WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

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

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

Thursday, June 28, 2018
1:00 p.m.

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

PUBLIC HEARING ITEM SCHEDULED ON THIS AGENDA
(Complete item description on second page.)

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)**
   June 28, 2018
5. ***Recognitions**

   A. Retirements
      i. Diane Freedman, 7/6/2018, Public Health Nurse – 25+ years, CCHS
      ii. Christina (Tina) Burton, 7/13/2018. Office Support Specialist – 29+ years, AQM

   B. Years of Service
      i. Michael Lupan, 20 years, Hired 6/5/1998 - EHS

   C. Promotions
      i. Maria Rodriguez, Community Health Aide to Human Services Support Specialist II in WIC - CCHS
      ii. Susan Hopkins, Office Assistant II to Office Support Specialist – EHS

   D. New Hires
      i. Steven Thalacker, 5/28/2018, Principal Account Clerk – AHS
      ii. Brittney Osborn – 5/29/2018, Air Quality Specialist Trainee – AQM
      iii. Nennette Cano – 6/11/2018, Account Clerk I - AHS

E. Accomplishments
   i. Lynnie Shore, Silver Syringe Award from Immunize Nevada

F. Shining Star
   i. Janet Smith – AQM
   ii. Elena Varganova – EPHP
   iii. Diana Karlicek – EHS
   iv. Nick Florey – EHS
   v. Amy Santos – EHS
   vi. Susan Hopkins - EHS

G. 2018 Extra Mile Awards
   i. FacesNV
   ii. Truckee Meadows Park Foundation
   Staff Representative: Kelli Goatley-Seals

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. May 24, 2018

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

   i. Approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health for the period July 1, 2018 through June 30, 2019 in the total amount of $64,582.00 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Fetal Infant Mortality Review (FIMR) Program IO# 11176 and authorize the District Health Officer to execute the Subgrant Award.
   Staff Representative: Nancy Kerns Cummins

C. Acceptance of the "Washoe County, Nevada Air Quality Trends (2008-2017)" Report - **(For possible action)**
   Staff Representative: Charlene Albee

D. Approval of authorization to travel and travel reimbursements for non-County employee Dr. John Novak for FY19 to include the approximate amount of $1,763.29 to attend the NALBOH Annual Conference in Raleigh, North Carolina, August 8-10, 2018, and the Annual NALBOH Board Meeting in the approximate amount of $1,600, date and location to be determined. - **(For possible action)**
   Staff Representative: Kevin Dick

E. Approve an amendment to the partnership agreement with Keep Truckee Meadows Beautiful for an increase of $11,111.00 in support of the Recycling and Solid Waste Management Plan program to cover activities retroactive to March 1, 2018 on behalf of the Environmental Health Services Division of the Washoe County Health District. - **(For possible action)**
   Staff Representative: Jim English

F. Authorize the creation of a 1.0 FTE, fully benefitted, full-time Public Health Investigator position to be evaluated by the Job Evaluation Committee to be supported by the Ryan

White Part B Program Grant IO# 11479 and to abolish vacant Public Health Nurse PC# 70002199. **– (For possible action)**
Staff Representative: Nancy Kerns Cummins

G. Presentation, discussion, and possible approval of a process to donate various obsolete monitoring equipment and associated supplies with a current market value estimated at $-0- that have exceeded the useful value for regulatory purposes but may still have value for educational, research and community organizations. **– (For possible action)**
Staff Representative: Charlene Albee

H. Retroactive Approval of Assistance Amendment PM-00T56401-7 from the U.S. Environmental Protection Agency (EPA) for the period 4/1/18 through 3/31/19 for the Air Quality Management, EPA Air Pollution Control Program, IO 10021. – **(For possible action)**
Staff Representative: Jennifer Pierce

I. District Board of Health approval to increase the District Health Officer's approval authority from a threshold of $50,000 to $100,000 for fiscal year cumulative purchases by vendor. **- (For possible action)**
Staff Representative: Anna Heenan

J. Acknowledge receipt of the Health Fund Financial Review for May, Fiscal Year 2018 **– (For possible action)**
Staff Representative: Anna Heenan

7. ***National Weather Service presentation on the effects of climate in regards to local vector issues.**
Presented by: Mark Deutschendorf of National Weather Service

8. **Resolution of Appreciation – (For possible action)**
   A. Michele C. Dennis, P.E. - 10/27/1999 - 10/23/2017, Sewage, Wastewater and Sanitation Hearing Board Member
   B. Steven H. Brigman, P.E. - 10/27/1999 - 10/23/2017, Sewage, Wastewater and Sanitation Hearing Board Member
   Staff Representative: Kevin Dick

9. **PUBLIC HEARING: Review, discussion and possible adoption of Proposed Revisions to the District Board of Health Regulations Governing Air Quality Management, Sections 020.040 (Civil Fines and Penalties) and 020.042 (Criminal Fines and Penalties. – (For possible action)**
Staff Representative: Charlene Albee

10. **Regional Emergency Medical Services Authority**
Presented by: Adam Heinz
   A. Review and Acceptance of the REMSA Operations Report for May, 2018 – **(For possible action)**
   B. *Update of REMSA's Public Relations during May, 2018

11. **Presentation, discussion and possible approval of revisions to the Multi-Casualty Incident Plan (MCIP). – (For possible action)**
Staff Representative: Brittany Dayton

12. **Presentation, discussion and possible direction regarding request for augmentation of budget and plans for FY19 mosquito abatement activities. – (For possible action)**
Staff Member: Chad Westom

13. Review and possible approval of 2018-2020 Community Health Improvement Plan. – (<u>For possible action</u>)
Staff Representative: Catrina Peters

14. *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 – New Third Party Payer; Data & Metrics; Program Reports

C. Environmental Health Services, Chad Westom, Director
Environmental Health Services (EHS) Division and Program Updates –Training Program, Epidemiology Program, Community Development, Food, Special Events, Hotel/Motel, Land Development, Safe Drinking Water, Schools, Vector-Borne Diseases, Inspections

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 – Public Health Accreditation, Quality Improvement, Workforce Development, Community Health Improvement Plan, Truckee Meadows Healthy Communities, Washoe Behavioral Health Policy Board, Plan Reviews, Other Events and Activities and Health District Media Contacts.

15. *Board Comment
Limited to announcements or issues for future agendas.

16. *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.

17. Adjournment – (<u>For possible action</u>)

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 HEALTH DISTRICT
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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, May 24, 2018
1:00 p.m.

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

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1. *Roll Call and Determination of Quorum

Chair Jung called the meeting to order at 1:03 p.m.
The following members and staff were present:
Members present: Kitty Jung, Chair
Dr. John Novak, Vice Chair
Michael Brown
Oscar Delgado
Dr. George Hess
Kristopher Dahir
Tom Young

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
Christina Conti

2. *Pledge of Allegiance

Dr. Slonim led the pledge to the flag.

3. *Public Comment

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

4. Approval of Agenda

May 24, 2018

It was confirmed that item 5C would be continued to the June 28, 2018 District Board of Health Meeting.

Dr. Novak moved to approve the agenda, with the removal of item 5C, for the May 24, 2018, District Board of Health regular meeting. Mr. Delgado seconded the motion which was approved unanimously.

5. Recognitions

A. Promotions

i. Jennifer Pierce – Principal Account Clerk to Fiscal Compliance Officer - AHS
ii. Kelly Verling – Public Health Nurse I to Public Health Nurse II - CCHS

Ms. Pierce and Ms. Verling were not present at the meeting. Mr. Dick congratulated them both on their promotions.

B. New Hires

i. Tyler Henderson, 5/14/18, Environmental Health Trainee – EHS

Mr. Henderson was not present at the meeting.

C. Resolution of Appreciation

i. Michele C. Dennis, P.E. - 10/27/1999 - 10/23/2017, Sewage, Wastewater and Sanitation Hearing Board Member
ii. Steven H. Brigman, P.E. - 10/27/1999 - 10/23/2017, Sewage, Wastewater and Sanitation Hearing Board Member

Mr. Dick informed that the Resolution of Appreciation for Ms. Dennis and Mr. Brigman would be presented at the June 28, 2018 District Board of Health Meeting.

Chair Jung noted that the Resolutions of Appreciation, Item 5C, are continued.

D. Accomplishments

i. Kelli Goatley-Seals, Community Partner Collaboration Award from UNR School of Community Health Sciences
ii. Washoe County Health District, Spread Health Award from UNR School of Community Health Sciences

Mr. Dick informed that the University of Nevada Reno School of Community Health Sciences had a very nice event last month in which they recognized the partners in the community that had hosted interns for them. Among them, Kelli Goatley-Seals received a Community Partner Collaboration Award from UNR for her work with interns here at the Health District.

Mr. Dick announced that the Health District received the Spread Health Award from UNR School of Community Health Sciences for being the organization that had the most interns work through a program over the years.

Chair Jung congratulated both Ms. Goatley-Seals and the Health District and expressed she was glad for these acknowledgements as the UNR School of Community Health Sciences is an important source for the Health District to fill positions requiring advanced healthcare degrees.

6. Proclamations

A. Emergency Medical Services Week
Accepted by: Christina Conti

Mr. Dick invited those present involved with Emergency Medical Services to come down and receive the Proclamation. Mr. Dick read the proclamation and Ms. Conti accepted it for the group.

Mr. Brown moved to adopt the Proclamation for Emergency Medical Services Week. Dr. Novak 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. April 26, 2018

B. Budget Amendments/Interlocal Agreements

   i. Approve Subgrant Amendment #2 from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health effective July 1, 2018 through June 30, 2019 in the amount of $284,986.00 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Immunization Program Internal Orders #10029 and #11319 and authorize the District Health Officer to execute the Subgrant Amendment.
   Staff Representative: Nancy Kerns Cummins

   ii. Accept cash donation in the amount of $5,000 from Arctica Ice Sales to purchase Long Acting Reversible Contraceptives (LARCs) to help decrease unintended pregnancy rates; approve amendments totaling an increase of $5,000 in both revenue and expense to the FY18 Arctica Ice Donation budget, IO# 20424.
   Staff Representative: Nancy Kerns Cummins

C. Possible reappointment of Dr. Andrew Michelson, Emergency Room Physician, to the Regional Emergency Medical Services Advisory Board
   Staff Representative: Kevin Dick

D. Recommendation to uphold the recommendation of the Sewage, Wastewater, and Sanitation Hearing Advisory Board with conditions for Variance #H18-0001VARI for APN 017-123-05, owned by Mike Fritz.
   Staff Representative: Jim English

E. Acknowledge receipt of the Health Fund Financial Review for April, Fiscal Year 2018
   Staff Representative: Anna Heenan

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

Chair Jung wished to highlight item 7Bii, informing that the District Board of Health is accepting a $5,000 cash donation from Arctica Ice Sales to purchase Long Acting Reversible Contraceptives (LARCs) to help decrease unintended pregnancy rates. She expressed thanks to Arctica Ice Sales for their donation on behalf of the Board and the Health District.

8. *Presentation on Renown's Community Benefits Plan

Presented by: Dr. Anthony Slonim, Renown CEO

Chair Jung introduced Dr. Slonim of Renown and thanked him for coming. She informed this presentation on Renown's Community Benefits Plan was requested by Mr. Delgado.

Dr. Slonim thanked Chair Jung and the Board for the opportunity to present at this

meeting.

Dr. Slonim acknowledged the Renown team members that were present with him at the meeting, and informed he would be speaking to the work at Renown Health. He added that he was honored to serve with Mr. Dick on the Truckee Meadows Healthy Communities project in the capacity of Co-Chair.

Dr. Slonim informed of the beneficial collaboration between the Health District, Renown Health and other not-for-profit organizations several years ago that produced the first Community Health Needs Assessment (CHNA), with the purpose of identifying where the community's vulnerabilities were. He outlined the focus areas identified in the CHNA and those new priorities identified in the CHNA that was just completed and published in January, 2018.

Dr. Slonim informed that Renown budgeted $1 million dollars within their next fiscal year beginning in July, 2018, to partner with community-based organizations that applied and were accepted to receive funding from Renown to work on priority areas identified in the Assessment.

Dr. Slonim spoke to his presentation regarding the definition of Community Benefit. He informed that Renown is the only not-for-profit integrated health system in Northern Nevada, and that Internal Revenue Service Code requires Renown to contribute financially to the community to retain their not-for-profit status. He informed that, of the programs Renown funds with Community Benefit dollars, many intersect with the goals of the Community Health Improvement Plan. He stated that Community Benefit specifically refers to dollars that are reportable to the IRS and the State of Nevada as Community Benefit dollars.

Dr. Slonim informed that dollars spent by Renown for Community Development are for internal or external efforts related to Community Investment, but are not counted toward the Community Benefit contribution. Similarly, Community Investment contributions are not included in the Community Benefit amount and go toward internal efforts to improve access to services or the services themselves.

Dr. Slonim informed that Renown does pay taxes regardless of their not-for-profit status and are proud to contribute publically in that manner.

Dr. Slonim detailed programs supported by Renown in 2017 with $120 million in Community Benefit dollars, and informed that the amount invested annually has increased.

Dr. Slonim spoke of the programs supported by Renown's Community Development contributions, including their partnership with Stanford Health for persons obtaining Hometown Health insurance through a Renown Health subsidiary. This partnership provides an in-network benefit for members to allow access to medical care not provided in this area.

Dr. Slonim detailed benefits to the community in 2016-2017 for Community Investment totaling $210 million dollars and informed that improvements to access to health and health care come directly from the Community Health Improvement Plan.

Mr. Young inquired what challenges Mr. Slonim could foresee with the population growth in the community. Mr. Slonim informed that there had not been difficulty in recruiting physicians or other team members within the last several years.

Mr. Slonim referred to the new hospital that will soon open in South Reno that will increase competition for personnel and stressed the importance of continuing to recruit to face this challenge.

Mr. Delgado thanked Dr. Slonim for presenting. He inquired how the portion of profits contributed to the community generated by a non-profit hospital is calculated, and if the amount of the contribution increases annually. Dr. Slonim informed that the calculation is determined by IRS statute, and that the Community Benefit contribution increased from $78

million in 2015 to $120 million dollars in 2017, and that these amounts don't include the Community Investment and Community Development contribution amounts.

Mr. Delgado spoke of the concept that it is not only the genes one is born with, but the effect of the area in which one lives that determines quality of health. He inquired how Renown is focusing efforts on those more impoverished areas of the community and how they are involving the community in decisions to positively impact those areas. Dr. Slonim outlined the steps of the process beginning with the Community Health Needs Assessment (CHNA) that was co-sponsored by Renown and the Health District which provided the areas of focus for the Community Health Improvement Plan (CHIP) and included input from a number of focus groups and individuals.

