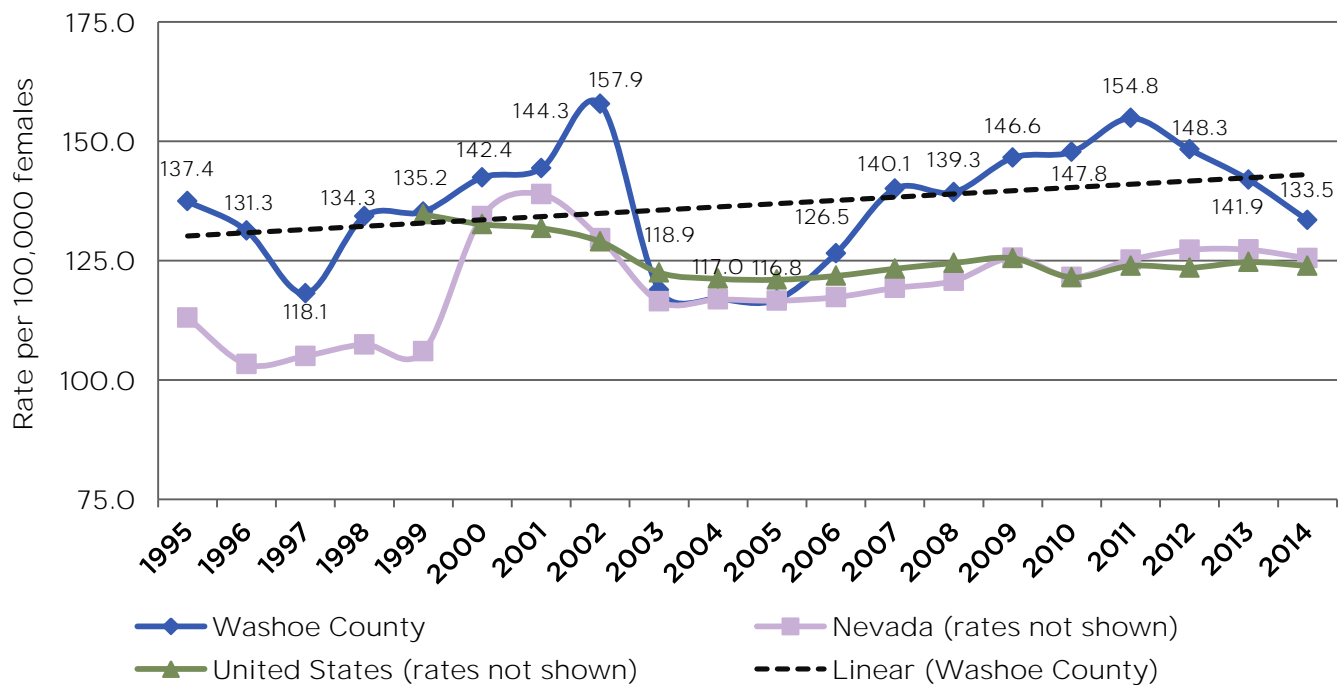
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products, and excessive alcohol consumption. In 2014, breast, prostate, and lung cancers were the leading types of cancers diagnosed nationwide and in Washoe County.^{178,179}

Breast Cancer

Although men and women can both get breast cancer, it is much more common among women. Risk factors for breast cancer include aging, genetic mutations (BRCA1 and BRCA2), first pregnancy after age 30 or never having a full-term pregnancy, having dense breast tissue, taking oral contraceptives, starting menstruation before age 12, starting menopause after age 55, drinking alcohol, physical inactivity, being overweight or obese, or having a family history of breast cancer.¹⁸⁰

Fig 167: Rate of Newly Diagnosed Breast Cancer Cases among Females, Washoe County, Nevada, & the United States, 1995-2014



- The rate of newly diagnosed cases of breast cancer in Washoe County has decreased from 1995 (137.4 per 100,000 females) to 2014 (133.5 per 100,000 females), however overall trends during this time period indicate there has been an increase, despite annual fluctuations (black dotted line).
- In 2014, the rate of newly diagnosed cases of breast cancer in Washoe County was higher (133.5) than Nevada (125.5) and the United States (123.9). Washoe County rates have also been higher than state and national rates since 2006.

¹⁷⁸ Centers for Disease Control and Prevention. Cancer Prevention and Control, Statistics for Different Kinds of Cancer. Accessed <https://www.cdc.gov/cancer/dpcp/data/types.htm>

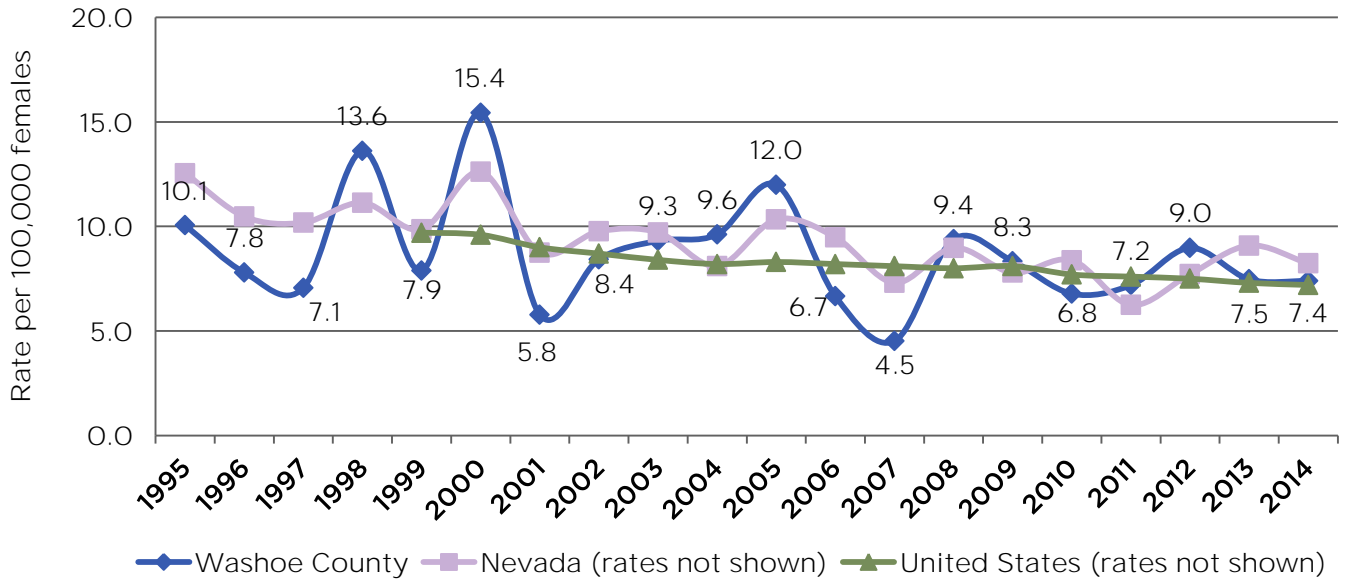
¹⁷⁹ Nevada Department of Health and Human Services, Nevada Central Cancer Registry. Data provided upon request. Carson City, NV.

¹⁸⁰ Centers for Disease Control and prevention. What are the Risk Factors for Breast Cancer. Accessed https://www.cdc.gov/cancer/breast/basic_info/risk_factors.htm

Cervical Cancer

Over the past four decades the number of cervical cancer cases and deaths has declined largely due to women getting regular Pap tests. Pap tests detect precancerous or cancerous cells on the cervix before they become invasive cancer. Human papilloma virus (HPV) is sexually transmitted and the main cause of cervical cancer.¹⁸¹

Fig 168: Rate of Newly Diagnosed Cervical Cancer Cases among Females, Washoe County, Nevada, & the United States, 1995-2014



- The rate of newly diagnosed cases of cervical cancer in Washoe County has decreased from 1995 (10.1 per 100,000 females) to 2014 (7.4 per 100,000 females).
- In 2014, the rate of newly diagnosed cases of cervical cancer in Washoe County was lower (7.4) than Nevada (8.2), however slightly higher than the United States (7.2).

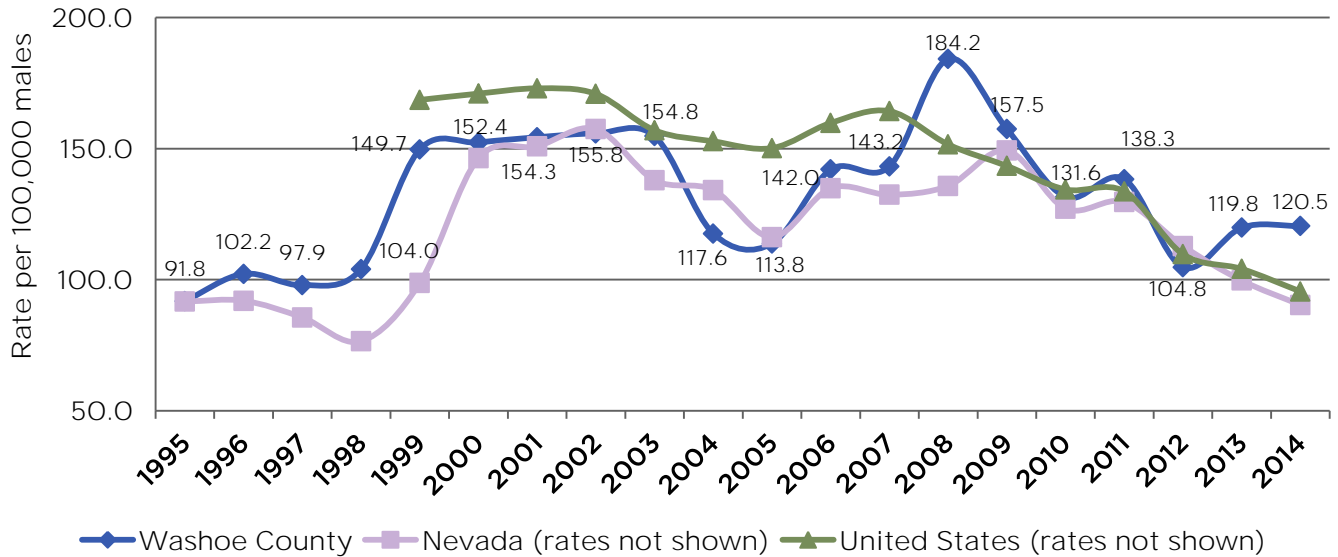
¹⁸¹ Centers for Disease Control and Prevention. Gynecological Cancers, Basic Information about Cervical Cancer. Accessed https://www.cdc.gov/cancer/cervical/basic_info/index.htm

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Prostate Cancer

Risk factors for prostate cancer include age, family history and race, as it is more common among African American men. However, researchers are still working to determine the causes of prostate cancer and whether it can be prevented.¹⁸²

Fig 169: Rate of Newly Diagnosed Prostate Cancer Cases among Males, Washoe County, Nevada, & the United States, 1995-2014



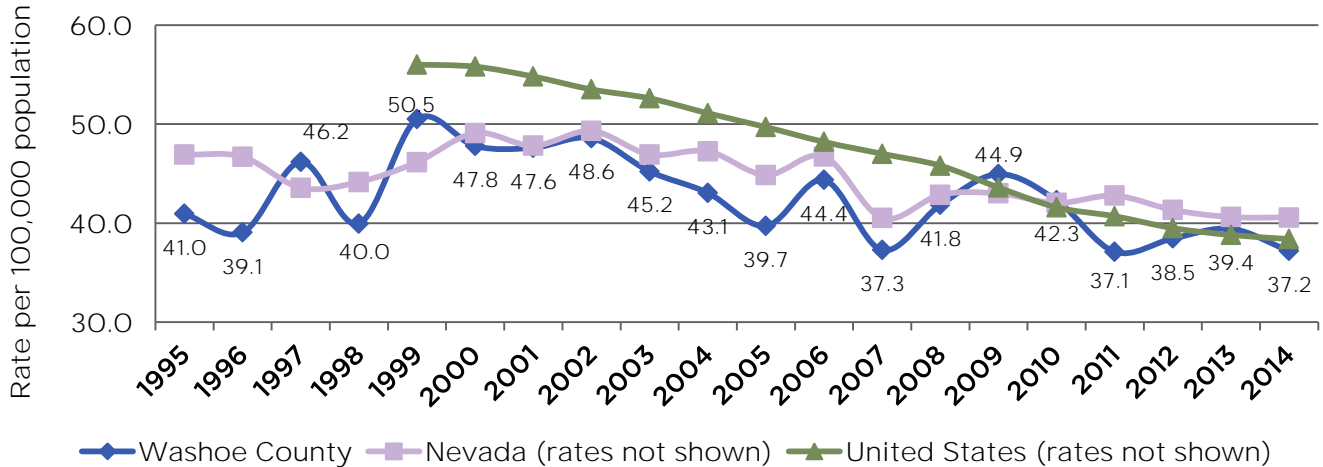
- The rate of newly diagnosed cases of prostate cancer in Washoe County has increased from 1995 (91.8 per 100,000 males) to 2014 (120.5 per 100,000 males).
- In 2014, the rate of newly diagnosed cases of prostate cancer in Washoe County was higher (120.5) than Nevada (90.3), and the United States (95.5).

¹⁸² Centers for Disease Control and Prevention. Prostate Cancer, What are the Risk Factors?. Accessed https://www.cdc.gov/cancer/prostate/basic_info/risk_factors.htm

Colorectal Cancer

Age contributes to an increased risk for colon and rectal cancers. Other risk factors include family history of colorectal cancer or colorectal polyps, Crohn’s disease, ulcerative colitis, lack of physical activity, low fruit and vegetable consumption, diet low in fiber and high in fat, being overweight or obese, alcohol consumption and tobacco use.¹⁸³

Fig 170: Rate of Newly Diagnosed Colorectal Cancer Cases, Washoe County, Nevada, & the United States, 1995-2014



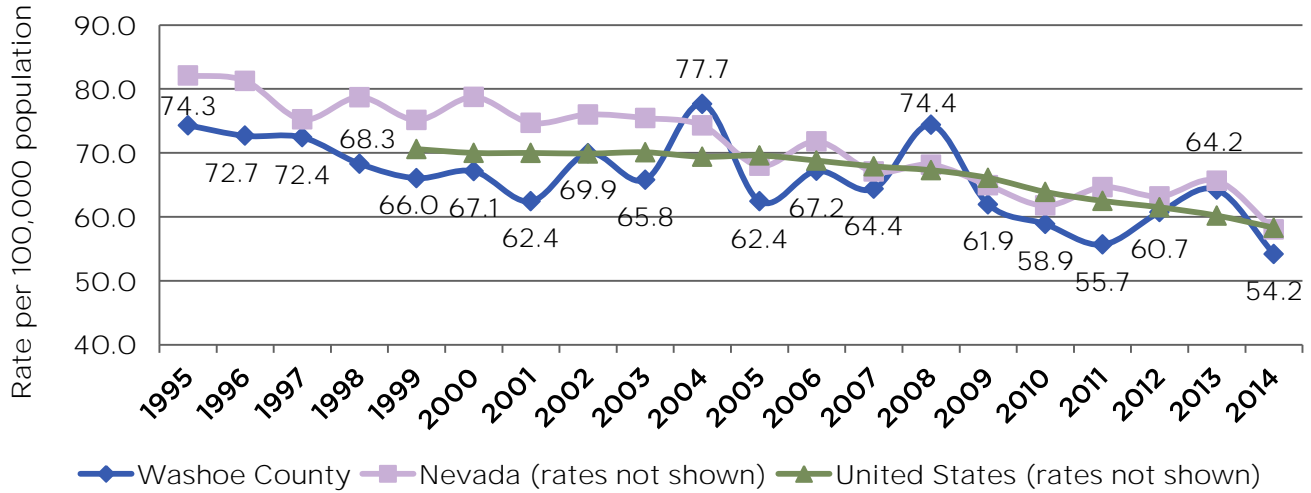
- The rate of newly diagnosed cases of colorectal cancer in Washoe County has decreased from 1995 (41.0 per 100,000 population) to 2014 (37.2 per 100,000 population).
- In 2014, the rate of newly diagnosed cases of colorectal cancer in Washoe County was lower (37.2) than Nevada (40.6), and the United States (38.4).

¹⁸³ Centers for Disease Control and Prevention. Colorectal (colon) Cancer, What are the Risk Factors for Colorectal Cancer?. Accessed https://www.cdc.gov/cancer/colorectal/basic_info/risk_factors.htm

Lung Cancer

Cigarette smoking is the number one risk factor for lung cancer linked to 80% to 90% of all cases. However, as smoking rates have decreased, so have the rates of lung cancer. Lung cancer can also be caused by exposure to second hand smoke, asbestos, or radon in the home or at work. A family history of lung cancer is also a risk factor.¹⁸⁴

Fig 171: Rate of Newly Diagnosed Lung Cancer Cases, Washoe County, Nevada, & the United States, 1995-2014



- The rate of newly diagnosed cases of lung cancer in Washoe County has decreased from 1995 (74.3 per 100,000 population) to 2014 (54.2 per 100,000 population).
- In 2014, the rate of newly diagnosed cases of lung cancer in Washoe County was lower (54.2) than Nevada (58.0), and the United States (58.3).

Cardiovascular Diseases

Cardiovascular disease impacts the heart and blood vessels and includes various conditions such as heart attacks, heart failure, heart arrhythmias, and strokes.

In 2015, heart disease was the number one cause of death nationwide and in Washoe County.^{185,186} The key risk factors for heart disease include high blood pressure, high LDL cholesterol, and smoking. In 2010, it was estimated that nearly half of Americans had at least one of these risk factors.¹⁸⁷ Additional risk factors for heart

¹⁸⁴ Centers for Disease Control and Prevention. Lung Cancer. Accessed <https://www.cdc.gov/cancer/lung/>

¹⁸⁵ United States: Xu, J., Murphy, S.L., Kochanek, K.D. & Arias, E. (2016). Mortality in the United States, 2015. National Center for Health Statistics Data Brief, no 267. Hyattsville, MD.

¹⁸⁶ Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

¹⁸⁷ Centers for Disease Control and Prevention.(2011). Million Hearts™: strategies to reduce the prevalence of leading cardiovascular disease risk factors. United States, 2011. Morbidity and Mortality Weekly Report;60(36):1248–51

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diseases include diabetes, being overweight or obese, having a poor diet, lack of physical activity, and excessive alcohol use.¹⁸⁸

In 2015, stroke was the fourth leading cause of death in Washoe County and Nevada, and was ranked as the fifth leading cause of death nationally.^{189,190} A stroke occurs when the blood supply to a part of the brain is blocked (ischemic stroke) or when a blood vessel in the brain bursts (hemorrhagic stroke). Without a regular supply of oxygen, brain death occurs, and if emergency care is not obtained quickly, permanent brain damage, long-term disability, or death may occur. Stroke symptoms include numbness or weakness in the face, arms, or legs particularly on one side of the body, sudden confusion, trouble speaking, or difficulty understanding speech, trouble walking, dizziness, loss of balance, or a sudden severe headache with no known cause.¹⁹¹ Risk factors for stroke include high blood pressure, high cholesterol, heart disease, diabetes, sickle cell disease, unhealthy diet, obesity, excessive alcohol, and tobacco use. Having a family history of stroke and some genetic disorders may also increase risk for stroke.¹⁹²

Table 155: Percent of Adults who have been told they have High Cholesterol*, 2013 & 2015

Location	2013	2015
Washoe County	36.7%	40.3%
Nevada	38.6%	36.7%
United States	38.4%	36.3%

* told by a doctor, nurse, or other health professional

- The percentage of adults in Washoe County reporting they have high cholesterol increased between 2013 (36.7%) and 2015 (40.3%).
- In 2015, the percentage of adults in Washoe County reporting they have high cholesterol was higher (40.3%) than both Nevada (36.7%) and the United States (36.3%).

Table 156: Percent of Adults who have been told they have High Blood Pressure*, 2013 & 2015

Location	2013	2015
Washoe County	28.0%	32.4%
Nevada	30.6%	28.3%
United States	31.4%	30.9%

* told by a doctor, nurse, or other health professional

- The percent of adults in Washoe County reporting they have high blood pressure increased between 2013 (28.0%) and 2015 (32.4%).
- In 2015, the percentage of adults in Washoe County reporting they have high blood pressure was higher (32.4%) than both Nevada (28.3%) and the United States (30.9%).

¹⁸⁸ Centers for Disease Control and Prevention. Heart Disease Fact Sheet. Accessed https://www.cdc.gov/dhbsp/data_statistics/fact_sheets/fs_heart_disease.htm

¹⁸⁹ Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

¹⁹⁰ United States: Xu, J., Murphy, S.L., Kochanek, K.D. & Arias, E. (2016). Mortality in the United States, 2015. National Center for Health Statistics Data Brief, no 267. Hyattsville, MD.

¹⁹¹ Centers for Disease Control and Prevention. Stroke Signs and Symptoms. Accessed https://www.cdc.gov/stroke/signs_symptoms.htm

¹⁹² Centers for Disease Control and Prevention. Stroke Risk. Accessed <https://www.cdc.gov/stroke/behavior.htm>

Table 157: Percent of Adults who have been told they had Angina or Coronary Heart Disease*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	2.8%	3.7%	3.1%	3.3%	4.1%
Nevada	4.3%	3.4%	4.7%	3.9%	4.4%
United States	4.3%	4.1%	4.2%	3.9%	4.3%

* told by a doctor, nurse, or other health professional

- The percentage of adults in Washoe County reporting they have had angina or coronary heart disease increased from 2012 (2.8%) to 2016 (4.1%).
- In 2016, the percentage of adults in Washoe County reporting they have had angina or coronary heart disease was slightly lower (4.1%) than Nevada (4.4%) and the United States (4.3%).

Table 158: Percent of Adults who have been told they had a Heart Attack*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	3.4%	5.0%	3.4%	4.9%	4.1%
Nevada	4.6%	4.4%	4.8%	4.2%	4.9%
United States	4.5%	4.3%	4.4%	4.2%	4.3%

* told by a doctor, nurse, or other health professional

- The percent of adults in Washoe County reporting they have had a heart attack increased from 2012 (3.4%) to 2016 (4.1%).
- In 2016, the percentage of adults in Washoe County reporting they have had a heart attack was slightly lower (4.1%) than Nevada (4.9%) and the United States (4.3%).

Table 159: Percent of Adults who have been told they had a Stroke*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	1.4%	2.4%	2.6%	2.1%	2.7%
Nevada	3.1%	2.9%	3.2%	2.4%	3.3%
United States	2.9%	2.8%	3.0%	3.0%	3.2%

* told by a doctor, nurse, or other health professional

- The percent of adults in Washoe reporting they have had a stroke increased from 2012 (1.4%) to 2016 (2.7%).
- In 2016, the percentage of adults in Washoe County reporting they have had a stroke was lower (2.7%) than Nevada (3.3%) and the United States (3.2%).

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) refers to a group of diseases which cause airflow blockage and breathing-related problems, including emphysema, chronic bronchitis, and in certain circumstances, asthma. In 2015, chronic lower respiratory disease, primarily COPD, was the third leading cause

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of death nationally and in Washoe County.^{193,194} Tobacco smoke is the primary risk factor for developing COPD however, exposure to air pollutants, genetic factors and respiratory infections can also contribute to COPD.¹⁹⁵

Table 160: Percent of Adults who have been told they have Chronic Obstructive Pulmonary Disease (COPD)*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	5.9%	5.4%	6.4%	5.7%	5.4%
Nevada	7.5%	6.7%	6.9%	6.6%	6.9%
United States	6.2%	6.5%	6.5%	6.2%	6.5%

* told by a doctor, nurse, or other health professional

- The percentage of adults in Washoe County reporting they have COPD remained relatively stable from 2012 (5.9%) to 2016 (5.4%).
- In 2016, the percentage of adults in Washoe County reporting they have COPD by a healthcare professional, was lower (5.4%) than Nevada (6.9%) and the United States (6.5%).

Type 2 Diabetes

Diabetes is a disease in which blood glucose levels are higher than normal. Most food consumed is turned into glucose (sugar) and stored by our bodies to be used for energy. Insulin, produced by the pancreas, assists glucose in entering into the cells for storage. When a person has diabetes, the pancreas either does not produce enough insulin or the body is unable to use insulin efficiently, which leads to high levels of glucose in the blood stream. Diabetes can also cause heart disease, blindness, kidney failure, and lower-extremity amputations.¹⁹⁶

There are two types of diabetes, Type 1 and Type 2. Type 1 is not associated with being overweight or obese but instead results from an immune malfunction where the immune system incorrectly identifies and attacks insulin-producing cells in the pancreases. Type 2 is not an autoimmune disease, but instead develops as a result from consuming high sugar foods, thus increasing demand for insulin production, and over time, the system loses the ability to respond to insulin. Risk factors for Type 2 diabetes include being overweight or obese, lack of physical activity, have high blood pressure, history of heart disease or stroke, being over the age of 45, or

¹⁹³ United States: Xu, J., Murphy, S.L., Kochanek, K.D. & Arias, E. (2016). Mortality in the United States, 2015. National Center for Health Statistics Data Brief, no 267. Hyattsville, MD.

¹⁹⁴ Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

¹⁹⁵ Centers for Disease Control and Prevention. Chronic Obstructive Pulmonary Disease (COPD). Accessed <https://www.cdc.gov/copd/index.html>

¹⁹⁶ Centers for Disease Control and Prevention. Basics About Diabetes. Accessed <https://www.cdc.gov/diabetes/basics/diabetes.html>

have a family history of diabetes.¹⁹⁷ In 2015, Type 2 diabetes was ranked the tenth leading cause of death in Washoe County and Nevada, however nationally was the seventh leading cause of death.^{198,199}

Table 161: Percent of Adults who have been told they have Diabetes*, 2012-2016

Location	2012	2013	2014	2015	2016
Washoe County	6.6%	7.8%	6.4%	7.9%	10.4%
Nevada	8.9%	9.6%	9.6%	9.7%	11.9%
United States	9.7%	9.7%	10.0%	9.9%	10.8%

* told by a doctor, nurse, or other health professional

- The percentage of adults in Washoe County reporting they have diabetes increased from 2012 (6.6%) to 2016 (10.4%).
- In 2016, the percentage of adults in Washoe County reporting they have diabetes was lower (10.4%) than Nevada (11.9%) and slightly lower than the United States (10.8%).

Summary of Chronic Diseases

The best treatment to reduce the occurrence of chronic disease is prevention. People can significantly reduce their risk for the top chronic conditions by eating a healthy diet composed of fruits and vegetables, reducing consumption of animal fats, maintaining a healthy weight, and engaging in regular adequate physical activity. Additional forms of prevention include not using tobacco products and limiting excessive alcohol consumption.

Unfortunately the risk for all chronic diseases increases with age, and as the Baby Boomer generation reaches their 60’s and 70’s, the prevalence of chronic disease is expected to continue to rise. Additionally, people are often diagnosed with more than one chronic conditions, which can complicate treatment regimens and often adds a financial burden to patients with multiple specialty doctors and various medications. By receiving appropriate screenings for pre-markers for chronic conditions such as high blood pressure, high cholesterol, and pre-cancerous lesions, conditions may be diagnosed in earlier stages. When conditions are caught early, they are more likely to be treated effectively and sometimes even reversed without surgical or pharmaceutical interventions, thus decreasing the burden of high-cost long-term treatments and procedures.

For detailed documents related to chronic diseases in Washoe County refer to:

Washoe County Health District Chronic Disease Report Card <https://www.washoecounty.us/health/programs-and-services/chronic-disease-prevention/media-and-reports.php>

¹⁹⁷ National Institute of Diabetes and Digestive and Kidney Diseases. Risk Factors for Type 2 Diabetes. Accessed <https://www.niddk.nih.gov/health-information/diabetes/overview/risk-factors-type-2-diabetes>

¹⁹⁸ Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

¹⁹⁹ United States: Xu, J., Murphy, S.L., Kochanek, K.D. & Arias, E. (2016). Mortality in the United States, 2015. National Center for Health Statistics Data Brief, no 267. Hyattsville, MD.

Chronic Diseases Sources**Table 153-Table 154 Same Source**

Table 153: Percent of Adults who have been told they have Arthritis*, 2012-2016

Table 154: Percent of Adults who currently have Asthma, 2012-2016

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

United States BRFSS data: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Fig 167-Fig 171 Same Source

Fig 167: Rate of Newly Diagnosed Breast Cancer Cases among Females, Washoe County, Nevada, & the United States, 1995-2014

Fig 168: Rate of Newly Diagnosed Cervical Cancer Cases among Females, Washoe County, Nevada, & the United States, 1995-2014

Fig 169: Rate of Newly Diagnosed Prostate Cancer Cases among Males, Washoe County, Nevada, & the United States, 1995-2014

Fig 170: Rate of Newly Diagnosed Colorectal Cancer Cases, Washoe County, Nevada, & the United States, 1995-2014

Fig 171: Rate of Newly Diagnosed Lung Cancer Cases, Washoe County, Nevada, & the United States, 1995-2014

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention and National Cancer Institute. (2017). U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2014 Incidence and Mortality Web-based Report. Atlanta, GA.

Table 155-Table 161 Same Source

Table 155: Percent of Adults who have been told they have High Cholesterol*, 2013 & 2015

Table 156: Percent of Adults who have been told they have High Blood Pressure*, 2013 & 2015

Table 157: Percent of Adults who have been told they had Angina or Coronary Heart Disease*, 2012-2016

Table 158: Percent of Adults who have been told they had a Heart Attack*, 2012-2016

Table 159: Percent of Adults who have been told they had a Stroke*, 2012-2016

Table 160: Percent of Adults who have been told they have Chronic Obstructive Pulmonary Disease (COPD)*, 2012-2016

Table 161: Percent of Adults who have been told they have Diabetes*, 2012-2016

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

United States BRFSS data: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Mortality

In 2015, the United States was ranked 31st by the World Health Organization in life expectancy at birth. The nation with the longest life expectancy was Japan, with a life expectancy at birth of 83.7 years. Life expectancy in the United States decreased from 78.9 years in 2014 to 78.8 years in 2015²⁰⁰, the first decline in life expectancy since 1993. In 2015, the death rates across the nation increased for eight of the 10 leading causes of death and only decreased for one, indicating more people died from the leading causes of death in 2015 compared to 2014. Rates of death among various racial and ethnic groups were also not equal in 2015, with highest rates of death among black males (1,070.0 per 100,000). The lowest rate was among Hispanic females (438.3 per 100,000).²⁰¹ The disparities in health behaviors, health access, and health outcomes which lead to the disparities in mortality, exist both nationwide and in Washoe County.

Indicator	Trend	Most Recent Year	HP 2020 Objective
Overall Mortality			
All-cause mortality rates	Increasing	1,062.3 per 100,000 (2015)	NA
Cause of death by rank	~	various	NA
Cause of death by sex	~	various	NA
Cause of death by age group	~	various	NA
Cause of death by race/ethnicity	~	various	NA
Cancer-Specific Mortality			
Lung cancer mortality	Decreasing	42.9 per 100,000 (2015)	45.5 per 100,000 population
Breast cancer mortality	Increasing	26.5 per 100,000 females (2015)	20.7 per 100,000 females
Cervical cancer mortality	Decreasing	1.7 per 100,000 females (2015)	NA
Colorectal cancer mortality	Decreasing	14.9 per 100,000 (2015)	14.5 per 100,000 population
Prostate cancer mortality	Decreasing	19.7 per 100,000 males (2015)	21.8 per 100,000 males
Leukemia mortality	Increasing	6.7 per 100,000 (2015)	NA
Melanoma mortality	~	3.1 per 100,000 (2015)	2.4 per 100,000 population
~not able to assess for trend; NA= identical HP 2020 objective not available			

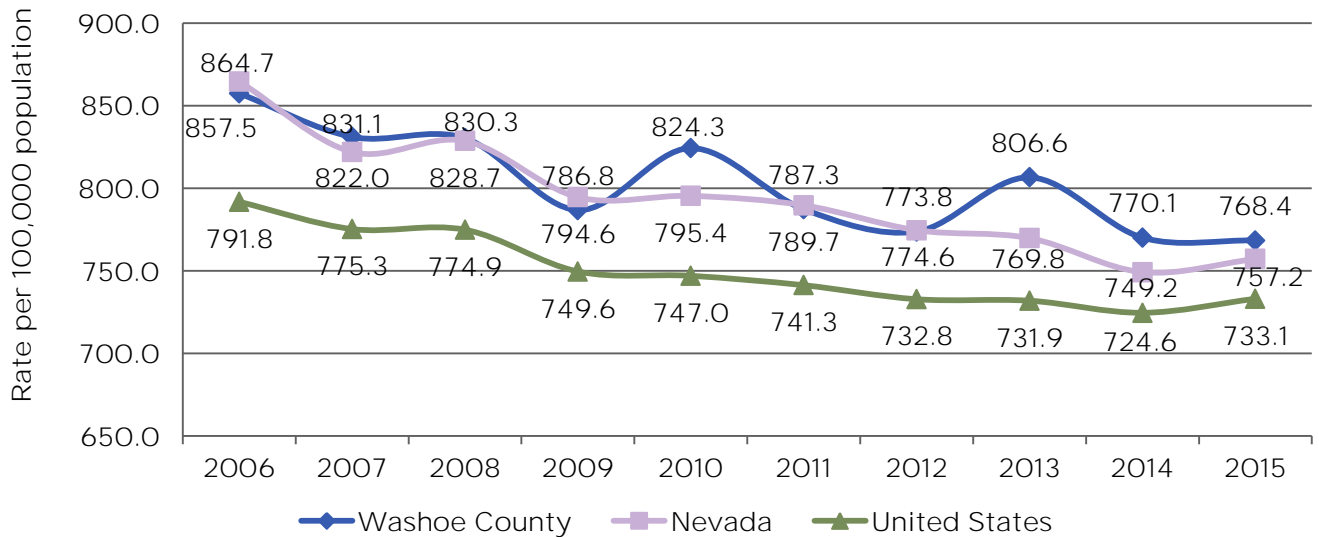
²⁰⁰ Xu, J., Murphy, S.L., Kochanek, K.D. & Arias, E. (2016). Mortality in the United States, 2015. National Center for Health Statistics Data Brief, no 267. Hyattsville, MD.