Mr. Delgado inquired when the Community Health Improvement Plan would be published. Dr. Slonim informed that they are still working to determine the Priorities for the CHIP, but that the CHNA had been published which provided the four Priority areas for the CHIP.

Dr. Slonim informed that Renown is partnering broadly across the community by sharing in the work of the CHNA and in identifying where impacts can be made by activities funded by Renown Health. This will allow Renown to carry on their not-for-profit mission to positively impact the community.

Mr. Delgado spoke to Dr. Slonim's presentation regarding partnerships, and stated he would like to see detail of funding for the Priorities. Dr. Slonim listed funding levels for 2017, and Mr. Delgado inquired if funding levels for Fiscal Year 2018-2019 were known and if there would be continued support for some of the partners. Dr. Slonim informed that some of the partnerships highlighted in the PowerPoint presentation would continue to be funded by Renown through the CHIP.

Mr. Delgado expressed concern that funding would be moved away from focus areas that are still an issue in the community. Dr. Slonim informed that, while funding all of the partners who do great work in the community would be optimum, it is not possible; however, since the CHNA's Priorities are the guide for the new CHIP, funding will continue to go toward those focus areas but possibly not with the same partners.

Mr. Delgado thanked Dr. Slonim for the information and requested that he extend thanks to Renown staff and commended them for the exceptional work they do in the community.

Mr. Delgado expressed his interest in seeing the finished Community Health Improvement Plan and how it will have evolved and will continue to evolve through its cycles in response to conditions within the community.

Dr. Slonim thanked the Board for being allowed to present to them and welcomed any suggestions for development of the CHIP.

Mr. Brown thanked Dr. Slonim for his presentation and work at Renown, and inquired if ambulance providers would be able to begin using their Urgent Care facilities for non-acute patients. Dr. Slonim stated he would love that opportunity to assure patients receive the correct level of care. He informed that most Urgent Care facilities in the community don't accept patients insured by Medicaid, and stated that Renown wants to make sure these patients have access to care at the appropriate level of care. He estimated it will take approximately a year to institute that capability.

Mr. Dahir expressed thanks for Dr. Slonim's presentation. He inquired about care for mental illness in the community and requested more information on Renown's efforts toward assisting those in need. Dr. Slonim stated that the mental health and addiction issue will require broader involvement due to the scope of work necessary to improve conditions that have been growing over the past three decades. Dr. Slonim informed that the worsening

conditions are a combination of lack of infrastructure and funding, and acknowledged that it will take leadership to begin to create the needed structure and financial involvement.

Dr. Slonim informed that the Behavioral Health and Addiction Institute is focused on addiction and on assessment necessary to identify people at risk for placement in programs for assistance.

Dr. Slonim informed that Washoe County is ranked number one in the nation for adolescent female suicide. He informed of a screening program being initiated in schools to identify those at risk and to understand the contributing factors, and informed that the prevalent demographic is young, Hispanic females.

Dr. Slonim stated that Renown is exploring ways to partner with the area's schools to screen all adolescents for suicide risk and direct those at risk to programs to learn ways to cope with life issues. Mr. Dahir thanked him for his information.

Chair Jung expressed she was thankful to be a part of Renown's Healthy Nevada Project DNA testing.

Chair Jung wished to state for the record that the very first donor for the 89502 Project was Commissioner Bob Lucey due to his commitment in Public Health.

Chair Jung informed that Behavioral Health is a Strategic Planning Goal for this District Board of Health due to it being a root factor to other health outcomes. She thanked Dr. Slonim and informed that she would be there for their Grand Opening of the Behavioral Health and Addiction Institute.

Chair Jung stated that she serves on the Nevada Works Board in collaboration with all but two Nevada counties, and they have defined the need provide telemedicine to rural areas. She informed that many of those areas have Broadband available, but that no major supplier will provide connection due to lack of volume.

Chair Jung stated she would like to investigate the possibility of providing that capability in conjunction with Renown's Urgent Care Facility in Tonopah, and to study best practices nationwide to provide health access to Nevada's rural citizens.

Dr. Slonim agreed that this conversation could be continued outside this meeting, and informed that Renown is very involved in providing telemedicine to rural communities and have a demonstration project with the prison system that is highly appreciated by the Governor.

Dr. Slonim informed that there is much more that can be done, and quoted Kaiser Insurance who stated they project fifty percent of their visits will be conducted through telemedicine.

Dr. Slonim stated that he serves as the Chair-Elect at the Systems Board of the American Hospital Association and this entity strongly advocates for investment in health care and Broadband and wire infrastructure development, particularly for rural areas, to the President of the United States.

Chair Jung informed that she greatly appreciated the ability to contact their Renown physician via email for issues that would otherwise require another appointment. Dr. Slonim agreed that providing care when it is needed and offering alternative ways of receiving this care is the most important capability that can be provided to deliver a more consumer-oriented service from a healthcare prospective.

Chair Jung requested Dr. Slonim to provide any assistance possible regarding access to information regarding the train wreck victim injured in Truckee, California. She stated that, due to the nature of the accident and Amtrak having jurisdiction over the investigation, information provided by Amtrak was not very transparent. Dr. Slonim agreed to assist, and Chair Jung thanked him again for his presentation.

9. Review, discussion and possible adoption of the Business Impact Statement regarding Proposed Revisions to the District Board of Health Regulations Governing Air Quality Management, Sections 020.040 (Civil Fines and Penalties) and 020.042 (Criminal Fines and Penalties) 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 June 28, 2018 at 1:00 pm.

Staff Representative: Charlene Albee

Ms. Albee informed the detail of the Business Impact Statement was included in the Board Member's packets, and that, prior to the legal requirements for public notice and formal workshops, she presented to the Associated General Contractors (AGC) group and the Builder's Association of Northern Nevada (BANN) as the two groups most likely to be impacted by these regulations and there were no objections received regarding the proposed revisions. She informed that it was understood that these revisions would not have any impact to companies that are operating in compliance with the regulations.

Dr. Novak inquired regarding Section G, wherein it appeared to read that money for payment of fines could be accepted by an Air Quality Management employee. Ms. Albee informed that, in her nearly twenty-four years of service, she has never seen staff accept a check for payment of penalty that was not first approved by the District Board of Health. She stressed that the revision to Section G was simply a bit of housekeeping to remove archaic verbiage to clearly state that all fines are to be assessed at the decision of the District Board of Health.

Mr. Dahir thanked Ms. Albee for her work in meeting with the AGC and BANN to make revisions to regulations transparent and understood, thereby alleviating some possibility for negative response.

Mr. Brown moved to adopt the Business Impact Statement regarding Proposed Revisions to the District Board of Health Regulations Governing Air Quality Management and set a public hearing for possible adoption of the proposed revisions to the Regulations for June 28, 2018 at 1:00 pm. Dr. Novak seconded the motion which was approved unanimously.

10. Regional Emergency Medical Services Authority

Presented by: J.W. Hodge

A. Review and Acceptance of the REMSA Operations Report for April, 2018

Mr. Dahir inquired regarding a complaint received involving a verbally abusive attendant that did not show as resolved. Mr. Hodge stated that due to the timing of the report, the resolution of a complaint will not always be captured; however, all complaints are processed by meeting with the involved crew who do occurrence reports and interviews are conducted with each crew member and the patient. Mr. Hodge informed that he would go back to that specific report and follow up with Mr. Dahir directly, and reported that all negative comments had been resolved for the month.

Mr. Dahir inquired how recruiting is going. Mr. Hodge informed that it had been difficult to recruit paramedics due to a regional shortage, but that situation has recently improved. Mr. Hodge stated that REMSA also constantly revamps customer service training and opportunities to teach crews how to deal with new issues in patient care and providing healthcare in the field.

Chair Jung informed that there is currently 100% percent employment locally, and that

employers will have to enhance environment, morale, benefits, pay and flexibility to retain employees and hire new staff. She opined that that a somewhat unknown benefit for employees is the transition possible between REMSA to firefighter, and it is a career trajectory that could be highlighted as a benefit.

Mr. Hodge opined that the work of the Board to provide a better community in which to live also helps for recruitment.

Mr. Dahir moved to accept the REMSA Operations Report for April 2018. Dr. Hess seconded the motion which was approved unanimously.

B. *Update of REMSA's Public Relations during April 2018

Mr. Hodge informed that the end of EMS Week culminates in a barbeque and awards ceremony on May 25th with lunch at 11:30 a.m. and presentation of awards at 12:30 p.m. He invited the Board Members and Mr. Dick to attend.

Chair Jung informed she would attend and encouraged the others to attend in support of the Emergency Medical Services personnel.

Mr. Hodge informed he would like to give an update on the Communications Center issue with the lightning strike that occurred the week of May 14th. He stated that a lightning strike that hit or nearly struck their building caused a critical system failure. He informed that this was the first instance of this sort in REMSA history and that the backup systems failed, despite being tested in annual drills and weekly through backup system tests. Mr. Hodge informed that immediately after power was lost, all of the regional partners and the REMSA team worked together and were operating from their backup center in eleven minutes with no loss in calls or the processing of calls. He stated that the Operations Team also immediately added additional ambulances to the system and through regional partnerships with the fire departments were able to staff ambulances at fire stations, as well. This assured there was bidirectional communication.

Mr. Hodge stated that, although the main center was brought back online within less than an hour, the backup center was kept in operation for multiple hours to make sure there was redundancy and that a dispatcher manned the backup center through the next morning.

Mr. Hodge informed thorough testing showed the system to be back to normal and that an internal after-action review is being conducted with technicians who maintain their power systems. They will determine whether any other form of backup is available that could have prevented the loss of power.

Mr. Hodge opined it ironic that the full scale communications system shut down failure drill was due to have occurred the week of May 21st, and thanked Mr. Dick and Ms. Conti for allowing this real life event to count as their drill.

Chair Jung expressed appreciation for being informed immediately of the situation.

11. *Staff Reports and Program Updates

A. Air Quality Management, Charlene Albee, Director
Program Update, Divisional Update, Program Reports

Ms. Albee brought attention to the map included in the Board's packets that shows the areas of the United States designated nonattainment for Ozone, and informed that Washoe County is attainment.

Chair Jung requested the map be shown for those viewing the meeting. Ms. Albee opined that Western Regional Transport presents the next challenge for our Air Quality Management Division due to the large area of nonattainment directly to the west of Washoe County, and that she has engaged the Environmental Protection Agency

Headquarters regarding the impact of that area of nonattainment affecting Washoe County due to prevailing winds.

Ms. Albee informed that AQM was contacted by Region 9 regarding the use of AQM's portable Particulate-Matter Monitor for the Hawaiian Islands. She stated that the Hawaii air quality has been impacted with the lava now reaching the ocean and the resulting emission of airborne pyroclastic particulates.

Ms. Albee stated that AQM had contacted Hawaii to offer loan of the portable EBAM monitor and are making arrangement to ship it to them. She informed that Hawaii is broadening their monitoring to as close to real-time as possible for evacuation noticing. She informed that Region 9 has staff there to set up and operate the monitors.

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

Program Report – Teen Pregnancy Prevention Month; Divisional Update –Client Satisfaction Survey Results; Nevada Childhood Lead Poisoning Prevention Program; Data & Metrics; Program Reports

Mr. Kutz informed he wished to highlight CCHS' Client Satisfaction Survey included in his report to the Board, and extended thanks to his great staff that contributes to their ongoing and highly rated results.

Mr. Kutz stated that he also wished to highlight the unveiling of the Healthy Living Mural that occurred earlier in May, and thanked Chair Jung for speaking at the event. He informed that Mr. Delgado also spoke at the unveiling, and that Health Officer Mr. Dick acted as Master of Ceremonies. Mr. Kutz informed that Reno Housing Authority and some students and staff from Traner Middle and Glenn Duncan Schools were in attendance, as well as members of the outstanding Chronic Disease Prevention Program team who helped organize the event. The video of the unveiling was presented.

Mr. Dahir asked how it would be possible to get such a mural in the City of Sparks, and expressed what a wonderful process and outcome it was.

Chair Jung informed that it was funded by the Reno Housing Authority.

Mr. Dahir inquired who the artist was, and Mr. Kutz informed that Eric T. Burke and Matt McDowell were the artists. Mr. Kutz reiterated Chair Jung's comment that Mr. Burke is a nationally and internationally known artist and how fortunate it was that he was awarded the project in the Request for Proposal process. Mr. Kutz expressed how pleased they were that Mr. Burke wanted to involve the children and the community, and how excited and proud of the mural they all are.

Chair Jung inquired if a mental health screening process similar to that mentioned by Dr. Slonim in his presentation was part of CCHS's procedure for all clients. Mr. Kutz informed that there is a basic screening given in all clinical encounters and immediate referrals are made if indicated to medical and behavioral health facilities for at risk clients.

Chair Jung congratulated Mr. Kutz on his son becoming a Captain at Truckee Meadows Fire Protection District.

C. Environmental Health Services, Chad Westom, Director

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

Mr. Westom informed that EHS is involved with the FDA Voluntary National Food Standards Program who has set their optimum level of inspections for a Risk Level 3 Food Establishment at three times per year. He stated that this type of establishment

includes full service restaurants, casino resort kitchens, buffets, food manufacturers and caterers serving potentially hazardous foods.

Mr. Westom explained that EHS is working to increase their inspections of Risk Level 3 Food Establishments to two times per year with the second inspection set for the Fall or Winter of 2018, and have met with industry leaders who have agreed the re-inspection fee of $180 is reasonable to cover the expense of the second inspection and assure the safety of their establishments.

Mr. Westom stated that he and the EHS staff agree this is an important step in protecting the safety of residents and visitors from non-compliant restaurants, and will provide added assurance to the entire restaurant-casino industry of Washoe County. He opined it is a firm step in the right direction to meet the requirements of the FDA Food Program Standards.

Dr. Hess inquired the amount of the first annual inspection fee for restaurants. Mr. Westom informed that the inspection fees vary depending on the category of the facility. He stated that he would send that information to the Board Members.

Dr. Hess inquired if EHS would be inspecting the Risk Level 3 Food Establishments two or three times per year. Mr. Westom informed that EHS is staffed to increase the number of inspections to two per year, but currently could not increase inspections to three per year. He explained that EHS strove for efficiencies in their program to allow capacity for a second inspection of these facilities, which will add over eight hundred more inspections per year.

Dr. Novak noted the information on the Household Hazardous Waste Collection Event included in Mr. Westom's report, and inquired where this information had been published. Mr. Westom informed that he could provide the media sources where it had been publicized to the Board and would request suggestions of other sources that would target a more wide-spread audience, but noted that it had been a successful event.

Mr. Dick informed he believed this program is a part of the Franchise Agreement the local governments have with Waste Management, and that it would be Waste Management's responsibility to publicize this event to the community. He opined the Health District could work to better support the advertisement of this program, but it is not a program run by the Health District.

Chair Jung mentioned that she believes this event is held twice per year. She requested that the Board be notified before the event in the future.

D. Epidemiology and Public Health Preparedness, Dr. Randall Todd, Director
Program Updates for Communicable Disease, Public Health Preparedness, and Emergency Medical Services

Dr. Todd stated he was pleased to have the final influenza report for this season. He informed that the season begins in the fortieth week of the year and continues through the twentieth week of the subsequent year, and that he had just received the twentieth week's statistics for the Board.

Dr. Todd informed that in Week 20, eleven of the twelve sentinel providers reported a total of sixty-four patients with influenza-like-illness (ILI), which was one percent of the total of persons seen. He noted that this is below the regional baseline of 2.4%, and that during Week 19, the percentage of visits to US sentinel providers due to ILI was down to 1.2%.

Dr. Todd informed there had been one death certificate received for Week 20 with pneumonia or influenza listed as a factor contributing to the cause of death. The total number of deaths for Week 20 was seventy-four, reflecting a P&I ratio of 1.4%. The

total P&I deaths registered to date in Washoe County for the 2017-2018 influenza season is 256, an overall P&I ratio of 7.9%.

Dr. Todd stated that this was a significant flu year with 5,521 laboratory-confirmed cases, and of the 542 that were hospitalized, 221 or 40.8% had been vaccinated. There were 88 ICU admits and 26 confirmed influenza deaths. He informed that the number of deaths was higher than in any recent flu season that he was able to find.

Dr. Todd stated that the Influenza A component of the vaccine was not as effective as they would have liked to have seen it be.

Dr. Todd informed that there continues to be media interest on the paper written by Dr. Lei Chen and himself in 2016 on New Delhi Metallo-Beta-Lactamase-Producing Klebsiella pneumoniae, with the latest being two different British media outlets who interviewed Dr. Todd by telephone and will interview Dr. Chen at a later time.

Chair Jung requested best practices for increasing influenza immunization rates be researched and reported at the next DBOH Meeting. She opined there may be a decrease in persons being immunized for the next flu season due to this year's vaccine being less effective than it could have been, and stated that she envisions a regionally-involved campaign.

Mr. Dick informed that Ms. Heidi Parker, Executive Director of Immunize Nevada, is scheduled to attend the September District Board of Health Meeting to speak on their flu immunization campaign. He stated that Dr. Slonim's presentation highlighted Renown's support of Immunize Nevada and informed that the Health District works very closely with both entities. He opined that it will provide a good opportunity to explore options for the regionally-involved campaign the Chair spoke of.

Dr. Novak agreed on the possibility of a decrease in influenza immunization, and opined it is important to develop a strong campaign.

Mr. Brown opined it important to partner not only with REMSA, but the fire-based services as well. He stated that it would not only provide more sites where the public can be immunized, but that they would have the capacity to go into the community to immunize those citizens who were unable to get out.

Mr. Young stated that involving more outlets in the community for immunizations could involve local businesses, as well, and offered his own business for the purpose. He opined it would provide a variety of venues that could improve the percentage of those being immunized.

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

District Health Officer Report – FY19 Budget, Water Projects, Public Health Accreditation, Community Health Improvement Plan, Truckee Meadows Healthy Communities, Quality Improvement Team, Workforce Development, Smoke Free Workplaces, REMSA Board Resignation, New CCHS Fees, Brazilian Delegation, Other Events and Activities and Health District Media Contacts.

Mr. Dick stated that earlier in the week, the Board of County Commissioners approved the County Budget that includes the General Fund Transfer for the Health District. He reminded the Board that the Health District budget includes the above base request for the additional positions that were approved, however, the portion of the Health District budget that was not approved was the above base request to fund the purchase of additional mosquito abatement chemicals.

Chair Jung inquired what can be done to treat the increased acreage of water for mosquitos.

Mr. Dick informed that the Vector Program is working now on a mosquito abatement

plan for the season for chemical amounts necessary for this summer and next spring that falls within FY19. He stated the outcome of that plan would be brought to the DBOH to decide what is feasible to accomplish within the existing Health District budget and whether to then go to the Board of County Commissioners to for additional funds.

Chair Jung opined that the request for additional funding should be taken to the BCC as soon as possible due to the increase in insect borne illness nationwide.

Chair Jung requested the National Weather Service be invited to attend the next DBOH Meeting to report on the effects of the wet spring and climate change in the area for additional information to present to the BCC in support of the request for funding.

Mr. Dick informed that the additional funding amount for mosquito abatement received in FY18 was approximately $750,000.

Mr. Dick agreed with Chair Jung's comments on climate change, and informed of discussions the Health District has had with Carson City and Southern Nevada Health District about state funding for mosquito abatement being necessary for resiliency.

Mr. Dick informed the Zika-carrying mosquito is now in Clark County which is a new development, but that they fortunately have not had Zika transmission to date.

Mr. Dahir spoke of a campaign he had seen previously to educate the public in ways they can help by eliminating standing water around their homes, and inquired if such a campaign could be broadcast again.

Chair Jung agreed that to be a good suggestion, and opined that the Communications Team at the County could assist in the campaign due to it being a County-wide issue.

Mr. Dick informed that the proposed revisions to the Nevada Administrative Code to streamline processes are proceeding to the State Environmental Commission on June 27th, and, if adopted, will become a permanent regulation due to their approval within the fiscal year.

Chair Jung opined a source for additional funding for the Health District could be obtained by requesting a portion of sales tax generated at marijuana dispensaries in unincorporated areas of the County from the County Commissioners. She stated that she would assist in presenting the concept to the Board.

Mr. Dick wished to update and correct a portion of his report on Truckee Meadows Healthy Communities regarding a community meeting scheduled for the evening of June 14th. He informed that the meeting has been postponed to occur tentatively in September, but that he still expects a presentation to the TMRPA Governing Board on June 14th.

Mr. Dick informed that funding has been secured for Phase II of the Affordable Housing Project and that the Project is moving forward.

Mr. Dick informed of the resignation of Mr. Jim Begbie as Chairman from the REMSA Board, and that he had served as Consumer Representative Appointee on the Board. He informed that volunteer opportunity would be posted on the Washoe County webpage and potential candidates would be brought before the DBOH for future appointment.

Mr. Dick stated that Mr. Tim Nelson had been elected at the last REMSA meeting to serve as Chairman of the Board, and that Mr. Nelson is the Accounting Profession Appointed Representative by the District Board of Health. He expressed his confidence that Mr. Nelson will do a good job in that capacity.

Chair Jung reminded the Board of their responsibility to recruit for Board openings, and that she would like to a person of Latin descent considered for the position of Consumer Representative Appointee as representation for the Latin citizens in the area.

Mr. Dahir inquired about the lower statistics in the QI survey for "I am able to

participate in QI without worrying about competing priorities" and "QI training is easy for me to attend", and whether there was action necessary to improve employee's ability to participate.

Mr. Dick noted that the Health District's QI Team is reviewing survey questions to determine if there are better questions that could be asked to obtain data more relevant to determining the state of the Health District. While the change in the statistic on competing priorities was not statistically significant, he explained that the question missed the mark of determining whether employees feel that QI is important.

Mr. Dick highlighted the categories of statistically significant change, noting an increase of responders who agreed that "Co-workers show confidence and trust in one another" and "Expect a high quality job from themselves and others". He opined the response to "Innovation and new ideas are encouraged" was discouraging in that fewer employees agreed with that statement.

Mr. Dahir opined that having a consistent survey is important to measure results from year to year.

12. *Board Comment

Mr. Dahir informed that he would not be able to attend the June District Board of Health Meeting.

Dr. Novak agreed that having the Weather Service attend the next meeting to obtain their predictions for weather conditions at three month intervals for the year would be advantageous.

Mr. Delgado invited the Board to the Traner Pool opening on June 11th at noon. He informed that the pool had been closed last year and expressed his excitement that it will be open this year.

Chair Jung thanked Mr. Delgado for his involvement being instrumental in the pool's reopening and commented that it is a valuable resource for the community's youth.

Chair Jung closed the Board comment period.

13. *Public Comment

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

15. Adjournment

Chair Jung adjourned the meeting at 2:49 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.

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6Bi

DD__AH__ __
DHO_____ KD __
DA_____
Risk_____

Staff Report
Board Meeting Date: June 28, 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 Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health for the period July 1, 2018 through June 30, 2019 in the total amount of $64,582.00 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Fetal Infant Mortality Review (FIMR) Program IO# 11176 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 June 11, 2018 to support the Fetal Infant Mortality Review (FIMR) Program. The funding period is effective July 1, 2018 and extends through June 30, 2019. A copy of the Notice of Subgrant Award is attached.

District Health Strategic Objective supported by this item: Achieve targeted improvements in health outcomes and health equity.

PREVIOUS ACTION

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

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: Maternal and Child Health - Fetal Infant Mortality Review Program

Scope of the Project: The application included the following objectives: conduct a community-based Fetal Infant Mortality Review (FIMR) Program based on Division of Public and Behavioral Health Maternal and Child Health Program guidelines; develop periodic local summary

report of findings and recommendations that address the identified contributing factors leading to fetal and infant deaths.

The Subgrant provides funding for personnel, local travel, operating supplies, educational supplies, incentives for home interviews (gift cards) and indirect expenditures.

Benefit to Washoe County Residents: This Award supports the Fetal Infant Mortality Review (FIMR) Program by looking at a variety of factors that affect the health of the mother, fetus and infant to learn more about how to reduce fetal and infant mortality.

On-Going Program Support: The Health District anticipates receiving continuous funding to support the Fetal Infant Mortality Review (FIMR) Program.

Award Amount:	$64,582.00 (includes $5,871 indirect)
Grant Period:	July 1, 2018 – June 30, 2019
Funding Source:	Federal MCH Block Grants and State General Funds
Pass Through Entity:	State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health
CFDA Number:	93.994
Grant ID Number:	B04MC30626 through 9/30/18; B04MC31501 after 9/30/18
Match Amount and Type:	No match required.

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

FISCAL IMPACT

The Division anticipated this subgrant award; the FY19 budget was adopted with $58,705.00 in expenditure authority. The total award amount is $64,582.00 ($58,711 direct and $5,871 indirect). A budget amendment in the amount of $6.00 is necessary to bring the Notice of Subgrant Award into alignment with the adopted budget expenditure authority.

Should the Board approve this Subgrant Award, the adopted FY 19 budget will need to be amended as follows:

Account Number	Description	Amount of Increase/(Decrease)
2002-IO-11176 -431100	Federal Revenue	$ 6.00
	Total Revenue	**$ 6.00**
2002-IO-11176 -701412	Salary Adjustment	$ 6.00
	Total Expenditures	**$ 6.00**

RECOMMENDATION

It is recommended that the Washoe County District Board of Health approve a Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health for the period July 1, 2018 through June 30, 2019 in the total amount of $64,582.00 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Fetal Infant Mortality Review (FIMR) Program IO# 11176 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 for the period July 1, 2018 through June 30, 2019 in the total amount of $64,582.00 (no required match) in support of the Community and Clinical Health Services Division (CCHS) Fetal Infant Mortality Review (FIMR) Program IO# 11176 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 #: **16536**
Budget Account: 3222
Category: 15
GL: 8516
Job Number: 9399417(18)/GFUND17(18)

NOTICE OF SUBGRANT AWARD

Program Name: Maternal and Child Health Program Bureau of Child, Family and Community Wellness	**Subgrantee Name:** Washoe County Health District
Address: 4150 Technology Way, Suite # 210 Carson City, NV 89706-2009	**Address:** P.O. Box 11130 Reno, NV 89520-0027
Subgrant Period: July 1, 2018 through June 30, 2019.	**Subgrantee's:** **EIN: 88-60000138** **Vendor #: T40283400** **Dun & Bradstreet: 073786998**

Purpose of Award: To conduct a community-based Fetal Infant Mortality Review (FIMR) Program and develop reports of findings and recommendations to address contributing factors to fetal and infant deaths.

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

Approved Budget Categories:

1. Personnel	$	**57,235.00**
2. Travel	$	**109.00**
3. Operating	$	**1,367.00**
4. Equipment	$	**0.00**
5. Contractual/Consultant	$	**0.00**
6. Training	$	**0.00**
7. Indirect	$	**5,871.00**
Total Cost:	**$**	**64,582.00**

Disbursement of funds will be as follows:

Payment will be made upon receipt and acceptance of an invoice and supporting documentation specifically requesting reimbursement for actual expenditures *specific to this subgrant*. Total reimbursement will not exceed **$64,582.00** during the subgrant period.

Source of Funds:	% Funds:	CFDA:	FAIN:	Federal Grant #:
1. MCH Block Grant – Federal. Through 9/30/2018	14.25%	93.994	B04MC30626	B04MC30626
2. MCH Block Grant – Federal. After 9/30/2018	42.75%	93.994	B04MC31501	B04MC31501
3. State General Fund	43%	n/a	n/a	n/a

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: DPBH Business Associate Addendum

	Signature	Date
Kevin Dick, Health Officer Washoe County Health District		
Beth Handler, MPH Bureau Chief, CFCW	BHandler	6/26/18
for Julie Kotchevar, PhD. 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 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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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

Objective	Activities	Due Date	Documentation Needed
1. Conduct a community-based Fetal Infant Mortality Review (FIMR) Program based on Division of Public and Behavioral Health Maternal and Child Health Program guidelines.	1.1. Identify disparately impacted (e.g.; by race and ethnicity, etc.) populations for Washoe County's (WC) fetal (greater than 20 weeks), neonatal (birth to 28 days) and post neonatal (29 days to 1 year) deaths.	06/30/19	1.1. Report the information detailed in the Annual Report.
	1.2. Examine contributing factors to fetal, neonatal, and post neonatal deaths.		1.2. Include in FIMR Annual Report, Community Action Team (CAT) and Community Review Team (CRT) agendas and meeting minutes.
	1.3. Collect and enter all required data in a data system, as specified by the DPBH.		1.3. Data template will be kept on file and provided in the annual report.
	1.4. Complete the FIMR review on at least 40 cases. This is approximately 50% of all fetal, neonatal, and post neonatal deaths in Washoe County per year.		1.4. Include in FIMR Annual Report, CAT and CRT agendas and meeting minutes
	1.5. Identify three recommendations and implement at least one intervention involving policy, systems, or community norm changes leading to the prevention of fetal, neonatal, and post neonatal deaths.		1.5. Include in FIMR Annual Report, CAT and Child Death Review (CDR) Agendas and meeting minutes.
	1.6. Maintain an Interlocal Agreement with the Division of Public and Behavioral Health (DPBH), granting authority to the WCHD to implement NAC 442.054 in respect to fetal, neonatal, and post neonatal deaths in Washoe County as they apply to FIMR, which authorizes identification and contact of patients who have been discharged with birth defects or adverse birth outcomes (including fetal and infant death).		1.6. Submit a copy of the Interlocal Agreement from the DPBH with the subgrant award.
	1.7. Participate in local Maternal Child and Adolescent Health (MCAH) trainings/meetings.		1.7. Document attendance at trainings/meetings and keep on file for audit purposes.
	1.8. Update and review the Washoe County FIMR Policies and Procedures, which are derived from the National FIMR policies. (See FIMR Policies and Procedures).		1.8. Submit any changes to the master copy of the Washoe County FIMR Policies and Procedures with the Annual Report.