²⁰¹ IBID 200

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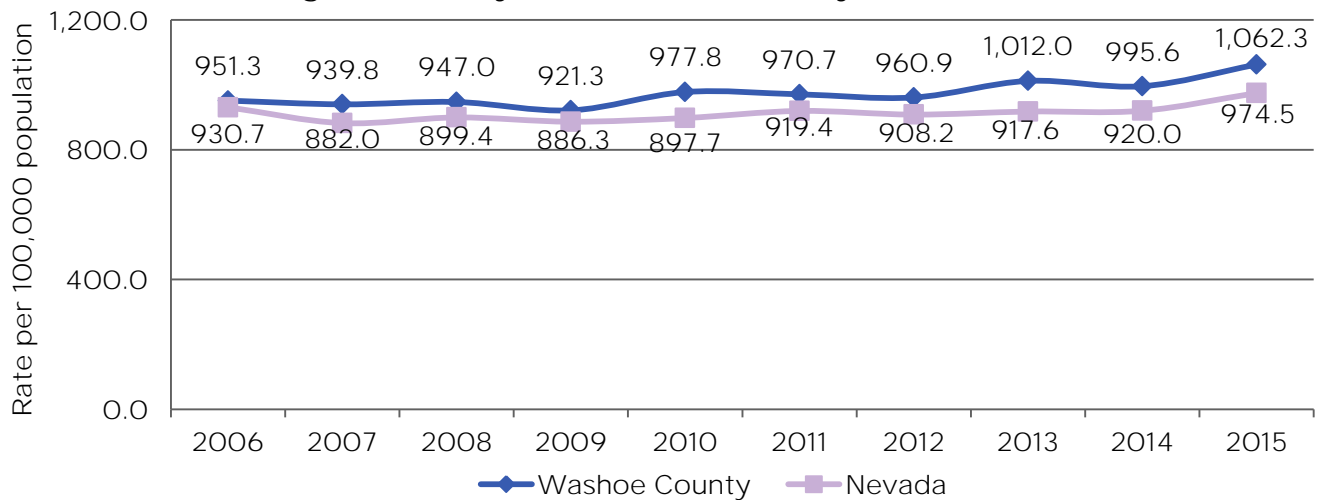
All-Cause Mortality

Fig 172: Age-Adjusted Mortality Rate for Underlying Causes of Death, all ages, Washoe County, Nevada, & the United States, 2006-2015



- The overall (all-cause) age-adjusted mortality rate among all residents of Washoe County decreased from 2006 (857.5 per 100,000) to 2015 (768.4 per 100,000).
- The overall age-adjusted mortality rate among Washoe County residents has been higher than the rate for the United States from 2006 through 2015.

Fig 173: Age-Adjusted Mortality Rate for all Causes of Death among those 15+ years, Washoe County & Nevada, 2006-2015



- The overall (all-cause) age-adjusted mortality rate among residents aged 15 years and older in Washoe County increased from 2006 (951.3 per 100,000) to 2015 (1,062.3 per 100,000).
- The overall mortality rate among Washoe County residents aged 15 years and older has been higher than the rate of residents aged 15 years and older for Nevada from 2006 through 2015.

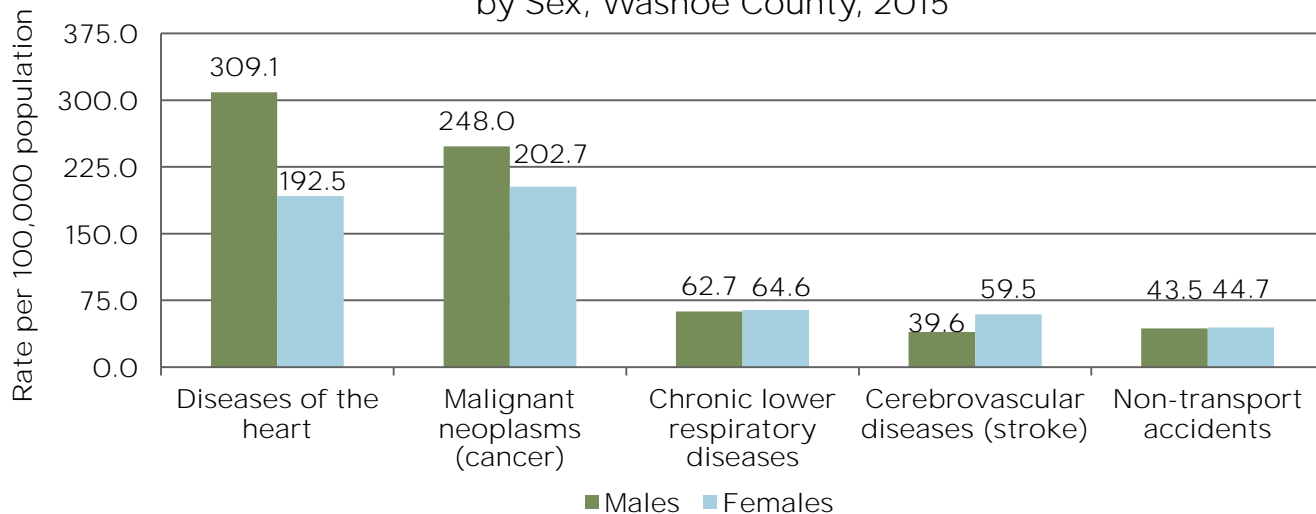
Table 162: Top Causes of Death, by Rank, 2015

Cause of Death	Washoe County	Nevada	United States
Diseases of the heart	1	1	1
Malignant neoplasms (cancer)	2	2	2
Chronic lower respiratory diseases	3	3	3
Cerebrovascular diseases (stroke)	4	4	5
Non-transport accidents	5	5	~
Alzheimer's disease	6	6	6
Intentional self-harm (suicide)	7	8	10
Chronic liver disease and cirrhosis	8	9	NR
Septicemia	9	NR	NR
Diabetes mellitus	10	10	7

NR= Not among top 10 causes of death for 2015
 ~United States data combined non-transport and transport accidents into single category, Washoe County and Nevada data do not include transport accidents

Cause of Death by Sex

Fig 174: Age-Adjusted Rate of Death for Top 5 Causes of Death by Sex, Washoe County, 2015



- The 2015 rate of death for the top two causes of death, diseases of the heart and cancer, were higher among males in Washoe County compared to females.
- The 2015 rate of death for the third, fourth, and fifth causes of death, chronic lower respiratory disease, strokes, and non-transport accidents respectively was slightly higher among females compared to males in Washoe County.

Cause of Death by Age Group

The following tables [Table 163-Table 170] illustrate the shift in cause of death as a population ages, with a higher rate of assault, suicide, and accidents contributing to death among those aged less than 44 years transitioning to a higher rate of diseases of the heart and malignant neoplasms (cancer) as age increases.

Table 163: Causes of Death among those Aged 15-24 Years, Washoe County, 2015

Rank	Cause of Death	Count	Rate
1	Assault (homicide)	9	15.4
2	Transport accidents	8	13.7
3	Non-transport accidents	5	8.5
3	Intentional self-harm (suicide)	5	8.5
4	Malignant neoplasms	3	5.1
5	Diabetes mellitus	2	3.4

- The top two causes of death among Washoe County residents aged 15-24 years were assault (homicide) and transport accidents.

Table 164: Causes of Death among those Aged 25-34 Years, Washoe County, 2015

Rank	Cause of Death	Count	Rate
1	Non-transport accidents	15	23.6
1	Intentional self-harm (suicide)	15	23.6
2	Transport accidents	9	14.2
3	Diseases of the heart	6	9.5
3	Malignant neoplasms	6	9.5
4	Chronic liver disease and cirrhosis	4	6.3
5	Diabetes mellitus	2	3.2
5	Pneumonitis due to solids and liquids	2	3.2
5	Assault (homicide)	2	3.2

- The top causes of death (tied) among Washoe County residents aged 25-34 years were non-transport accidents and intentional self-harm (suicide).

Table 165: Causes of Death among those Aged 35-44 Years, Washoe County, 2015

Rank	Cause of Death	Count	Rate
1	Non-transport accidents	19	34.8
2	Intentional self-harm (suicide)	17	31.2
3	Diseases of the heart	13	23.8
4	Malignant neoplasms	12	22.0
5	Transport accidents	11	20.2

- Similar to those aged 25-34 years, the top two causes of death among Washoe County residents aged 35-44 years were non-transport accidents and intentional self-harm (suicide).

Table 166: Causes of Death among those Aged 45-54 Years, Washoe County, 2015

Rank	Cause of Death	Count	Rate
1	Diseases of the heart	60	104.5
2	Malignant neoplasms	44	76.7
3	Non-transport accidents	30	52.3
4	Chronic liver disease and cirrhosis	26	45.3
5	Intentional self-harm (suicide)	21	36.6

- The top two causes of death among Washoe County residents aged 45-54 years were diseases of the heart and malignant neoplasms (cancer).

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Table 167: Causes of Death among those Aged 55-64 Years, Washoe County, 2015

Rank	Cause of Death	Count	Rate
1	Malignant neoplasms	153	269.3
2	Diseases of the heart	146	257.0
3	Chronic lower respiratory diseases	34	59.8
4	Non-transport accidents	27	47.5
5	Chronic liver disease and cirrhosis	23	40.5

- The top two causes of death among Washoe County residents aged 55-64 years were malignant neoplasms (cancer) and diseases of the heart.

Table 168: Causes of Death among those Aged 65-74 Years, Washoe County, 2015

Rank	Cause of Death	Count	Rate
1	Malignant neoplasms	258	638.0
2	Diseases of the heart	222	549.0
3	Chronic lower respiratory diseases	52	128.6
4	Cerebrovascular diseases (stroke)	28	69.2
5	Diabetes mellitus	18	44.5

- The top two causes of death among Washoe County residents aged 65-74 years were malignant neoplasms (cancer) and diseases of the heart.

Table 169: Causes of Death among those Aged 75-84 Years, Washoe County, 2015

Rank	Cause of Death	Count	Rate
1	Diseases of the heart	195	1,191.9
2	Malignant neoplasms	188	1,149.1
3	Chronic lower respiratory diseases	69	421.7
4	Cerebrovascular diseases (stroke)	47	287.3
5	Alzheimer's disease	32	195.6

- The top two causes of death among Washoe County residents aged 75-84 years were diseases of the heart and malignant neoplasms (cancer).

Table 170: Causes of Death among those Aged 85+ Years, Washoe County, 2015

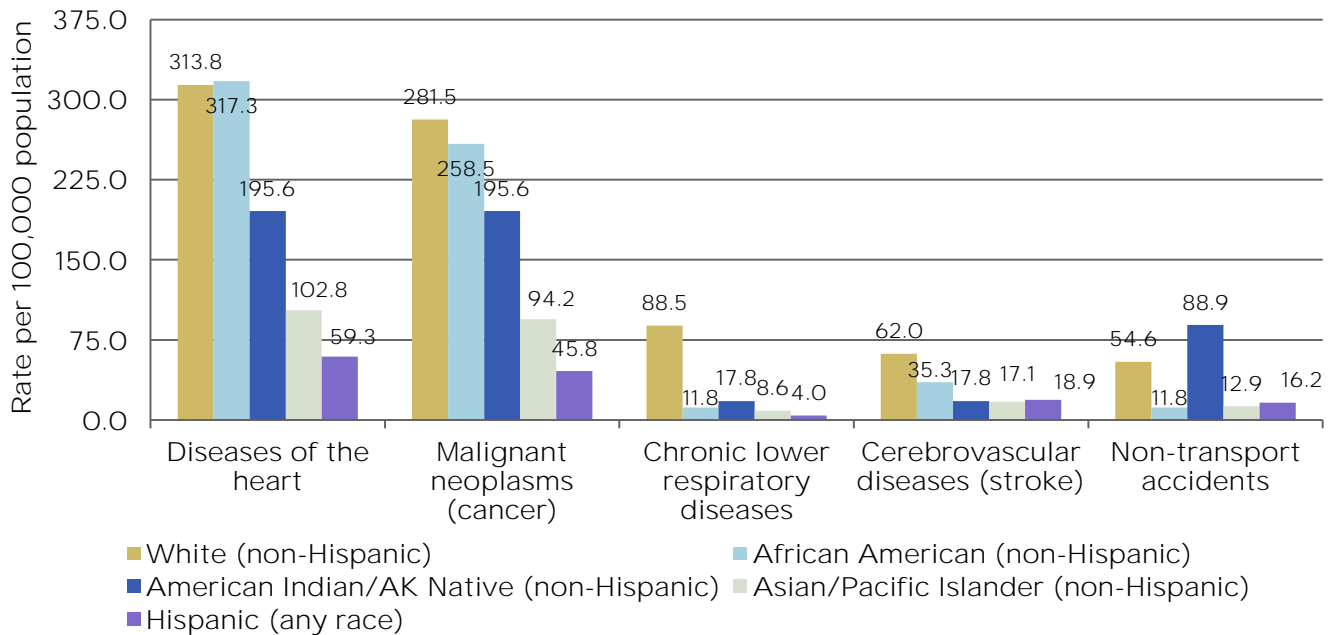
Rank	Cause of Death	Count	Rate
1	Diseases of the heart	245	4,056.1
2	Malignant neoplasms	133	2,201.9
3	Alzheimer's disease	84	1,390.7
4	Cerebrovascular diseases (stroke)	74	1,225.1
5	Chronic lower respiratory diseases	67	1,109.2

- The top two causes of death among Washoe County residents aged 85+ years were diseases of the heart and malignant neoplasms (cancer).

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Cause of Death by Race & Ethnicity

Fig 175: Age-Adjusted Rate of Death for Top 5 Causes of Death by Race/Ethnicity, Washoe County, 2015



- The rate of death for the number one cause of death, diseases of the heart, was highest among non-Hispanic African Americans (317.3 per 100,000) compared to the lowest rate of death which was among Hispanics (59.3 per 100,000).
- The rate of death for the number two ranked cause of death, cancer, was highest among white, non-Hispanics (281.5 per 100,000) compared to the lowest rate of death which was among Hispanics (45.8 per 100,000).
- The rate of death for the number three ranked cause of death, chronic lower respiratory diseases, was highest among white, non-Hispanics (88.5 per 100,000) compared to the lowest rate of death which was among Hispanics (4.0 per 100,000).
- The rate of death for the number four ranked cause of death, stroke, was highest among white, non-Hispanics (62.0 per 100,000) compared to the lowest rate of death which was among non-Hispanic Asian/Pacific Islanders (17.1 per 100,000).
- The rate of death for the number five ranked cause of death, non-transport accidents, was highest among non-Hispanic American Indian/Alaska Natives (88.9 per 100,000) compared to the lowest rate of death which was among non-Hispanic African Americans (11.8 per 100,000).

Table 171: Rank & Cause of Death by Race/Ethnicity, Washoe County, 2015

Rank	Hispanic	African American	American Indian/Alaska Native	Asian	White
1	Diseases of the heart	Diseases of the heart	Diseases of the heart	Diseases of the heart	Diseases of the heart
2	Malignant neoplasms (cancer)	Malignant neoplasms (cancer)	Malignant neoplasms (cancer)	Malignant neoplasms (cancer)	Malignant neoplasms (cancer)
3	Chronic liver disease and cirrhosis	Cerebrovascular disease (stroke); Transport accidents (tie)	Non-transport accidents; Chronic liver disease and cirrhosis (tie)	Intentional self-harm (suicide)	Chronic lower respiratory diseases
4	Cerebrovascular disease (stroke)	~	~	~	Cerebrovascular diseases (stroke)
5	Non-transport accidents	~	~	~	Non-transport accidents

~ suppressed due to counts smaller than 5

- The top two causes of death for all races and ethnicities in Washoe County during 2015 were diseases of the heart and malignant neoplasms (cancer).
- The third highest cause of death was different among all racial and ethnic groups in Washoe County. Among Hispanics the third highest ranked cause of death was chronic liver disease and cirrhosis. Among African Americans it was tied between cerebrovascular diseases (stroke) and transport accidents. Among American Indians/Alaska Natives it was tied between non-transport accidents and chronic liver disease and cirrhosis. Among Asians the third highest ranked causes of death was intentional self-harm (suicide). Among whites, the third highest ranked cause of death was chronic lower respiratory diseases.
- The fourth (cerebrovascular disease-stroke) and fifth (non-transport accidents) ranked causes of death were the same for Hispanic and white residents.

Cancer-Specific Mortality

Malignant neoplasms (cancer) are the second leading cause of death and are responsible for one in every four deaths in the United States. Cancer is a disease where the cells of the body grow out of control, which when left undiagnosed and untreated can spread and impact other organs.²⁰² The causes of cancer differ from type to type, however there are behavioral factors which increase the risk of many cancers. These include being obese, using tobacco products, and excessive alcohol consumption. In 2014, lung and bronchial cancers were the leading cause of cancer-specific deaths in the United States, followed by colon and rectal cancers, breast cancer (females), and prostate cancer (males).²⁰³

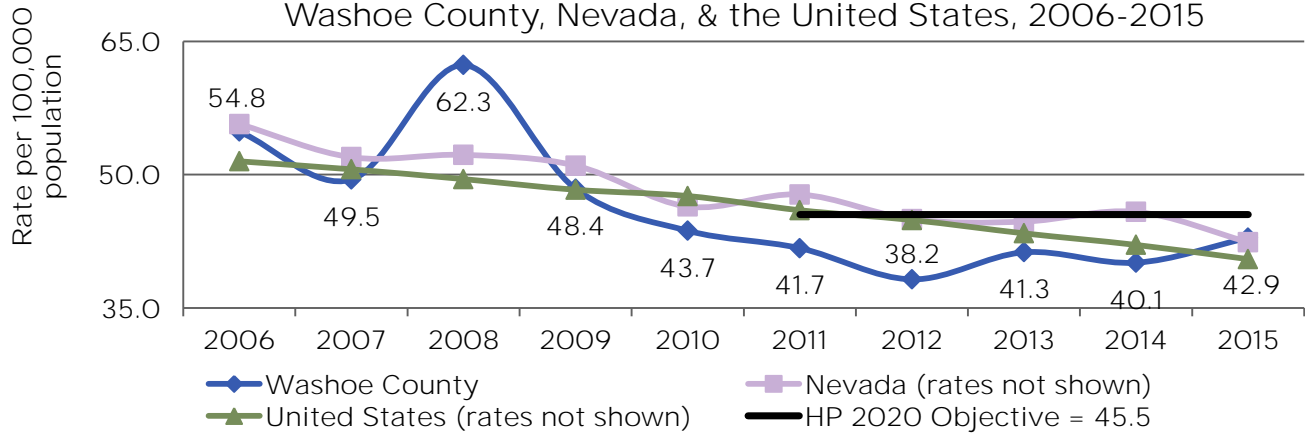
²⁰² Centers for Disease Control and Prevention. Cancer Prevention and Control, Statistics for Different Kinds of Cancer. Accessed <https://www.cdc.gov/cancer/dpcp/data/types.htm>

²⁰³ Centers for Disease Control and Prevention. United States Cancer Statistics (USCS). 2014 Top Ten Cancers. Accessed <https://nccd.cdc.gov/uscs/toptencancers.aspx>

Lung Cancer

Lung cancer is the leading cancer-related cause of death. In 2011, it accounted for 27% of all cancer deaths in the United States. Cigarette smoking is the number one risk factor for lung cancer linked to 80% to 90% of all cases. However, as smoking rates have decreased, so have the rates of lung cancer. Lung cancer can also be caused by exposure to second hand smoke, asbestos, or radon in the home or at work. An additional risk factor includes having a family history of lung cancer.²⁰⁴

Fig 176: Age-Adjusted Rate of Death Due to Lung Cancer, Washoe County, Nevada, & the United States, 2006-2015



- The mortality rate due to lung cancer in Washoe County decreased from 2006 (54.8 per 100,000 population) to 2015 (42.9 per 100,000 population) and was below the Healthy People 2020 Objective (45.5 per 100,000).
- In 2015 the mortality rate due to lung cancer in Washoe County was relatively similar to (42.9 per 100,000 population) Nevada (42.4 per 100,000 population).
- As of 2015, the mortality rate due to lung cancer in Washoe County (42.9 per 100,000 population) was higher than the United States (40.5 per 100,000 population).

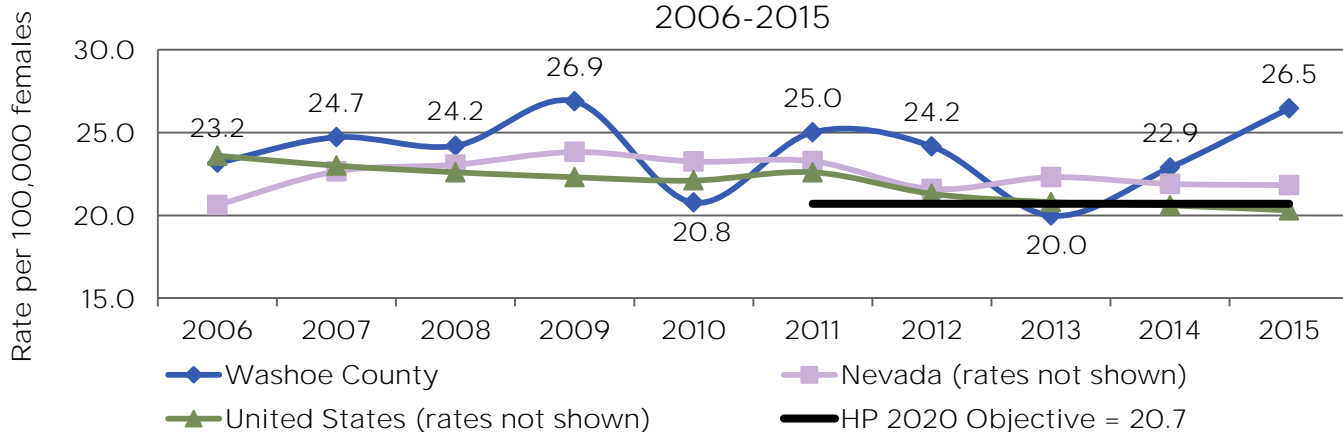
Breast Cancer

Breast cancer is the highest cancer-specific death rate among women. Although men and women can both get breast cancer, it is much more common among women. Risk factors for breast cancer include aging, genetic mutations (BRCA1 and BRCA2), first pregnancy after age 30 or never having a full-term pregnancy, having dense breast tissue, taking oral contraceptives, starting menstruation before age 12, starting menopause after age 55, drinking alcohol, physical inactivity, being overweight/obese, or having a family history of breast cancer.²⁰⁵

²⁰⁴ Centers for Disease Control and Prevention. Lung Cancer. Accessed <https://www.cdc.gov/cancer/lung/>

²⁰⁵ Centers for Disease Control and prevention. What are the Risk Factors for Breast Cancer. Accessed https://www.cdc.gov/cancer/breast/basic_info/risk_factors.htm

Fig 177: Age-adjusted Rate of Death Due to Breast Cancer among Females, Washoe County, Nevada, & the United States, 2006-2015

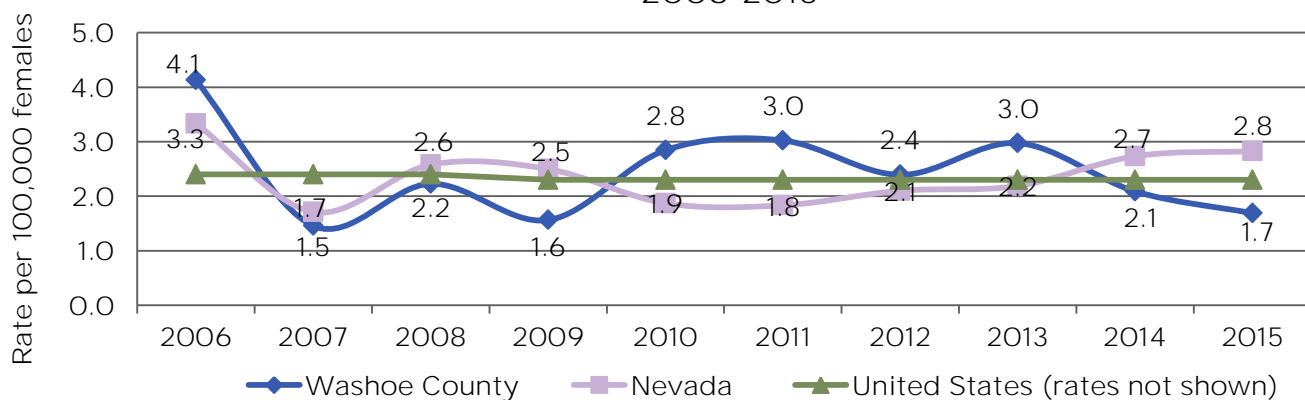


- The mortality rate due to breast cancer among females in Washoe County increased from 2006 (23.2 per 100,000 females) to 2015 (26.5 per 100,000 females) and was above the Healthy People 2020 objective (20.7 per 100,000 females).
- In 2015 the mortality rate due to breast cancer among females in Washoe County was higher (26.5 per 100,000 females) than Nevada (21.8 per 100,000 females) and the United States (20.3 per 100,000 females).

Cervical Cancer

Cervical cancer used to be the leading cause of cancer-specific deaths among women. However, over the past four decades the number of cervical cancer cases and deaths has declined largely due to women getting regular pap tests. Pap tests find precancerous or cancerous cells on the cervix before they become invasive cancer. Human papilloma virus (HPV), is sexually transmitted, and is the main cause of cervical cancer.²⁰⁶

Fig 178: Age-adjusted Rate of Death Due to Cervical Cancer among Females, Washoe County, Nevada, & the United States, 2006-2015



- The mortality rate due to cervical cancer among females in Washoe County decreased from 2006 (4.1 per 100,000 females) to 2015 (1.7 per 100,000 females).

²⁰⁶ Centers for Disease Control and Prevention. Gynecological Cancers, Basic Information about Cervical Cancer. Accessed https://www.cdc.gov/cancer/cervical/basic_info/index.htm

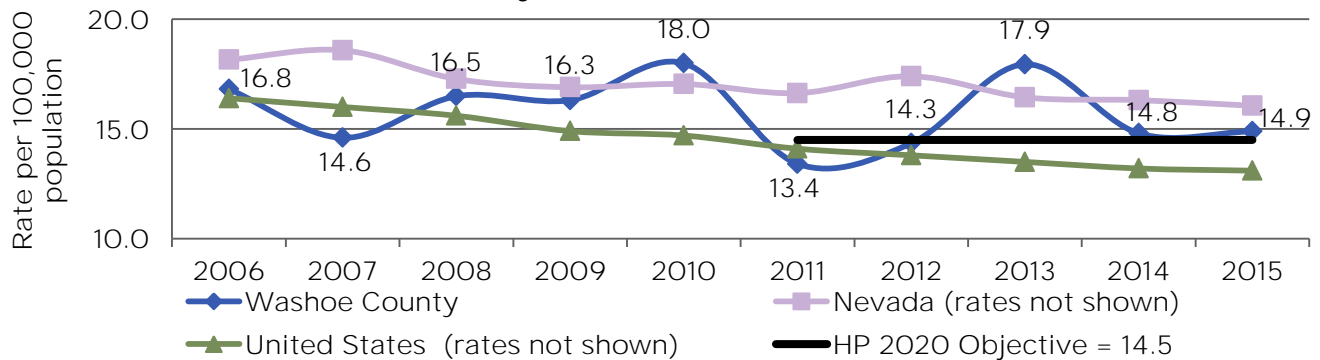
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- In 2015 the mortality rate due to cervical cancer among females in Washoe County was lower (1.7 per 100,000 females) than Nevada (2.8 per 100,000 females) and the United States (2.3 per 100,000 females).

Colorectal Cancer

Among cancers impacting both men and women, colorectal cancer is the second highest cause of cancer-specific deaths in the United States. Age is a contributing factor to increased risk for colon and rectal cancers. Other risk factors include family history of colorectal cancer or colorectal polyps, Crohn’s disease, ulcerative colitis, lack of physical activity, low fruit and vegetable consumption, diet low in fiber and high in fat, being overweight or obese, alcohol consumption and tobacco use.²⁰⁷

Fig 179: Age-adjusted Rate of Death Due to Colorectal Cancer, Washoe County, Nevada, & the United States, 2006-2015



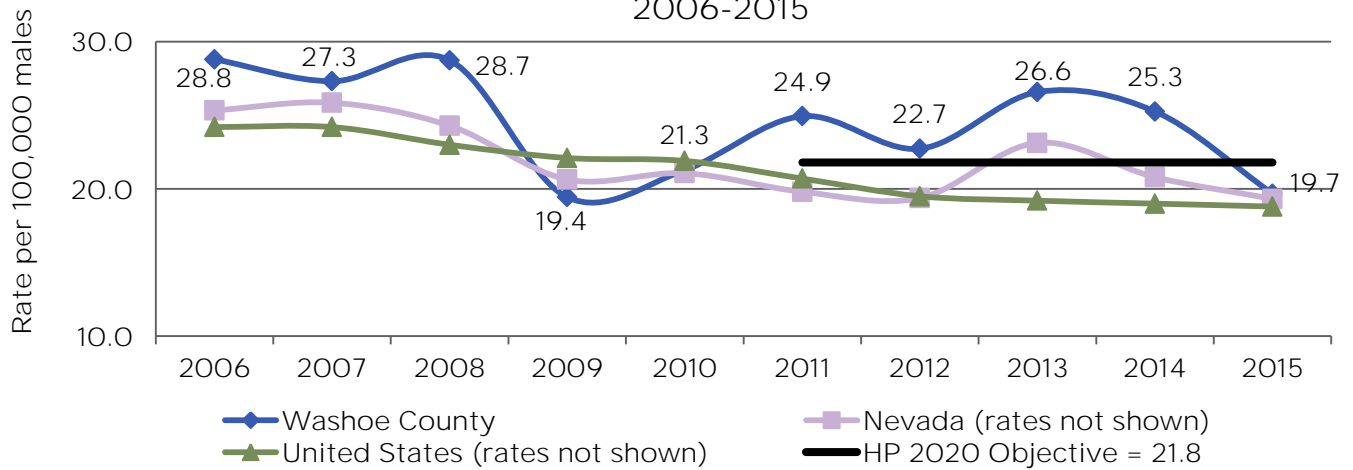
- The mortality rate due to colorectal cancer in Washoe County decreased from 2006 (16.8 per 100,000 population) to 2015 (14.9 per 100,000 population) and was slightly above the Healthy People 2020 objective (14.5 per 100,000 population).
- In 2015 the mortality rate due to colorectal cancer in Washoe County was lower (14.9 per 100,000 population) than Nevada (16.1 per 100,000 population).
- In 2015 the mortality rate due to colorectal cancer in Washoe County was higher (14.9 per 100,000 population) than the United States (13.1 per 100,000 population).

²⁰⁷ Centers for Disease Control and Prevention. Colorectal (colon) Cancer, What are the Risk Factors for Colorectal Cancer?. Accessed https://www.cdc.gov/cancer/colorectal/basic_info/risk_factors.htm

Prostate Cancer

Prostate cancer is responsible for one of the highest cancer-specific death rates, and among male-specific cancers is second only to non-melanoma skin cancer. Many men die of prostate cancer without ever having experienced any symptoms. Risk factors include age, family history and race, as it is more common among African American men. However, researchers are still working to determine the causes of prostate cancer and whether it can be prevented.²⁰⁸

Fig 180: Age-adjusted Rate of Death Due to Prostate Cancer among Males, Washoe County, Nevada, & the United States, 2006-2015



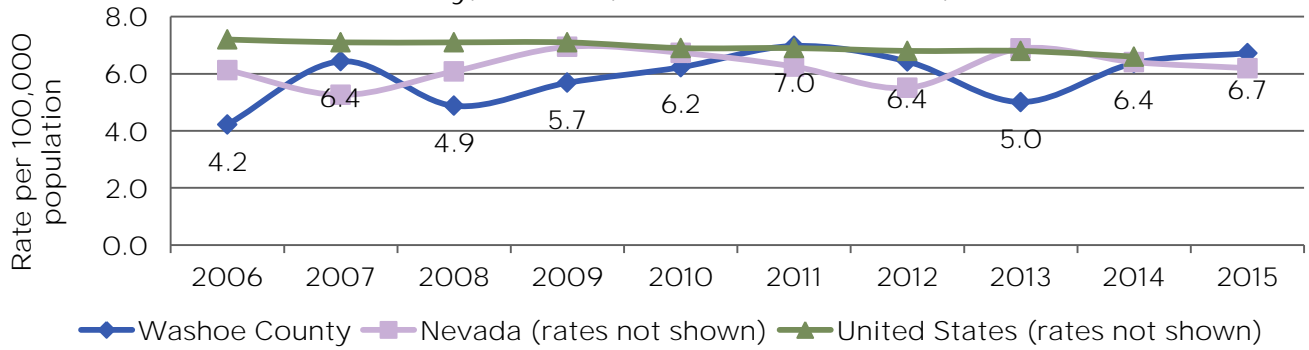
- The mortality rate due to prostate cancer in Washoe County decreased from 2006 (28.8 per 100,000 males) to 2015 (19.7 per 100,000 males) and below the Healthy People 2020 objective (21.8 per 100,000 males).
- In 2015 the mortality rate due to prostate cancer in Washoe County was relatively similar to (19.7 per 100,000 males) Nevada (19.3 per 100,000 males) and the United States (18.8 per 100,000 males).

²⁰⁸ Centers for Disease Control and Prevention. Prostate Cancer, What are the Risk Factors?. Accessed https://www.cdc.gov/cancer/prostate/basic_info/risk_factors.htm

Leukemia

Leukemia is the cancer of the bone marrow and blood and is the most common type of cancer among children and adolescents. However, as with all cancer, risk increases with age. Therefore, most cases occur among adults. Researchers have not determined all the causes of leukemia, however there are several factors which have been linked including repeated benzene exposure, large doses of ionizing radiation, tobacco smoke, family history, or genetic mutations.²⁰⁹

Fig 181: Age-Adjusted Rate of Death Due to Leukemia, Washoe County, Nevada, & the United States, 2006-2015



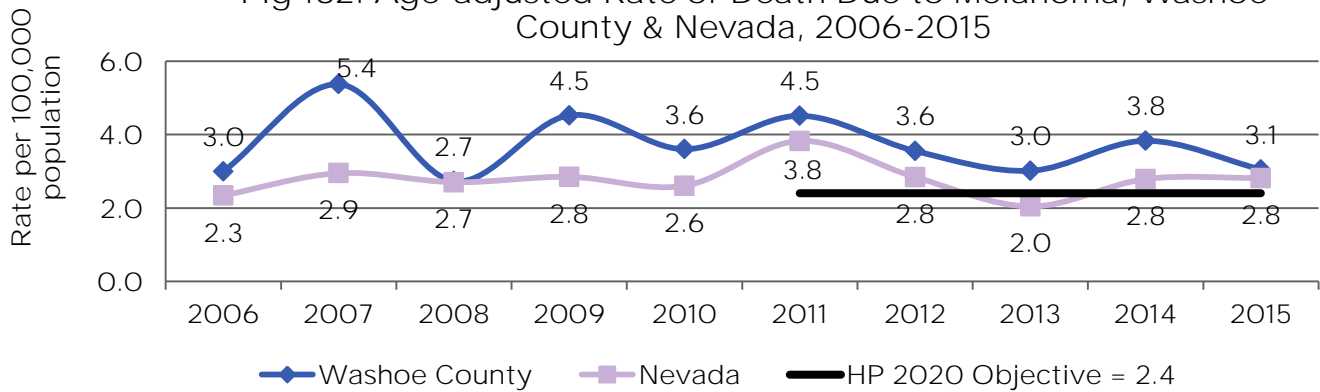
- The mortality rate due to leukemia in Washoe County increased from 2006 (4.2 per 100,000 population) to 2015 (6.7 per 100,000 population).
- In 2015 the mortality rate due to leukemia in Washoe County was relatively similar to (6.7 per 100,000 population) Nevada (6.2 per 100,000 population).