	1.9. The WCHD will facilitate and maintain a CRT and CAT to: 1.9.1. Review selected cases 1.9.2. Identify medical and nonmedical factors contributing to fetal and infant deaths 1.9.3. Recommend and implement changes addressing the review findings designed to prevent further infant deaths. 1.10. Develop a sustainability plan to secure new funding after the end of the subgrant period.		1.9. Complete and submit the following forms: • Committee Membership • FIMR Issues Checklist • FIMR Tracking Log • Report the information requested in the Annual Report. 1.10. Share sustainability progress plan quarterly (Oct, Jan, April).
2. Develop periodic local summary report of findings and recommendations addressing the identified contributing factors leading to fetal and infant deaths.	2.1 Based on case findings with community input, develop and implement objectives, interventions, timelines and evaluation components for identified recommendations addressing systems, community norm or public policy changes. 2.2 Disseminate local periodic summary report findings and recommendations to the CAT, WC CDR, local and state policymakers, the community at large, and other local Maternal and Child Health Programs through published reports, press releases, and presentations to increase public awareness of recurring factors causing or contributing to fetal and infant deaths. 2.3 Analyze and make recommendations relating to any identified disparities in infant mortality by race and ethnicity.		2.1 Report the information requested in the Annual Report. 2.2 Report the information requested in the Annual Report. 2.3 Report the information requested in the Annual Report.

Goal 2: Provide information and promote 2-1-1.

Objective	Activities	Due Date	Documentation Needed
1. Ensure information is up to date on the Nevada 2-1-1 website.	1.1 Complete 2-1-1 forms with both program and agency information by August 1, 2017 1.2 Promote referral agencies posting on 2-1-1	Ongoing through subgrant period	Documentation regarding Nevada 2-1-1 status will be provided when requested.

Goal 3: Promote the Tobacco Quitline.

Objective	Activities	Due Date	Documentation Needed
1. Promote the Nevada Tobacco Quitline.	1.1 Include the Nevada Tobacco Quitline information at the Health District	Ongoing through subgrant period	Documentation on the Nevada Tobacco Quitline information included at the Health District will be provided in the Annual Report.

Goal 4: Promote the Medical Home Portal.

Objective	Activities	Due Date	Documentation Needed
1. Promote the Nevada Children's Medical Home Portal.	1.1 Include Nevada Children's Medical Home Portal information at the Health District.	Ongoing through subgrant period	Documentation on the Nevada Children's Medical Home Portal information included at the Health District will be provided in the Annual Report.

Goal 5: Provide information and promote Nevada Pregnancy Risk Assessment Monitoring System (PRAMS).

Objective	Activities	Due Date	Documentation Needed
1. Promote Nevada PRAMS.	1.1 Include Nevada PRAMS information at the Health District.	Ongoing through subgrant period	Documentation on the Nevada PRAMS information included at the Health District will be provided in the Annual Report.

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 B04MC30626 and B04MC31501 from the United States Health Resources and Services Administration (HRSA) and State General Fund. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor HRSA.

Any activities performed under this subgrant shall acknowledge the funding was provided through the Division by Grant Numbers B04MC30626 and B04MC31501 from HRSA and State General Fund.

Subgrantee agrees to adhere to the following budget:

Category	Total cost	Detailed cost	Details of expected expenses
1. Personnel	$ 57,235		
		$ 31,163	One (1) .24 FTE Public Health Nurse II: Base Salary of $88,121 x .24 = $21,149 + Fringe of $10,014 ($3,599 Group Insurance+ $152 Workers Compensation + $16 Unemp. Ins + $5,955 Retirement + $292 Medicare) = $31,162
		$ 26,072	One (1) .33 of FTE Public Health Nurse II: Base salary of $52,873 x .33 = $17,448 + Fringe of $8,624 ($3,353 Group Insurance + $126 Workers Compensation + $23 Unemp Ins + $4,885 Retirement + $237 Medicare) = $26,072
2. Travel	$ 109		
		$ 109	Mileage for home interviews and local trips to community agencies, doctor offices, and hospitals for medical record reviews (20 trips @ 10 miles each x $.545/mile) = $109
3. Operating	$ 1,367		
		$ 150	Educational supplies - booklets and brochures as indicated by the Case Review Team and Community Action recommendations
		$ 100	Office supplies (paper, pens, staples, dry erase markers)
		$ 360	Copy Machine ($30/mo x 12 months = $360)
		$ 360	Telephone – Conference calls: 12 Maternal Child Health (MCH) Coalition meetings at 2 hours per call, 10 Case Review Team meetings at 2 hours per call. $30/month x 12 months = $360)
		$ 30	Postage for mailing reports, interview requests, thank you cards and evaluations ($2.50/month x 12 = $30)
		$ 100	Incentives 10 Walmart gift cards @ $10.00 ea. Utilized as incentives for clients to participate in the home interview.
		$ 267	Printing of information packets $50 (10 @ $5.00 ea) + annual reports $75 (25 @ 3.00 ea)+ FIMR brochures $42 (300 @ $0.14) + thank you cards for families ($100) = $267
4. Equipment	$ 0		
		$	
5. Contractual Consultant	$ 0		
		$	
6. Training	$ 0		
		$	
7. Indirect	$ 5,871		
		$ 5,871	10% of direct costs of $=58,711
Total Cost	$ 64,582		

- The Division of Public and Behavioral Health allows no more than 10% flexibility, within the approved Scope of Work, and authorized in writing (email is acceptable) by the Maternal and Child Health (MCH) Program Coordinator.

- 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 available through subgrant is **$64,582.00**, of which funding will be provided by Grant B04MC30626 for a maximum amount of $9,203 (or 14.25%) through September 30, 2018, and a maximum of $27,770 (or 43%) through State General Fund appropriations throughout the subgrant term. The remainder of the unobligated balance will be funded with Grant B04MC31501.

- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred;

- 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 Title V/MCH Program will provide to the subgrantee, to ensure successful completion of this project, the following:
    - Technical assistance, upon request from the Subgrantee;
    - Prior approval of reports or documents to be developed;

- 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 Subgrantee will make appropriate personnel available during any scheduled site visits/monitoring.

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, 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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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBGRANT AWARD

SECTION D

Request for Reimbursement

HD #: 16536
Budget Account: 3222
GL: 8516
Draw #:

Program Name: Maternal and Child Health Program Bureau of Child, Family and Community Wellness	**Subgrantee Name:** Washoe County Health District
Address: 4150 Technology Way, Suite # 210 Carson City, NV 89706-2009	**Address:** P.O. Box 11130 Reno, NV 89520-0027
Subgrant Period: July 1, 2018 through June 30, 2019	**Subgrantee's:** **EIN: 88-60000138** **Vendor #: T40283400**

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	$57,235.00	$0.00	$0.00	$0.00	$57,235.00	0.0%
2. Travel	$109.00	$0.00	$0.00	$0.00	$109.00	0.0%
3. Operating	$1,367.00	$0.00	$0.00	$0.00	$1,367.00	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. Indirect	$5,871.00	$0.00	$0.00	$0.00	$5,871.00	0.0%
Total	**$64,582.00**	**$0.00**	**$0.00**	**$0.00**	**$64,582.00**	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

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? _____
4. What is the official name of your organization? _____
5. How often is your organization audited? _____
6. When was your last audit performed? _____
7. What time-period did your last audit cover? _____
8. Which accounting firm conducted your last audit? _____

_____ _____ _____
Signature Date 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.

8. **Electronic Protected Health Information** means individually identifiable health information transmitted by electronic media or maintained in electronic media as set forth under 45 CFR 160.103.
9. **Electronic Health Record** means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. Refer to 42 USC 17921.
10. **Health Care Operations** shall have the meaning given to the term under the Privacy Rule at 45 CFR 164.501.
11. **Individual** means the person who is the subject of protected health information and is defined in 45 CFR 160.103.
12. **Individually Identifiable Health Information** means health information, in any form or medium, including demographic information collected from an individual, that is created or received by a covered entity or a business associate of the covered entity and relates to the past, present, or future care of the individual. Individually identifiable health information is information that identifies the individual directly or there is a reasonable basis to believe the information can be used to identify the individual. Refer to 45 CFR 160.103.
13. **Parties** shall mean the Business Associate and the Covered Entity.
14. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 CFR Parts 160 and 164, Subparts A, D and E.
15. **Protected Health Information** means individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Refer to 45 CFR 160.103 for the complete definition.
16. **Required by Law** means a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law. This includes, but is not limited to: court orders and court-ordered warrants; subpoenas, or summons issued by a court; and statues or regulations that require the provision of information if payment is sought under a government program providing public benefits. For the complete definition refer to 45 CFR 164.103.
17. **Secretary** shall mean the Secretary of the federal Department of Health and Human Services (HHS) or the Secretary's designee.
18. **Security Rule** shall mean the HIPAA regulation that is codified at 45 CFR Parts 160 and 164 Subparts A and C.
19. **Unsecured Protected Health Information** means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued in Public Law 111-5. Refer to 42 USC 17932 and 45 CFR 164.402.
20. **USC** stands for the United States Code.

II. OBLIGATIONS OF THE BUSINESS ASSOCIATE.

1. **Access to Protected Health Information.** The Business Associate will provide, as directed by the Covered Entity, an individual or the Covered Entity access to inspect or obtain a copy of protected health information about the Individual that is maintained in a designated record set by the Business Associate or, its agents or subcontractors, in order to meet the requirements of the Privacy Rule, including, but not limited to 45 CFR 164.524 and 164.504(e) (2) (ii) (E). If the Business Associate maintains an electronic health record, the Business Associate or, its agents or subcontractors shall provide such information in electronic format to enable the Covered Entity to fulfill its obligations under the HITECH Act, including, but not limited to 42 USC 17935.
2. **Access to Records.** The Business Associate shall make its internal practices, books and records relating to the use and disclosure of protected health information available to the Covered Entity and to the Secretary for purposes of determining Business Associate's compliance with the Privacy and Security Rule in accordance with 45 CFR 164.504(e)(2)(ii)(H).
3. **Accounting of Disclosures.** Promptly, upon request by the Covered Entity or individual for an accounting of disclosures, the Business Associate and its agents or subcontractors shall make available to the Covered Entity or the individual information required to provide an accounting of disclosures in accordance with 45 CFR 164.528, and the HITECH Act, including, but not limited to 42 USC 17935. The accounting of disclosures, whether electronic or other media, must include the requirements as outlined under 45 CFR 164.528(b).
4. **Agents and Subcontractors.** The Business Associate must ensure all agents and subcontractors to whom it provides protected health information agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to all protected health information accessed, maintained, created, retained, modified, recorded, stored, destroyed, or otherwise held, transmitted, used or disclosed by the agent or subcontractor. The Business Associate must implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation as outlined under 45 CFR 164.530(f) and 164.530(e)(1).

5. **Amendment of Protected Health Information.** The Business Associate will make available protected health information for amendment and incorporate any amendments in the designated record set maintained by the Business Associate or, its agents or subcontractors, as directed by the Covered Entity or an individual, in order to meet the requirements of the Privacy Rule, including, but not limited to, 45 CFR 164.526.
6. **Audits, Investigations, and Enforcement.** The Business Associate must notify the Covered Entity immediately upon learning the Business Associate has become the subject of an audit, compliance review, or complaint investigation by the Office of Civil Rights or any other federal or state oversight agency. The Business Associate shall provide the Covered Entity with a copy of any protected health information that the Business Associate provides to the Secretary or other federal or state oversight agency concurrently with providing such information to the Secretary or other federal or state oversight agency. The Business Associate and individuals associated with the Business Associate are solely responsible for all civil and criminal penalties assessed as a result of an audit, breach, or violation of HIPAA or HITECH laws or regulations. Reference 42 USC 17937.
7. **Breach or Other Improper Access, Use or Disclosure Reporting.** The Business Associate must report to the Covered Entity, in writing, any access, use or disclosure of protected health information not permitted by the 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

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.

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:

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

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** **Phone: (775) 684-4220** **Fax: (775) 684-4211**	_____ Business Name _____ Business Address _____ Business City, State and Zip Code _____ Business Phone Number _____ Business Fax Number
_____ Authorized Signature	_____ Authorized Signature
for Julie Kotchevar, PhD. Print Name	_____ Print Name
Administrator, Division of Public and Behavioral Health Title	_____ Title
_____ Date	_____ Date

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6C

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Risk

STAFF REPORT
BOARD MEETING DATE: June 28, 2018

TO: District Board of Health

FROM: Charlene Albee, Director
775-784-7211, calbee@washoecounty.us

SUBJECT: Acceptance of the "Washoe County, Nevada Air Quality Trends (2008-2017)" Report

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SUMMARY

The Air Quality Management Division (AQMD) operates and maintains an ambient air monitoring program to determine compliance with health-based National Ambient Air Quality Standards. This annual report summarizes the previous year's ambient air monitoring data and provides a long-term trend for each pollutant.

Health District strategic objective supported by this item:
Local Culture of Health: Lead a transformation in our community's awareness, understanding, and appreciation of health resulting in direct action.

PREVIOUS ACTION

The Air Quality Trends Report is updated and presented annually to the District Board of Health (DBOH) for acceptance. The most recent action occurred on May 25, 2017 with the acceptance of the "Washoe County, Nevada Air Quality Trends (2007-2016)" Report.

BACKGROUND

The Environmental Protection Agency (EPA) establishes health-based National Ambient Air Quality Standards (NAAQS) for six criteria air pollutants including Ozone and Particulate Matter. Each year, the AQMD prepares this report, which summarizes the previous year's monitoring data. Although there are no statutory requirements to publish an annual report of ambient air monitoring data, EPA strongly encourages air quality management agencies to do so.

This Air Quality Trends Report summarizes 2017 and the ten-year trend for each pollutant. A new feature in this year's report is the addition of Burn Code statistics. The AQMD has been implementing a Burn Code program since the 1980's and along with the Woodstove program, has significantly improved wintertime particulate and carbon monoxide levels. The full report is available at the AQMD website (OurCleanAir.com). Following is a review of 2017, a summary of last year's Air Quality Index (AQI) levels and the AQI trend for the previous ten years.

A Review of 2017

The very active winter continued through February with flooding of nearly all Northern Nevada water systems. The water year was the wettest ever recorded. The last week of January through the first week of February resulted in elevated $PM_{2.5}$ and PM_{10} beneath a cold air inversion. This resulted in one red and three yellow burn codes. The highest 24-hour concentration during the burn code season for $PM_{2.5}$ was 35.0 µg/m^3 on January 31 in Sparks.

The first ozone exceedance of the year occurred on May 24. The 8-hour rolling average for O_3 was 0.071 ppm at Lemmon Valley. Elevated ozone affected all of our sites with the more northerly sites having the highest concentrations. This exceedance was out outside of the typical ozone season. Strong westerly winds with partly cloudy conditions that day and high ozone concentrations in the Sacramento Valley the preceding days indicate this to be an interstate transport event.

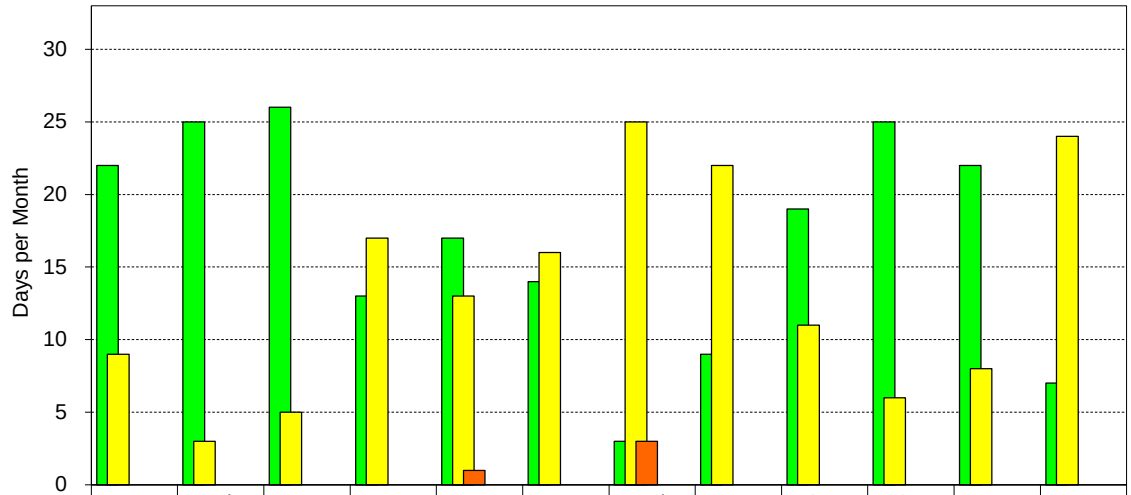
The active weather pattern continued through the beginning of June. June had drastic temperature changes followed by a record high temperature for Reno of 104 °F on June 19. Critical fire conditions started soon thereafter and didn't cease until the fall. A total of nine wildfires in Nevada and California affect the Southern Washoe County in July. The Detwiler Fire started on July 16 in Mariposa County, California. It burned over 81,000 acres and sent smoke to Reno/Sparks. On July 19, Reno3 monitored the only exceedance in 2017 for $PM_{2.5}$ with a 24-hour concentration of 45.6 µg/m^3. This also impacted ozone concentrations with exceedances at Toll, Spanish Springs, Sparks, and Reno3. The highest 8-hour rolling average for O_3 was 0.074 ppm at Toll on July 19 and 20.

Figure 3
Detwiler Fire Smoke Obscures Downtown Reno on July 19

Red flag conditions with high heat and low humidity resulted in region wide wildfire activity. Fires near Yosemite brought smoke and haze in Reno and Sparks throughout August and Early September. The smoke from wildfires in Sonoma and Napa Counties affected Northern Nevada in the middle of October. Despite several cold fronts, the region was dry without much precipitation to begin the water year.

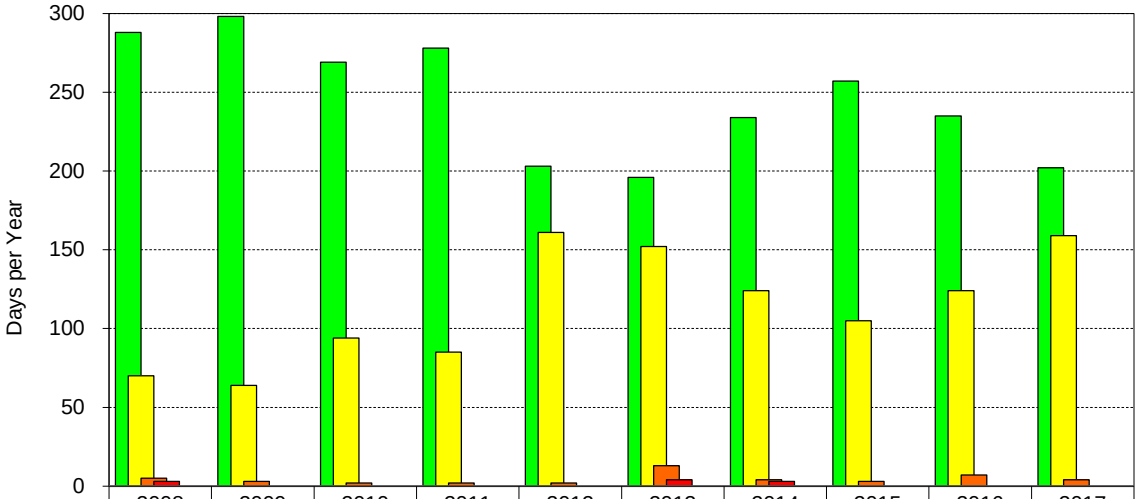
Atmospheric rivers with high winds returned in November and provided much needed precipitation. Between storms, prescribed fires were being conducted throughout Nevada and California. December ushered in prolonged periods of high pressure resulting in cold air inversions. Thirteen yellow burn codes and one red burn code were issued. The highest 24-hour concentration for $PM_{2.5}$ was 34.1 µg/m^3 on December 29 at Sparks.

Monthly AQI Summary for All Pollutants (2017)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Good	22	25	26	13	17	14	3	9	19	25	22	7
Moderate	9	3	5	17	13	16	25	22	11	6	8	24
USG	-	-	-	-	1	-	3	-	-	-	-	-
Unhealthy	-	-	-	-	-	-	-	-	-	-	-	-
Very Unhealthy	-	-	-	-	-	-	-	-	-	-	-	-
Hazardous	-	-	-	-	-	-	-	-	-	-	-	-

AQI Trend (2008-2017)



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Good	288	298	269	278	203	196	234	257	235	202
Moderate	70	64	94	85	161	152	124	105	124	159
USG*	5	3	2	2	2	13	4	3	7	4
Unhealthy	3	-	-	-	-	4	3	-	-	-
Very Unhealthy	-	-	-	-	-	-	-	-	-	-
Hazardous	-	-	-	-	-	-	-	-	-	-

* Unhealthy for Sensitive Groups

FISCAL IMPACT

There is no additional fiscal impact to the FY 2017-18 budget should the DBOH accept the "Washoe County, Nevada Air Quality Trends (2008-2017)" report.

RECOMMENDATION

Staff recommends that the DBOH accept the "Washoe County, Nevada Air Quality Trends (2008-2017)" report.

POSSIBLE MOTION

Should the DBOH accept the trends report, a possible motion could be "Move to accept the "Washoe County, Nevada Air Quality Trends (2008-2017)" report".

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6D

DD_____ __
DHO____ KD __

Staff Report
Board Meeting Date: June 28, 2018

TO: District Board of Health

FROM: Kevin Dick, District Health Officer
775-328-2416, kdick@washoecounty.us

SUBJECT: Approval of authorization to travel and travel reimbursements for non-County employee Dr. John Novak for FY19 to include the approximate amount of $1,763.29, to attend the NALBOH Annual Conference in Raleigh, North Carolina, August 8-10, 2018, and the Annual NALBOH Board Meeting in the approximate amount of $1,600, date and location to be determined.

SUMMARY

The District Board of Health must authorize travel and travel reimbursements for non-County employees.

District Health Strategic Objective supported by this item: Strengthen WCHD as an innovative, high- performing organization.

PREVIOUS ACTION

No previous action has been taken relevant to this item.

BACKGROUND

The National Association of Local Boards of Health (NALBOH) Annual Conference will provide attendees with information, skills and resources focused on the six functions of public health governance. The conference will also provide time for attendees to learn and share information on critical public health issues.

Dr. Novak has expressed interest in attending the conference and bringing back valuable information regarding health governance to the Washoe County Health District.

Dr. Novak will travel on August 6th and spend the evening in Dallas to avoid an additional night in Raleigh as a cost savings to the County. Due to arrival times in Raleigh, Dr. Novak would have had to travel on August 6th regardless of where he stayed.

The cost of this travel is estimated to be approximately $1,763.29 and includes airfare, lodging, per diem and ground transportation.

Dr. Novak is the Treasurer for NALBOH and will also be attending the Annual Board Meeting in the Spring of 2019; the location of the meeting has tentatively been set for Denver, CO. The cost for travel and reimbursements for the 2017 Annual Board Meeting held in Atlanta, GA was $1,432.16. Costs estimated for this trip are $1,600 and actual figures will be included in the District Health Officer's Report to the DBOH once actual amounts are known.

FISCAL IMPACT

Should the Board approve this authorization to travel and travel reimbursement, there will be no additional fiscal impact to the adopted FY19 budget as travel expenses were anticipated and projected in the budget of the Office of the District Health Officer (Cost Center 170202).

RECOMMENDATION

Staff recommends the District Board of Health approve the authorization to travel and travel reimbursements for non-County employee Dr. John Novak in the approximate amount of $1,763.29 to attend the NALBOH Annual Conference in Raleigh, North Carolina from August 8-10, 2018 and the Annual NALBOH Board Meeting in the approximate amount of $1,600, date and location to be determined.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be: "Approve authorization to travel and travel reimbursements for non-County employee Dr. John Novak in the approximate amount of $1,763.29 to attend the NALBOH Annual Conference in Raleigh, North Carolina from August 8-10, 2018, and the Annual NALBOH Board Meeting in the approximate amount of $1,600, date and location to be determined."

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6E

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STAFF REPORT
BOARD MEETING DATE: June 28, 2018

TO: District Board of Health

FROM: Jim English, Environmental Health Specialist Supervisor
775-328-2610, jenglish@washoecounty.us

SUBJECT: Approve an amendment to the partnership agreement with Keep Truckee Meadows Beautiful for an increase of $11,111.00 in support of the Recycling and Solid Waste Management Plan program to cover activities retroactive to March 1, 2018 on behalf of the Environmental Health Services Division of the Washoe County Health District.

SUMMARY

The Washoe County District Board of Health (Board) 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 $100,000 would require the approval of District Board of Health and the Board of County Commissioners.

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

At the February 22, 2018 Board meeting the Board approved an agenda item to fund Keep Truckee Meadows Beautiful (KTMB) for $100,000.00 for the 2018 calendar year effective April 1, 2018 through December 31, 2018.

BACKGROUND

The Washoe County Health District proposes to partner with 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.

When the original contract encompassed calendar year 2018, the February 22, 2018 Board item had an attached Purchase Order effective April 1, 2018 to December 31, 2018. KTMB understood the contract to begin when approved and therefore completed the terms of the contract for March 2018. Since the previous Board item and the purchase order stated a begin date of April 1st, this Board item requests an amendment to the contract to provide payment for the month of March at the additional cost of $11,111.00.

Should the District Board of Health approve this contract amendment, Purchase Order #6500002469 will be updated as the Board of County Commissioners has already approved KTMB as a vendor exceeding $100,000.00.

FISCAL IMPACT

Should the Board approve the amendment, the additional fiscal impact for the Solid Waste Program would be $11,111.00. The additional amount can be covered by the current approved Solid Waste Management Program budget.

RECOMMENDATION

Staff recommends that the District Board of Health approve an amendment to the agreement with Keep Truckee Meadows Beautiful for an increase of $11,111.00 in support of the Recycling and Solid Waste Management Plan program to cover activities retroactive to March 1, 2018 on behalf of the Environmental Health Services Division of the Washoe County Health District.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to approve an amendment to the agreement with Keep Truckee Meadows Beautiful for an increase of $11,111.00 in support of the Recycling and Solid Waste Management Plan program to cover activities retroactive to March 1, 2018 on behalf of the Environmental Health Services Division of the Washoe County Health District."

Washoe County Health District
Independent Contractor Agreement for Litter Control
Calendar Year 2018

Keep Truckee Meadows Beautiful
$111,111
For period March 1, 2018 through December 31, 2018

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

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6F

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STAFF REPORT
BOARD MEETING DATE: June 28, 2018

TO: District Board of Health

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

SUBJECT: Authorize the creation of a 1.0 FTE, fully benefitted, full-time Public Health Investigator position to be evaluated by the Job Evaluation Committee to be supported by the Ryan White Part B Program Grant IO# 11479 and to abolish vacant Public Health Nurse PC# 70002199.

SUMMARY

The Community and Clinical Health Services (CCHS) Division is requesting the creation of a 1.0 FTE, fully benefitted, full-time Public Health Investigator position to be evaluated by the Job Evaluation Committee to be supported by the Ryan White Part B Program Grant IO# 11479 and to abolish vacant Public Health Nurse PC# 70002199.

Health District Strategic Priorities supported by this item:
Organizational Capacity: Strengthen our workforce and increase operational capacity to support a growing population.

PREVIOUS ACTION

On April 26, 2018, the Board approved a Subgrant Award retroactive to April 1, 2018 through March 31, 2019 in the total amount of $168,597.33 in support of the Community and Clinical Health Services Division (CCHS) Ryan White Part B Program.

BACKGROUND

The Community and Clinical Health Services (CCHS) Division received a Notice of Subgrant Award from the State of Nevada Department of Health and Human Services, Division of Public & Behavioral Health to support the Ryan White Part B Program. In reviewing the scope of work, program management determined a Public Health Investigator I (PHI I) position was a more appropriate classification to perform the duties rather than a Public Health Nurse. A registered nurse is not needed to routinely perform the required tasks. The State approved the classification change and will be issuing an amended Subgrant to update the staffing model.