²⁰⁹ Centers for Disease Control and Prevention. Leukemia. Accessed <https://www.cdc.gov/cancer/leukemia/index.htm#statistics>

Melanoma

Skin cancer, is the most common type of cancer diagnosed in the United States. Melanoma is the third most common type of skin cancer, is more dangerous and leads to more deaths, although the rate of death is lower than several other types of cancer. Most cases of skin cancer are caused by overexposure to ultraviolet (UV) light, the radiation from sun, tanning beds, and sunlamps. Factors which increase the risk of developing skin cancer include naturally light skin color, exposure to sun, history of sunburn, indoor tanning, having blue or green eyes, blond or red hair, and having certain types and high numbers of moles.²¹⁰

Fig 182: Age-adjusted Rate of Death Due to Melanoma, Washoe County & Nevada, 2006-2015



- The mortality rate due to melanoma in Washoe County remained relatively similar from 2006 (3.0 per 100,000 population) to 2015 (3.1 per 100,000 population) and was above the Healthy People 2020 objective (2.4 per 100,000 population).
- From 2006 through 2015 the rate of death due to melanoma in Washoe County has remained higher than Nevada, with the exception of 2008 when the melanoma mortality rates were the same (2.7 per 100,000 population).
- In 2015 the mortality rate due to melanoma in Washoe County was higher (3.1 per 100,000 population) than Nevada (2.8 per 100,000 population).

Summary of Mortality

In 2015, the age-adjusted mortality rate among residents in Washoe County fell to a low of 768.4 per 100,000 population. The top two causes of death were due to disease of the heart and malignant neoplasms (cancer). This is the same for Nevada and the United States. Diseases of the heart and malignant neoplasms (cancer) were also the top two causes of death for all age groups 45 years and older as well as all racial and ethnic groups. The causes of death for those aged 15-24 years were assault (homicide) and transport accidents, for those aged 25-34 years and those aged 35-44 years the top two causes of death were non-transport accidents and intentional self-harm (suicide).

²¹⁰ Centers for Disease Control and Prevention. Skin Cancer, What are the Risk factors for Skin Cancer?. Accessed https://www.cdc.gov/cancer/skin/basic_info/risk_factors.htm

The risk factors which lead up to diseases of the heart include overweight and obesity, poor diet, high cholesterol, excessive alcohol use, physical inactivity, smoking, high blood pressure, and diabetes. According to the Centers for Disease Control and Prevention nearly half of Americans have at least three of these risk factors.^{211, 212}

Several of these same risk factors also increase the risk of cancer such as excessive alcohol intake, poor diet, obesity, physical inactivity, smoking and tobacco intake. Other cancer-related risk factors are radiation, including exposure to sunlight and UV-rays, environmental toxins, and in some cases viruses such as human papilloma virus (HPV), hepatitis B and C viruses (HBV, HCV) among others.^{213,214}

Mortality Sources

Fig 172: Age-Adjusted Mortality Rate for Underlying Causes of Death, all ages, Washoe County, Nevada, & the United States, 2006-2015

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html>

Fig 173: Age-Adjusted Mortality Rate for all Causes of Death among those 15+ years, Washoe County & Nevada, 2006-2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Table 162: Top Causes of Death, by Rank, 2015

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Xu, J., Murphy, S.L., Kochanek, K.D. & Arias, E. (2016). Mortality in the United States, 2015. National Center for Health Statistics Data Brief, no 267. Hyattsville, MD.

Fig 174; Table 163-Table 170; Fig 175; Table 171 Same Source

Fig 174: Age-Adjusted Rate of Death for Top 5 Causes of Death by Sex, Washoe County, 2015

Table 163: Causes of Death among those Aged 15-24 Years, Washoe County, 2015

Table 164: Causes of Death among those Aged 25-34 Years, Washoe County, 2015

Table 165: Causes of Death among those Aged 35-44 Years, Washoe County, 2015

Table 166: Causes of Death among those Aged 45-54 Years, Washoe County, 2015

Table 167: Causes of Death among those Aged 55-64 Years, Washoe County, 2015

Table 168: Causes of Death among those Aged 65-74 Years, Washoe County, 2015

Table 169: Causes of Death among those Aged 75-84 Years, Washoe County, 2015

Table 170: Causes of Death among those Aged 85+ Years, Washoe County, 2015

Fig 175: Age-Adjusted Rate of Death for Top 5 Causes of Death by Race/Ethnicity, Washoe County, 2015

Table 171: Rank & Cause of Death by Race/Ethnicity, Washoe County, 2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

²¹¹ Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division for heart Disease and Stroke Prevention. Heart Disease Facts. Accessed <https://www.cdc.gov/heartdisease/facts.htm>

²¹² U.S. Department of Health and Human Services. National Institutes of Health, National Heart, Lung, and Blood Institute. What Causes Heart Disease?. Accessed <https://www.nhlbi.nih.gov/health/health-topics/topics/hdw/causes>

²¹³ American Cancer Society. Cancer A-Z. Accessed <https://www.cancer.org/cancer/cancer-causes.html>

²¹⁴ U.S. Department of Health and Human Services. National Institutes of Health, National cancer Institute. Risk Factors for Cancer. Accessed <https://www.cancer.gov/about-cancer/causes-prevention/risk>

Fig 176-Fig 180 Same Source

Fig 176: Age-Adjusted Rate of Death Due to Lung Cancer, Washoe County, Nevada, & the United States, 2006-2015

Fig 177: Age-adjusted Rate of Death Due to Breast Cancer among Females, Washoe County, Nevada, & the United States, 2006-2015

Fig 178: Age-adjusted Rate of Death Due to Cervical Cancer among Females, Washoe County, Nevada, & the United States, 2006-2015

Fig 179: Age-adjusted Rate of Death Due to Colorectal Cancer, Washoe County, Nevada, & the United States, 2006-2015

Fig 180: Age-adjusted Rate of Death Due to Prostate Cancer among Males, Washoe County, Nevada, & the United States, 2006-2015

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html>

Fig 181: Age-Adjusted Rate of Death Due to Leukemia, Washoe County, Nevada, & the United States, 2006-2015

Nevada and Washoe County: Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

United States: Centers for Disease Control and Prevention. United States Cancer Statistics (USCS), Top Ten Cancers. Accessed <https://nccd.cdc.gov/uscs/toptencancers.aspx>

Fig 182: Age-adjusted Rate of Death Due to Melanoma, Washoe County & Nevada, 2006-2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Community Needs Index

The Community Needs Index (CNI) is a standardized tool used to measure and compare socioeconomic factors and health outcomes at the ZIP code level within a community. To rank the health needs of a community this tool assigns a CNI score from 1 (lowest need) to 5 (highest need). Truven Health Analytics calculates CNI scores on an annual basis by examining five socioeconomic health indicators: income, culture/language, education level, housing status and medical insurance coverage. Researchers have found when analyzing national CNI data, residents in communities with the highest CNI scores were shown to be twice as likely to be hospitalized for preventable conditions when compared to communities with the lowest CNI scores.¹ This emphasizes the importance of accounting for socioeconomic factors when trying to understand health disparities across ZIP codes.

For the purpose of this assessment, the five ZIP codes with the highest CNI scores over the past four years (2013-2016) were selected for a deep dive [Table 172]. Hospitalization and mortality rates for select conditions for the highest five CNI ZIP codes were compared to Washoe County overall.

Indicator
CNI scores by ZIP code
Select Demographics
Number and percent of total population
Age group and median age
Race and ethnicity
Median household income
Unemployment rates
Educational attainment
Select Hospitalization Rates
Asthma
COPD
Hypertension
Stroke
Select Mortality Rates
Heart disease
Cancer
Accidents
Infant mortality

¹ Roth, R. & Barsi, E.. (2005). The "Community Need Index": A New Tool Pinpoints Health Care Disparities in Communities throughout the Nation. Health Progress. Accessed <http://www.chausa.org/docs/default-source/health-progress/the-community-need-index-pdf.pdf?sfvrsn=0>

2.0 COMMUNITY NEEDS INDEX

CNI Scores by ZIP Code

Table 172 indicates the CNI scores for 2013, 2014, 2015, and 2016, as reported by Truven Health Analytics, an organization which annually provides a CNI score at the ZIP code level nationwide. The cumulative CNI score is the sum of scores for the past four years (2013-2016). All Washoe County ZIP codes are presented in order from highest cumulative CNI score (highest need) to lowest cumulative CNI score (lowest need).

Table 172: CNI Scores for ZIP Codes in Washoe County, 2013-2016

Zip	2013 CNI Score	2014 CNI Score	2015 CNI Score	2016 CNI Score	Cumulative Score
89512	5.0	5.0	5.0	5.0	20.0
89502	5.0	4.8	4.8	4.8	19.4
89431	4.8	4.8	4.8	4.6	19.0
89433	4.2	4.0	4.4	4.4	17.0
89501	4.4	4.2	4.2	4.2	17.0
89424	3.6	4.0	4.4	4.2	16.2
89442	3.8	4.0	4.4	4.0	16.2
89503	3.8	3.8	4.0	4.0	15.6
89405	4.0	4.0	3.8	3.6	15.4
89412	4.2	3.8	3.8	3.6	15.4
89506	3.6	3.6	3.8	3.8	14.8
89434	3.6	3.8	3.6	3.6	14.6
89509	3.8	3.4	3.8	3.6	14.6
89451	3.0	2.6	3.4	3.4	12.4
89523	3.2	3.0	3.0	3.0	12.2
89521	3.0	2.6	2.6	2.6	10.8
89508	2.2	2.4	2.8	3.2	10.6
89510	2.6	2.8	2.6	2.6	10.6
89511	2.8	2.2	2.4	2.2	9.6
89436	2.2	2.2	2.4	2.4	9.2
89441	2.2	2.4	2.2	2.2	9.0
89704	2.4	2.4	1.8	1.8	8.4
89519	2.4	1.8	1.8	2.0	8.0
89439	~	~	3.0	2.2	5.2
89402	~	~	~	2.4	2.4
Washoe County Average	3.5	3.4	3.5	3.3	12.9
~ data unavailable					

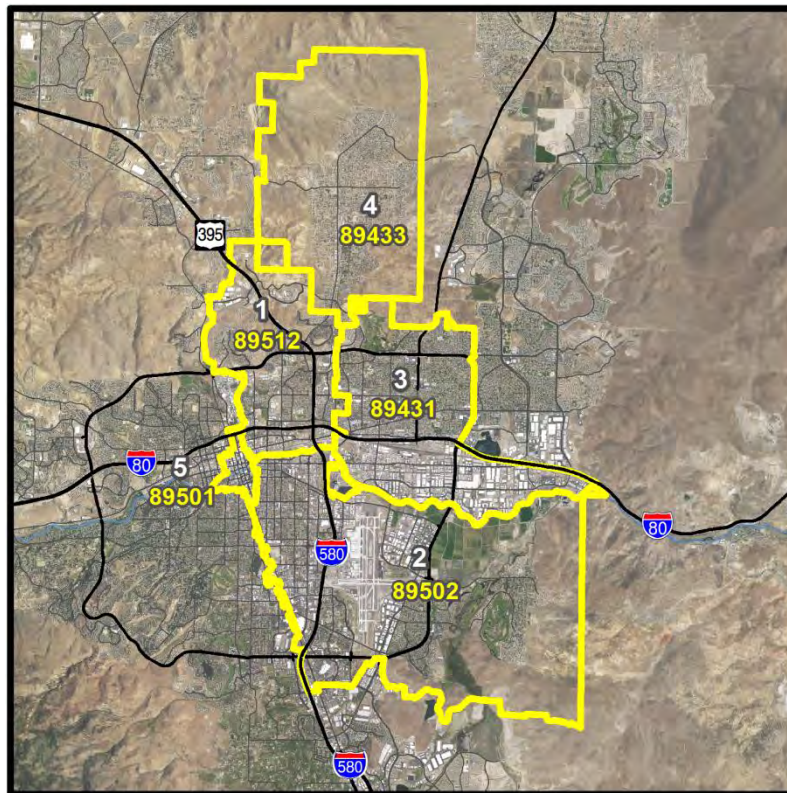
Top 5 ZIP Codes

The five ZIP codes in Washoe County with the highest CNI scores over the past four years (2013-2016) in order of need from highest to lowest, were 89512, 89502, 89431, 89433, and 89501². Together, these five ZIP codes account for nearly one-third (30.3%) of Washoe County’s population and incorporate much of the downtown and inner-city regions of Reno-Sparks metropolitan areas [Image 8].

Table 173: Number & Percent of Washoe County Population Residing in Top 5 CNI ZIP codes, 2011-2015 Aggregate Data

ZIP Code	Number of People	Percent of Washoe County Population
89512	25,561	5.9%
89502	44,777	10.3%
89431	37,800	8.7%
89433	20,232	4.7%
89501	3,551	0.8%
Washoe County	131,921	30.3%

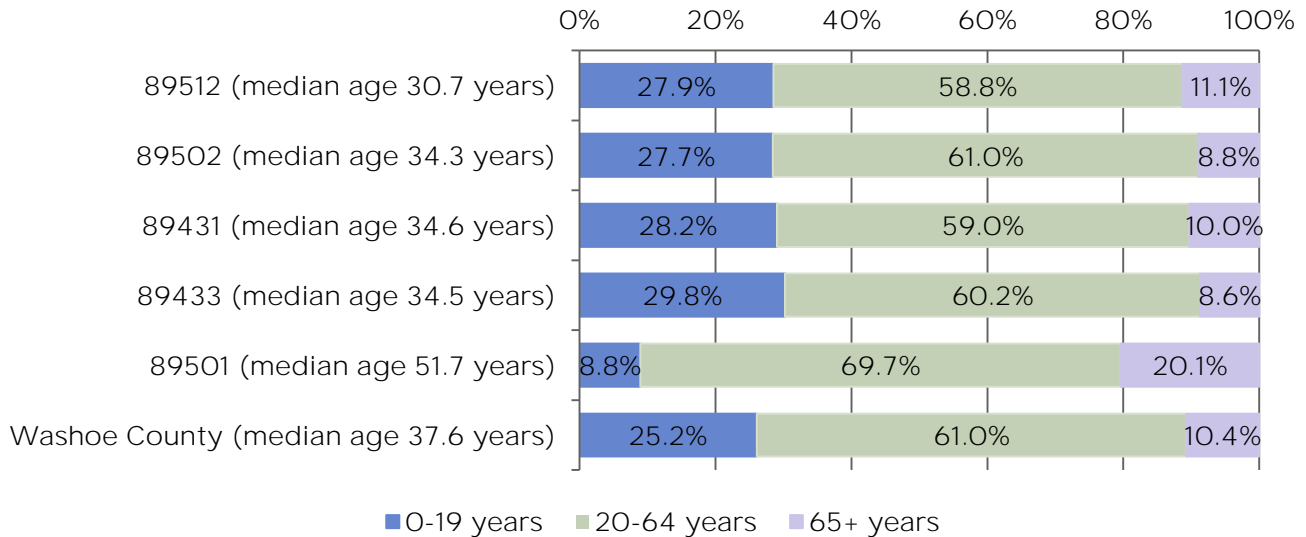
Image 8: Top 5 CNI ZIP Codes, Washoe County, 2016



² 89501 & 89433 were tied for cumulative 4-year score; however, 89433 CNI scores have increased, while 89501 CNI scores decreased and as of the most recent year, 2016, the 89433 score was higher.

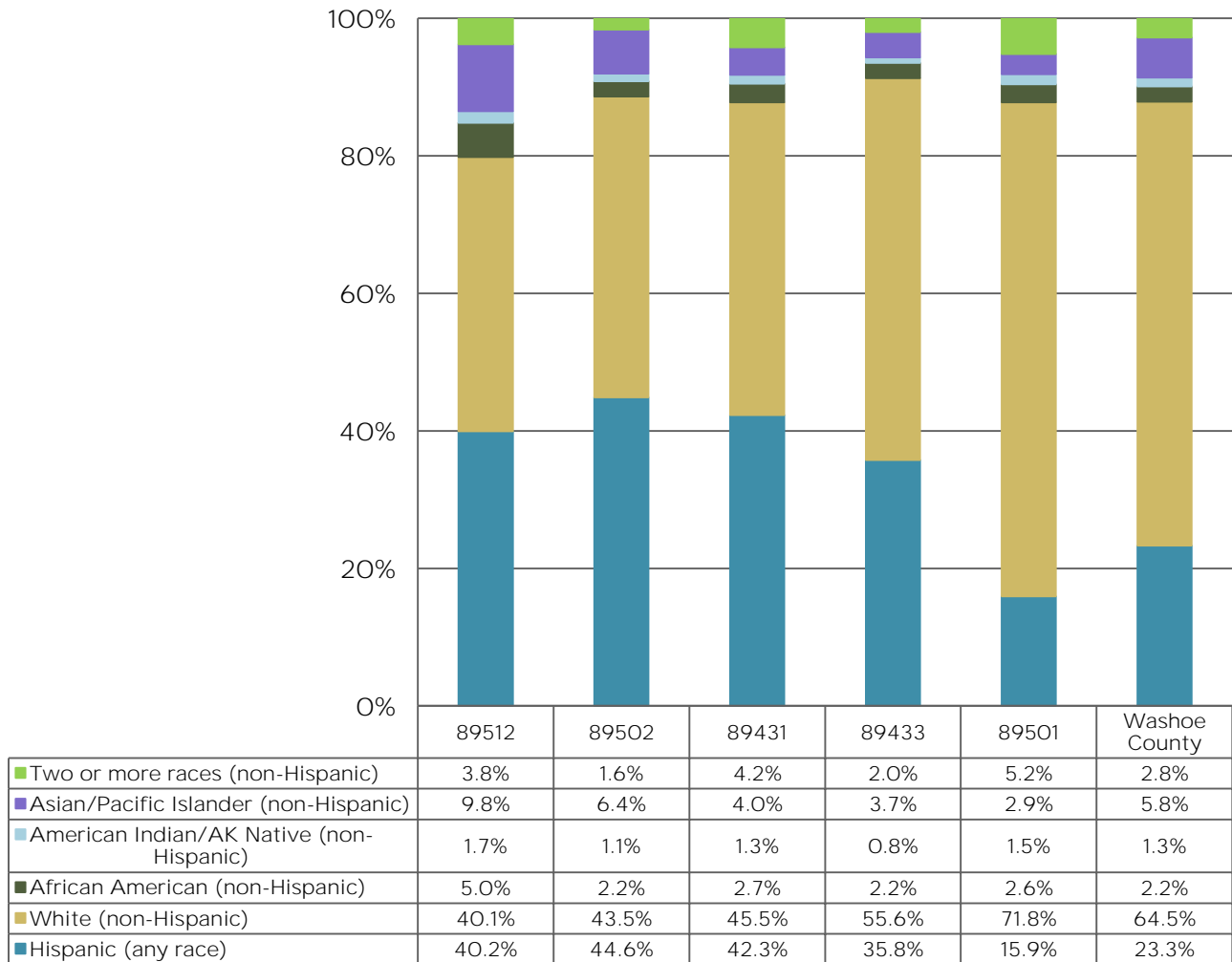
2.0 COMMUNITY NEEDS INDEX

Fig 183: Percent of Population by Age Group, Top 5 CNI ZIP Codes Compared to Washoe County, 2011-2015 Aggregate Data



- With the exception of 89501, the top 5 CNI ZIP code residents were slightly younger, had a higher proportion of population aged 0-19 years and proportionately fewer residents aged 65 years or older compared to Washoe County overall.
- 89501 is unique in that the median age of residents (51.7 years) is nearly 15 years older than Washoe County residents (37.6 years), much lower proportion of residents within 89501 were in the 0-19 age group and nearly twice the proportion of residents were 65 years and older, relative to Washoe County overall.

Fig 184: Percent of Population by Race/Ethnicity, Top 5 CNI ZIP Codes Compared to Washoe County, 2011-2015 Aggregate Data



- There is a higher proportion of minority populations in the 5 top CNI ZIP codes, except for 89501, compared to Washoe County overall.
- With the exception of 89501, over one in three residents in the top 5 CNI ZIP codes were Hispanic (any race), while Washoe County overall was around one in four (23.3%).

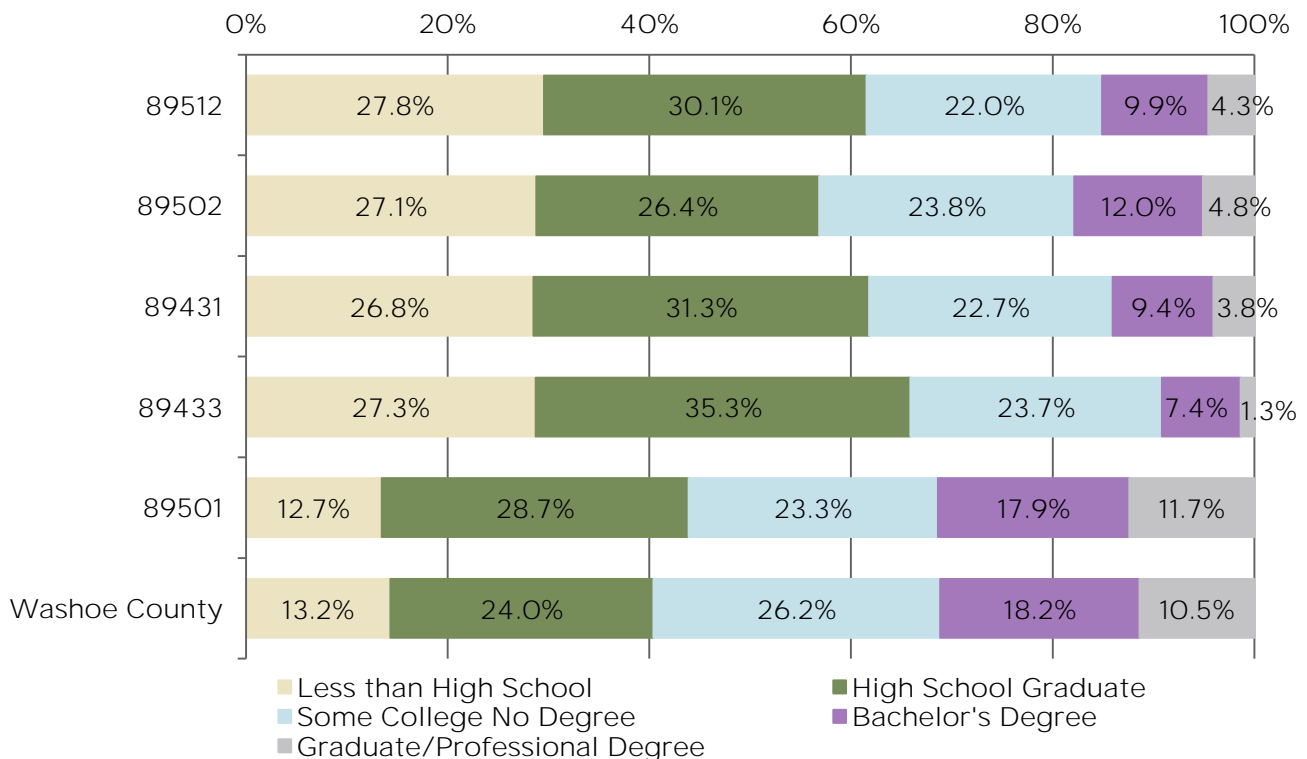
2.0 COMMUNITY NEEDS INDEX

Table 174: Median Household Income & Percent Unemployed, Top 5 CNI ZIP Codes Compared to Washoe County, 2011-2015 Aggregate Data

Location	Median Household Income	% Unemployed
89512	\$30,574	12.1%
89502	\$34,095	9.6%
89431	\$38,830	13.7%
89433	\$42,479	10.8%
89501	\$20,808	21.0%
Washoe County	\$52,870	9.1%

- The median household income for the top 5 CNI ZIP codes ranged from a low in 89501 (\$20,808) to a high in 89433 (\$42,479) compared to Washoe County (\$52,870).
- The unemployment rate for the top 5 CNI ZIP codes was also higher, ranging from a low in 89502 (9.6%) to a high in 89501 (21.0%), compared to Washoe County (9.1%).

Fig 185: Educational Attainment among Adults 25+ years, Top 5 CNI ZIP Codes Compared to Washoe County, 2011-2015 Aggregate Data



Note: Does not account for all levels of educational attainment therefore totals do not add up to 100%

- Apart from 89501, the percentage of residents with less than a high school degree in each of the other four top CNI ZIP codes was twice as high ranging from 89431 (26.8%) to 89512 (27.8%), compared to Washoe County (13.2%).
- The percentage of residents that graduated from high school and did not obtain a college degree was higher in each of the top 5 CNI ZIP codes compared to Washoe County (24.0%).
- The percentage of residents that obtained a bachelor's degree was lower in all 5 top CNI ZIP codes, ranging from a low in 89433 (7.4%) to a high in 89501 (17.9%), compared to Washoe County (18.2%).

2.0 COMMUNITY NEEDS INDEX

- Again, with the exception of 89501, the percentage of residents in each of the remaining top CNI ZIP codes that obtained a graduate or professional degree was lower compared to Washoe County residents overall (10.5%), ranging from a low in 89433 (1.3%) to 89502 (4.8%).

Hospitalization Rates for Select Conditions

Table 175: Rate of Hospitalizations for Top 5 CNI ZIP codes Compared to Washoe County, 2015

Location	Asthma	COPD	Hypertension	Stroke
89512	77.0	166.4	420.9	23.3
89502	208.4	613.9	1,292.6	70.4
89431	92.4	188.8	453.7	32.6
89433	90.9	170.2	476.4	30.1
89501	120.1	248.0	604.4	31.7
Washoe County	70.2	130.5	409.6	25.4

*rate per 10,000 population

- In 2015, the rate of hospitalization for asthma was higher in all of the top 5 CNI ZIP codes than Washoe County, with the highest rate in 89502 (208.4 per 10,000 population), nearly three times the rate for Washoe County (70.2 per 10,000 population).
- The 2015 hospitalization rates for COPD were higher for all of the top 5 CNI ZIP codes compared to the overall rate for Washoe County. The highest rate, also in 89502 (613.9 per 10,000), was nearly five times the rate for Washoe County (130.5 per 10,000 population).
- The 2015 rates of hospitalizations due to hypertension were also higher in all 5 of the top CNI ZIP codes compared to Washoe County overall. The highest rate of hospitalizations due to hypertension was in 89502 (1,292.6 per 10,000 population), a rate three times higher than Washoe County overall (409.6 per 10,000 population).
- The rate of hospitalization due to stroke was lowest of all select indicators, however all top 5 CNI ZIP codes, except for 89512, had higher rates than Washoe County overall in 2015. The highest rate of hospitalization due to stroke was again in 89502 (70.4 per 10,000 population), a rate nearly three times higher than Washoe County (25.4 per 10,000 population).

Mortality Rates for Select Causes of Death

Table 176: Crude Mortality Rate for Top 5 CNI ZIP Codes Compared to Washoe County, 2015

Location	Heart Disease	Cancer	COPD	Unintentional Accidents	Infant death rate (<1 year)	Overall Mortality Rate
89512	21.1	18.4	11.7	3.9	20.3	82.9
89502	22.1	16.7	13.8	6.9	2.7	88.9
89431	20.1	22.2	13.2	6.6	6.5	97.9
89501	180.2	138.0	112.6	36.6	0.0	613.9
89433	16.8	15.8	9.9	5.4	3.3	74.6
Washoe County	20.3	18.1	10.7	4.9	5.7	86.5

*Crude mortality-rate per 10,000 population (all ages); Infant death rate is per 1,000 live births

Note: Since the above mortality rates are not age-adjusted, the rates are a reflection of the population age of residents in these ZIP codes, rather than a reflection of true rates of death.

- In 2015, the overall crude mortality rate (not adjusted for age), was higher in 89502, 89431, and 89501 compared to Washoe County's (86.5 per 10,000) overall mortality rate.

2.0 COMMUNITY NEEDS INDEX

- In 2015, the mortality rate for heart disease ranged from a low in 89433 (16.8 per 10,000 population) to a high in 89501 (180.2 per 10,000 population).
- The mortality rate for cancer (all types combined) was highest in 89501 (138.0 per 10,000 population), while cancer mortality rates in 89502 (16.7) and 89433 (15.8) were slightly lower relative to Washoe County.
- The mortality rate due to COPD in 2015 was higher in 89501, 89502, 89431, and 89512 compared to Washoe County overall (10.7 per 10,000 population).
- In 2015, the mortality rate due to unintentional accidents was highest among residents in 89501 (36.6 per 10,000). Mortality rates due to unintentional accidents were also higher in 89502 (6.9), 89431 (6.6), and 89433 (5.4) compared to the Washoe County rate (5.4 per 10,000 population).
- The infant (< 1 year) death rate was highest among 89512 (20.3 per 1,000 live births), however the infant death rate in 89431 (6.5) was also higher than the infant death rate for Washoe County (5.7 per 1,000 live births).

Primary Survey Data Related to Community Needs

Primary data were collected via an online community survey from over 1,400 survey participants. The survey included 44 questions and analyses for questions related to perceived community needs are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community Survey Demographics section.

Table 177 illustrates community survey respondents' top five highest scoring health topics by ZIP code, relative to the overall rankings of all survey respondents. Survey participants were asked to rate 11 health topics in terms of perceived importance. Environmental health, social determinants, and health access (access to health services) were among the highest scoring health topics across all five of the top CNI ZIP codes.

Table 177: Top 5 Ranked Health Topics by Residents of Top 5 CNI ZIP Codes						
Rank	89512	89502	89431	89501	89433	All Respondents
1	Safety & Security	Health Access	Environmental Health	Environmental Health	Health Access	Health Access
2	Environmental Health	Social Determinants	Health Access	Health Access	Social Determinants	Environmental Health
3	Social Determinants	Environmental Health	Mental Health	Social Determinants	Environmental Health	Social Determinants
4	Health Access	Safety & Security	Social Determinants	Preventive Health	Safety & Security	Safety & Security
5	Injury Prevention	Mental Health	Safety & Security	Mental Health	Community Services	Mental Health

Note: Health access (increased primary and specialty providers, affordable insurance and more providers who accept insurance).

Environmental health (clean air, water, illegal dumping, food safety and mosquito abatement).

Social determinants (education system, employment, wages, hunger, poverty, affordable housing and homelessness).

Safety and security (property damage, violent crimes, sexual assault, domestic violence and overall safe neighborhoods).

Mental health (stress reduction, bullying, suicide, serious mental illnesses, and mental and behavioral health services and programs).
Preventive health (physical activity, nutrition, overweight/obesity, immunizations, oral health, cancer screenings, and chronic disease management).
Injury prevention (motor vehicle and pedestrian accidents, reckless driving, falls among elderly populations, accidental poisonings and drownings).
Community services (teen youth centers, community centers, services for immigrants, senior centers, affordable child care).

Community Needs Index Summary

The five ZIP codes in Washoe County with the highest CNI scores have remained the same from 2013 to 2016 and combined, these ZIP codes account for nearly one-third (30.3%) of Washoe County's population. The five high CNI ZIP codes are demographically similar with the exception of 89501, the smallest ZIP code encompassing downtown Reno. The other four high needs ZIP codes (89512, 89502, 89431, and 89433) had a higher proportion of minority populations, primarily Hispanic, relative to the county overall. Again, with the exception of 89501, the other four high needs ZIP codes were slightly younger in terms of median age, relative to Washoe County. The median age among residents in 89501 was 51.7 years, which is nearly 15 years older than the County overall (37.6 years). Median household income in the five high CNI ZIP codes were \$10,000 to \$32,000 below the Washoe County median income, and the rates of unemployment were higher as well. Educational attainment was also lower in the five highest CNI ZIP codes relative to Washoe County overall. Hospitalization rates for asthma, COPD, and hypertension were higher in all five ZIP codes and hospitalization rates for stroke were higher in four of five ZIP codes compared to Washoe County. The 2015 overall crude (not adjusted for age) mortality rates for three top five CNI ZIP codes (89502, 89431, and 89501) were also higher than Washoe County.

Community Needs Index scores are a helpful mechanism for evaluating a wide range of indicators pertaining to socioeconomic status, and help provide a visual cue of where high needs neighborhoods are located. The community survey responses illustrate how perceived needs vary among neighborhoods. CNI scores should be interpreted in conjunction with the existing gaps and assets of each neighborhood in order to provide the most effective models for improving the health and wellbeing of each neighborhood and community as a whole.

Community Needs Index Sources

Table 172: CNI Scores for ZIP Codes in Washoe County, 2013-2016

2013-2014: Truven Health Analytics. Data provided upon request. Reno, NV.

2015- 2016: Truven Health Analytics, Dignity Health. Community Needs Index. Accessed <http://cni.chw-interactive.org/>

Table 173: Number & Percent of Washoe County Population Residing in Top 5 CNI ZIP codes, 2011-2015 Aggregate Data

U.S .Census Bureau, 2011-2015 American Community Survey 5-Year Estimates. Table DP05.

Image 8: Top 5 CNI ZIP Codes, Washoe County, 2016

Washoe County GIS. Data provided upon request. Reno, NV.

Fig 183: Percent of Population by Age Group, Top 5 CNI ZIP Codes Compared to Washoe County, 2011-2015 Aggregate Data

U.S .Census Bureau, 2011-2015 American Community Survey 5-Year Estimates. Table S0101.

Fig 184: Percent of Population by Race/Ethnicity, Top 5 CNI ZIP Codes Compared to Washoe County, 2011-2015 Aggregate Data

U.S .Census Bureau, 2011-2015 American Community Survey 5-Year Estimates. Table DP05.

Table 174: Median Household Income & Percent Unemployed, Top 5 CNI ZIP Codes Compared to Washoe County, 2011-2015 Aggregate Data

U.S .Census Bureau, 2011-2015 American Community Survey 5-Year Estimates. Table DP03.

Fig 185: Educational Attainment among Adults 25+ years, Top 5 CNI ZIP Codes Compared to Washoe County, 2011-2015 Aggregate Data

U.S .Census Bureau, 2011-2015 American Community Survey 5-Year Estimates. Table S1501.

Table 175-Table 176 Same Source

Table 175: Rate of Hospitalizations for Top 5 CNI ZIP codes Compared to Washoe County, 2015

Table 176: Crude Mortality Rate for Top 5 CNI ZIP Codes Compared to Washoe County, 2015

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. Data provided upon request. Carson City, NV.

Table 177: Top 5 Ranked Health Topics by Residents of Top 5 CNI ZIP Codes

Online Community Survey

Community Strengths & Challenges

The previous Washoe County CHNA (2015-2018) included an asset list as a mechanism for community strengths and assets, while this assessment does not. Asset lists are helpful, however persons seeking assistance for a specific need are not likely to utilize this document as a resource, instead there are several local entities that provide a comprehensive list of referral options and community connections. This includes Nevada 211 (dial 2-1-1) or contacting United Way of Northern Nevada and the Sierra (775-322-8668).

There are three major resources used in this section to highlight community strengths and challenges. Results from the online community survey, results from an agency survey, and feedback from a Community Workshop. Each resource provides a different perspective from the community to help create a robust assessment of community strengths and assets, as well as gaps and challenges.

The online community survey was widely distributed through supporting partner organizations, resulting in over 1,400 survey respondents and the results indicate which organizations residents perceive to be a resource for seven specific health issues. The online community survey responses show people may benefit from more education on what services are provided by each agency. Additionally the results indicate some organizations may benefit from improved marketing and education regarding the services they provide. A non-referral question from the online community survey was also included and the question asked respondents what resource they rely on for information in the event of a disaster or emergency. While the results are not generalizable, they reflect how some community members perceive the available services of the community.

The invitation to the Community Workshop and an electronic agency survey was sent to 250 individuals representing 96 different organizations across Washoe County. The invitation to participate in the Community Workshop and the link to the agency survey was distributed to the January 2015 Truckee Meadows Healthy Communities Conference attendees, current Community Health Improvement Plan workgroup members, government entities, City Council members, County Commissioners, UNR and TMCC leadership and faculty, and nonprofit organizations. The intent was to solicit participation from a diverse range of organizations and councils.

Attendees at the Community Workshop were provided an update on the purpose, contents and preliminary results of the CHNA, and were asked to vote on focus areas related to 12 major health topics. The electronic agency survey asked respondents to identify the types of services the organization provides to clients and types of populations served by age and subgroup. Additional questions included communicating with and collaborating on current initiatives with other organizations in the region.

The information within this section is not intended to promote one agency over another.

Online Community Survey Results

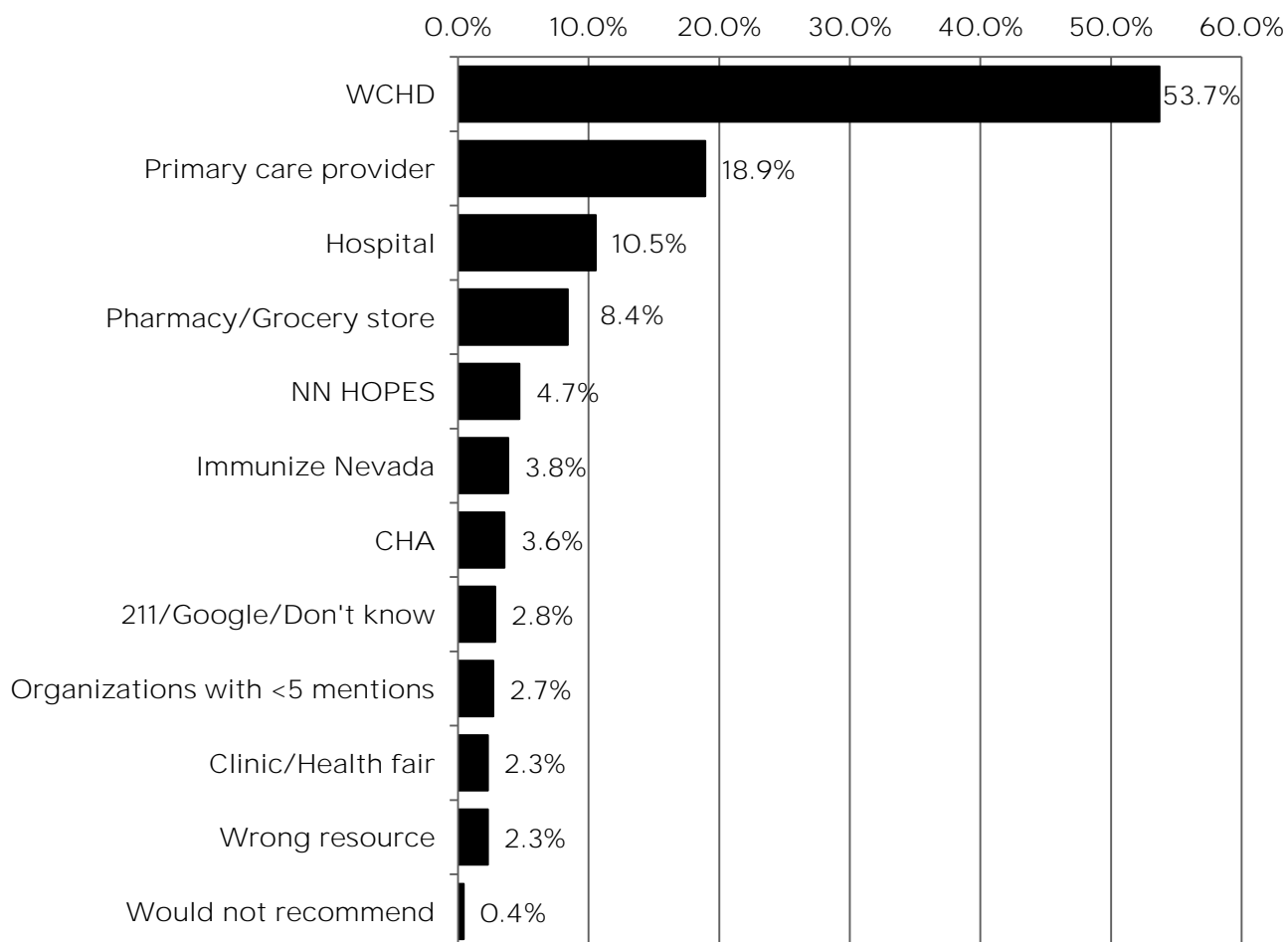
Primary data were collected via an online community survey from over 1,400 survey participants in Washoe County. The survey included 44 questions and analyses for those questions related to community resources and assets are provided within this section. Results and findings from the online community survey are not intended to be applied to or descriptive of all Washoe County residents and only represent the survey respondents themselves. Overall, the online community survey respondents were slightly younger, proportionally less Hispanic, and had higher educational attainment relative to the general Washoe County population. For complete survey methodology and participant demographics refer to the Contents, Methodology, & Community Survey Demographics section.

The online community survey included a question stating, **“If a friend or family member needed access to care for a health-related issue, where would you refer them for each of the following?”**. The health-related issues included referral for those seeking immunizations, sexual health services, health insurance, experiencing domestic abuse, mental health services, experiencing substance use or addiction, and nutrition counseling. Results for each health-related issue are presented in Figure 186 through Figure 193.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Immunizations: Approximately 49% (n=702) of survey respondents provided an answer to the immunization referral question.

Fig 186: Referral for Immunizations (n=702)



Note: Respondents often listed more than one referral location and each answer was counted under the respective category, therefore the combined percentage in the figure is greater than 100%.

Locations Providing Vaccinations

Combined, two in three (64.7%) of the referrals were to a specific agency that directly provides vaccinations.

This included the following:

- Over half (53.7%) of the referral were to the Washoe County Health District. Other specific organizations included Northern Nevada HOPES (4.7%), Community Health Alliance/CHA (3.6%), organizations with fewer than 5 mentions (2.7%) included UNR student clinic, Kids to Seniors Korner, Tribal Health Center, and the UNR (non-student) health center combined. Most of these locations are specific to insurance type, age, or pre-enrollment in other programs to qualify for vaccination at the location.

Approximately 8.4% of referrals were to a pharmacy or a specific grocery store.

Another 2.3% of referrals mentioned a general health clinic, health fair, or free-clinics.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Primary Care Providers & Hospitals

- Nearly one in four (18.9%) of referral were for a primary care provider, general practitioner, or doctor.
- One in ten (10.5%) listed a hospital. The most frequently identified hospital was Renown, however Saint Mary's, Northern Nevada Medical, and the VA were mentioned as well.

211/Google/Do Not Know & Wrong Resource

- Among the 702 respondents, 2.8% indicated they would call Nevada-211, Google/Use the internet, or stated they did not know where to refer someone for immunizations.
- 2.3% listed a wrong resource. The wrong resource responses included organizations that do not provide vaccinations, however most of these agencies could refer someone to an appropriate resource.

Immunize Nevada

- Approximately 3.8% of referrals were to Immunize Nevada. Immunize Nevada is a widely recognized coalition working to improve vaccination rates across Nevada. While the organization does not directly provide vaccines to the public, they organize many free and low-cost vaccine clinics in partnerships with a wide variety of other organizations across Nevada, provide a vast amount of information for the public and providers and also conducts trainings, outreach, and is overall an in-depth resource.

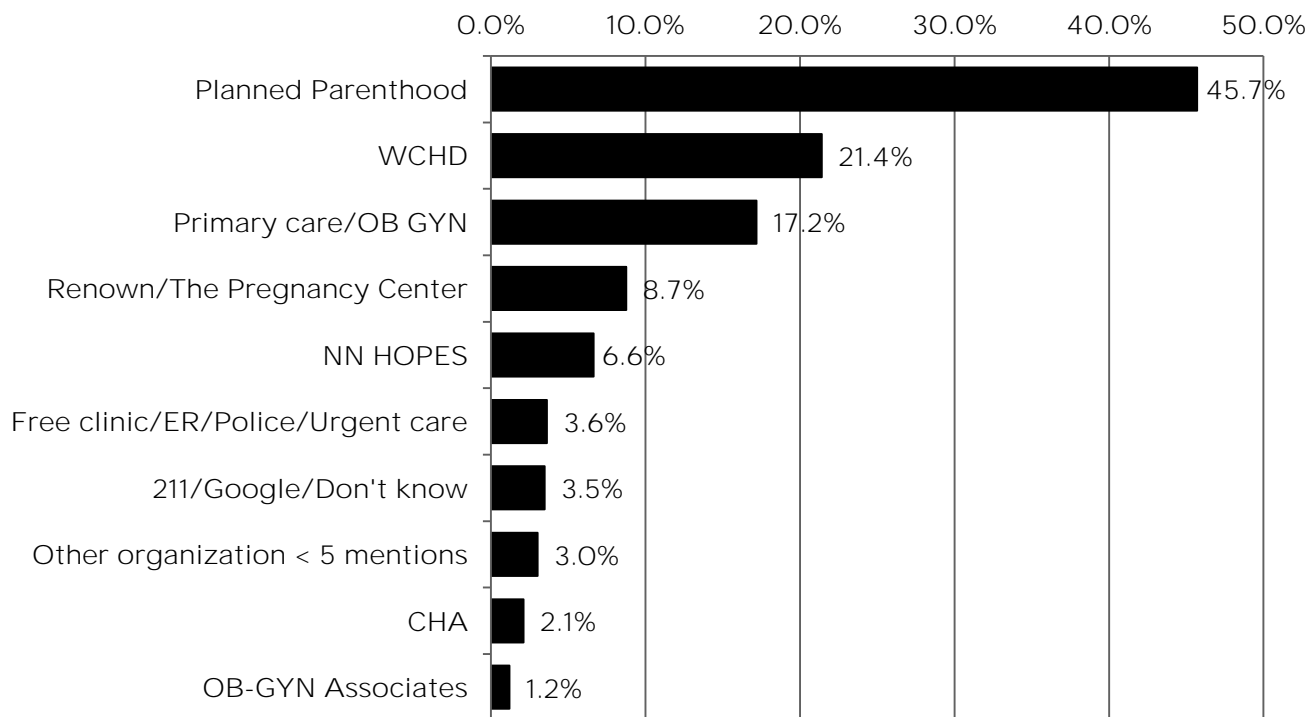
Would Not Recommend

- There were survey respondents (0.4%) who stated they would not recommend vaccination or to friends or family seeking access to immunizations. This illustrates the ongoing need for education related to the benefit and purpose of receiving appropriate vaccinations.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Sexual Health Services: Approximately 46% (n=663) of survey participants provided an answer to the sexual health services referral question. Examples provided included birth control, sexually transmitted diseases and prenatal care.

Fig 187: Referral for Sexual Health Services-i.e. birth control, STD screening, prenatal care (n=663)



Note: Respondents often listed more than one referral location and each answer was counted under the respective category, therefore the combined percentage in the figure is greater than 100%.

Sexual Health or Family Planning Agencies

- The majority of agencies listed (88.8%) were an organization that provides testing and counseling for sexually transmitted diseases (STDs) as well as birth control options, however not all locations provide prenatal care services. These agencies included Planned Parenthood (45.7%), Washoe County Health District/WCHD (21.4%), Renown/The Pregnancy Center (8.7%), Northern Nevada HOPES/NN HOPES (6.6%), other organizations with fewer than 5 mentions (3.0%), Community Health Alliance/CHA (2.1%) and OB-GYN Associates (1.2%).
- Another 17.2% of referrals stated “doctor” or the term “OB-GYN”, the term “depends on insurance” was also included in this category.
- The terms “Free Clinic”/ER/Police/Urgent Care were listed by 3.6% of respondents, likely as a response to a sexual assault incident or in the event of needing emergency contraception.

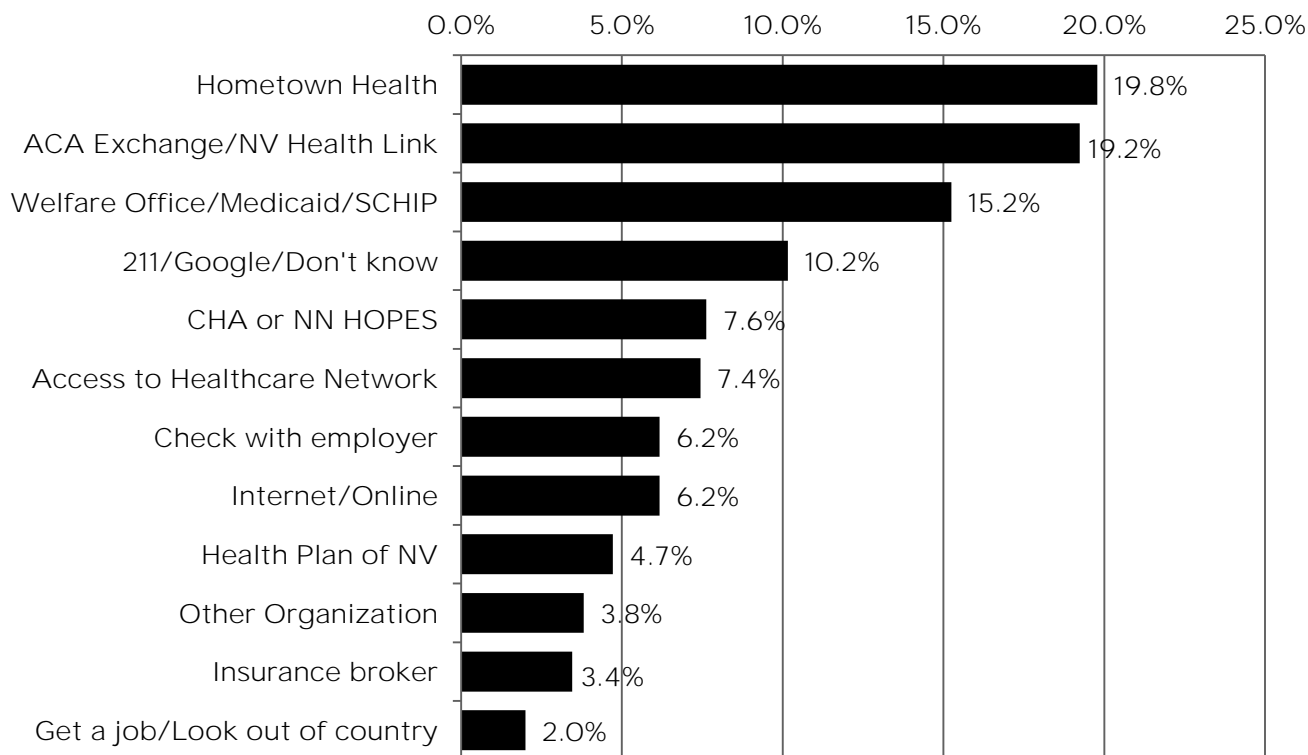
211/Google/Don't know

- Approximately 3.5% of respondents stated they would call 211, Google, or did not know where to refer someone for sexual health services.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Obtain Health Insurance: Approximately 38% (n=551) of survey participants provided an answer to the obtain health insurance referral question.

Fig 188: Referral to Obtain Health Insurance (n=551)



Note: Respondents often listed more than one referral location and each answer was counted under the respective category, therefore the combined percentage in the figure is greater than 100%.

Recommended Specific Health Insurance Provider

Nearly half (47.2%) recommended a specific type of health insurance provider. This included the following:

- Nearly one in five (19.8%) recommended the insurance plan Hometown Health. Hometown Health is offered through Renown to the public for purchase, as well as by several major employers throughout the county. This category also included Senior Care Plus, a Medicare Advantage organization and prescription drug plan for those with a Medicare contract; Hometown Health is the parent company for Senior Care Plus.
- Another 15.2% stated they would refer a friend to family member to Medicaid or to go to a Welfare Office to sign up for Medicaid.
- While Access to Healthcare Network (AHN) is *not an insurance plan*, 7.4% of respondents would refer friends or family to this organization. AHN is a non-profit organization offering members access to a discounted provider network and to participating healthcare providers. Members pay an income-based membership fee for healthcare access. Members are primarily those whose income places them above the threshold for Medicaid, however are still unable to afford to purchase health insurance through alternative means.
- Health Plan of Nevada (4.7%) offers insurance for purchase through the ACA exchange and those not on the ACA Exchange.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Source for Access or Seek More Information

Approximately 42.8% of respondents would refer a friend or family member to a resource to seek further information, including the following:

- About one in five would refer to the Affordable Care Act (ACA) Marketplace Exchange.
- One in 10 (10.2%) indicated they would call Nevada 211, Google, or they didn't know. "Google it" or "Google" was reported separate from those who stated "Internet/Online" (6.2%). Since the ACA Exchange is primarily accessed online it was unclear if respondents who listed "Internet/Online" were referring to the ACA Exchange or if this term was interchangeable with Google.
- 3.8% listed some other organization. Many of these were clinics with a sliding-fee scale for services or social service-type resources where assistance with health insurance enrollment may or may not be available. None of these locations offers health insurance directly.
- Another 3.4% listed an insurance broker as a resource to find an appropriate health insurance plan.

Community Health Centers

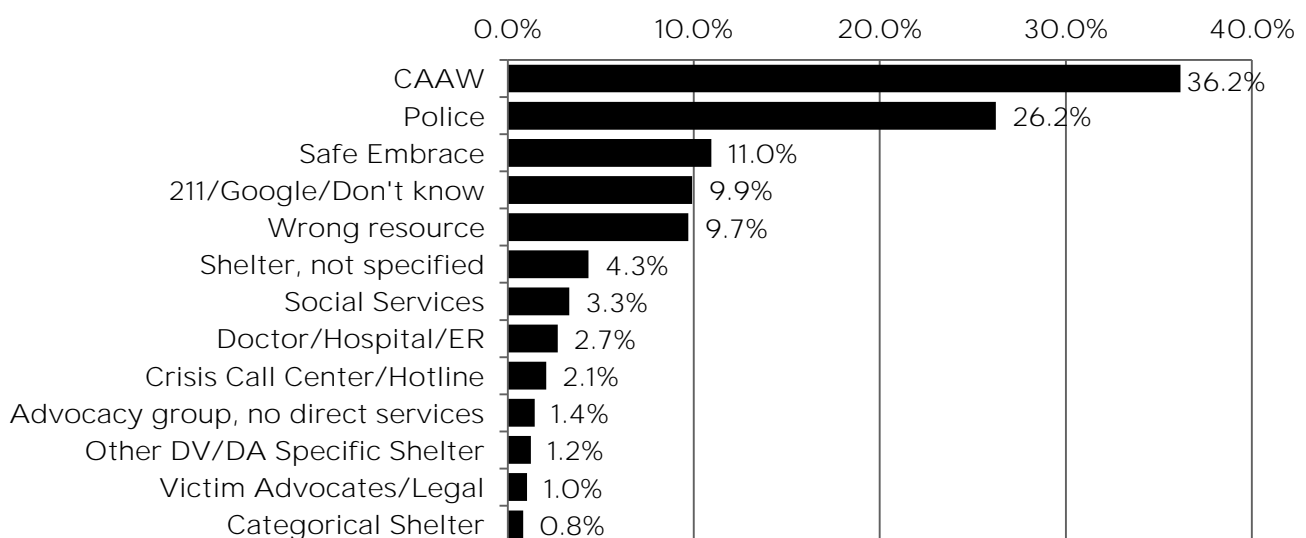
- Combined 7.6% stated they would refer friends or family to either Community Health Alliance (n =21) or Northern Nevada HOPES (n=21). Both offer sliding-fee scale and have staff to assist with enrollment in health insurance plans.

Employer-based

- 6.2% of respondents stated they would tell a friend or family to check with their employer or HR. This was not viewed as helpful since most employees are generally made aware of benefit options available to them or are mandated to enroll with a health insurance provider upon hire.
- Another 2.0% claimed they would tell friends or family to "get a job", or "to look outside of the United States". This indicates a general frustration with this service or that the perception is people must be employed to have access to health insurance.

Domestic Abuse: Only 34% (n=484) of survey participants provided an answer to the domestic abuse referral question.

Fig 189: Referral for Domestic Abuse (n=484)



Note: Respondents often listed more than one referral location and each answer was counted under the respective category, therefore the combined percentage in the figure is greater than 100%.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Shelters Specific to Domestic Abuse/Violence

- Over one in three (36.2%) of the 484 respondents indicated they would refer to the Committee to Aid Abuse Women (CAAW). CAAW was established in 1977, however as of September 2017 (after the close of the online community survey), changed their name to Domestic Violence Resource Center (DVRC). The DVRC provides comprehensive, free services for persons experiencing family violence.
- Another 11.0% listed Safe Embrace, a women's shelter specific to domestic abuse in the Washoe County area. Safe Embrace also offers free services including shelter, transitional living, counseling and advocacy options. Additionally, 1.2% listed Tahoe SAFE Alliance, an agency in North Lake Tahoe that offers an array of services specific to persons experiencing violence.
- 4.3% listed "shelter", but did not specify a name or location. Approximately 0.8% (n=4) respondents listed a categorical shelter; these agencies offer an array of services specific to pregnant women, women with children, or women who are intravenous drug users, however these locations and shelters are not specific to domestic violence, have very long wait lists, and many participants are court-ordered primarily for substance use issues.

Legal Intervention

- The second most common referral was for the police or 911 (26.2%). The issue with relying on police authority or a 911 response is that is primarily effective only for the physical abuse phase and does not remove the victim from the situation. Additionally, the perpetrator may lash out at the victim(s) the following episode for having contacted police on previous occasions.

Referral Agency

- Doctor/Hospital/ER (2.7%) may only be available for those with health insurance or those who are seeking direct medical care for physical injuries, crisis call centers/hotlines (2.1%) can provide verbal referrals and advice, however do not physically offer services or shelter, similar to advocacy groups (1.4%).
- Another 1.0% of the 484 respondents listed victim advocates/defense attorney or lawyer. Again, these may help with connecting a person to resources, but do not provide shelter or other direct services aside from counseling.

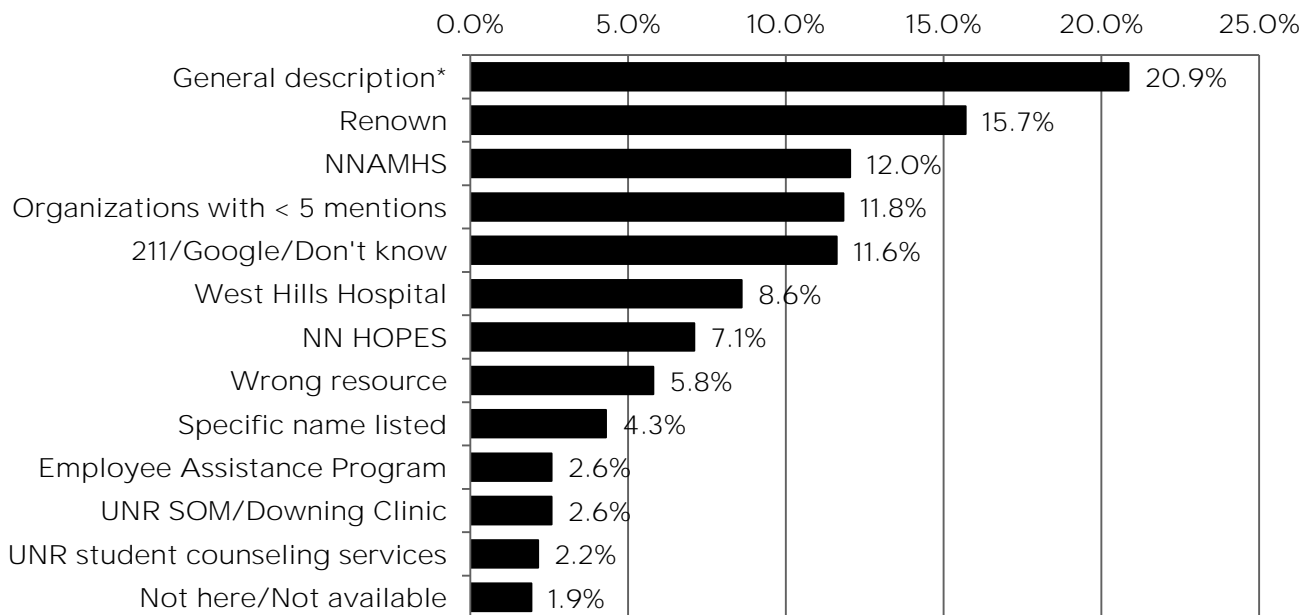
211/Google/Do Not Know & Wrong Resource

- Combined, nearly one in five respondents stated they would have to call Nevada-211, Google/Use the internet, stated they did not know (9.9%) or listed a wrong resource (9.7%). The 211/Google/Do not know responses show people would need to go to another resource to find an appropriate agency. The wrong resource responses included organizations that do not provide resources for domestic violence, however most answers were agencies that could refer someone to an appropriate resource.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Mental Health: Only 32% (n=465) of survey participants provided an answer to the mental health referral question. The examples listed under the mental health question included stress reduction, counseling, psychiatrist. There were included to prompt respondents to list only mental health resources and not substance use resources. Substance use is often associated with “behavioral health”, an umbrella term which includes both mental health and substance use. Referrals for substance use, although often intertwined, were asked in a separate fill-in-the-blank box.

Fig 190: Referral for Mental Health Services-i.e. stress reduction, counseling, psychiatrist (n=465)



Note: Respondents often listed more than one referral location and each answer was counted under the respective category, therefore the combined percentage in the figure is greater than 100%.

*General description included generic terms such as “primary care provider”, “doctor”, “mental health clinic”, “counselor”, “insurance provider list” and “psychiatrist” these reflected the examples provided.

Specific Mental Health Organizations & Providers

Combined, two in three (64.3%) of the 465 respondents listed a specific agency or a provider name that directly provides some aspect of mental health screening and treatment. This included the following:

- Renown (15.7%), Northern Nevada Adult Mental Health Services (NNAMHS) (12.0%), West Hills Hospital (8.6%), Northern Nevada HOPES (7.1%).
- Organizations with fewer than 5 mentions (11.8%) included Zephyr Wellness, Great Basin Behavioral Health, Life quest, Alliance, Healing Minds, Midtown Mindfulness, Mobile Crisis Unit through the school district, Mojave Mental Health, West Care, the Reno-Sparks Tribal Health Center, True North, Senior Bridges Program, Washoe County Social Services, the VA, Saint Mary’s, Quest Counseling, Willow Springs, WestCare and Sierra Counseling and Neurotherapy.
- UNR School of Medicine/Downing Clinic (2.6%), available to the public, generally uninsured and underinsured and the UNR student counseling services (2.2%), available to UNR students only.

3.0 COMMUNITY STRENGTHS & CHALLENGES

- Another 4.3% of respondents listed the name of a provider, although unverified, these were assumed to be names of providers currently offering some form of behavioral health services, and were endorsed by those respondents.

211/Google/Do Not Know & Wrong Resource

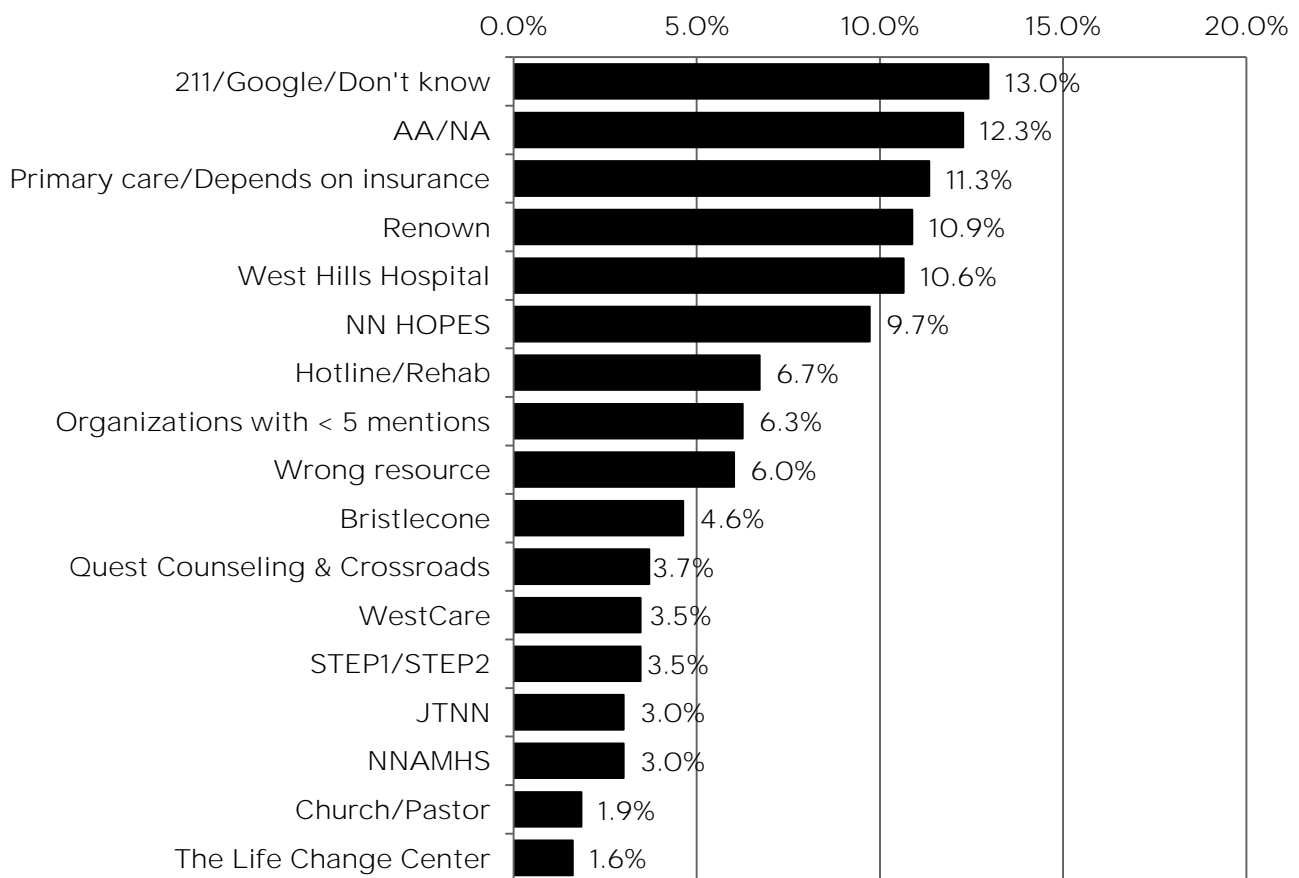
- Over one in ten (11.6%) did not know or would call Nevada 211, Google or have to use the internet to find an appropriate resource. Another 5.8% listed a wrong resource often listing an agency which could provide a referral, but does not provide any direct mental or behavioral health services.

Not here/Not available

- The least often listed resource, “Not here/Not available” was cited by 1.9% (n=9) respondents, however was indicative of negative personal experiences trying to seek mental health care. Often these answers cited lack of providers willing to accept new patients, or wait lists longer than 4 or 5 months.

Substance Use or Addiction: Only 30% (n=432) of survey participants provided an answer to the substance use or addiction referral question.

Fig 191: Referral for Substance Use or Addiction (n=432)



Note: Respondents often listed more than one referral location and each answer was counted under the respective category, therefore the combined percentage in the figure is greater than 100%.

3.0 COMMUNITY STRENGTHS & CHALLENGES

General Referrals

- Combined, 30.3% listed a generic referral type. This included Alcoholic Anonymous (AA) or Narcotics anonymous (NA) (12.3%), a primary care provider or depends on the person's insurance provider (11.3%), and those who stated call a hotline or go to rehab (6.7%).

Locations with Inpatient Options

- Combined just over one in five (21.8%) respondents listed an organization with inpatient options, this included West Hills hospital (10.6%), Bristlecone (4.6%), WestCare a short-term detox center (3.5%), and Northern Nevada Adult Mental Health Services/NNAMHS (3.0%). These locations are known for providing some form of mental and behavioral health services, however those seeking treatment in these locations may be faced with long waiting lists.
- Combined 15.0% of the 432 respondents listed an organization which may not have inpatient options, however many of these organizations serve specific populations, a person is usually court-ordered to attend services, or the organization treats only those with specific substance addiction, such as opioids. The 15.0% includes, organization with fewer than 5 mentions each (6.3%), Quest Counseling (outpatient adolescents) and Crossroads (usually court-ordered) with equal number of mentions and combined (3.7%), STEP 1, Inc. (men only, priority intravenous drug users)/STEP2 (pregnant women only) combined (3.5%), and The Life Change Center which is specific for those with opioid addiction (1.6%)

Other Mentions

- Renown Behavioral Health program was mentioned by 10.9% of the 432 respondents. Renown's Behavioral Health program provides specialized care for mental health and substance abuse offering counseling and medication treatment.
- Northern Nevada HOPES/NN HOPES was mentioned by 9.7% of respondents. NN HOPES is home to the only syringe exchange program in northern Nevada, Change Point, which offers harm reduction supplies, counseling, as well as HIV and hepatitis C (HCV) testing. Additionally NN HOPES offers behavioral health counseling including substance use counseling and treatment plans, however there are no inpatient beds.
- Join Together Northern Nevada/JTNN was mentioned by 3.0% of respondents. JTNN is a coalition offering several programs to prevent substance use, they provide resources including trainings, educational outreach and referrals, but JTNN does not directly treat patients.
- Church or pastor was listed by 1.9% of respondents.