In addition, CCHS has a vacant .9 FTE Public Health Nurse position that had been funded by various grants in the past and no longer has funding. As such, the Division is requesting the position be abolished.

FISCAL IMPACT

This request has no fiscal impact as the Subgrant budget has sufficient authority to support the PHI position.

RECOMMENDATION

It is recommended that the District Board of Health authorize the creation of a 1.0 FTE, fully benefitted, full-time Public Health Investigator position to be evaluated by the Job Evaluation Committee to be supported by the Ryan White Part B Program Grant IO# 11479 and to abolish vacant Public Health Nurse PC# 70002199.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be: "Move to authorize the creation of a 1.0 FTE, fully benefitted, full-time Public Health Investigator position to be evaluated by the Job Evaluation Committee to be supported by the Ryan White Part B Program Grant IO# 11479 and to abolish vacant Public Health Nurse PC# 70002199."

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6G

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STAFF REPORT
BOARD MEETING DATE: June 28, 2018

TO: District Board of Health

FROM: Charlene Albee, Director, Air Quality Management Division
(775) 784-7211, calbee@washoecounty.us

SUBJECT: Presentation, discussion, and possible approval of a process to donate various obsolete monitoring equipment and associated supplies with a current market value estimated at $-0- that have exceeded the useful value for regulatory purposes but may still have value for educational, research and community organizations.

SUMMARY

The Washoe County District Board of Health must approve the donation of equipment to ensure there is a benefit to the citizens of Washoe County.

District Health Strategic Objective supported by this item: Impactful Partnerships: Extend our impact by leveraging partnerships to make meaningful progress on health issues.

PREVIOUS ACTION

September 28, 2017. The District Board of Health approved the donation of five pieces of obsolete equipment with a current market value estimated at $-0- to other air monitoring agencies in need of such equipment coordinated by National Association of Clean Air Agencies (NACAA); and if no interest received from other air monitoring agencies, donate the equipment to the Atmospheric Sciences Program at the University of Nevada, Reno.

BACKGROUND

The U.S. Environmental Protection Agency (EPA) establishes the technical requirements for ambient air quality monitoring programs. Air quality management agencies are required to submit annual monitoring network plans, conduct network assessments every five (5) years, and perform quality assurance activities. AQMD currently operates and maintains a network of seven (7) monitoring sites located in Southern Washoe County. As a result of EPA's review of the monitoring program, AQMD established a 10-year replacement schedule for monitoring equipment. This schedule allows for the replacement of equipment that has reached a current market value of $-0- and is considered obsolete for regulatory purposes.

Rather than disposing of the obsolete equipment, AQMD has established relationships with a number of organizations in the community that identified research and educational value in the equipment. Past donations of this type of equipment have enabled the University of Nevada, Reno Atmospheric Sciences Program to collaborate with the Orvis School of Nursing to provide an understanding of the linkage between air quality and public health.

Through the equipment replacement schedule, AQMD accumulates equipment on an annual basis that is considered eligible for donation. In order to streamline the process of donating the obsolete equipment, the AQMD is proposing to establish guidelines for the donation of equipment with District Board of Health approval. Instead of presenting a staff report requesting approval for reoccurring donations, AQMD is proposing the following process for general approval of donations:

1. Notify Washoe County Purchasing and Health District Administrative Health Services to confirm $-0- value of equipment and coordinate the removal of the equipment from the current inventory. This will include complying with grant obligations for disposal of equipment.
2. Initially offer the equipment to all Washoe County Departments. If there is no interest from within the County, then offer the equipment to community organizations. These organizations include, but are not limited to, the Washoe County School District, University of Nevada, Reno, Desert Research Institute, and Habitat for Humanity. AQMD will ensure all interested parties are provided an equal opportunity to acquire the equipment.
3. If no interest from our community partners, then the equipment will be recycled or disposed of, depending on the available options.
4. An annual report will be provided to the District Board of Health at the end of each fiscal year summarizing the equipment's final disposition.

AQMD feels this streamlined process will ensure compliance with Washoe County and Health District purchasing policies while satisfying the requirement for District Board of Health approval for donations.

FISCAL IMPACT

Should the Board approve this donation process, there will be no fiscal impact to the adopted budgets as the eligible equipment will have $-0- value.

RECOMMENDATION

Staff recommends the District Board of Health approve the process to donate various obsolete monitoring equipment and associated supplies with a current market value estimated at $-0- that have exceeded the useful value for regulatory purposes but may still have value for educational, research and community organizations.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to approve the process to donate various obsolete monitoring equipment and associated supplies with a current market value estimated at $-0- that have exceeded the useful value for regulatory purposes but may still have value for educational, research and community organizations."

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6H

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Staff Report
Board Meeting Date: June 28, 2018

TO: District Board of Health

FROM: Jennifer Pierce, Fiscal Compliance Officer, Washoe County Health District
775-328-2418, jpierce@washoecounty.us

SUBJECT: **Retroactive Approval of Assistance Amendment PM-00T56401-7 from the U.S. Environmental Protection Agency (EPA) for the period 4/1/18 through 3/31/19 for the Air Quality Management, EPA Air Pollution Control Program, IO 10021.**

SUMMARY

The Washoe County District Board of Health must approve and execute Interlocal Agreements and amendments to the adopted budget. 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 Air Quality Management Division received an Assistance Amendment from the EPA, which extends the budget and project period end dates from 4/1/18 to 3/31/19 for the on-going Air Pollution Control Program, PM 2.5 Program, IO 10021. A copy of the Assistance Amendment PM-00T56401-7 is attached.

District Board of Health strategic priority: Healthy Environment: Create a healthier environment that allows people to safely enjoy everything Washoe County has to offer.

PREVIOUS ACTION

The prior EPA PM 2.5 Grant Award Amendment that provided the extension of the budget and project period to March 31, 2019 was approved by the DBOH on April 26, 2018.

BACKGROUND/GRANT AWARD SUMMARY

Project/Program Name: EPA PM2.5 Monitoring Network

Scope of the Project:

This Assistance Amendment was received on June 4, 2018. The Amendment is being presented for District Board of Health approval per the EPA procedure that does not require signature.

This Amendment extends the budget and project period end dates from 3/31/18 to 3/31/19. The change raises the Total Approved Assistance Amount from $329,462 to $432,351. This PM 2.5 funding will provide support for salaries and benefits, travel, and indirect expenditures.

Benefit to Washoe County Residents: This award supports the Health District Air Quality Program Mission to implement clean air solutions that protect the quality of life for the citizens of Reno, Sparks and Washoe County.

On-Going Program Support: These funds support on-going PM 2.5 activities in the Air Quality Program.

Award Amount: Total award was $432,351

Grant Period: April 1, 2018 – March 31, 2019

Funding Source: U.S. Environmental Protection Agency

Pass Through Entity: Not applicable

CFDA Number: 66.034

Grant ID Number: PM – 00T56401 - 7

Match Amount and Type: No match required

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

FISCAL IMPACT

Should the Board retroactively approve the Assistance Amendment from EPA, there is no additional fiscal impact to the adopted FY18 budget or FY19 budget.

RECOMMENDATION

It is recommended that the Washoe County District Board of Health retroactively approve of Assistance Amendment PM-00T56401-7 from the U.S. Environmental Protection Agency (EPA) for the period 4/1/18 through 3/31/19 for the Air Quality Management, EPA Air Pollution Control Program, IO 10021.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be: "Move to retroactively approve the Assistance Amendment PM-00T56401-7 from the U.S. Environmental Protection Agency (EPA) for the period 4/1/18 through 3/31/19 for the Air Quality Management, EPA Air Pollution Control Program, IO 10021."

U.S. ENVIRONMENTAL PROTECTION AGENCY

Assistance Amendment

GRANT NUMBER (FAIN): 00T56401 **MODIFICATION NUMBER:** 7 **PROGRAM CODE:** PM	**DATE OF AWARD** 06/04/2018
TYPE OF ACTION Augmentation: Increase	**MAILING DATE** 06/11/2018
PAYMENT METHOD: Advance	**ACH#** 90104

RECIPIENT TYPE:
County

Send Payment Request to:
Las Vegas Finance Center email:
lvfc-grants@epa.gov

RECIPIENT:	**PAYEE:**
Washoe Cnty Dist Hlth Dept P.O. Box 11130 Reno, NV 89520 **EIN:** 88-6000138	Washoe Cnty Dist Hlth Dept P.O. Box 11130 Reno, NV 89520

PROJECT MANAGER	**EPA PROJECT OFFICER**	**EPA GRANT SPECIALIST**
Charlene Albee P.O. Box 11130 Reno, NV 89520 **E-Mail:** calbee@washoecounty.us **Phone:** 775-784-7211	Roberto Gutierrez 75 Hawthorne Street, AIR-8 San Francisco, CA 94105 **E-Mail:** Gutierrez.Roberto@epa.gov **Phone:** 415-947-4276	Veronica Adams Grants Management Section, EMD-6-1 **E-Mail:** adams.veronica@epa.gov **Phone:** 415-972-3677

PROJECT TITLE AND EXPLANATION OF CHANGES
PM 2.5 Monitoring Network

To provide funding to monitor fine particulate matter with a diameter equal to or smaller than 2.5 micrometers (PM 2.5) in order to determine compliance with the PM 2.5 National Ambient Air Quality Standard and determine reductions in air emissions.

This assistance amendment increases the federal funding by $102,889 (which includes $52,834 for in-kind costs for PM2.5 EPA contractual support), from $329,462, to the revised Total Approved Assistance Amount of $432,351.

Note: The EPA Grant Specialist is changed to Veronica Adams.

BUDGET PERIOD	**PROJECT PERIOD**	**TOTAL BUDGET PERIOD COST**	**TOTAL PROJECT PERIOD COST**
04/01/2015 - 03/31/2019	04/01/2015 - 03/31/2019	$432,351.00	$432,351.00

NOTICE OF AWARD

Based on your Application dated 03/21/2018 including all modifications and amendments, the United States acting by and through the US Environmental Protection Agency (EPA) hereby awards $50,055. EPA agrees to cost-share 100.00% of all approved budget period costs incurred, up to and not exceeding total federal funding of $432,351. Recipient's signature is not required on this agreement. The recipient demonstrates its commitment to carry out this award by either: 1) drawing down funds within 21 days after the EPA award or amendment mailing date; or 2) not filing a notice of disagreement with the award terms and conditions within 21 days after the EPA award or amendment mailing date. If the recipient disagrees with the terms and conditions specified in this award, the authorized representative of the recipient must furnish a notice of disagreement to the EPA Award Official within 21 days after the EPA award or amendment mailing date. In case of disagreement, and until the disagreement is resolved, the recipient should not draw down on the funds provided by this award/amendment, and any costs incurred by the recipient are at its own risk. This agreement is subject to applicable EPA regulatory and statutory provisions, all terms and conditions of this agreement and any attachments.

ISSUING OFFICE (GRANTS MANAGEMENT OFFICE)	**AWARD APPROVAL OFFICE**
ORGANIZATION / ADDRESS	**ORGANIZATION / ADDRESS**
U.S. EPA, Region 9 - Grants Management Section, EMD 6-1 75 Hawthorne Street San Francisco, CA 94105	U.S. EPA, Region 9 Air Division, AIR-1 75 Hawthorne Street San Francisco, CA 94105

THE UNITED STATES OF AMERICA BY THE U.S. ENVIRONMENTAL PROTECTION AGENCY

Digital signature applied by EPA Award Official Carolyn Truong - Grants Management Officer	**DATE** 06/04/2018

EPA Funding Information

FUNDS	FORMER AWARD	THIS ACTION	AMENDED TOTAL
EPA Amount This Action	$ 170,960	$ 50,055	$ 221,015
EPA In-Kind Amount	$ 158,502	$ 52,834	$ 211,336
Unexpended Prior Year Balance	$ 0	$	$ 0
Other Federal Funds	$ 0	$	$ 0
Recipient Contribution	$ 0	$	$ 0
State Contribution	$ 0	$	$ 0
Local Contribution	$ 0	$	$ 0
Other Contribution	$ 0	$	$ 0
Allowable Project Cost	$ 329,462	$ 102,889	$ 432,351

Assistance Program (CFDA)	Statutory Authority	Regulatory Authority
66.034 - Surveys-Studies-Investigations-Demonstrations and Special Purpose Activities relating to the Clean Air Act	Clean Air Act: Sec. 103	2 CFR 200 2 CFR 1500 and 40 CFR 33

Fiscal

Site Name	Req No	FY	Approp. Code	Budget Organization	PRC	Object Class	Site/Project	Cost Organization	Obligation / Deobligation
-	1809M7S025	18	E1	09M4	000A04XPM	4112	-	-	50,055
									50,055

Budget Summary Page: PM2.5 Monitoring

Table A - Object Class Category (Non-construction)	Total Approved Allowable Budget Period Cost
1. Personnel	$119,918
2. Fringe Benefits	$58,930
3. Travel	$6,500
4. Equipment	$0
5. Supplies	$1,100
6. Contractual	$229,599
7. Construction	$0
8. Other	$4,800
9. Total Direct Charges	$420,847
10. Indirect Costs: % Base See Below	$11,504
11. Total (Share: Recipient 0.00 % Federal 100.00 %.)	$432,351
12. Total Approved Assistance Amount	$432,351
13. Program Income	$0
14. Total EPA Amount Awarded This Action	$102,889
15. Total EPA Amount Awarded To Date	$432,351

Table B - Program Element Classification (Non-construction)	Total Approved Allowable Budget Period Cost
1. Table A, Line 6 Contractual includes	$
2. in-kind contractor support through	$
3. an EPA-HQ national contract.	$
4. Therefore, No M/WBE Reporting required.	$
5.	$
6. Table A, Line 10 Indirect is based on an	$
7. Indirect Cost Rate Proposal updated	$
8. annually.	$
9.	$
10.	$
11. Total (Share: Recip % Fed %)	$
12. Total Approved Assistance Amount	$

Administrative Conditions

General, Administrative, and Programmatic Terms and Conditions of the previous assistance amendment remain in full force and effect. See paragraph below for the most current EPA General Terms and Conditions. All applicable terms and conditions are reflected in this assistance amendment, PM-00T56401-7.

GENERAL TERMS AND CONDITIONS:
The recipient agrees to comply with the current EPA general terms and conditions available at:
https://www.epa.gov/grants/epa-general-terms-and-conditions-effective-october-2-2017-or-later .

These terms and conditions are in addition to the assurances and certifications made as a part of the award and the terms, conditions, or restrictions cited throughout the award.