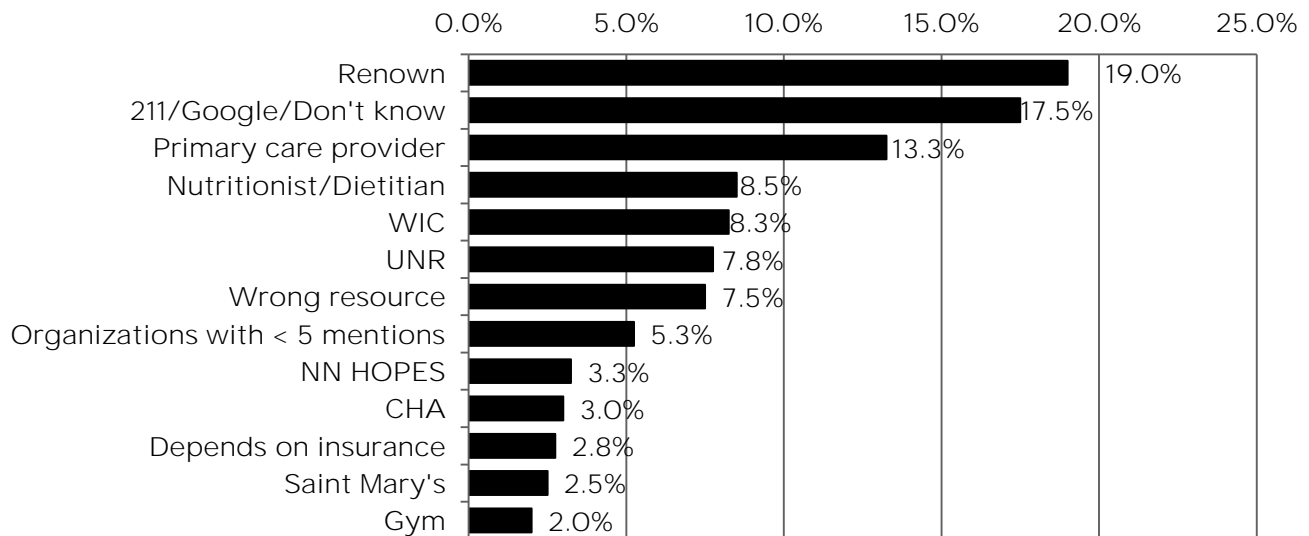
211/Google/Do Not Know & Wrong Resource

- Combined nearly one in five (19.0%) respondents stated they would call Nevada 211, Google, or did not know where to go (13.0%) or they listed an organization that does not provide substance use treatment/counseling (6.0%), however many of those listed would be able to refer to an appropriate resource.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Nutrition counseling: Only 28% (n=400) of survey participants provided an answer to the nutrition counseling referral question.

Fig 192: Referral to Obtain Nutrition Counseling (n=400)



Note: Respondents often listed more than one referral location and each answer was counted under the respective category, therefore the combined percentage in the figure is greater than 100%.

Hospitals/Clinics

- Combined, just over one in three (35.5%) of the 400 respondents would refer a friend or family to one of the local health systems to obtain nutrition counseling. This includes Renown (19.0%), UNR School of Medicine Clinic (7.8%), Northern Nevada HOPES/NN HOPES (3.3%), Community Health Alliance/CHA (3.0%), and Saint Mary's (2.5%).

Specific Provider

- Combined, one in five (21.8%) of the 400 respondents would refer to a primary care provider (13.3%) or to a nutritionist or dietitian (8.5%).
- Approximately 5.3% would refer to a different organization, many of these were wellness clinics that offer a range of services.
- Another 2.8% stated it depends on the insurance type or a person should check their insurance provider list to find an appropriate counselor within the insurance network.

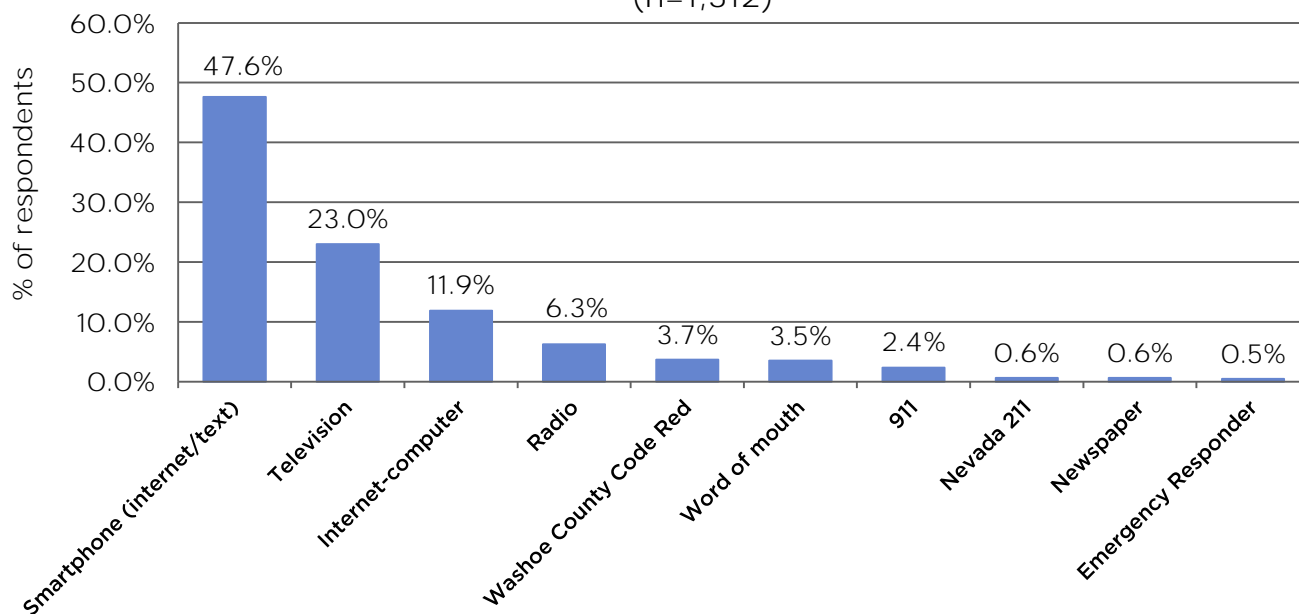
211/Google/Do Not Know, Wrong Resource, & Gyms

- Combined one in four (25.0%) respondents indicated they would have to call Nevada 211, Google, or did not know where to go (17.5%) or they listed an organization that does not provide nutritional counseling (7.5%), however many of those listed would be able to refer to an appropriate resource.
- Additionally 2.0% of respondents indicated they would refer someone to the gym. It was unclear if these referrals related to nutritionists or personal trainers who work at the gym or if this was a response for the person to engage in more physical activity.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Question: “What is your main source of information in a disaster or emergency, such as a fire, earthquake, or flood? Select one.”

Fig 193: Main Source of Information in Emergency Event
(n=1,312)



- Nearly half (47.6%) of the 1,312 survey respondents indicated they rely on their smartphones for obtaining information during an emergency, while another 23.0% indicated the main source of information is the television.
- Calling 911, as identified by 2.4% of respondents, is **NOT advised** during an emergency unless there is an immediate threat to life. Emergency dispatchers experience a spike in 911 calls during widespread emergencies and it is imperative the 911 phone lines be limited to true life-threatening emergencies.
- Washoe County Code Red (3.7%) is a more appropriate resource. Code Red sends a recorded message for emergency notifications in order to receive notifications sign up here <https://public.coderedweb.com/cne/en-US/169EBBD0A3AE>.

Community Workshop Results

The invitation to the Community Workshop was sent to 250 individuals representing 96 different organizations across Washoe County. Over 80 participants, representing 45 agencies were in attendance at the Community Workshop. Each workshop participant was provided five stickers to place under any of the 47 focus areas. Guidance for “voting” included considering 1) which focus areas organizations could have a sustainable impact on and 2) would success in those focus areas improve health outcomes among residents of Washoe County. This opportunity for community-lead prioritization of focus areas identifies a more narrow the scope of health needs to be addressed during the next planning cycle. Table 178 shows the Community Workshop focus area vote results.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Table 178: Summary of Community Workshop Results, Health Topic Total Votes*, & Focus Area Votes

Health Topic	Total Votes	Focus Areas	Examples	# of Votes
Social Determinants	132	Housing	lack of affordable housing, homelessness	52
		Educational attainment		27
		Poverty/Household composition	number of people per household, poverty rates overall and among children and seniors	5
		Food Insecurity/Hunger	food policy, WIC, SNAP, and free or reduce meal enrollment	20
		Community services	youth centers, senior centers, services for people with disabilities,	10
		Income/Financial stability		9
		Employment/Unemployment/Underemployment		9
Mental Health	70	Diagnosable mental illnesses	screening, treatment	36
		Depression	diagnosed and undiagnosed	22
		Suicide rates	attempted, completed, follow-up with patients	12
Access to Health	66	Health care workforce	number of providers, ratio of providers to population	38
		Preventive care services	insurance coverage, adults with a primary care provider, dental visits, physical/annual check ups	24
		Number of health care clinics	bed capacity, health provider shortage areas, telehealth	4
Substance Use	55	Prescription drug use	sedatives, painkillers, stimulants	21
		Alcohol use	heavy drinking, binge drinking, age at first drink	10
		Opiate use	legally prescribed and illegal use of opiates	10
		Marijuana use	recreational, medical	9
		Illicit drug use	methamphetamine, inhalants, cocaine, ecstasy, psychedelics	4
		Tobacco use	e-cigarettes, vaping, cigarettes, chewing tobacco	1
General Health & Wellness	42	Built environment/infrastructure	access to parks, recreation, walking paths, promoting active transport	14
		Nutrition		13
		Weight status	overweight and obesity	9
		Physical activity		6
Chronic Diseases	23	Diabetes		11
		Cardiovascular diseases	stroke	8
		Cancer	prevention, screenings, & treatment	2
		COPD		2
		Asthma		0
Safety & Security	20	Domestic violence	intimate partner violence, child abuse, elderly abuse	18
		Bullying/School violence	weapons in schools, threats, physical fighting	1
		Electronic crimes	cyber-bullying, identify theft, sex trafficking	1
		Property crimes		0
		Violent/gang-related crimes		0
Maternal & Child Health	17	Healthy pregnancy	early initiation of prenatal care, low-birth weights, preterm births	10
		Postpartum	maternal and infant check-ups, breastfeeding, infant mortality	4
		Teen pregnancy rates	pregnancy and births among teens 15-19 years	3
Infectious Disease	9	Immunizations/Vaccine-preventable diseases	influenza, MMR, varicella, pertussis, tuberculosis, HPV	5
		Antibiotic resistance	pan-resistant diseases, healthcare associated infections, sepsis, antibiograms	4
Sexual Health	6	Safe sex behaviors	sexual education, condom use, birth control	3
		Sexually transmitted diseases	HIV, chlamydia, syphilis, gonorrhea	1
		Sexual identity/Cultural safety	LGBTQ rights, safe sexual spaces	2
Environmental Health	4	Air quality		2
		Water quality and safety		2
Injury Prevention	0	Poisonings	children, seniors, cross-reaction with medications	0
		Falls		0
		Traffic safety	pedestrian, bicycle, motor vehicle accidents	0
		Other unintentional injuries	drowning, workplace safety	0

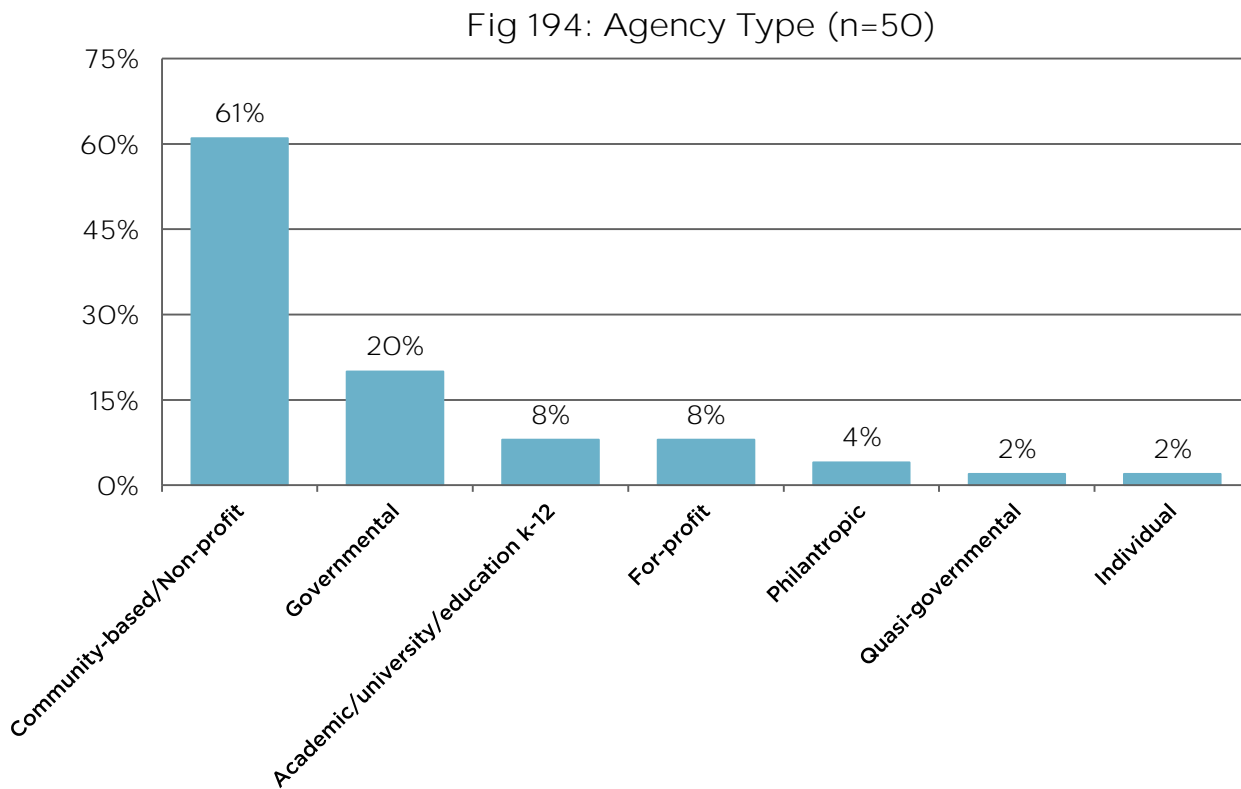
*Note: Total votes are largely influenced by the number of focus areas within each health topic

3.0 COMMUNITY STRENGTHS & CHALLENGES

Agency Survey Results

The electronic agency survey was sent to 250 individuals representing 96 different organizations across Washoe County. Seventy people representing 50 agencies responded to the agency survey. In some instances, an agency had multiple respondents on their behalf and the selected responses were different from one another, however each answer selection was only counted once. Some questions were also measured at the agency level and the denominator was 50, while other questions were measured at the individual level, with a denominator of 70. Denominators are identified in parentheses in the title of each figure.

Question: “What type of organization are you representing? Select all that apply.”

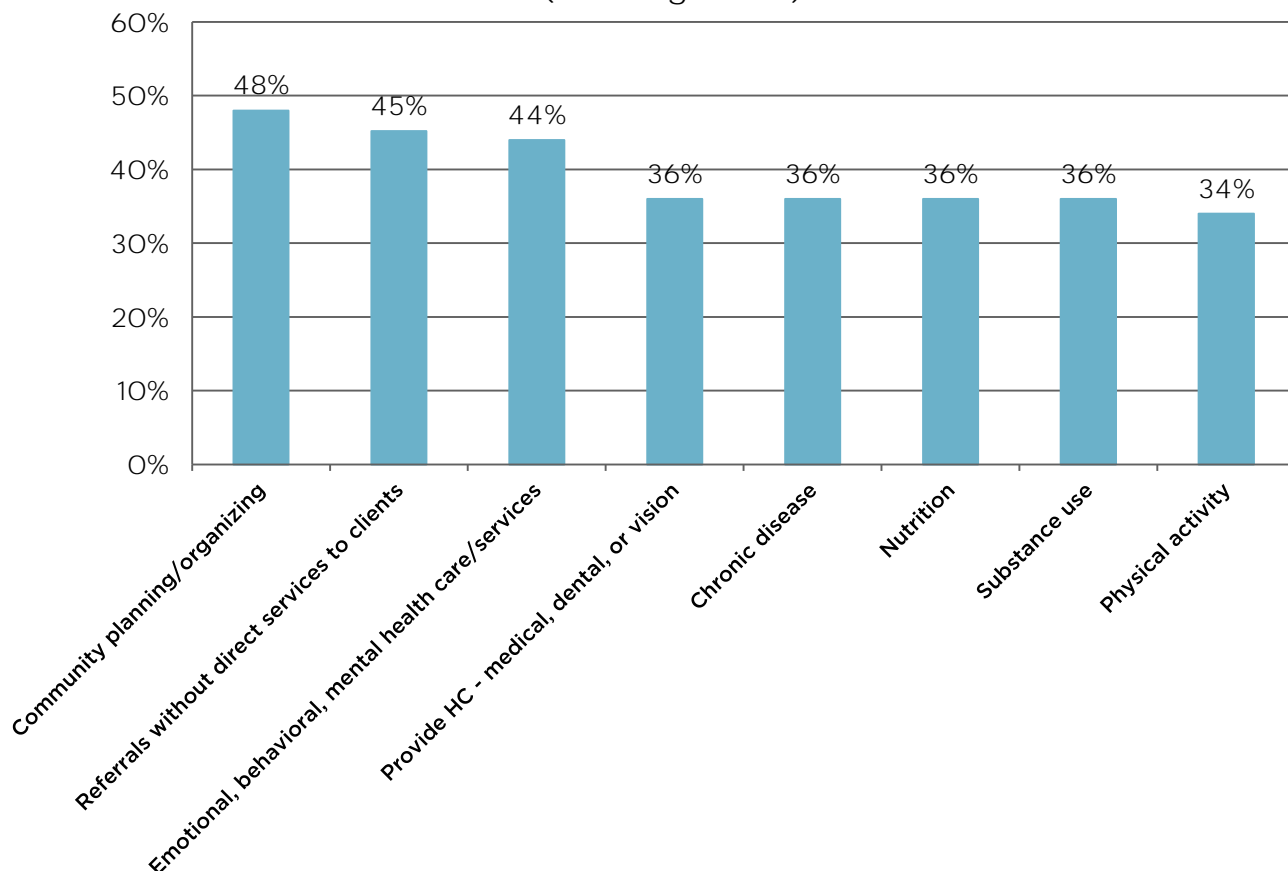


- The majority of agencies were community-based and/or non-profit agencies (61%) and one in five (20%) agencies were a governmental entity.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Question: “Which of the following areas is the organization currently addressing? Select all that apply.”

Fig 195: Top 8 Areas Agencies Currently Addressing (n=50 agencies)



- Nearly half of the agencies are involved in community organizing or community planning (48%), while 45% provide referrals without direct services to clients, the third most frequently identified area being addressed is emotional, behavioral, or mental health care services (44%).
- Approximately 36% of agencies each indicated they currently provide medical, dental or vision healthcare services, chronic diseases, nutrition or substance use. While 34% of agencies indicated they address physical activity.

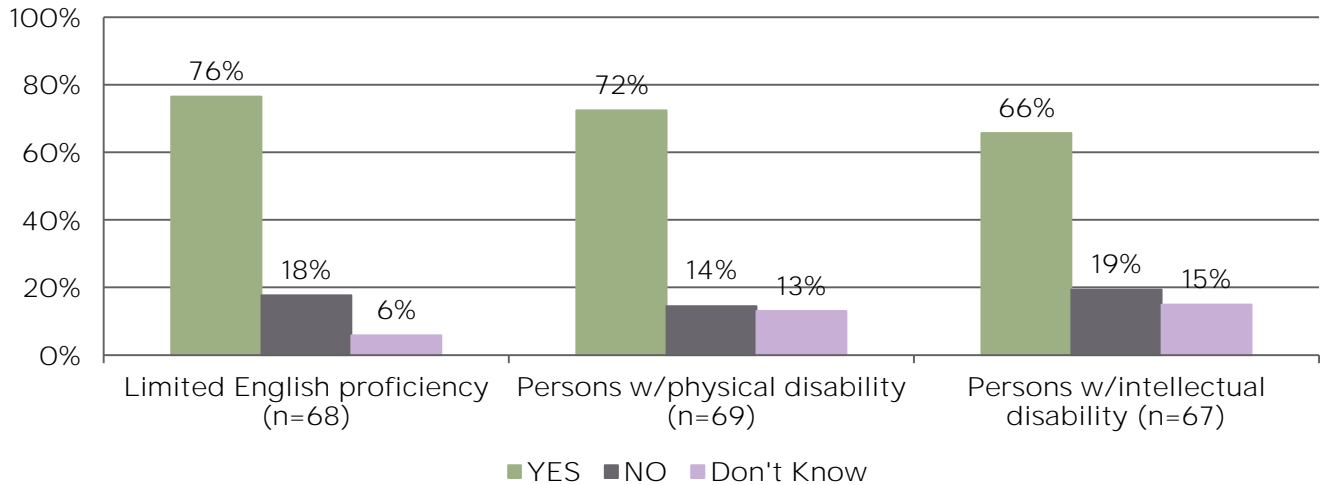
Although not pictured in Figure 195, additional topics being addressed included:

- Food assistance (28%)
- Housing/homelessness (24%)
- Job acquisition/skills training/employment (24%)
- Immunizations (22%)
- Education (20%)
- Sexual health (18%)
- Transportation (18%)
- Public safety (14%)
- Financial aid/stability (12%)
- Public utilities (6%)
- Arts (4%)
- Spiritual counsel/guidance (4%)
- Medical resources (4%)
- Legal aid counsel (2%)
- Community clean up/environmental health (2%)

3.0 COMMUNITY STRENGTHS & CHALLENGES

Question: “Indicate if your organization has existing policies, procedures, or trainings on how to work and communicate with the following groups.” 1) Persons who speak languages other than English, 2) Persons with physical disabilities, and 3) Persons with intellectual or developmental disabilities.

Fig 198: Policies, Procedures, or Trainings to Work & Communicate with the Following Groups



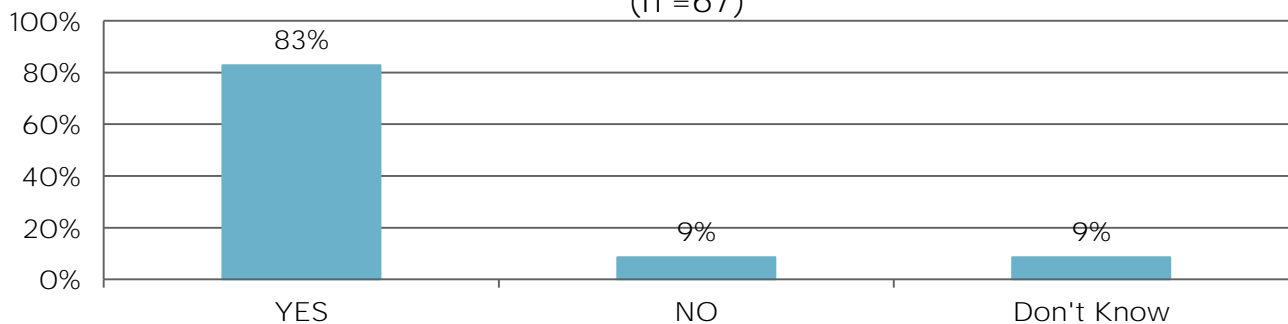
- The majority of people who responded to the agency survey indicated their agency had policies, procedures, or trainings to work and communicate with people who had limited English proficiency (76%), persons with physical disabilities (72%) and persons with intellectual disabilities (66%).

Outreach & Collaboration

The majority (83%) of agency respondents indicated they felt there were opportunities to inform other entities about the organization’s current initiatives and they were able to learn what others were doing as well [Figure 199]. Among the agencies surveyed, 99% indicated they have collaborated on a project, funded, or provided in-kind support to other local organizations in the past 12 months. This demonstrates interconnectedness among organizations across the region, among those agencies with representatives who completed the agency survey.

Question: “Do you feel there are external meetings or events where there is the opportunity to inform others about what the organization is currently working on and learn what others are doing?”

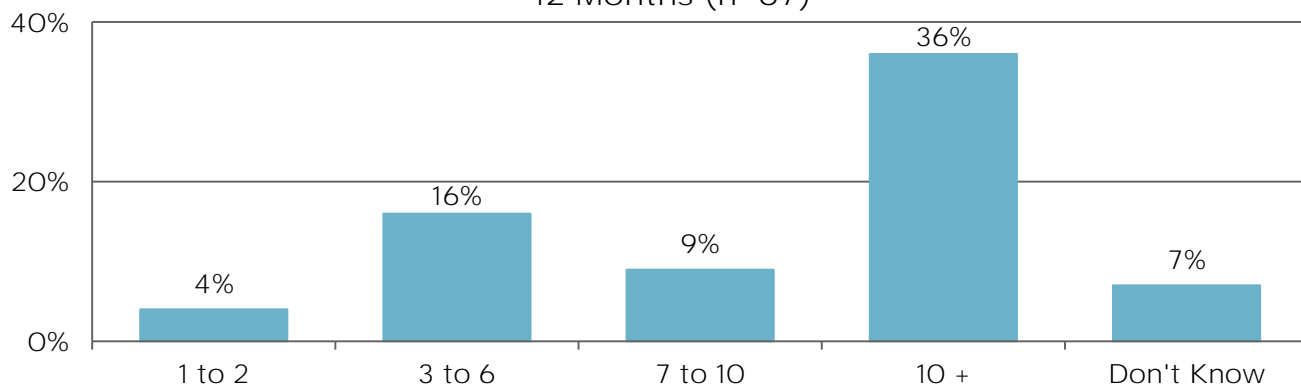
Fig 199: Opportunity to Inform & Learn from Other Agencies (n = 67)



3.0 COMMUNITY STRENGTHS & CHALLENGES

Question: Indicate the number of local organizations your agency has collaborated on a project, funded, or provided in-kind support to other local organizations in the past 12 months.

Fig 200: Number of Local Organizations Collaborated with Past 12 Months (n=67)



- About one in three indicated their agency had partnered with more than 10 (36%) other local organizations.

Community Strengths & Challenges Summary

According to responses to the community survey, it is important to continue to improve outreach and marketing to describe the types of services different organizations provide. A limitation of the data is that over half of the total survey respondents (1,438) skipped the referral questions, however the lack of input may be an indication of need for education on local resources [Table 179].

The question which asked community survey respondents to identify the source of information they rely on the most in the event of an emergency or disaster show that the internet and television continue to be the predominant forms of communication. It is important to design webpages and messaging that is compatible with cells phones, as sometimes websites may look and work well on a computer, but then fail in the mobile environment. Keeping up with evolving technology in the era of social media is and will continue to remain a challenge.

Changing the names of organizations may be necessary or even unavoidable, however great lengths should be undertaken to make those changes known throughout the community. One scenario is demonstrated by the numerous community survey respondents who identified Community Health Alliance (CHA) by the previous name, HAWC. This will likely be a challenge for Domestic Violence Resource Center (formerly CAAW). Recognizing the importance of names and branding, emphasizing any changes and conducting a Google search to identify inaccuracies will help to reduce future client confusion.

3.0 COMMUNITY STRENGTHS & CHALLENGES

Table 179: Summary of Community Online Survey Referral Responses

Health Referral Topic	% total (n=1,438) that provided a referral	Strengths	Challenges	% 211/ Google/ Don't know	% Wrong Referral
Vaccination/ Immunizations	49%	64.7% referrals to agency that administers vaccinations	Agencies identified prioritize low-income populations; assumes people have access to a medical provider	2.8%	2.3%
Sexual health services	46%	88.8% listed sexual health or family planning agencies	One category was more geared towards birth control and sexually transmitted disease (STD) testing, while the other category included more locations that provide prenatal and OB-GYN services in addition to birth control and STD testing	3.5%	None
Health insurance	38%	47.2% recommended a specific type of health insurance provider; 15.2% would refer to Medicaid	42.8% of respondents would refer a friend of family member to a resource to seek further information; Respondents clearly frustrated with the issue	10.2%	None
Domestic abuse	34%	48.4% listed a shelter for victims of domestic abuse	Number one agency listed, CAAW, now known as the Domestic Violence Resource Center-name changes confusing for the general public; high proportion of respondents (26.2%) would call the police or utilize 911	9.9%	9.7%
Mental health	32%	64.3% identified a facility that does offer mental health services	shortage of mental health providers and many facilities have long waiting lists	11.6%	5.8%
Substance use/Addiction	30%	21.8% respondents listed an organization with inpatient options	30.3% listed generic service- Alcoholics or Narcotics Anonymous; shortage of substance use treatment options	32.0%	6.0%

An additional strength of local agencies is that many serve all clients regardless of age, or other categorical demographics, however many organization may benefit from having staff specialized to work with and communicate with different subgroups. The subgroups of concern include adults over 50 years of age, as Baby Boomers continue to age growth is expected at a higher rate than the general population, this is compounded by the increased utilization and complexity of health services as a person ages. Persons who speak languages other than English, most notably Hispanic populations, again a subgroup estimated to experience population growth at a higher rate than the overall population. Although decreasing in recent years, increased awareness and outreach to low-income populations is essential, as they disproportionately experience poor health outcomes.

According to agency survey data, local agency strengths include the ability to refer to other agencies. As 45% of agencies that participated in the agency survey stated they provide referrals, additionally many of the “wrong resource” agencies identified across all referral types through the online community survey were agencies that could refer someone to an appropriate location. It is important for agencies to implement an evaluation process in order to asses if referrals are appropriate or effective. For example, providing contact information for a specific person or connecting a client right there via phone, is often more productive than

3.0 COMMUNITY STRENGTHS & CHALLENGES

handing out a brochure or verbally rattling off alternative agencies when making a referral. Agencies may also consider formalizing a referral relationship through a memorandum of understanding or determining regular intervals to verify the services are available and if the referral relationship is still appropriate.

Another strength of local agencies is interconnectedness. Among the 50 agencies that responded to the agency survey, 99% stated they had collaborated with another local entity within the past 12 months and nearly one in three stated they collaborated with 10 or more other agencies. Expanding into new partnerships is key for stretching resources and can be helpful to ensure duplicative projects are minimized. Additionally the region will benefit from continued collaborative endeavors.

Community Strengths & Challenges Sources

Online Community Survey

Fig 186: Referral for Immunizations (n=702)

Fig 187: Referral for Sexual Health Services-i.e. birth control, STD screening, prenatal care (n=663)

Fig 188: Referral to Obtain Health Insurance (n=551)

Fig 189: Referral for Domestic Abuse (n=484)

Fig 190: Referral for Mental Health Services-i.e. stress reduction, counseling, psychiatrist (n=465)

Fig 191: Referral for Substance Use or Addiction (n=432)

Fig 192: Referral to Obtain Nutrition Counseling (n=400)

Fig 193: Main Source of Information in Emergency Event (n=1,312)

Community Workshop

Table 178: Summary of Community Workshop Results, Health Topic Total Votes*, & Focus Area Votes

Agency Survey

Fig 194: Agency Type (n=50)

Fig 195: Top 8 Areas Agencies Currently Addressing (n=50 agencies)

Fig 196: Age Groups Agency Serves (n=50)

Fig 197: Subgroup Agency Serves (n=50)

Fig 198: Policies, Procedures, or Trainings to Work & Communicate with the Following Groups

Fig 199: Opportunity to Inform & Learn from Other Agencies (n =67)

Fig 200: Number of Local Organizations Collaborated with Past 12 Months (n=67)

Online Community Survey

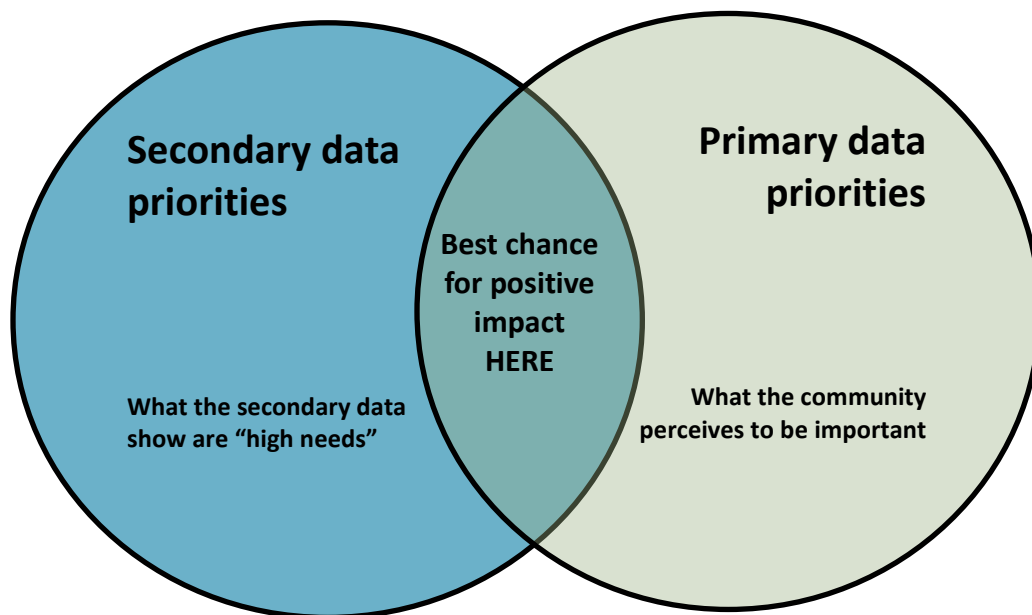
Table 179: Summary of Community Online Survey Referral Responses

Scoring, Ranking & Prioritization

This section describes the methodology for determining health needs in Washoe County. Prioritization of needs provides a means for understanding and organizing the large amount of secondary data (county, state and national level statistics/numbers) and primary data (online community survey) contained within the assessment. Although the health topics rank differently when looking at only primary or only secondary data, the overall rank, which includes both, identifies which areas of need community members may be more inclined to support and ultimately where efforts will have the best capacity to influence.

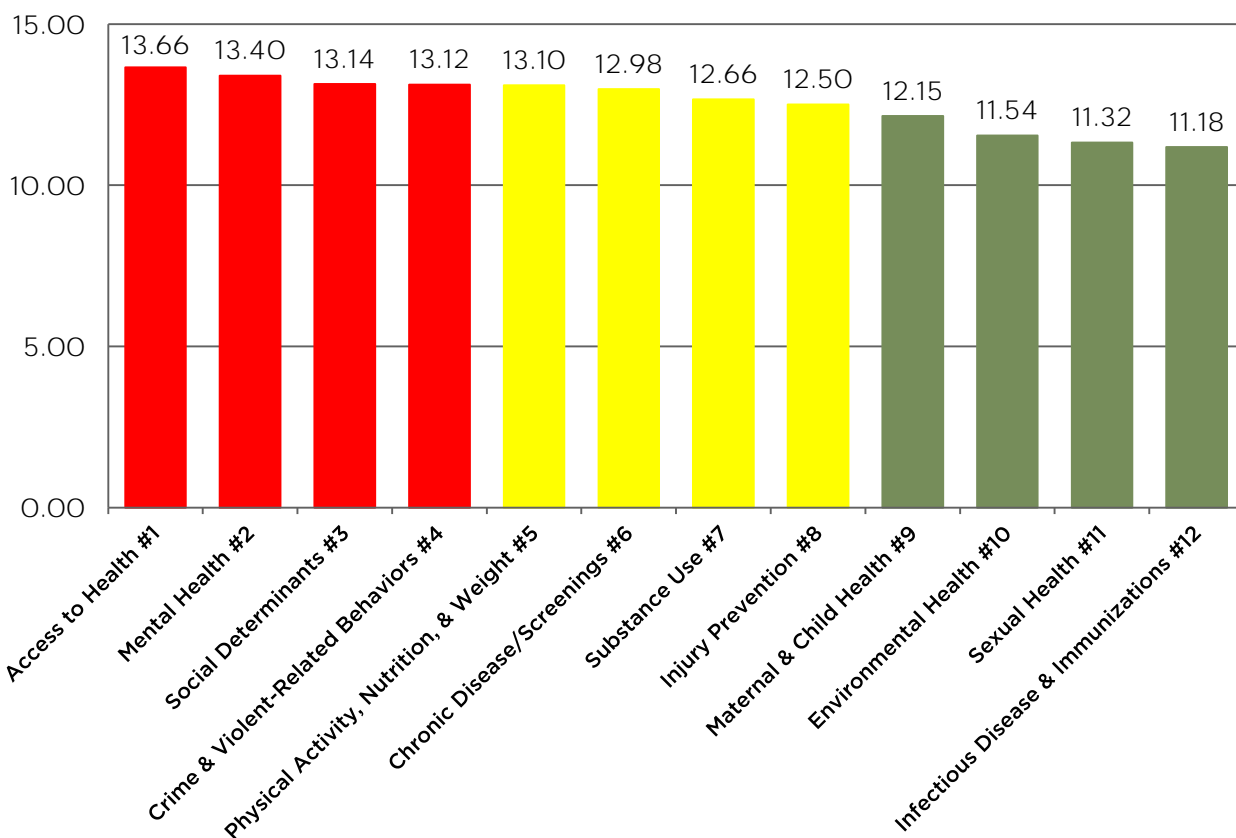
It is important to consider both the secondary data indicators and the primary data input (community's perception of important health topics) for prioritization. Future programs and initiatives based on only the secondary data rankings may not be endorsed by the community and could result in an ineffective expenditure of resources. Alternatively, creating programming based solely on the primary data, would ignore reliable and accurate data provided through the secondary data sources.

Image 9: Identifying Opportunities for Positive Impacts



An objective approach was developed to score, rank, and prioritize the health topics. Five criteria, magnitude, severity, trend, benchmark, and community perception, were utilized to score the health topics. The overall score and rank combines secondary and primary data for 12 major health topics, the results are shown in Figure 201.

Fig 201: Overall Health Topic Score & Rank



Although ranks appear to be straightforward, there are considerations for interpretation. The range of scores is relatively small, with only a 2.48 point spread between the highest and the lowest rank and as little as 0.02 separating multiple categories. Additionally, health behaviors and health outcomes are influenced by dynamic and complex factors not captured within a single health topic. Mental health (#2), for example, coincides with substance use (#7). Substance use serves as a coping mechanism among many people with mental illness, which can in turn exacerbate mental health issues and both factors may be influenced by having access to healthcare (#1). Any approach to address health needs should be aware of and recognize the relationships between human nature, behavioral changes, and the systemic factors that influence health outcomes.

4.0 SCORING, RANKING, & PRIORITIZATION

Methodology for Scoring & Ranking Health Topics

Scores were calculated for each of the 250+ secondary data indicators using the criteria in Table 180.

1. **Magnitude:** The percent, rate, or number of measured population impacted by each indicator.
2. **Severity:** Severity or duration of indicator; acute, short-term or long-term/permanent impact.
3. **Trend:** Improvement, no improvement, or worsening over time.
4. **Benchmark:** Washoe County percentage or rate relative to Nevada, United States, or Healthy People 2020 objective.
5. **Community Perception:** Perceived importance as determined by the score resulting from the online community survey respondents.

Criteria	Score	Definition
Magnitude [weight 1.0]	0	0-.9% of population impacted
	1	.91-3.0% of population impacted
	2	3.1-7.0% of population impacted
	3	7.1% + of population impacted
Severity [weight .75]	0	Not serious/short-term issue (0-2 weeks)
	1	Moderately serious/medium length of impact 2 weeks-1 year
	2	Very serious/1+ years of impact
Trend [weight .75]	0	Improvement over the past 5-10 years
	1	No clear trend up or down
	2	Getting worse over time
Benchmark [weight .5]	0	Better than Nevada or National level by more than 3%
	1	Same as Nevada or National level; within 1-2%
	2	Worse than Nevada or National level by 3-5%
	3	Worse than Nevada or National level by 6% or higher
Community Perception [weight 2.0]		The calculated average score resulting from the health topic prioritization survey question, [multiplied by 2]

Comparing Across All Forums

Comparing rankings across the different sources of primary and secondary data is challenging due to the nature and variety of data collection and input. For example, a few health topics were not included in the overall ranking due to a lack of reliable secondary data. Additionally, some health topics were grouped differently across the variety of input mechanisms depending on the type of audience and form of input. Table 181 summarizes the health topic rankings across the different data sources.

4.0 SCORING, RANKING, & PRIORITIZATION

Table 181: Health Topic Ranking by Mechanism

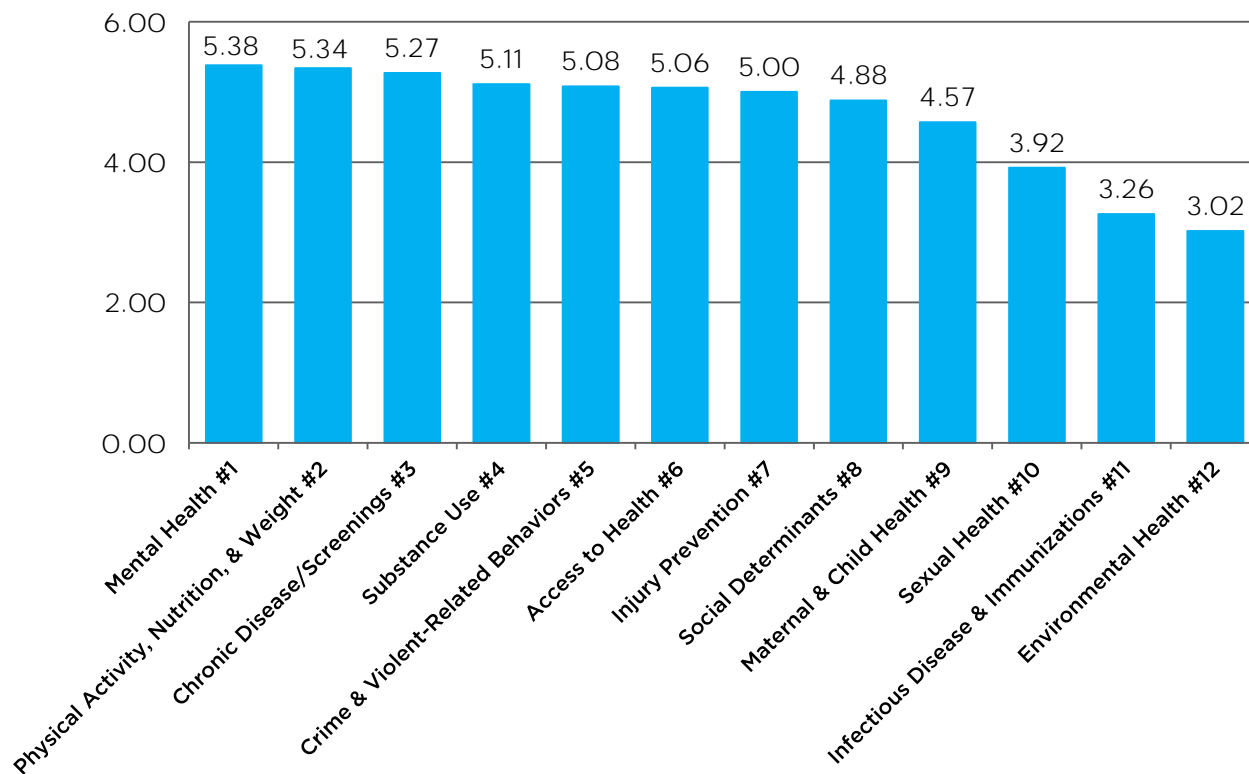
Health Topic	Overall Rank	Secondary Data Rank	Primary Data Rank (Online Community Survey)
Access to Health	1	6	1
Mental Health	2	1	5
Social Determinants	3	8	3
Crime & Violent-Related Behaviors	4	5	4
Physical Activity, Nutrition, & Weight	5	2	6 (Listed as Preventive Health Behaviors)
Chronic Disease/Screenings	6	3	6 (Listed as Preventive Health Behaviors)
Substance Use	7	4	7 (tied)
Injury Prevention	8	7	7 (tied)
Maternal & Child Health	9	9	GE (Grouped with Sexual Health)
Sexual Health	10	10	10
Environmental Health	11	12	2
Infectious Disease & Immunizations	12	11	6
Community Services	NR	NR	9
Built Environment	NR	NR	11

NR=Not ranked due to lack of data ; GE=Grouped elsewhere, not ranked independently

Score & Rank According to Secondary Data Only

The secondary data score and rank [Figure 202] were calculated by the combined scores from Criteria #1 through Criteria #4.

Fig 202: Secondary Data Score & Rank



4.0 SCORING, RANKING, & PRIORITIZATION

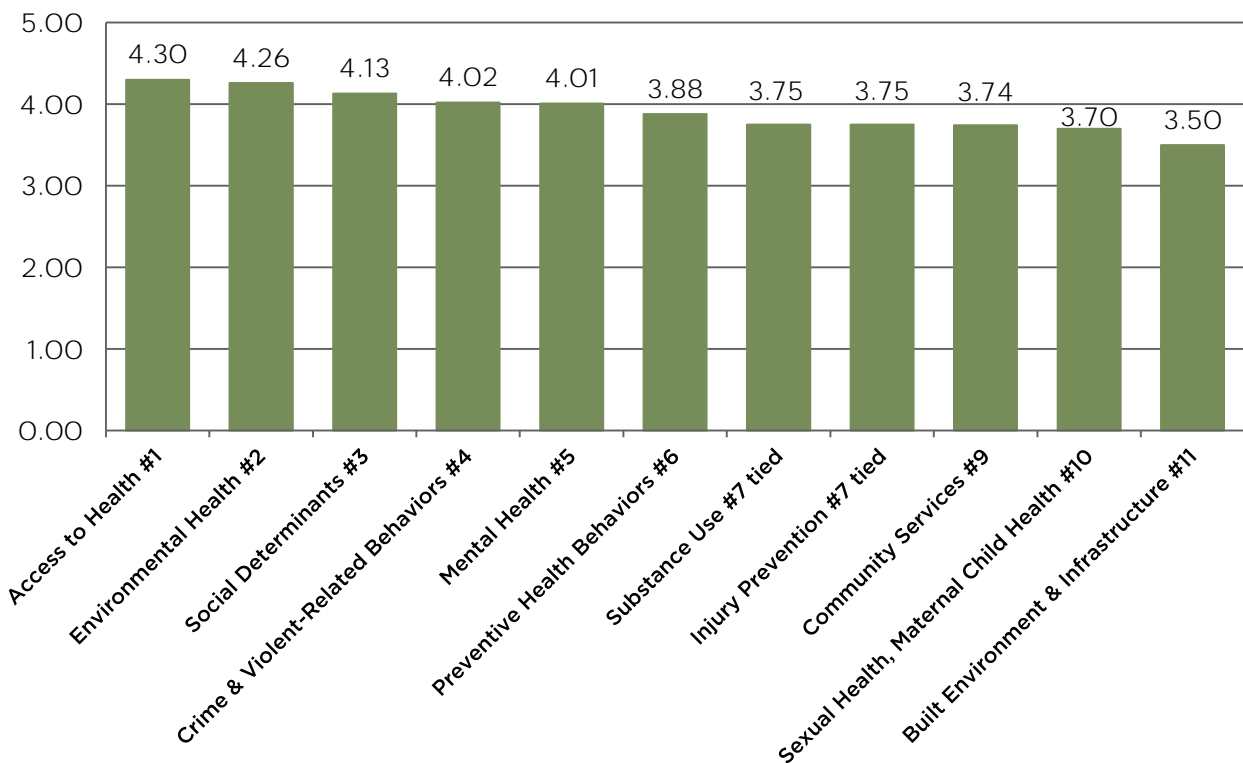
Score & Rank According to Primary Data Only

Criteria #5, the Community Perception Score, was calculated from the online community survey question that asked respondents to rate 11 major health topics on a scale from “1-Not a priority” to “5-Essential”. Three to six examples associated with each of the 11 health topics were provided so survey respondents would have a general concept and shared understanding of the terms “preventive health behaviors” or “access to health services”. For example, Access to Health Services was one of the 11 health topics and examples were “more primary care doctors”, “affordable health insurance”, “more specialty providers”, and “providers who accept your insurance” [Image 9]. It was not feasible to ask survey respondents to indicate a priority level for all examples provided for each health topic.

Image 10: Example of Online Community Survey Scoring of Health Topics-Access to Health Services

Access to Health Services	1-Not a priority	2-Low Priority	3-Medium priority	4-High priority	5-Essential
More primary care doctors					
Affordable health insurance					
More specialty providers					
Providers who accept your insurance					

Fig 203: Online Community Survey Health Topic Score & Rank



Scoring, Ranking, & Prioritization Summary

It is important to note, the prioritization method developed for the 2018-2020 Washoe County Community Health Needs Assessment has limitations. While it provides an objective way to measure needs, the scores and ranks could differ based on any number of changes. These changes include the grouping of health topics, the online community survey development and administration, and the individual indicators (secondary data) that were included in the assessment. The ranking helps to summarize the health topics in an organized manner by simplifying the large amount of data included in the assessment. It is important to recognize the limitations of the methods employed to score and rank this data and most importantly to acknowledge that health behaviors and outcomes are influenced by a dynamic, complex range of factors.

Conclusion

It is challenging to determine when a community has reached the status of “healthy”. A metric to consider might be the Healthy People objectives; however, Washoe County falls short of achieving the majority of those measures. Additionally, there are tools such as Robert Wood Johnson Foundation’s County Health Rankings for in-state comparisons and other websites that compare peer counties across state lines, which allow for quantifiable success relative to the nation. However, the United States remains among one of the least healthy developed countries as measured by life expectancy and premature mortality.³

Focusing on continued outreach, support, and partnership at the individual and agency- levels will enhance opportunities for innovative approaches to improving health outcomes. Achieving a healthy community is not a one-time success, it involves ongoing and cross-sector collaboration, as there will always be areas to improve upon to directly or indirectly affect the health of the community.

Moving forward, the CHNA will serve as guiding document for the goals and objectives of the Community Health Improvement Plan and Renown Health’s Community Benefits plan. These two documents will outline the next steps taken over the coming three years to address the community health needs identified and will rely heavily on a collaborative approach to make a collective, broad impact on the health of our community.

³ United Health Foundation. (2017). America’s Health Rankings Annual Report 2017. Accessed <https://assets.americashealthrankings.org/app/uploads/2017annualreport.pdf>

The following links contain secondary data presented in the assessment. The advantage of the assessment is the secondary data were obtained directly from the source and are the most recent data available. These following websites are more user friendly and allow for an interactive interface. Additionally, many of these also allow for the creation of maps.

Community Resources

<https://www.washeschools.net/Page/6128>
<https://www.truckeemeadowstomorrow.org/>

Mapping Health Indicators

<https://med.unr.edu/statewide/instant-atlas>
<https://www.cdc.gov/500cities/>
<https://www.communitycommons.org/>
<http://www.countyhealthrankings.org/>
<http://www.measureofamerica.org/maps/>
<http://localdata.assetsandopportunity.org/map>

Health Rankings Websites

<https://wwwn.cdc.gov/communityhealth>
<http://www.countyhealthrankings.org/>
<http://www.americashealthrankings.org/>
<http://www.stateoftheusa.org/>
<http://www.healthindicators.gov/>
<http://datacenter.kidscount.org/>

Behavioral Risk Factor Surveillance Survey (BRFSS) data

https://nccd.cdc.gov/s_broker/WEATSQL.exe/weat/index.hsqli
<https://www.cdc.gov/brfss/brfssprevalence/index.html>
<https://chronicdata.cdc.gov/health-area/behavioral-risk-factors>
<https://www.cdc.gov/cdi/>

Health topic specific mapping tools

Vaccinations <https://www.cdc.gov/vaccines/vaxview/>

Opioids

<http://urbanobservatory.maps.arcgis.com/apps/Cascade/index.html?appid=f86499d99e4340b68229eacafb02b29f>

Food Access <https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/>

AIR QUALITY MANAGEMENT DIVISION DIRECTOR STAFF REPORT
BOARD MEETING DATE: January 25, 2018

DATE: January 12, 2018
TO: District Board of Health
FROM: Charlene Albee, Director
775-784-7211, calbee@washoecounty.us
SUBJECT: Program Update, Divisional Update, Program Reports

1. Program Update

- a. Regional Transportation Commission (RTC) – Clean Air Partner



Over the past year, AQM has been focused on one goal – attainment of the 2015 Ozone National Ambient Air Quality Standard (NAAQS). On December 22, 2017, the U.S. Environmental Protection Agency issued a letter to Governor Sandoval informing him of the intended designations for the State of Nevada. The designations identified Washoe County as attainment. This is a major accomplishment for the overall health of our community.

Now that attainment has been achieved, the efforts must turn to maintaining the status. Vehicle emissions in the Truckee Meadows are responsible for up to 57% of the nitrogen oxide emissions which contribute to the formation of ozone. One of the strongest clean air partners is the Regional Transportation Commission of Washoe County (RTC). In addition to the adoption of a resolution of support for the Ozone Advance Program, RTC has committed to supporting clean air initiatives through the 2040 Regional Transportation Plan, adopted in May 2017, as identified in Chapter 5 Healthy Communities and Sustainability.

In 2015, the RTC Ride Program was responsible for 2,183,970 gallons of fuel savings, a 15,000 ton Green House Gas reduction, and a reduction in criteria pollutant emissions of 629 tons. Continued emission reductions are expected from the expansion of the RTC Electric Bus Program. Currently, the four electric buses put into service in downtown Reno in 2014 have eliminated the use of over 53,000 gallons of fuel representing a direct air quality benefit and reduction in operating costs. Five additional electric buses have been ordered for use on the 4th Street/Prater Way Lincoln Line. The long term goal is to transition the entire fleet to alternative fuels by 2030.

The operation of the fleet is only one component of the RTC clean air commitment. Transportation plans must also conform to air quality plans, especially the motor vehicle emissions budgets for particulate matter of 10 microns in diameter or less (PM10) and carbon monoxide (CO). The vehicle emissions budgets limit the allowable vehicle miles traveled (VMT) as a result of development. The implementation of programs to integrate all types of transportation also helps to reduce VMT throughout the community. RTC has committed to the development of a number of programs to reduce VMT including complete streets projects, regional connectivity, Safe Routes to School, and a new Bike Share Program.

The Ozone Advance Program identifies employee trip reduction programs as a strategy to reduce VMT in the community. The RTC Vanpool Program is one of the fastest growing components of their trip reduction program. Vanpool vehicles now represent the largest portion of the transit vehicle fleet, increasing to 97 at the end of fiscal year 2016, eliminating 211,690 vehicle trips and 10.1 million vehicle miles traveled. The Vanpool Program currently has vans traveling to Carson City, the Tahoe-Reno Industrial Center, North Spanish Springs, Stead, Herlong and Susanville.

Through the efficient and effective operation of the RTC fleet, participation in Ozone Advance Program strategies, and the integration of multi-modal transportation, RTC

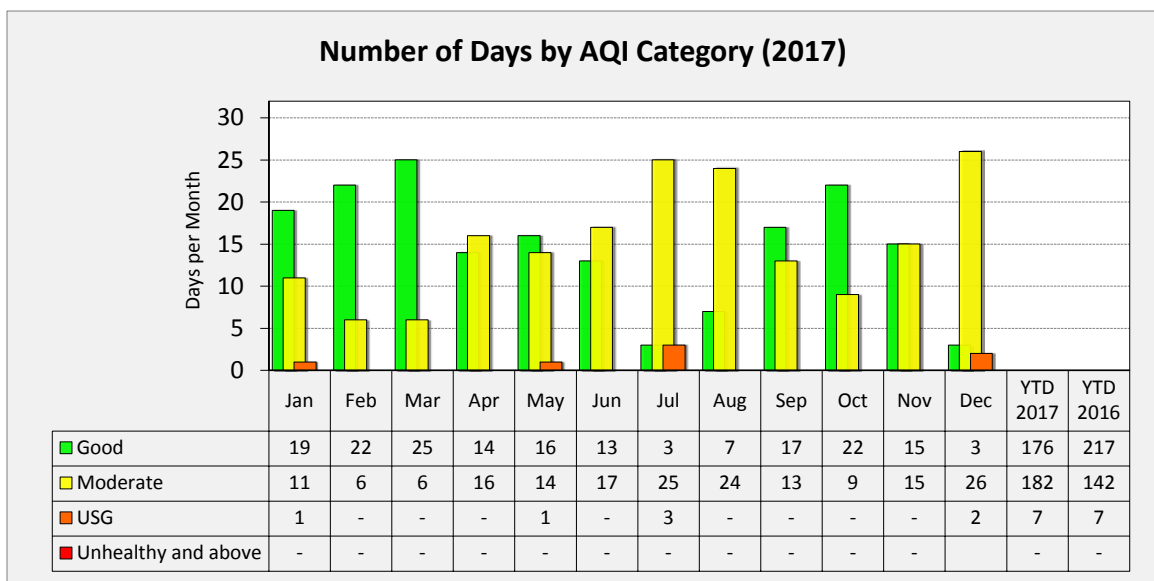
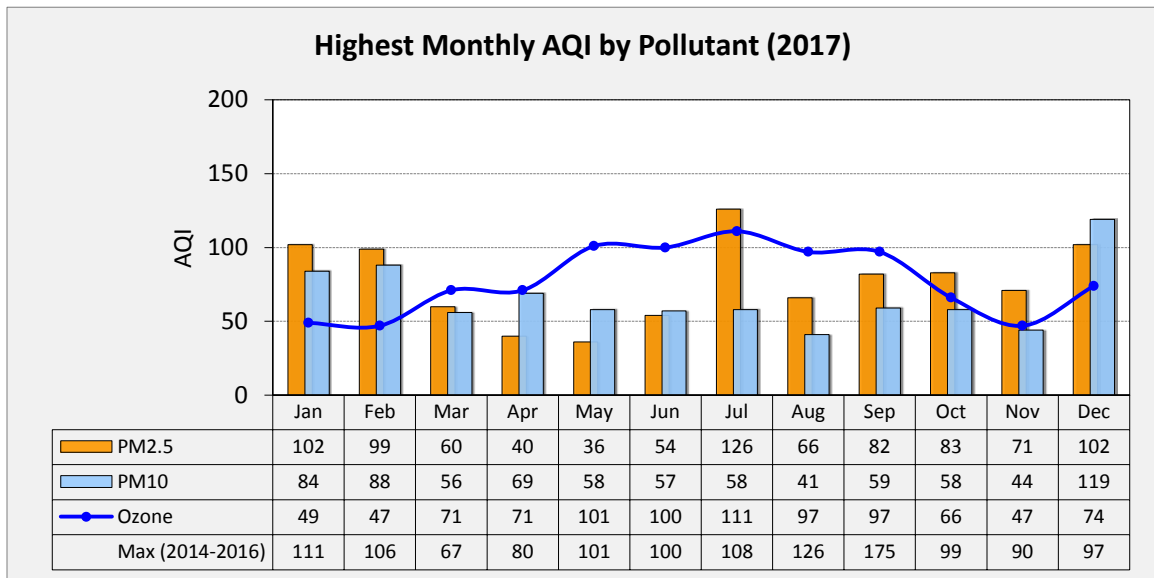


continues to demonstrate its commitment to supporting air quality initiatives. As attentions turn to future emissions reductions to continue to meet the ozone NAAQS, RTC's role as a valued clean air partner will be critical to *Keep it Clean* for a healthy community.

Charlene Albee, Director
Air Quality Management Division

2. Divisional Update

- a. Below are two charts detailing the most recent ambient air monitoring data. The first chart indicates the highest AQI by pollutant and includes the highest AQI from the previous three years in the data table for comparison. The second chart indicates the number of days by AQI category and includes the previous year to date for comparison.



Please note the ambient air monitoring data are neither fully verified nor validated and should be considered PRELIMINARY. As such, the data should not be used to formulate or support regulation, guidance, or any other governmental or public decision. For a daily depiction of the most recent ambient air monitoring data, please visit OurCleanAir.com.

3. Program Reports

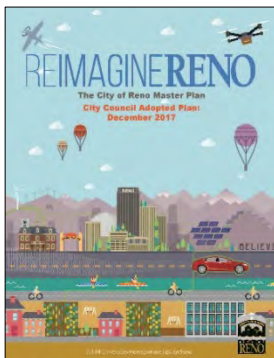
a. Monitoring & Planning

December Air Quality and Know the Code: December is typically the month when we monitor our highest non-wildfire PM_{2.5} concentrations. Temperature inversions, colder temperatures, and more residential woodburning all contribute to these higher pollution levels. There were 17 Green, 13 Yellow, and one Red Burn Codes issued in December (see burn code calendar). The AQM's woodstove program, including Know the Code, has helped improve wintertime air quality since the 1980's.

December 2017						
Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

As a reflection of the effectiveness of the Know the Code program, there were no exceedances of any National Ambient Air Quality Standard (NAAQS) during December; however, the AQI exceeded 100 on portions of two days.

ReImagine Reno: The Reno City Council unanimously voted on December 13 to adopt the updated City of Reno Master Plan (www.reimaginereno.us). The vote represents a major milestone in the two-and-a-half year process to update the plan, which guides where and how the city will grow and develop over the next 20 years. AQM staff has been actively involved in the update to ensure the plan supports AQM and Health District goals.



The Plan includes 8 guiding principles, dozens of policies, and 17 performance measures. These performance measures monitor Reno's progress towards the Master Plan's desired outcomes. Five of the performance measures are also used to monitor effectiveness of the Ozone Advance program, specifically:

- Multimodal transportation options
- Walkability
- Access to transit
- Air quality
- Tree canopy cover

Many of the plan's policies directly or indirectly support Health District goals. The Washoe County District Board of Health is identified as one of the key partners to help implement the Master Plan. DBOH members have a unique perspective on this partnership. They also serve on other councils, commissions, and boards that can leverage the collective impact of plans such as the Community Health Improvement Plan, Urban Forestry Management Plan, Ozone Advance, and many other plans that will move us closer to becoming a healthier community.

Daniel K. Inouye
Chief, Monitoring and Planning

b. Permitting and Enforcement

Type of Permit	2017		2016	
	December	YTD	December	Annual Total
Renewal of Existing Air Permits	84	1055	79	1297
New Authorities to Construct	5	60	3	99
Dust Control Permits	10 (115 acres)	173 (2653 acres)	11 (129 acres)	151 (2129 acres)
Wood Stove (WS) Certificates	31	474	62	391
WS Dealers Affidavit of Sale	7 (5 replacements)	54 (40 replacements)	17 (16 replacements)	135 (85 replacements)
WS Notice of Exemptions	832 (8 stoves removed)	9722 (88 stoves removed)	478 (6 stoves removed)	7490 (50 stoves removed)
Asbestos Assessments	68	1029	76	1077
Asbestos Demo and Removal (NESHAP)	12	241	19	150

Staff reviewed sixty-three (63) sets of plans submitted to the Reno, Sparks or Washoe County Building Departments to assure the activities complied with Air Quality requirements.

- The vacant Air Quality Specialist (Inspector) position interviews were completed and a candidate selected. The candidate has accepted the offer for the position and started January 8, 2018. Now that the fourth inspector position has been filled the AQMD Permitting and Enforcement Branch is fully staffed.
- Permitting and planning staff have updated all the AQMD applications available on our web site (www.OurCleanAir.com) resulting in active documents that can be filled out on-line. This makes the application process easier for customers to complete and is one step toward utilizing more of Accela's functionality.

Staff conducted inspections of sixty (60) stationary sources inspections and one (1) initial compliance inspection in December 2017. Staff was also assigned ten (10) new asbestos-related projects and ten (10) new construction/dust projects to monitor. Enforcement staff continues to monitor each asbestos removal and construction/dust control projects until such time as the projects are completed and closed.

COMPLAINTS	2017		2016	
	December	YTD	December	Annual Total
Asbestos	0	13	1	25
Burning	1	10	3	8
Construction Dust	3	42	4	32
Dust Control Permit	0	2	1	6
General Dust	1	54	1	48
Diesel Idling	0	0	0	3
Odor	0	15	3	30
Spray Painting	0	11	0	8
Permit to Operate	1	3	0	12
Woodstove	1	7	0	13
TOTAL	7	157	13	185
NOV's	December	YTD	December	Annual Total
Warnings	0	10	0	24
Citations	0	7	1	8
TOTAL	0	17	1	32

*Discrepancies in totals between monthly reports can occur due to data entry delays.

Mike Wolf
 Chief, Permitting and Enforcement

DD	SK	-
DHO	KD	-

**Community and Clinical Health Services
Director Staff Report
Board Meeting Date: January 25, 2018**

DATE: January 12, 2018
TO: District Board of Health
FROM: Steve Kutz, RN, MPH
775-328-6159; skutz@washoecounty.us
SUBJECT: Divisional Update – 2017 Year in Review; Data & Metrics; Program Reports

1. Divisional Update

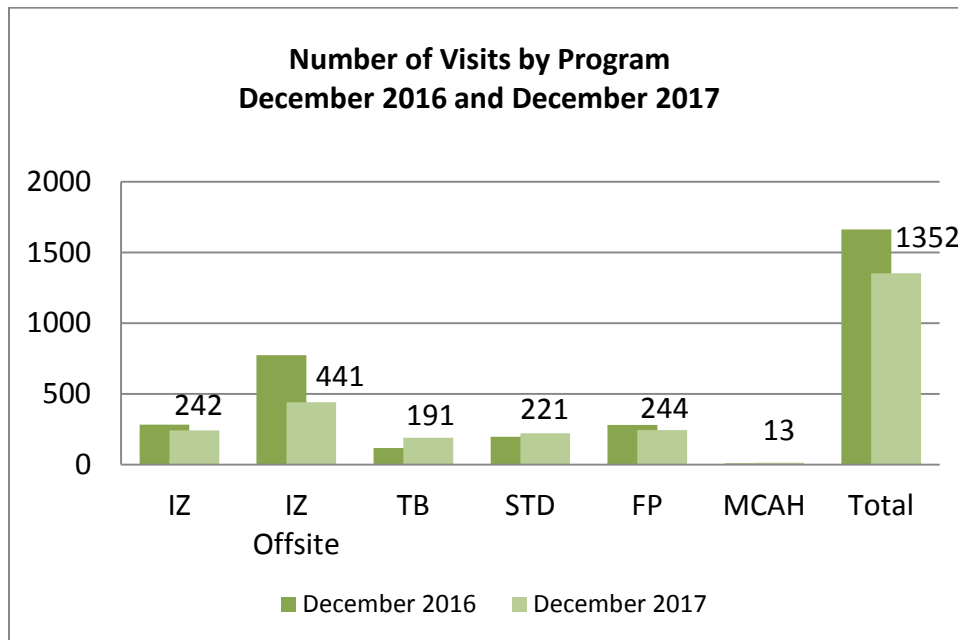
- a. **2017 Year in Review** – CCHS continued to grow and evolve in 2017, working to improve service to internal and external customers. A few of the more significant highlights include:
- i. Provided almost 15,000 important and needed clinical service encounters both here and in the community.
 - ii. Issued over 49,000 WIC benefits to mothers and children.
 - iii. Increased grant funding in the Chronic Disease Prevention Program with the addition of the SNAP Ed (Supplemental Nutrition Assistance Program Education) and PHHS (Preventive Health and Health Services) grants, totaling over \$100,000.
 - iv. Completed the transition to Patagonia Health as the Division’s Electronic Health Record (EHR), for all clinical programs, in January.
 - v. Transitioned our WIC Program to their new participant database, NV WISH, in November.
 - vi. Submitted a successful application and subsequent two year assignment of a Public Health Associate in the Immunization Program.
 - vii. Completed a Strategic Plan for the Division in line with the Health District’s Strategic Plan. Goals include:
 1. CCHS Programs will be **sustainable**
 2. CCHS will provide **fast, efficient and effective Clinic Services**
 3. CCHS will have a **nimble, adaptable and well-trained workforce**
 4. CCHS will enact **Policy, Systems and Environmental changes that improve the health of our community**

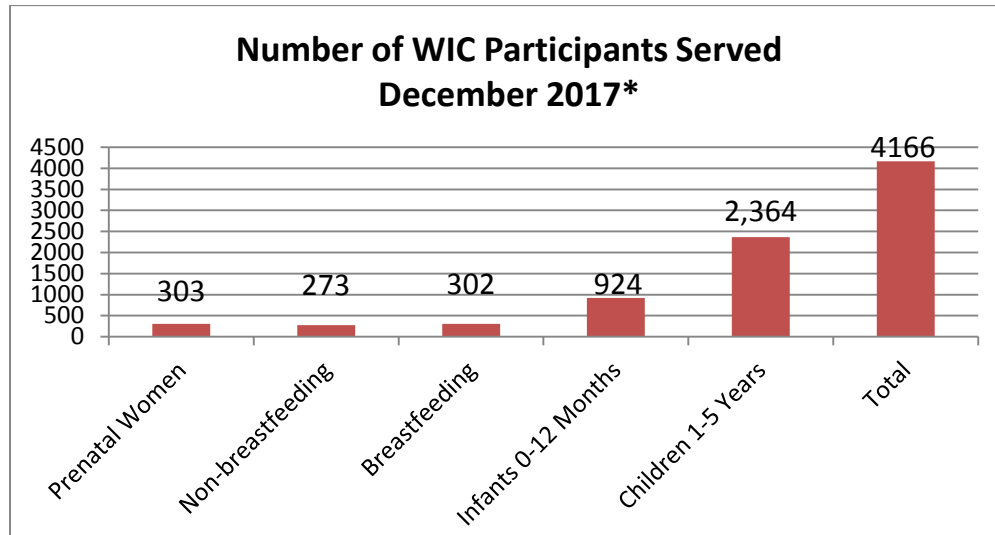
Each goal includes various strategies and action steps with timelines.