The EPA repository for the general terms and conditions by year can be found at https://www.epa.gov/grants/grant-terms-and-conditions

A. Annual Federal Financial Report (FFR) - SF 425
For awards with cumulative project and budget periods greater than 12 months, the recipient will submit an annual FFR (SF 425) covering the period from "project/budget period start date" to September 30 of each calendar year to the U.S. EPA Las Vegas Finance Center (LVFC). The FFR will be submitted electronically to lvfc-grants@epa.gov no later than December 31 of the same calendar year. The form with instructions can be found on LVFC's website at https://www.epa.gov/financial/grants.

This agreement also includes EPA in-kind services. Invoices will not be provided to the recipient for recording of actual in-kind cost, however, the total in-kind amount shall be reflected as an expenditure on the Federal Financial Report(s).

B. Procurement
The recipient will ensure all procurement transactions will be conducted in a manner providing full and open competition consistent with 2 CFR Part 200.319. In accordance 2 CFR Part 200.323 the grantee and subgrantee(s) must perform a cost or price analysis in connection with applicable procurement actions, including contract modifications.

State recipients must follow procurement procedures as outlined in 2 CFR Part 200.317.

C. Six Good Faith Efforts 40 CFR Part 33, Subpart C
Pursuant to 40 CFR Section 33.301, the recipient agrees to make the following good faith efforts whenever procuring construction, equipment, services and supplies under an EPA financial assistance agreement, and to require that sub-recipients, loan recipients, and prime contractors also comply. Records documenting compliance with the six good faith efforts shall be retained:

(a) Ensure DBEs are made aware of contracting opportunities to the fullest extent practicable through outreach and recruitment activities. For Indian Tribal, State and Local and Government recipients, this will include placing DBEs on solicitation lists and soliciting them whenever they are potential sources.

(b) Make information on forthcoming opportunities available to DBEs and arrange time frames for contracts and establish delivery schedules, where the requirements permit, in a

way that encourages and facilitates participation by DBEs in the competitive process. This includes, whenever possible, posting solicitations for bids or proposals for a minimum of 30 calendar days before the bid or proposal closing date.

(c) Consider in the contracting process whether firms competing for large contracts could subcontract with DBEs. For Indian Tribal, State and local Government recipients, this will include dividing total requirements when economically feasible into smaller tasks or quantities to permit maximum participation by DBEs in the competitive process.

(d) Encourage contracting with a consortium of DBEs when a contract is too large for one of these firms to handle individually.

(e) Use the services and assistance of the SBA and the Minority Business Development Agency of the Department of Commerce.

(f) If the prime contractor awards subcontracts, require the prime contractor to take the steps in paragraphs (a) through (e) of this section.

D. Utilization of Disadvantaged Business Enterprises
General Compliance, 40 CFR Part 33
The recipient agrees to comply with the requirements of EPA's Disadvantaged Business Enterprise (DBE) Program for procurement activities under assistance agreements, contained in 40 CFR Part 33.

Fair Share Objectives, 40 CFR Part 33, Subpart D
A recipient must negotiate with the appropriate EPA award official, or his/her designee, fair share objectives for MBE and WBE participation in procurement under the financial assistance agreements.

In accordance with 40 CFR Section 33.411 some recipients may be exempt from the fair share objective requirements as described in 40 CFR Part 33, Subpart D. Recipients should work with their DBE coordinator if they think their organization may qualify for an exemption.

The dollar amount of this assistance agreement, or the total dollar amount of all of the recipient's financial assistance agreements in the current federal fiscal year from EPA is $250,000 or more. The recipient accepts the applicable MBE/WBE fair share objectives/goals negotiated with EPA by the Nevada Department of Conservation and Natural Resources (NV DCNR), as follows:

	MBE	WBE
Construction	02%	02%
Equipment	01%	01%
Services	01%	02%
Supplies	01%	01%

The recipient accepts the fair share objectives/goals stated above and attests to the fact that it is purchasing the same or similar construction, supplies, services and equipment, in the same or similar relevant geographic buying market as NV DCNR

Negotiating Fair Share Objectives/Goals, Section 33.404
The recipient has the option to negotiate its own MBE/WBE fair share objectives/goals. If the recipient wishes to negotiate its own MBE/WBE fair share objectives/goals, the recipient agrees to submit proposed MBE/WBE objectives/goals based on an availability analysis, or disparity study, of qualified MBEs and WBEs in their relevant geographic buying market for construction, services, supplies and equipment.

The submission of proposed fair share goals with the supporting analysis or disparity study means that the recipient is **not** accepting the fair share objectives/goals of another recipient. The recipient agrees to submit proposed fair share objectives/goals, together with the supporting availability analysis or disparity study, to the Regional MBE/WBE Coordinator, Joe Ochab at Ochab.Joe@epa.gov, within 120 days of its acceptance of the financial assistance award. EPA will respond to the proposed fair share objective/goals within 30 days of receiving the submission. If proposed fair share objective/goals are not received within the 120-day time frame, the recipient may not expend its EPA funds for procurements until the proposed fair share objective/goals are submitted.

Contract Administration Provisions, 40 CFR Section 33.302
The recipient agrees to comply with the contract administration provisions of 40 CFR Section 33.302.

Bidders List, 40 CFR Section 33.501(b) and (c)
Recipients of a Continuing Environmental Program Grant or other annual reporting grant, agree to create and maintain a bidders list. Recipients of an EPA financial assistance agreement to capitalize a revolving loan fund also agree to require entities receiving identified loans to create and maintain a bidders list if the recipient of the loan is subject to, or chooses to follow, competitive bidding requirements. Please see 40 CFR Section 33.501 (b) and (c) for specific requirements and exemptions.

E. MBE/WBE Reporting – Non-Reporting Condition
General Compliance, 40 CFR, Part 33, Subpart E
MBE/WBE reports are required annually. Reporting is required for assistance agreements where there are funds budgeted for procuring construction, equipment, services and supplies, including funds budgeted for direct procurement by the recipient or procurement under subawards or loans in the "Other" category, that exceed the threshold amount of $150,000, including amendments and/or modifications.

Based on EPA's review of the planned budget, this award does not meet the conditions above and is not subject to Disadvantaged Business Enterprise (DBE) Program reporting requirements. However, if during the performance of the award the total of all funds expended for direct procurement by the recipient and procurement under subawards or loans in the "Other" category exceeds $150,000, annual reports will be required and you are required to notify your EPA grant specialist for additional instructions.

The recipient also agrees to request prior approval from EPA for procurements that may activate DBE Program reporting requirements.

This provision represents an approved deviation from the MBE/WBE reporting requirements as described in 40 CFR Part 33, Section 33.502; however, the other requirements outlined in 40 CFR Part 33 remain in effect, including the Good Faith Effort requirements as described in 40 CFR Part 33, Subpart C, and Fair Share Objectives negotiation as described in 40 CFR Part 33, Subpart D.

F. Indirect Costs
Recipients are entitled to reimbursement of indirect costs, subject to any statutory or regulatory administrative cost limitations, if they have a current rate agreement or have submitted an indirect cost rate proposal to their cognizant federal agency for review and approval. Recipients are responsible for maintaining an approved indirect cost rate throughout the life of the award. Recipients may draw down grant funds once a rate has been approved, but only for indirect costs incurred during the period specified in the rate agreement. Recipients are not entitled to indirect costs for any period in which the rate has expired.

Recipients with differences between provisional and final rates are not entitled to more than the

award amount. Recipients may request EPA approval to rebudget funds from direct cost categories to the indirect cost category (to grants which have not expired or been closed out) to cover increased indirect costs.

Programmatic Conditions

a). **Quality Assurance:** This grant includes the performance of environmental measurements; therefore a Quality Management Plan (QMP) and Quality Assurance Project Plans (QAPPs) are required. QA plans are current for five years, after which time they should be reviewed, revised and submitted to EPA for approval. A QMP for the Washoe County District Health Dept (WCDHD) was approved on October 2, 2014 and should be resubmitted in FY2019. A QAPP for criteria pollutants was approved approved by EPA on February 12, 2013 and must be resubmitted in FY-2018. EPA's Quality Assurance Office can be contacted at 415-972-3411.

b). **Problems, Delays or Adverse Conditions:** The recipient agrees to include in performance reports submitted under this agreement brief information on each of the following areas: 1) a comparison of actual accomplishment with the anticipated outputs/outcomes specified in the assistance agreement work plan; 2) reasons why anticipated outputs/outcomes were not met; and 3) additional pertinent information, including, when appropriate, analysis and formation of cost overruns or high unit costs.

c). **Green/Environmentally Sustainable Practices:** Consistent with local, state, and federal grant procurement rules, recipient shall, when feasible, purchase environmentally preferable products/services and hold conferences/meetings using environmentally preferable measures. Environmentally preferable products/services and environmentally preferable measures include those that have a lesser or reduced effect on the environment when compared with competing products, services, or measures that serve the same purpose. This comparison may consider raw material acquisition, production, manufacturing, packaging, distribution, reuse, operation, maintenance, or disposal of the product or service. In addition, environmentally preferable measures for conferences/meetings apply to large gatherings of ten or more persons.

d). **Cybersecurity:**

(a) The recipient agrees that when collecting and managing environmental data under this assistance agreement, it will protect the data by following all State or Tribal law cybersecurity requirements as applicable.

(b)(1) EPA must ensure that any connections between the recipient's network or information system and EPA networks used by the recipient to transfer data under this agreement, are secure. For purposes of this Section, a connection is defined as a dedicated persistent interface between an Agency IT system and an external IT system for the purpose of transferring information. Transitory, user-controlled connections such as website browsing are excluded from this definition.

If the recipient's connections as defined above do not go through the Environmental Information Exchange Network or EPA's Central Data Exchange, the recipient agrees to contact the EPA Project Officer (PO) no later than 90 days after the date of this award and work with the designated Regional/Headquarters Information Security Officer to ensure that the connections meet EPA security requirements, including entering into Interconnection Service Agreements as appropriate. This condition does not apply to manual entry of data by the recipient into systems operated and used by EPA's regulatory programs for the submission of reporting and/or compliance data.

(b)(2) The recipient agrees that any subawards it makes under this agreement will require

the subrecipient to comply with the requirements in (b)(1) if the subrecipient's network or information system is connected to EPA networks to transfer data to the Agency using systems other than the Environmental Information Exchange Network or EPA's Central Data Exchange. The recipient will be in compliance with this condition: by including this requirement in subaward agreements; and during subrecipient monitoring deemed necessary by the recipient under 2 CFR 200.331(d), by inquiring whether the subrecipient has contacted the EPA Project Officer. Nothing in this condition requires the recipient to contact the EPA Project Officer on behalf of a subrecipient or to be involved in the negotiation of an Interconnection Service Agreement between the subrecipient and EPA.

e). **Competency of Organizations Generating Environmental Measurement Data:** Following EPA Policy Director Number FEM-2012-02, recipient agrees to demonstrate competency of any laboratory carrying out any activities involving the generation of environmental data on its behalf. Laboratory competency shall be maintained for the duration of the project period of this agreement and documented during the annual reporting process. A copy of the Policy is available online at http://www.epa.gov/fem/lab_comp.htm.

-- END OF AGREEMENT --

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6I

DD__NA__ _
DHO_____ KD _
DA__NA_____
Risk_NA_____

STAFF REPORT
BOARD MEETING DATE: June 28, 2018

TO: District Board of Health

FROM: Anna Heenan, Administrative Health Services Officer
328-2417, aheenan@washoecounty.us

SUBJECT: District Board of Health approval to increase the District Health Officers approval authority from a threshold of $50,000 to $100,000 for fiscal year cumulative purchases by vendor

SUMMARY

Staff is recommending that the District Board of Health approve an increase to the District Health Officers approval authority from a threshold of $50,000 to $100,000 for fiscal year cumulative purchases by vendor.

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

November 1993, the District Board of Health established a policy to authorize the District Health Officer to execute agreements on its behalf not to exceed a cumulative amount of $10,000.

September 23, 2004, the Board took action to amend the dollar threshold from $10,000 to $25,000.

July 27, 2006, the Board took action to amend the dollar threshold from $25,000 to $50,000.

June 26, 2014, the Board approved the District Health Officer to have sole discretion to approve a contract up to $50,000 but would require the approval of the Chair or the Board designee up to $100,000. The Board must approve contract amounts over $100,000.

BACKGROUND

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. The term of such agreements may not exceed the period for which funds have been appropriated and are available. In the event of an emergency, the Health Officer may execute an interim agreement in excess of $50,000 to ensure continuation of essential services, provided the agreement is brought before the Board of Health at its next regular meeting for ratification and extension of its term. The Chair of the Board must approve cumulative contracts per vendor that fall between $50,001 and $100,000.

Over the last couple of years, the contracts that fall into the threshold for the Chair approval include vendors for the chemical supplies and helicopter services needed for the Mosquito Abatement program; biological supplies required for the clinic programs; and, various media buys for grant deliverables.

Approval of the increased threshold for the District Health Officer from $50,000 to $100,000 will remove the Chair from the process for cumulative purchases from $50,001 to $100,000 it will also be at the same level as the County Purchasing and Contracts Administrator. Any fiscal year cumulative purchases over $100,000 will continue to require the approval by the District Board of Health and the Board of County Commissioners.

FISCAL IMPACT

No fiscal impact associated with the approval of this staff report.

RECOMMENDATION

Staff recommends that the District Board of Health approve an increase to the District Health Officers approval authority from a threshold of $50,000 to $100,000 for fiscal year cumulative purchases by vendor.

POSSIBLE MOTION

Move to approve staff recommendation for the District Board of Health to approve an increase to the District Health Officers approval authority from a threshold of $50,000 to $100,000 for fiscal year cumulative purchases by vendor.