- viii. Implemented a Phone Queue system (a QI Project) in the Fall to improve our *call answer rate* which had a range of 18-76%. Through the diligent work of CCHS staff, and both AHS and Technology Services assistance, our *call answer rate* range is now 90-99%.
- ix. Increased clinic show rates from approximately 58% to 79% by the end of the year. A number of factors have contributed to this increase including our phone queue system, being fully functional in Patagonia Health and having our clerical and clinical areas fully staffed.
- x. Completed another outstanding year of revenue and reimbursement in our clinical programs, with a 103% increase over CY16:

	CY Revenue				
	2017	2016	2015	2014	2013
CY Totals	\$ 593,144.00	\$ 292,562.00	\$ 210,277.00	\$ 195,839.00	\$ 163,266.00
% Increase	103%	39%	7%	20%	NA

b. Data/Metrics





*The new electronic records system participant numbers are not comparable to the previous system's numbers at this time. The State WIC office has been notified.

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, all which may affect the availability of services.

2. Program Reports – Outcomes and Activities

- a. **Sexual Health** – Sheila Juskiw, Advanced Practice Registered Nurse, joins the Sexual Health team on January 22, 2018. Establishing this position supports changes in staffing structure that will allow for more comprehensive sexual health clinic services, and will improve revenue generated for the program.

Staff are preparing data for year-end reports for 2017 in the HIV, STD, and Family Planning programs. Working with Patagonia Health and EPHP staff, data extraction reports are being developed and will provide data for analysis and reporting.

- b. **Immunizations** – Eight School Located Vaccination Clinics (SLVCs) were held in December, in partnership with Immunize Nevada and the Washoe County School District. A total of 394 children and 45 adults received flu vaccine at those clinics. Additionally, 12 flu shots were administered at the Children's Cabinet on December 2, 2017. Program staff participated in a meeting with Immunize Nevada to discuss opportunities for SLVC program improvements for the remainder of the 2017-2018 school year.

Data loggers for continuous temperature monitoring have been installed on all clinic refrigerators and freezers that store Vaccine For Children (VFC) vaccine to be in line with new CDC requirements. A new pager system has also been purchased to notify nurses when clients are ready to increase clinic efficiency.

- c. **Tuberculosis Prevention and Control Program** – 2017 ended a bit quieter for the TB program with no new active cases after November; though 2017 ended with a total of 17 active cases, nearly three times those reported in 2016. Currently there are eight clients being monitored with direct observation therapy (DOT). Nevada TB Controller and Program Manager for the State, Susan McElhany, DMD, visited the TB Clinic January 10, 2018 to meet staff and participate in some informal information sharing. Staff are researching an alternative TB lab test for diagnosing TB, and will be meeting with a vendor representative at the end of the month to gather additional information.

- d. **Family Planning/Teen Health Mall** – In addition to routine Family Planning clinical services, staff have been assisting management in preparation of an upcoming lab audit.

- e. **Chronic Disease Prevention Program (CDPP)** – CDPP program is beginning work on the SNAP-ed and PHHS awards and is looking forward to a successful 2018.

- f. **Maternal, Child and Adolescent Health (MCAH)** – Fetal Infant Mortality Review (FIMR) staff continue to abstract data on fetal and infant deaths from local hospitals. In the second quarter of FY 2018, staff presented on 12 cases at two separate Case Review Team meetings.

- g. **Women, Infants and Children (WIC)** – The WIC program is rapidly becoming experts in the state on the NV WISH electronic records system. Staff are quickly adapting to the new system and will be paperless in a few short months.

DD	<u>CW</u>
DHO	_____ <i>KD</i>
DA	_____
Risk	_____

Staff Report
Board Meeting Date: January 25, 2018

DATE: January 12, 2018
TO: District Board of Health
FROM: Chad Warren Westom, Division Director, Environmental Health Services (EHS)
775-328-2644; cwestom@washoecounty.us
SUBJECT: EHS Division and Program Updates – Child Care, Community Development, Food, Land Development, Safe Drinking Water, Schools, Vector-Borne Disease and Waste Management

DIVISION UPDATES

- **Environmental Health Services Training Program** – A new staff member completed training in Pool and Spa inspections in November of 2017, and assisted in completion of annual inspections for the program. A draft school inspection field guide was also completed in November by School Inspection Program staff and is being finalized by Training Program staff to train all Area Environmental Health Inspectors on school inspections starting in 2018. A short version of the field guide will be used initially to train Registered Environmental Health Specialist (REHS) staff. The final version will be updated in 2018 and added to the EHS Training Manual for incoming REHS staff. Additionally, two staff members from the Vector Control Program were successfully trained to conduct Hotel/Motel inspections. Training was completed between 11/14/2017 and 11/21/2017 on 24 facilities using the current version of the EHS Training Manual and the remaining 50 inspections were completed independently by the Vector staff members by year end of 2017.
- **Environmental Health Services Epidemiology Program** – Environmental Health Services (EHS) Epidemiology program staff worked with the Communicable Disease (CD) program on outbreaks of gastrointestinal (GI) illness at fourteen Washoe County schools between late October and late December when the schools went on break. There were additional outbreaks of GI illness at three childcare facilities during the same time period. Stool samples were collected by EHS from students and staff at several schools and taken to the Nevada State Public Health Lab (NSPHL). Norovirus GI was detected at two schools and a childcare facility. Samples were also submitted to the California State Health lab for additional testing and two samples that were negative for norovirus came back positive for other gastrointestinal viruses; one for sapovirus and another for a subtype of adenovirus that can result in GI symptoms.

Staff from EHS responded to two of the schools to conduct outbreak investigations due to 5-week and 8-week durations. At one of the schools it was noted there was breakdown in sanitation for public vomiting incidents (PVIs) and for the concentrations of solutions required for sanitation in high-touch areas. During the investigation, EHS staff educated the site facility coordinator and kitchen and administrative staff on sanitizing and control measures for outbreaks. Washoe County School District (WCSD) facilities management was contacted by EHS and arrangements were made to have additional sanitizing and disinfection assistance and oversight at the school.

Investigations at both schools revealed that tables in the cafeteria were not being sanitized in-between lunches due to the short breaks. The school principals were notified and written orders given to change the lunch periods to allow for at least twenty minutes between lunch periods to allow WCSD staff to sanitize all tables in the cafeteria at each school. Additionally, WCSD staff was required to switch to virucidal solution instead of the kitchen bactericidal solution they were using. There was indication that the same issue may be occurring with staggered lunch periods district-wide, which will be addressed by EHS and CD staff in an upcoming meeting with WCSD officials. About half of the GI outbreaks in the schools and the three outbreaks in the childcares were closed prior to WCSD winter break and all were closed by the first of the year.

Another case of significance involved positive Hepatitis A with a food worker at Trader Joe's, received by CD staff on November 14, 2017. The food worker was excluded from duty by the Health Officer until November 20, 2017. The worker stocked produce along with cashier duties during his/her infectious period between 10/20/2017 and 11/14/2017. As a result, EHS staff required Consumer Health Warnings to be posted at fourteen locations throughout the store for people who may have shopped there between 10/20/2017 and 10/31/2017. Informational letters were offered as part of the Warnings and postings were required until 12/20/2017. A total of 103 letters were given to consumers at the Trader Joe's location. As of 12/19/2017, there were no other complaints of illness or positive Hepatitis A cases reported for the facility and the referral was closed on 12/22/2017.

During November and December, EHS staff continued to assist CD staff with the Aseptic Meningitis outbreak in the community. On December 7, 2017, there were two cases reported from students at the same elementary school who resided in separate households. An outbreak was declared at the school and EHS staff contacted the WCSD facilities administrator and required that the entire school be disinfected with a deep clean of 1,000 parts-per-million sodium hypochlorite (bleach) solution. Additionally, EHS staff worked with CD staff to notify other schools that may have been affected during the outbreak. On December 28, 2017, the community-wide outbreak was closed and a final report was constructed by CD staff. Of the 59 total cases between July and December of 2017, 31 or 53% were school-aged children. There were cases in twelve elementary schools, four middle schools and four high schools in the WCSD.

PROGRAM UPDATES

Child Care

- Childcare program staff completed all of the 2017 licensing inspections by the end of 2017 and started on the 2018 inspections. Staff met in December to discuss a number of items to address in 2018. The first is an overhaul of the webpage for the program. Outdated and inaccurate information will be removed and new information provided. Another topic of discussion was to align EHS information with the newer Quality Ratings and Improvement System (QRIS) guidelines that are governing how childcare facilities operate. Of significance is the fact that nutritional requirements are difficult to meet under the current permit restrictions, with some of the facilities opting not to pull kitchen permits. Staff is working to provide information on what types of food can be served with and without a permit. Another related topic is that child care facilities are adding food preparation to curriculum activities. A lot of the activities identified in 2017 were subject to permitting requirements so EHS staff will be drafting guidelines that, if followed, additional permits will not be required.

Community Development

- Please see the table below for the specific number of plans per program, inspections and the number of lots or units that were approved for construction within Washoe County:

Community Development	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUN 2017	JULY 2017	AUG 2017	SEP 2017	OCT 2017	NOV 2017	DEC 2017	YR Total	Mo. Avg
Development	30	34	38	38	35	41	16	36	41	40	40	37	426	36
Commercial Plans	17	53	45	64	51	90	72	90	85	74	64	75	780	65
Commercial Plan	16	19	25	54	52	44	15	56	31	34	25	36	407	34
Water Projects	19	21	34	20	39	36	25	23	21	21	15	13	287	24
Lots/Units Approved for Construction	0	64	464	269	471	568	819	321	607	427	76	31	4,117	343

Food

- The draft final report for the 2017 risk factor study has been completed and is under review. The risk factor study is a research project designed to assess the occurrence of food preparation procedures and practices and employee behaviors most commonly reported to the Centers for Disease Control and Prevention (CDC) as contributing factors to foodborne illness outbreaks at the retail level. The report includes the results of the data collected from January 2017 to June 2017 which provides guidance to industry food safety professionals to assist them in addressing food safety issues that have the most significant impact on protecting public health. Completion of a risk factor study at least every five years to measure trends in the occurrence of foodborne illness risk factors meets the criteria of Standard 9 – Program Assessment.
- Staff partnered with the Southern Nevada Health District (SNHD) to complete field standardization training. A SNHD Supervisor, who is an FDA Standard instructor, visited Reno in December to conduct the field standardization of James English, EHS Supervisor using the FDA Standardization Procedures. James successfully completed standardization and can now assist with evaluating field inspectors’ abilities to apply food safety knowledge and skills. It also ensures staff is conducting risk-based inspections and obtaining corrective actions for those factors that will directly contribute to foodborne illness. Field Standardization of staff conducting food establishment inspections meets the criteria of Standard 2 –Trained Regulatory Staff.
- The Food Safety Program was awarded three Retail Food Program Standards grants funded by the US Food and Drug Administration (FDA) administered by the Association of Food and Drug Officials (AFDO). The grants will provide funding for staff training and design and printing of “dog access approved” signs will be provided to food establishment operators that have been approved to allow dogs on outdoor patio areas. The signs will help alert patrons that the establishment has been approved to allow pet dogs on outdoor dining patios. Participation in food safety related training meets the criteria of Standard 2 – Trained Regulatory Staff; and participation in consumer outreach activities meets the criteria of Standard 7 – Industry and Community Relations.
- **Special Events** – Staff is assisting various other programs to complete required routine inspections.

Land Development

- With the good weather continuing into December, construction inspections and plan submittals continued throughout the month. The team did enjoy about a week and a half of respite over the holidays but overall the growth rate is expected to continue into 2018.
- Final year over year counts for septic plans processed were 821 in 2017 versus 733 in 2016 for a 12% growth rate. Well plans year over year were down approximately 10%, with 149 plans being processed in 2017 versus 164 in 2016.
- The scanning project of old records is making good progress. All recent plans have been scanned and now the drawers of old plans are beginning to be processed. If the dedicated temporary services staff can be maintained it is expected that by the end of the first quarter of 2018, all records will be digital and able to be searched by plan reviewers. There are other items targeted for scanning as well, such as old subdivision files. All of these improvements will improve the quality and efficiency of the plan review by staff and public record requests.

Land Development	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUN 2017	JULY 2017	AUG 2017	SEP 2017	OCT 2017	NOV 2017	DEC 2017	YR Total	Mo. Avg
Plan Review (Residential -	41	67	88	74	117	81	57	72	65	47	59	48	816	68
Residential Septic/Well Inspections	18	52	84	102	89	97	169	100	91	90	79	85	1,056	88
Well Permits	4	9	14	21	14	19	17	11	7	13	14	3	146	12

Safe Drinking Water

- All sanitary survey reports were issued prior to the end of December. With basic training levels completed for all staff, it is expected that surveys will be completed earlier in the year in 2018.
- Water systems will be held to their approved deadlines on their surveys in 2018, as the group continues to work on stabilizing and creating consistent processes. This will lead directly to creating a standardized process within the group for turning non-compliant water systems over to the State for formal enforcement.
- The State is involving the team in more conversations as abilities improve and due to pressures on them from the EPA to resolve longstanding non-compliant systems. This creates additional workload but also demonstrates that the team is able to handle greater scope of issues. Overall, the Safe Drinking Water team made huge strides and is looking forward to 2018 to build on their success.

Schools

- School inspections for the fall of 2017 were completed in early December. In mid-November a new staff member was trained to conduct school inspections and assisted with other program staff as the two intermittent hourly Environmental Health Specialists who were inspecting schools the past seven years both retired. Follow-up inspections indicated compliance at several high schools and middle schools with getting hazardous chemical inventories under control in the science labs. In addition, capital improvements to address years of lingering violations were noted during 2017 inspections and WCSD facility staff indicates there are more to follow in 2018. Along with the schools are the school kitchen (SKIT) inspections, all of which were completed for both spring and fall

of 2017, with contributions from existing staff following the two intermittent hourly retirements.

Vector-Borne Diseases

- Vector staff was asked to participate in a conference call with the Nevada Department of Agriculture to discuss updating the Nevada state rabies regulations in NAC441A (Vector program staff represents the Health Officer as the Rabies Control Authority for Washoe County following the guidelines in the Compendium of Animals Rabies Prevention and Control). The proposed changes addresses proper quarantine methods for dogs and cats overdue for their rabies vaccinations and how to quarantine these animals when exposed to wildlife which are either positive on a rabies test, unavailable, or samples unsuitable for testing. Current regulations state six month quarantine at a facility with human and animal exposure at the owner's expense or euthanasia. The quarantine is expensive and the euthanasia provides no options. With recent research findings, the quarantine period would be decreased from a six month quarantine period to a four month home quarantine. Instead of euthanasia, animals not current on their rabies vaccination would be revaccinated. This gives animal control and the Rabies Control Authority more options than the draconian approach of quarantine at the owner's expense and the difficult issue of putting an animal down.
- Staff was invited to a meeting on the proposed development called Day Break, formerly the Bella Vista Ranch. In attendance was the Army Corp of Engineers along with Wood Rodgers who is representing the project applicant. The applicant is proposing to fill Alexander Lake and restore Thomas Creek to its original meander to Steam Boat Creek. In this process, the applicant would need to restore eight acres of wetland habitat lost or a 1:1 ratio. The Vector-Borne Diseases Program on a previous Washoe County wetland restoration project required low flow channels in the wetland and/or subsurface irrigation instead of sheet flow. This minimized, if not eliminated, the breeding of mosquitoes that occurs from poorly designed wetlands. Wood Rodgers will work with our Program's design criteria where mosquito activity would not pose issues for their proposed single family housing project development.
- Vector Responses to Public Requests:

	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUNE 2017	JULY 2017	AUG 2017	SEP 2017	OCT 2017	NOV 2017	DEC 2017	YR Total	Mo. Avg
Mosquito	1	2	11	11	72	44	57	52	27	5	5	2	289	24.1
Mosquito Fish – Gambusia	0	0	10	25	36	36	12	4	0	1	0	0	124	10.3
Gambusia Delivered	0	0	0	0	0	492	315	0	0	0	0	0	807	67.3
Hantavirus	5	0	2	6	6	10	8	12	10	53	11	3	126	10.5
Plague	0	0	5	0	0	2	4	2	3	0	1	0	17	1.4
Rabies	2	0	6	5	4	25	17	16	10	6	3	10	104	8.7
Planning Calls	21	6	6	3	14	8	15	21	23	17	14	15	163	13.6
Lyme Disease/Ticks	0	1	0	2	2	3	7	6	0	2	3	0	26	2.2
Media	0	1	0	4	3	9	11	9	7	2	0	1	47	3.9
Outreach / Education / Misc.	2	4	24	90	22	147	43	55	15	31	5	4	442	36.8
Cockroach / Bedbug	12	8	13	18	16	26	22	31	19	20	26	16	227	18.9
West Nile Virus	0	0	0	2	0	0	5	31	17	0	0	0	55	4.6
Zika	1	1	0	1	0	0	7	1	1	0	0	0	12	1.0
TOTAL	44	23	77	167	175	802	523	240	132	137	68	51	2439	203.3
Planning Projects	12	6	26	8	12	15	14	16	7	18	12	3	149	12.4

Waste Management

- All permitted Waste Management facilities were inspected in 2017 and inspector assignments for 2018 were sent out on December 29, 2017.

EHS 2017 Inspections	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUN 2017	JULY 2017	AUG 2017	SEP 2017	OCT 2017	NOV 2017	DEC 2017	YR Total	Mo. Avg
Child Care	1	4	9	6	8	23	6	16	13	14	9	6	115	10
Complaints	40	61	93	98	59	96	139	83	59	52	51	52	883	74
Food	212	282	367	377	325	445	306	515	582	685	482	419	4997	416
General*	45	36	75	93	363	182	191	503	153	107	126	158	2032	169
Commercial Plan Inspections	16	19	25	54	52	44	15	56	31	34	25	36	407	34
Plan Review (Residential - Septic/Well)	41	67	88	74	117	81	57	72	65	47	59	48	816	68
Residential Septic/Well Inspections	18	52	84	102	89	97	169	100	91	90	79	85	1056	88
Temporary Foods/Special Events	22	22	29	85	85	224	167	428	450	123	36	15	1686	141
Temporary IBD Events	0	0	45	45	0	0	0	0	6	0	0	0	96	8
Well Permits	4	9	14	21	14	19	17	11	7	13	14	3	146	12
Waste Management	21	23	16	18	30	27	27	15	16	49	14	30	286	24
TOTAL	420	575	845	973	1,142	1,238	1,094	1,799	1,473	1,214	895	852	12,520	1,043

* **General Inspections Include:** Invasive Body Decorations; Mobile Homes/RVs; Public Accommodations; Pools; Spas; RV Dump Stations; and Sewage/Wastewater Pumping.

Cleaning up after Christmas: What's recyclable and what's not

By [Denise Wong](#) | Posted: Tue 5:20 PM, Dec 26, 2017 |

RENO, Nev. (KOLO) -- Just outside the Waste Management station on Commercial Row, folks are pulling up and dropping off old appliances they don't need any more now that they got new ones for Christmas. Eddy Swainston knows it's an easy way to get rid of his old stove without the hassle of going to the dump. And it's free.

"You don't have to wait in line, so I mean anybody that has metal, you just pull up, drop it off and you go," says Swainston. "No paperwork, no muss, no fuss."

Most of that scrap metal can be recycled as well as a lot of other holiday trash. Things like broken down cardboard boxes and tissue paper. But there are a lot of things that cannot go into the single stream recycling bin outside of your home. For instance, certain wrapping paper.



"If you have a plain wrapping paper, you can put that into recycling, but if it has plastic or foil, it can't be separated in that single-stream process, so that should definitely go in your trash can," says Kendra Kostelecky, Communications Specialist for Waste Management.

In addition, there are some small holiday items that can cause big problems at the Reno facility that processes recyclables. On this day after Christmas, workers had to shut down the line because something got wrapped around the machinery that sorts the recyclables. It's an occurrence that is pretty common after the holidays when people mistakenly try to recycle ribbon or string lighting.

"We can't separate that in single-stream. That should actually go into your trash," says Kostelecky.

This time of year, it's easy to have excess waste. Just make sure that if you have items that don't fit into your trash and recycling bins, you use those "excess waste" stickers from Waste Management. If you don't, crews may not pick up those items on your curb.

Also, if you are trying to get rid of your Christmas tree -- real or fake -- Kostelecky says don't put it in the recycling bin. She says if you have a fake tree, try to break it down into smaller pieces and put it into the trash bin. If you have a real tree, you should cut it up into three-foot pieces and put those into the trash bin. If you cannot fit those tree pieces in the trash bin, you can put them near your trash with the Waste Management excess waste stickers on them.

Kostelecky also has a reminder that every resident in Reno, Sparks and Washoe County has four free dumps per year to use at their convenience during normal business hours. Reno residents must use the transfer station for those dump days while Sparks and Washoe County can dump at the transfer station or the landfill. She says that could be another option for people this time of year who collected a lot of waste over the holidays.

**EPIDEMIOLOGY AND PUBLIC HEALTH PREPAREDNESS
DIVISION DIRECTOR STAFF REPORT
BOARD MEETING DATE: January 25, 2018**

DATE: January 11, 2018
TO: District Board of Health
FROM: Randall Todd, DrPH, EPHP Director
775-328-2443, rtodd@washoecounty.us
Subject: Program Updates for Communicable Disease, Public Health Preparedness, and
Emergency Medical Services

Communicable Disease (CD)

Outbreaks – Since the last District Board of Health meeting in December, the CD Program has opened 13 outbreak investigations. Of these outbreaks, six (6) were viral gastroenteritis in a school, a senior independent living complex, and four child care facilities. One child care facility outbreak was confirmed as Norovirus GII. Three (3) schools had outbreaks with both influenza like illness (ILI) and viral gastroenteritis. One school and one child care facility had outbreaks of ILI. Two child care facilities had an outbreak of respiratory syncytial virus (RSV). As of January 11, three of these outbreak investigations are still open.

Aseptic meningitis outbreak – On December 28, 2017 the aseptic meningitis outbreak was declared over. Between July 15 and December 3, a total of 59 cases had been reported. Historically between 2005 and 2016, there was an average of 11 cases reported per year (range: 5-23 cases per year). Of the 59 cases reported since July 15, 73% were children. School aged children (5-17 years of age) accounted for 53%. Enterovirus was confirmed as the etiology for this outbreak. Specifically, Echovirus 30, a part of the Enterovirus family, is the strain confirmed by CDC. This also matched with the viral meningitis outbreak strain in Lassen County. Echovirus 30 is a common cause for viral meningitis in the United States according to CDC. In addition, two cases had Echovirus 9, 1 case had Coxsackievirus A10 and 1 case had Coxsackievirus B5. The CD Program interviewed 40 cases to obtain exposure history to identify any epidemiological links among cases. Overall, a total of 15 risk communications and interventions have been completed by the Outbreak Response Team (ORT) members, which resulted in more than 100 stories generated from local media outlets.

Overall Communicable Disease Investigations – For 2017, a total of 1,177 cases of reportable general communicable disease (CD) requiring follow up by the CD Program have been recorded in the log. This number does **not** include influenza, STD, HIV, TB, or animal bites. By way of comparison, for 2016 there were 794 cases. This represents a workload increase of 48% (1,177 records in 2017 vs. 794 records in 2016). The CD log is a real-time system for CD staff to document all cases being investigated or needing follow-up activities.

Seasonal Influenza Surveillance – For the week ending January 6, 2018, (CDC Week 1) 12 participating sentinel providers reported a total of 458 patients with influenza-like-illness (ILI). The percentage of persons seen with ILI by the 12 providers was 5.7% (448/7,846) which is above the regional baseline of 2.4%. During the previous week (CDC Week 52), the percentage of visits to U.S. sentinel providers due to ILI was 5.8%. This percentage is above the national baseline of 2.2%. On a regional level, the percentage of outpatient visits for ILI ranged from 2.4% to 11.3%.

Thirteen death certificates were received for week 1 that listed pneumonia (P) or influenza (I) as a factor contributing to the cause of death. The total number of deaths submitted for week 1 was 117. This reflects a P&I ratio of 11.1%. The total P&I deaths registered to date in Washoe County for the 2017-2018 influenza surveillance season is 104. This reflects an overall P&I ratio of 7.9% (104/1,309).

Media – For 2017 the CD Program, along with the PIO, had 77 media contacts for Epi related stories - New Delhi metallo-beta-lactamase CRE (27), viral meningitis outbreak (16), influenza (13), West Nile Virus (7), Trader Joes/Hepatitis A (4), Hantavirus (4), viral meningitis outbreak and Hantavirus (3), Rabies (1), Scabies (1), and drinking water related to flooding (1).

Altmetric Report – A report published on January 13, 2017 in the Morbidity and Mortality Weekly Report (MMWR) made the top 100 reports in Altmetric. This is among 2.2 million reports published worldwide and tracked by Altmetric. The report, “Notes from the Field: Pan-Resistant New Delhi Metallo-Beta-Lactamase-Producing *Klebsiella pneumoniae* – Washoe County, Nevada, 2016,” was actually ranked 78th overall. The authors of this report included Dr. Lei Chen as first author and Dr. Randall Todd. As of December 13, the Altmetric score was 2088. Any score greater than 200 is considered to be a high attention score. Only one other MMWR article scored among the top 100 in 2017. That article was ranked 44th and was about increases in drug and opioid-involved deaths. Altmetric is a tool that is used by several journals, including JAMA. Altmetric pulls in data from social media sources such as Facebook and Twitter, from traditional mainstream and science-specific media, and from online reference managers such as Mendeley. It allows authors almost immediately to see how their work is being read and used, including exactly what is being stated about it, months and years before it is formally cited.

Public Health Preparedness (PHP)

The Program Manager met with Federal Victim Service Unit Agents to provide a high level training of the Health District plans for emergency response. Of specific interest were the mass casualty incident plan and the “alpha” plan currently being drafted. Federal partners are planning a field exercise with regional law enforcement agencies in the summer; it could be an opportunity to test the “alpha” plan.

Regional sub-acute care agencies (home health, dialysis and hospice) worked with staff and developed an information sharing process for citizens with access and/or functional needs. This project provides a way for Emergency Operations Center representatives to receive information on citizens who may need assistance evacuating during an emergency due to medical needs.

The grantees of the CDC and ASPR grants held their quarterly meeting on January 10th. The Local Health Authorities, tribes, Nevada Hospital Association, and State Lab are the sub grantees of the Division of Public and Behavioral Health. Agenda items included updates on strategic

planning objectives and the healthcare coalition. The partners reiterated what the Health Officers said in December about the funding formula being discussed and adjusted.

Emergency Medical Services (EMS)

On December 6 the EMS Coordinator provided training to patient registration staff at Incline Village Community Hospital (IVCH) on WebEOC. Training included an overview of disaster response planning in Washoe County, including the Multi-Casualty Incident Plan (MCIP) and the Mutual Aid Evacuation Annex (MAEA). IVCH staff were also given a guidebook with step-by-step instructions on how to access and input information into three of the WebEOC boards if they were a Hospital Representative during a disaster in Washoe County. EMS staff also conducted the same training with Renown personnel on January 12.

The Dispatch Subcommittee held its quarterly meeting on December 13. There was quality discussion about staging protocols, FirstNet, and regional projects. The purpose of the subcommittee was discussed, to include the initial objectives of creating the subcommittee. It was determined that this group has solved the previously identified communication gaps between the three dispatch centers. Moving forward, the PSAPs will meet monthly to discuss current topics and invite REMSA and the Health District on a quarterly basis. The quarterly meeting will also begin to include incident review.

EMS Program staff continues to work on the deliverables for the Nevada Governor's Council on Developmental Disabilities (NGCDD) grant. The EMS Coordinator drafted the training content for the first grant objective, which is a short 5-minute training video for first responders to watch during shift change. The content has been reviewed by a subject matter expert as well as NGCDD staff and council member. Staff is working to complete the first training video during the second quarter of the grant. Staff also met with NCGDD personnel on December 29 because the Nevada Division of Aging and Disability Services is interested in collaborating with the Program on training first responders. Staff is scheduled to meet with the Division of Aging and Disability Services on January 12.

The EMS Coordinator developed a regional EMS and law enforcement tabletop exercise that focuses on on-scene coordination during a multi-casualty incident (MCI). The tabletop will identify possible planning gaps for the revision of the Multi-Casualty Incident Plan (MCIP). In preparation for the exercises and to ensure the scenario was realistic, the EMS Coordinator collaborated with Washoe County Emergency Management and Truckee Meadows Water Authority. The exercises are scheduled for January 22, 24 and 26.

The EMS Advisory Board held their quarterly meeting on January 4. The Board heard a variety of agenda items to include an update on mutual aid agreements in the region, a presentation on the EMS Strategic Plan objectives, a data report on special areas of interest, and a presentation on the EMS Program Manager's response to the Las Vegas Family Assistance Center after the Route 91 incident.

The EMS Coordinator participated in a FirstNet webinar on January 10 and learned that all 50 stated opted into the system. The presentation covered why FirstNet is being developed, when agencies will be able to use the functionality, how it can be used for day-to-day operations and

how it connects with current systems. The overarching message was that FirstNet will simplify processes but expand capabilities for public safety agencies.

EMS Program staff continues to work on initiative 2.2.5.1 of the Washoe County Strategic Plan. Staff requested quotes from various graphic design agencies to develop materials to increase awareness of alternate resources and appropriate utilization of the 911 system. Staff met with the selected agency on January 10 for an initial meeting to discuss graphic design and the overall marketing strategy.

**REMSA Percentage of Compliant Responses
 FY 2017 -2018**

Month	Zone A	Zone B	Zone C	Zone D	Zones B, C and D	All Zones
July 2017	93%	88%	100%	100%	91%	93%
August 2017	93%	94%	91%	100%	93%	93%
September 2017	92%	96%	100%	100%	97%	92%
October 2017	92%	92%	91%	100%	92%	92%
November 2017	92%	93%	100%	100%	96%	92%
December 2017	92%	95%	87%	100%	93%	92%
YTD	92%	93%	94%	100%	94%	92%

REMSA 90th Percentile Responses

Month	Zone A 8:59	Zone B 15:59	Zone C 20:59	Zone D 30:59
July 2017	8:18	16:56	18:14	N/A*
August 2017	8:29	14:51	15:28	N/A*
September 2017	8:32	13:06	18:30	N/A*
October 2017	8:31	14:15	19:32	N/A*
November 2017	8:33	13:01	17:42	N/A*
December 2017	8:41	14:06	21:43	N/A*

*There were 5 or less calls per month in Zone D, therefore a statistically meaningful 90th percentile analysis cannot be conducted. However, no calls in Zone D exceeded the 30:59 time requirement.

Influenza in Washoe County & Surrounding Area

Randall Todd, DrPH

Director, Epidemiology & Public Health Preparedness

A Weekly Influenza Surveillance Report Prepared by the Influenza Division

Weekly Influenza Activity Estimates Reported by State and Territorial Epidemiologists*

Week Ending Jan 13, 2018 - Week 2



*This map indicates geographic spread and does not measure the severity of influenza activity.

A Weekly Influenza Surveillance Report Prepared by the Influenza Division

Weekly Influenza Activity Estimates Reported by State and Territorial Epidemiologists*

Week Ending Feb 11, 2017 - Week 6



*This map indicates geographic spread and does not measure the severity of influenza activity.

A Weekly Influenza Surveillance Report Prepared by the Influenza Division

Weekly Influenza Activity Estimates Reported by State and Territorial Epidemiologists*

Week Ending Mar 12, 2016 - Week 10



*This map indicates geographic spread and does not measure the severity of influenza activity.

A Weekly Influenza Surveillance Report Prepared by the Influenza Division

Weekly Influenza Activity Estimates Reported by State and Territorial Epidemiologists*

Week Ending Jan 10, 2015 - Week 1

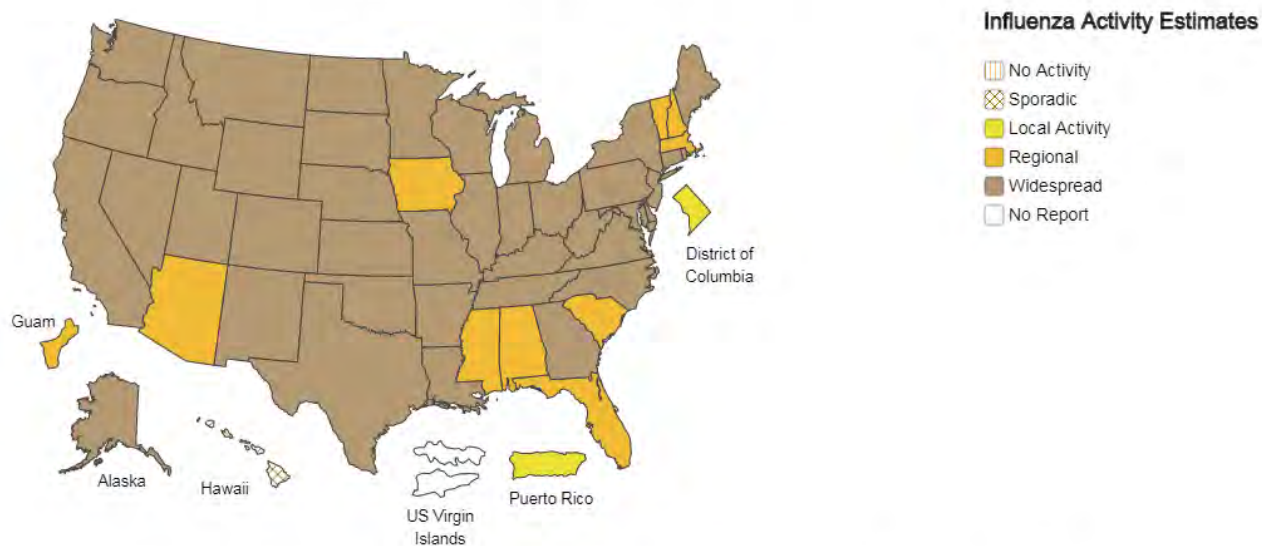


*This map indicates geographic spread and does not measure the severity of influenza activity.

A Weekly Influenza Surveillance Report Prepared by the Influenza Division

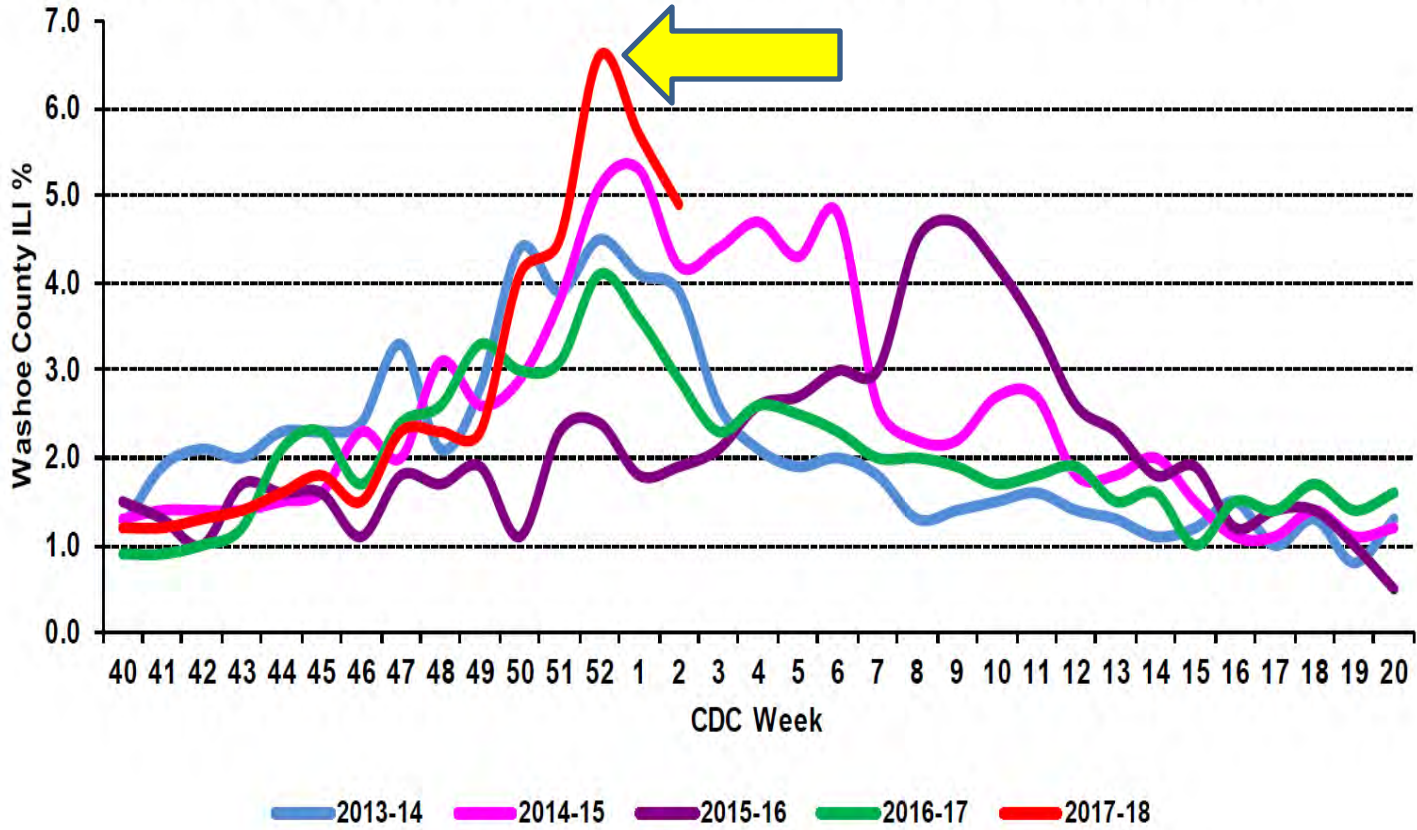
Weekly Influenza Activity Estimates Reported by State and Territorial Epidemiologists*

Week Ending Jan 11, 2014 - Week 2

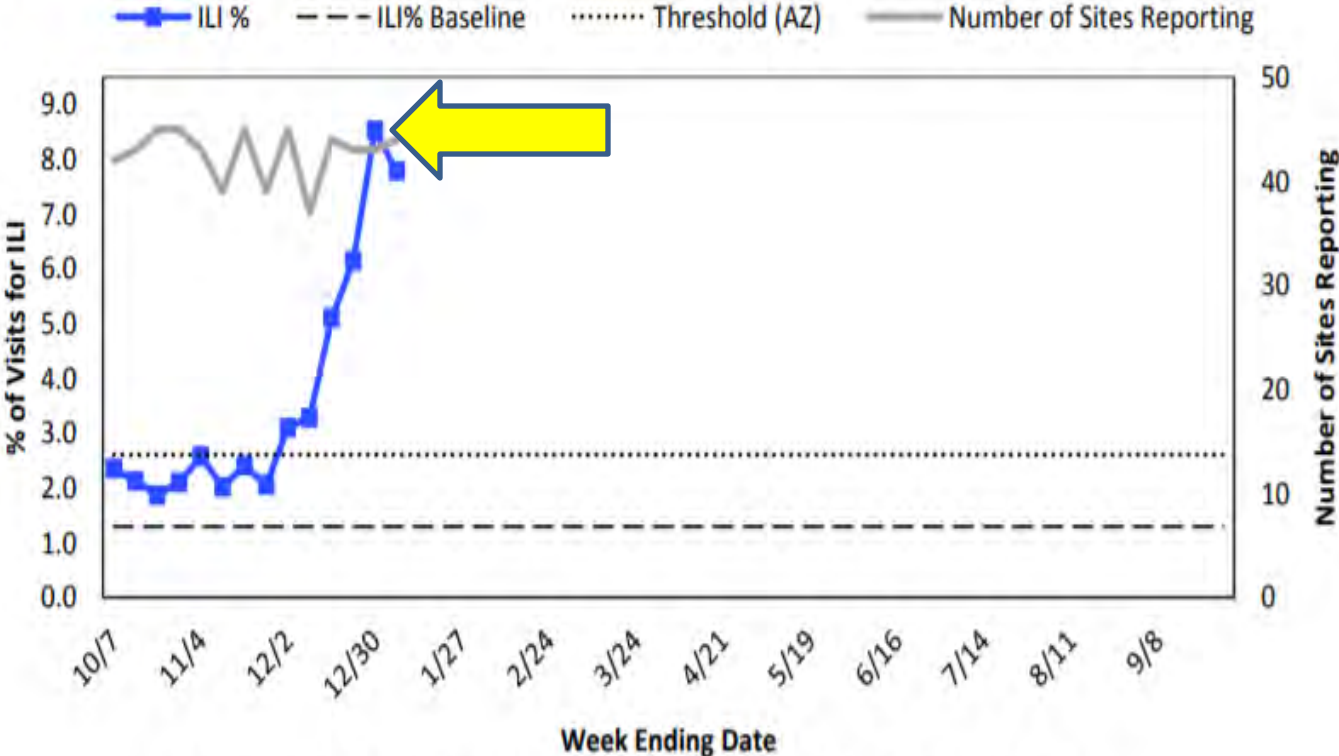


*This map indicates geographic spread and does not measure the severity of influenza activity.

Figure 7. Washoe County ILI Cases Reported by Sentinel Providers, 2013-2018 Seasons:



ILI percent was above threshold at 7.8% in week 1.



Percentage of Visits for ILI at Sentinel Providers, 2017–2018, Arizona

Figure 8. Percentage of Influenza-like Illness Visits among Patients Seen by Sentinel Providers — **California** Border Region, 2015–2018

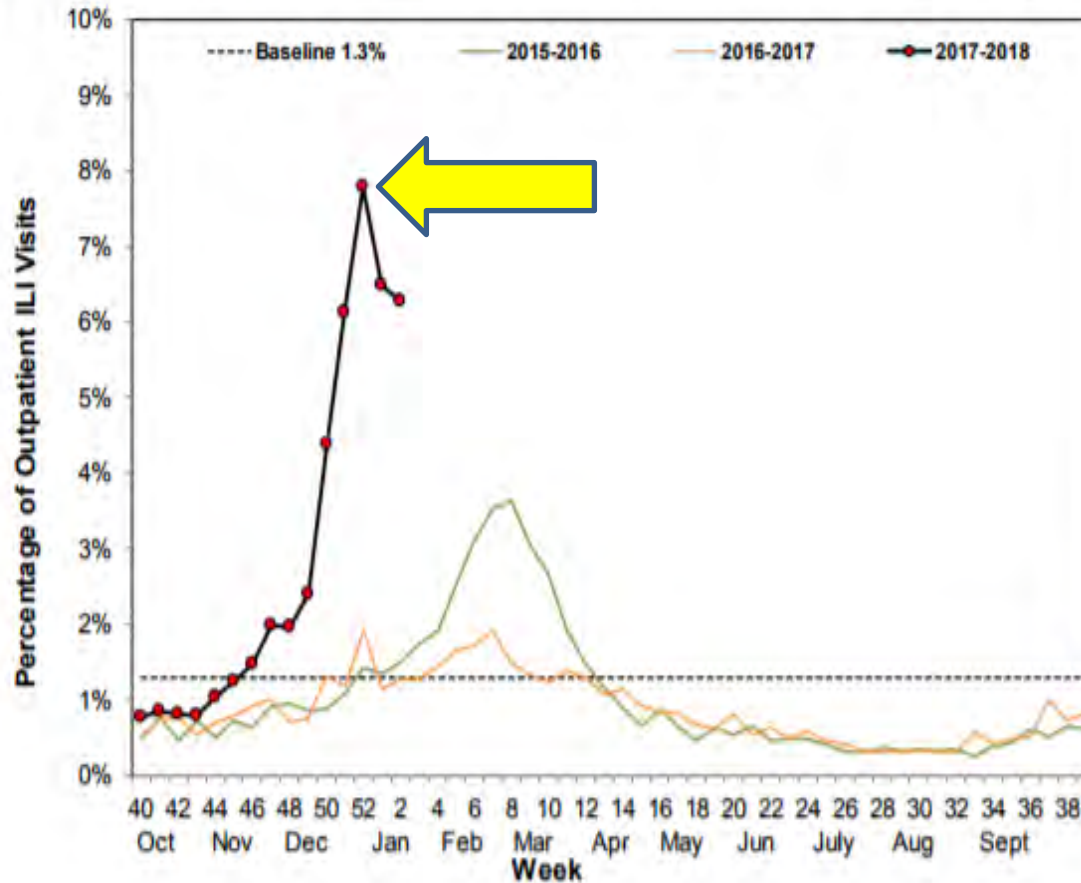
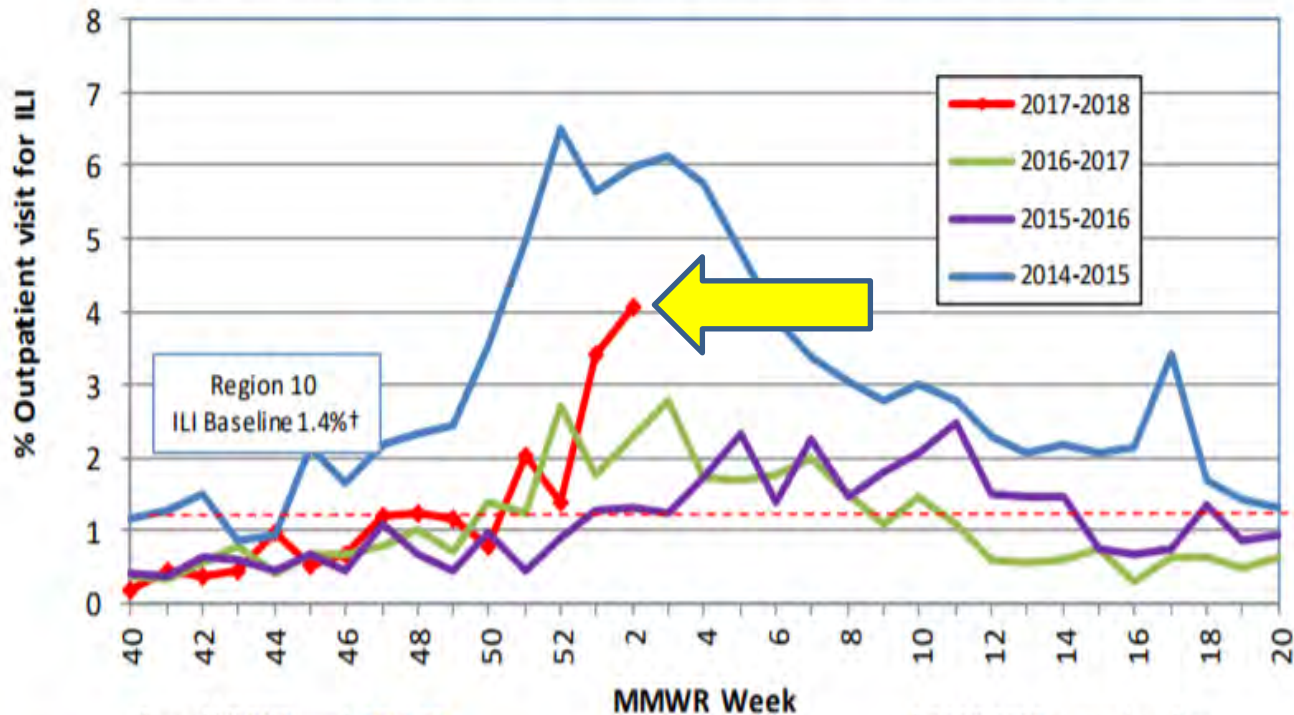


Figure 1. Percentage of visits for influenza-like illness (ILI) reported by participants of the U.S. outpatient ILI surveillance network—Idaho, influenza seasons 2014–2015 through 2017–2018*



* as of MMWR week 2018-02

† 2017-2018 season baseline

ILI "Influenza like illness" is defined as fever $\geq 100^{\circ}\text{F}$ (37.8°C) AND cough and/or sore throat without a known cause other than influenza.

During MMWR week 2018-02 the percent of visits for ILI reported by Idaho ILINet providers was 4.06%.

Region 10 includes AK, ID, OR, and WA. [Click here](#) to learn more about data sources.

Figure 1. Percentage of ED Visits for ILI, Oregon ESSENCE Syndromic Surveillance, 2014–2015, 2015–2016, 2016–2017, 2017–2018

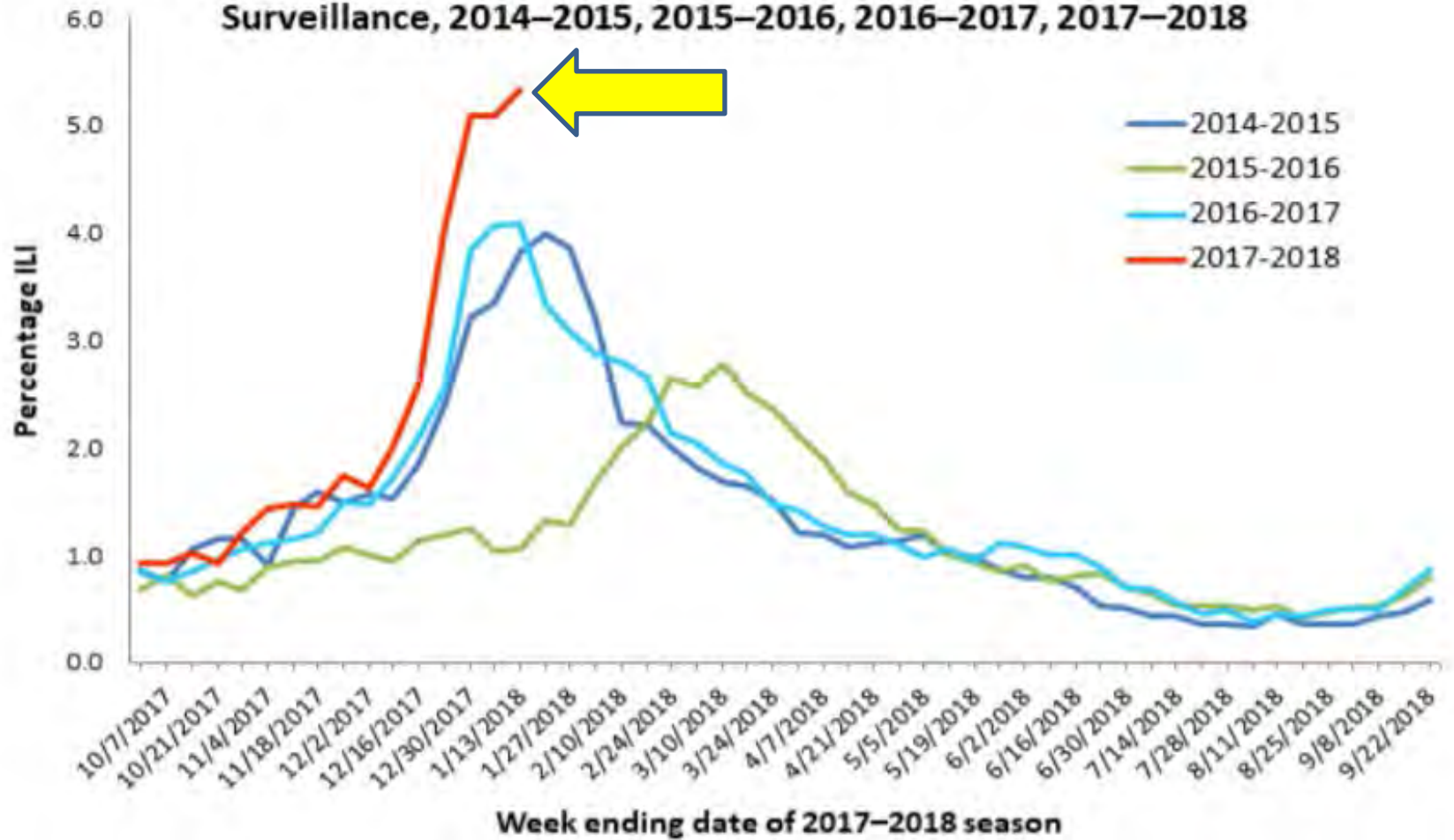
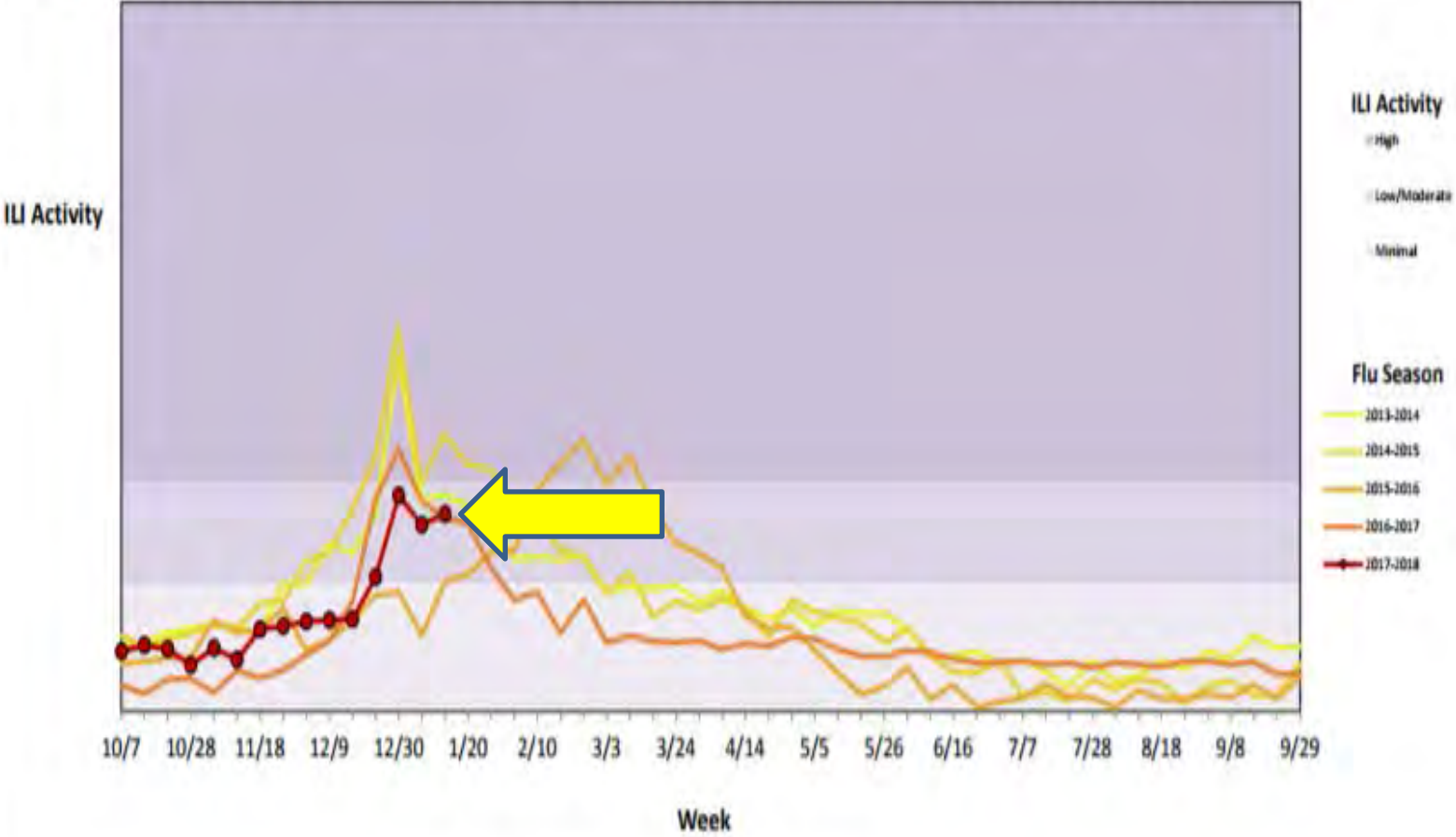
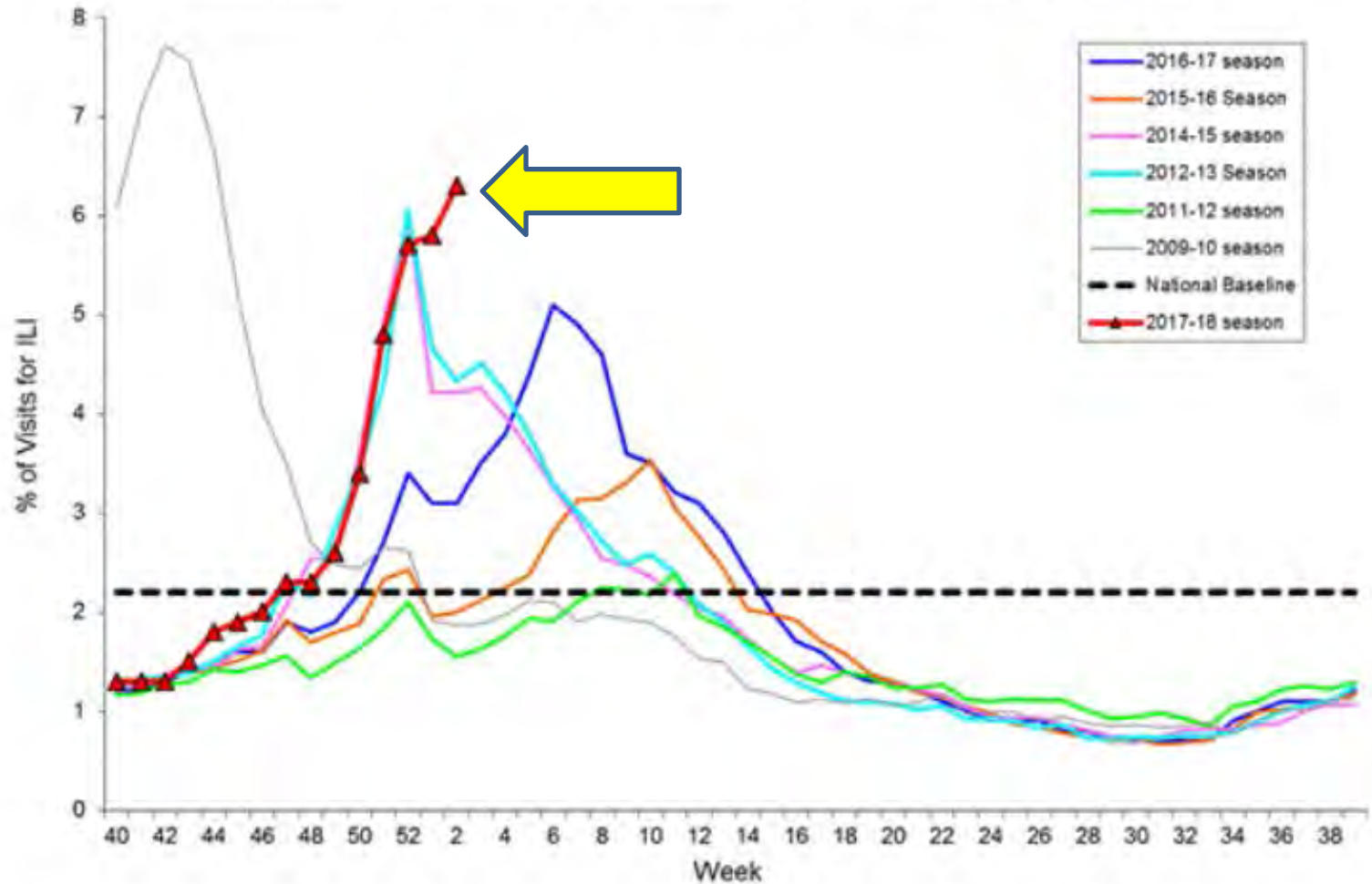


Figure 1. Weekly Influenza-like Illness Activity

Influenza-like illness (ILI) activity as measured by the number of standard deviations from the epidemic threshold - Utah, 2017-2018



Percentage of Visits for Influenza-like Illness (ILI) Reported by the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet), Weekly National Summary, 2017-2018 and Selected Previous Seasons



Influenza Vaccination Rates

<https://www.cdc.gov/flu/fluview/reportshtml/trends/index.html>

DHO_ KD _____

**District Health Officer Staff Report
Board Meeting Date: January 25, 2018**

TO: District Board of Health
FROM: Kevin Dick, District Health Officer
(775) 328-2416, kdick@washoecounty.us
SUBJECT: District Health Officer Report – Water Projects, FY19 Budget, Strategic Planning Update, Public Health Accreditation, Quality Improvement, Community Health Needs Assessment, Community Health Improvement Plan, Truckee Meadows Healthy Communities, Other Events and Activities and Health District Media Contacts.

Water Projects

Mr. Westom and I attended the December 19, Reno Building Enterprise Fund Advisory Committee Meeting. Dan Holly provided an update on time-periods for review of building plan submittals by various departments, which showed that the Health District met the City of Reno’s ten-day plan review goal for 100% of the plans reviewed during the report period. The Health District provided an update on our efforts to address plan review issues. Councilman McKenzie expressed his appreciation for the work the Health District had done to resolve these issues.

The Nevada Division of Environmental Protection (NDEP) held its second workgroup meeting to discuss potential revisions to Nevada Administrative Code (NAC) 445A, on January 9, 2018. NDEP provided a presentation, which stated that 90% of western states (west of Mississippi river) utilize 10’ horizontal separations. Separation of sewer lines and potable water lines was a primary topic of this meeting.

There was much discussion with NDEP about various definitions, including NAC 445A.6639 regarding sewer lines. There was significant and interesting input from stakeholders. TMWA asked about manhole separation. Southern Nevada Health District (SNHD) / Las Vegas Valley Water District (LVVWD) generally doesn’t have an issue with 10’ pipe separation; it’s the 10’ pipe to manhole separation that creates difficulties.

TMWA raised the issue of fire hydrants and backflow. LVVWD asked if TMWA backflow protected fire hydrants, and TMWA said it was dependent on interpretation. LVVWD backflow-protects and meters fire services because the water system has no idea what the customer does. LVVWD collects \$2,000,000/year in fines from private fire service use.

January 30th is the next workgroup meeting. NDEP’s goal is to reach consensus with the stakeholders on the regulation changes, and continue on the path towards permanent regulation adoption within 2018.

FY19 Budget

The Divisions and the Office of the District Health Officer have been working with Administrative Health Services on estimates for completion for the current fiscal year budget activities and to develop budgets for FY19. The Health District will present a proposed FY19 budget for Board approval during the February DBOH meeting.

Strategic Planning Update

A short presentation was conducted at the December 20th Division Directors meeting and an informational guide was shared to assist with entering targets and achievements into the online tracking system. Catrina Peters continues to work with OnStrategy to determine how we can optimize use of the online tracking system to measure completion of strategic plan items.

Public Health Accreditation

The PHAB team met on Dec 18th and January 8th to review current progress and discuss challenges. Further documents have been submitted and we now have 70 required documents gathered of the needed 213. Travel for staff to attend the February 12th -14th Public Health Accreditation in-person training has been arranged and confirmed.

Quality Improvement

A Quality Improvement (QI) exercise was conducted at the January 2nd General Staff meeting in an effort to improve understanding of QI and encourage staff to pursue QI projects. Additionally, the QI team has developed a revised set of QI forms that are easier to complete to further encourage QI participation. The revised forms were distributed to all WCHD employees.

Community Health Needs Assessment

The 2018-2020 Community Health Needed Assessment has been posted to the Health District website and is available at the link below:

<https://www.washoecounty.us/health/data-publications-and-reports.php>

Community Health Improvement Plan

Drafts of the 2017 CHIP Annual Progress Report are being prepared using the data available. The final should be complete by early March 2018, pending receipt of key data from the Youth Risk Behavior Survey, which is anticipated in February of 2018.

Truckee Meadows Healthy Communities

The TMHC January 10 Steering Committee meeting focused on discussion of priorities for the upcoming TMHC 2018-2020 Community Health Improvement Plan. An additional Steering Committee meeting is scheduled for January 24 to continue the discussion and identify priorities and focus areas. Committees will be formed at the January 24 TMHC meeting to develop action plans for creation of the 2018-2020 CHIP around the priorities and focus areas selected by the TMHC Steering Committee.

Enterprise Community Partners is working on Phase I of the Regional Housing Roadmap project. Phone interviews with community stakeholders are being conducted in January. Face-to-face meetings with other stakeholders and elected officials are planned to be conducted in February.

A TMHC Board meeting is scheduled for January 25.

Other Events and Activities

12/15/17	NPHA Advocacy Call
12/18/17	Regional Business Licenses and Permits Program Oversight Group Meeting
12/19/17	Reno Building Enterprise Fund Advisory Committee Meeting
12/19/17	Reno Central Rotary Presentation on Health District and CHNA
12/20/17	Pignic Variance Hearing of the Food Protection Hearing and Advisory Board
12/20/17	NALHO Teleconference Call
12/21/17	Meeting with Argentum, SNHD lobbying firm re: legislative items/potential state funding for Vector-Mosquitos
1/2/18	General Staff Meeting
1/3/18	Division Directors and Supervisors Meeting
1/4/18	EMS Advisory Board Meeting
1/4/18	NV Health Authority Conference Call
1/5/18	Monthly Meeting w/John Slaughter
1/5/18	Meeting with Pignic Pub & Patio Owners and PR representative
1/9/18	Advancing Rural Board of Health Capacity to Improve Public Health in Nevada Meeting
1/10/18	Department Heads Meeting
1/10/18	TMHC Steering Committee Meeting
1/11/18	Interim Legislative Committee on Health Care
1/12/18	Meeting with Medical Examiner on Prophylaxis for Bacterial Meningitis
1/17/17	Meeting w/Chair Jung
1/17/18	Division Directors Meeting
1/18/18	CCHS – DHO/DD/Board Member Meeting
1/19/18	Health District/UNR School of Community Health Sciences Coffee Mixer
1/19/18	NPHA Advocacy Call
1/19/18	AQM – DHO/DD/Board Member Meeting
1/23/18	CCHS – DHO/DD/Board Member Meeting
1/23/18	NALHO Conference Call
1/24/18	TMHC Steering Committee Meeting
1/25/18	TMHC Board of Director’s Meeting

Health District Media Contacts: December 2017

<u>DATE</u>	<u>MEDIA</u>	<u>REPORTER</u>	<u>STORY</u>
12/29/2017	Reno Gazette-Journal	Marcella Corona	Air Quality - Inouye
12/28/2017	KRNV CH 2 - CBS Reno	Diana Thao	Flu - Todd
12/28/2017	KOLO CH8 - ABC Reno	Ed Pierce	Flu - Todd
12/7/2017	KRNV CH4 - NBC Reno	Kristen Mugnango	Flu - Chalkley
12/7/2017	KTVN CH2 CBS Reno	Paul Nelson	Flu - Chalkley
12/7/2017	KOLO CH8 - ABC Reno	Ed Pierce	Flu - Chalkley
12/1/2017	This is Reno	Bob Conrad	Pignic Bar - Dick
11/29/2017*	KTVN CH 2 - CBS Reno	Angela Schilling	Know the Code - Inouye/Peterson/Crawford
11/29/2017*	KTVN CH 2 - CBS Reno	Mike Alger	Know the Code - Schnieder
11/28/2017*	KRNV CH4 - NBC Reno	Diana Thao	Hep A - Todd
11/28/2017*	UNIVISION	Carolina Lopez	Hep A - Ulibarri

** and shading denotes unreported contacts in late November*

Press Releases/Media Advisories/Editorials/Talking Points

12/28/2017	We Order Well - Advisory to restaurant owners/managers	English
12/18/2017	Holiday tips to keep food safe	Ulibarri
12/7/2017	First Flu deaths of 2017/18 season	Ulibarri
12/1/2017	HIV Testing and Partnerships / World Aids Day	Ulibarri/Howell

Social Media Postings

Facebook

AQMD/CCHS/ODHO 141 (CCHS 35 EHS 8 ODHO 1 AQM 97)
EHS

Twitter

AQMD/CCHS 101 (AQM 95 CCHS 6)

Grindr

CCHS 5



VISION
A healthy community
MISSION
...
VALUES
...
STRATEGIC DIRECTION

University of Nevada
School of Community Health Sciences
The School of Community Health Sciences (Public Health) offers the following degrees:
PhD in Public Health, Areas in:
• Epidemiology
• Social and Behavioral Health
Master of Public Health (MPH), Areas in:
• Epidemiology
• Health Administration and Policy
• Social and Behavioral Health
PhD in Science in Community Health Sciences, Areas in:
• Public Health
• Epidemiology
• Health Professional Physical Education