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 6J

DD	NA
DHO	KD
DA	NA
Risk	NA

STAFF REPORT
BOARD MEETING DATE: June 28, 2018

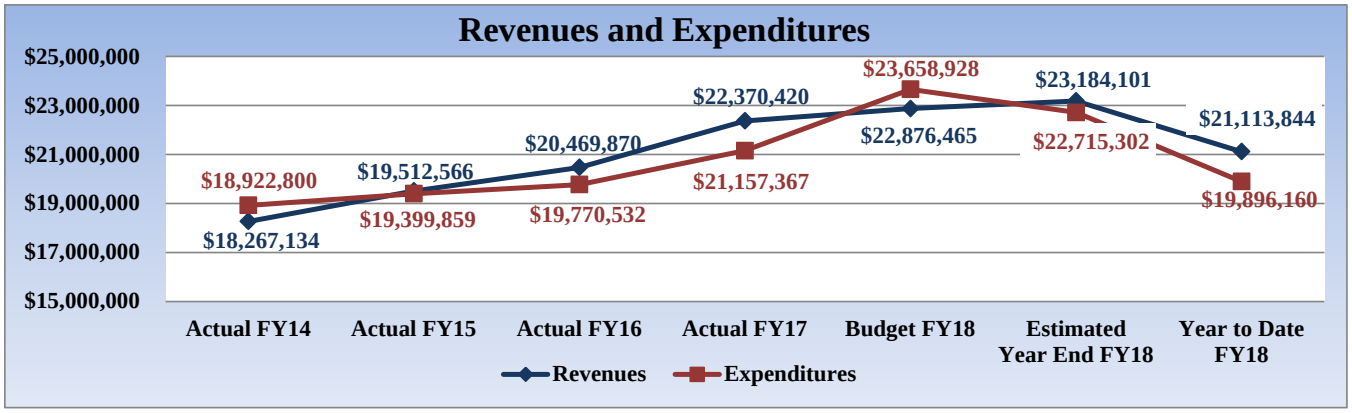
TO: District Board of Health

FROM: Anna Heenan, Administrative Health Services Officer
328-2417, aheenan@washoecounty.us

SUBJECT: Acknowledge receipt of the Health Fund Financial Review for May, Fiscal Year 2018

SUMMARY

May year to date for fiscal year 2018, (FY18) ended with a cash balance of $6,032,315. Total revenues of $21,113,844 were 92.3% of budget and an increase of $1,793,779 over May FY17. The expenditures totaled $19,896,160 or 84.1% of budget and up $864,059 compared to May FY17.



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.

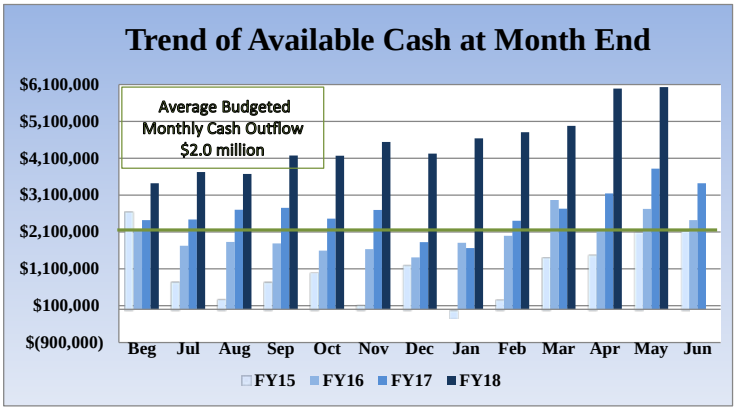
PREVIOUS ACTION

Fiscal Year 2018 Budget was adopted May 23, 2017.

BACKGROUND

Review of Cash

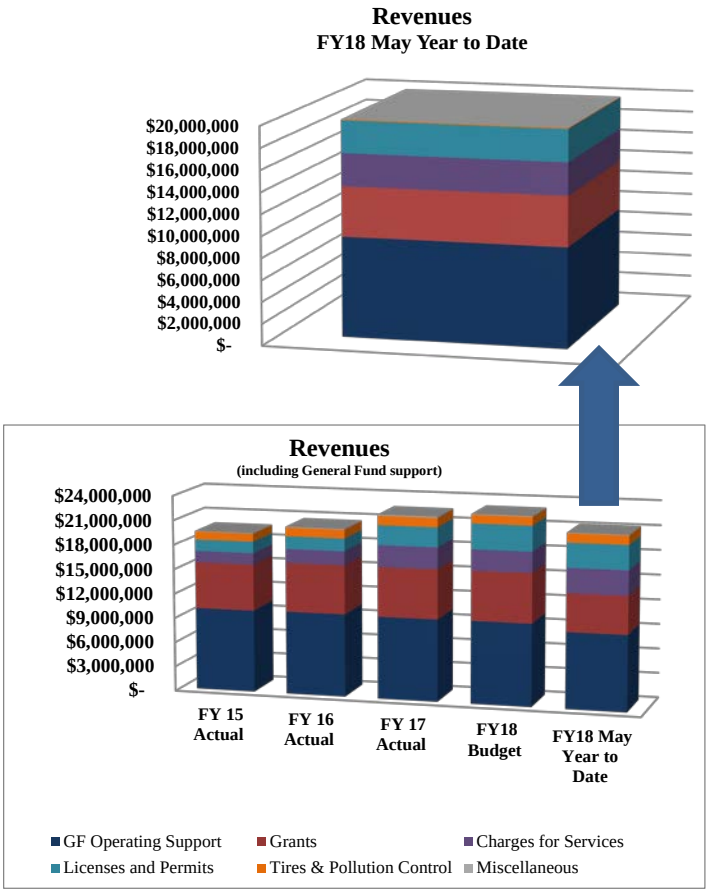
The available cash at the end of May, FY18, was $6,032,315 which is enough cash to cover three months of expenditures. The encumbrances and other liability portion of the cash balance totals $1.2 million; the portion of cash restricted as to use is approximately $1.2 million (e.g. Air Quality and the Solid Waste Management programs restricted cash); leaving a balance of approximately $3.6 million.



Note: January FY15 negative cash is due to no County General Fund support transferred to the Health Fund.

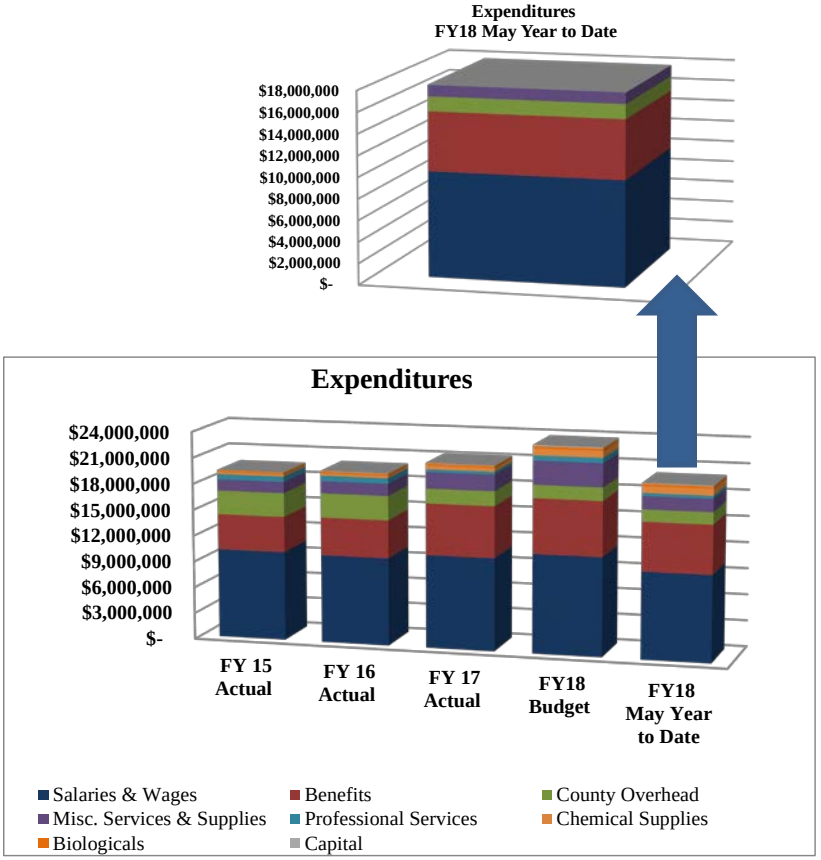
Public Health
Prevent. Promote. Protect.

***Review of Revenues** (including transfers from General Fund) and Expenditures by category*



The total **revenues** year to date were $21,113,844 up $1,793,779 or 9.3% compared to May FY17. The revenue categories up over last fiscal year include: licenses and permits of $2,981,803 were up $837,558 or 39.1% mainly due to fee increases and an increase in work load; charges for services of $3,021,885 up $747,121 or 32.8%; tire and pollution control revenues of $1,135,588 up $114,046 or 11.2%; and, the County General Fund transfer of $9,258,620 up $278,169 or 3.1% due to the contingency transfer for mosquito abatement. The revenue categories down included: miscellaneous revenues of $61,867 down $37,637 or 37.8%; and, the state and federal grant reimbursements of $4,654,081 down $145,477 or 3.0%.

The total year to date **expenditures** of $19,896,160 increased by $864,059 or 4.5% compared to the same period in FY17. Salaries and benefits expenditures for the fiscal year were $15,547,232 up $434,893 or 2.9% over the prior year. The total services and supplies of $4,253,522 were up $452,557 due to the increase in chemical costs. The major expenditures included in the services and supplies are: the professional services which totaled $348,141 and were up $105,931 or 43.7% over the prior year; chemical supplies of $767,103 were up 225.4% or $531,373 over last year; the biologicals of $262,477 were up $50,488 or 23.8%; and, County overhead charges of $1,393,903 were down 10.6% or $165,161. There has been $95,406 in capital expenditures up $34,692 or 57.1% compared to FY17.



Review of Revenues and Expenditures by Division

ODHO has received grant funding of $3,365 for workforce development initiatives and spent $858,600 up $38,983 over FY17 mainly due to the support given for the Community Health Needs Assessment and Public Health Accreditation dues.

AHS has spent $1,058,148 up $34,238 or 3.3% compared to FY17 mainly due to $34,990 paid out for accrued vacation time for employees that have left Health District employment.

AQM revenues were $3,169,892 up $584,224 with the largest year over year increase of $144,029 in the air pollution permits and $126,411 increase in the Woodstove Notice of Exemption fees. The Division spent $2,614,257 down $13,470 or 0.5% over FY17.

CCHS revenues were $3,430,167 up $356,469 over FY17 mainly due to additional $105,427 in grant funding the Chronic Disease program, $57,765 in Medicaid reimbursements, and $85,423 additional insurance reimbursements and spent $6,816,148 or $242,457 more than FY17 due to an increase in salaries and benefits costs and additional biologicals needed for the Immunization Program.

EHS revenues were $3,781,890 up $839,202 over FY17 with $693,529 of the increase in licenses and permits, mainly in food service, pool and septic system permits, and $272,881 in charges for services of which $201,970 of the increase is in general/land development, and grants and restricted tire fees were down $127,209. EHS spent $6,266,472, an increase of $617,489, over last year due to the $531,061 increase in chemical costs for the Vector program.

EPHP revenues were $1,469,910 down $218,036 over last year mainly due to loss of grant funding and spent $2,282,536 down $55,637 over FY17 with the majority of that decrease in the operating supplies due to grant funding that ended in FY17.

Washoe County Health District
Summary of Revenues and Expenditures
Fiscal Year 2013/2014 through May 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)	May Year to Date	Adjusted Budget	May Year to Date	Percent of Budget	FY18 Increase over FY17
Revenues (all sources of funds)									
ODHO	-	-	15,000	51,228	**49,614**	6,639	**3,365**	50.7%	-93.2%
AHS	87,930	151	-	-	-	-	-	-	-
AQM	2,491,036	2,427,471	2,520,452	2,979,720	**2,585,668**	3,197,645	**3,169,892**	99.1%	22.6%
CCHS	3,388,099	3,520,945	3,506,968	3,872,898	**3,073,698**	3,905,663	**3,430,167**	87.8%	11.6%
EHS	1,890,192	2,008,299	2,209,259	3,436,951	**2,942,688**	3,868,937	**3,781,890**	97.8%	28.5%
EPHP	1,805,986	1,555,508	2,141,334	2,027,242	**1,687,946**	1,845,890	**1,469,910**	79.6%	-12.9%
GF support	8,603,891	10,000,192	10,076,856	10,002,381	**8,980,451**	10,051,691	**9,258,620**	92.1%	3.1%
Total Revenues	$18,267,134	$19,512,566	$20,469,870	$22,370,420	**$19,320,065**	$22,876,465	**$21,113,844**	92.3%	9.3%
Expenditures (all uses of funds)									
ODHO	-	481,886	594,672	904,268	**819,617**	1,163,286	**858,600**	73.8%	4.8%
AHS	1,336,740	1,096,568	996,021	1,119,366	**1,023,910**	1,156,241	**1,058,148**	91.5%	3.3%
AQM	2,524,702	2,587,196	2,670,636	2,856,957	**2,627,727**	3,439,932	**2,614,257**	76.0%	-0.5%
CCHS	6,949,068	6,967,501	6,880,583	7,294,144	**6,573,691**	7,797,722	**6,816,148**	87.4%	3.7%
EHS	5,737,872	5,954,567	5,939,960	6,366,220	**5,648,983**	7,510,913	**6,266,472**	83.4%	10.9%
EPHP	2,374,417	2,312,142	2,688,659	2,616,411	**2,338,173**	2,590,833	**2,282,536**	88.1%	-2.4%
Total Expenditures	$18,922,800	$19,399,859	$19,770,532	$21,157,367	**$19,032,101**	$23,658,928	**$19,896,160**	84.1%	4.5%
Revenues (sources of funds) **less Expenditures** (uses of funds)**:**									
ODHO	-	(481,886)	(579,672)	(853,040)	**(770,003)**	(1,156,647)	**(855,235)**		
AHS	(1,248,810)	(1,096,417)	(996,021)	(1,119,366)	**(1,023,910)**	(1,156,241)	**(1,058,148)**		
AQM	(33,666)	(159,725)	(150,184)	122,763	**(42,059)**	(242,288)	**555,635**		
CCHS	(3,560,969)	(3,446,556)	(3,373,615)	(3,421,246)	**(3,499,993)**	(3,892,059)	**(3,385,981)**		
EHS	(3,847,680)	(3,946,268)	(3,730,701)	(2,929,270)	**(2,706,295)**	(3,641,976)	**(2,484,582)**		
EPHP	(568,431)	(756,634)	(547,325)	(589,168)	**(650,227)**	(744,943)	**(812,626)**		
GF Operating	8,603,891	10,000,192	10,076,856	10,002,381	**8,980,451**	10,051,691	**9,258,620**		
Surplus (deficit)	$ (655,666)	$ 112,707	$ 699,338	$ 1,213,053	**$ 287,964**	$ (782,463)	**$ 1,217,684**		
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%		14%			

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 May, Fiscal Year 2018.

POSSIBLE MOTION

Move to acknowledge receipt of the Health Fund Financial Review for May, Fiscal Year 2018.

Attachment:
Health District Fund financial system summary report

Period: 1 **thru** 11 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%
422503	Environmental Permits	79,990-	91,429-	11,439	114	56,527-	79,125-	22,598	140
422504	Pool Permits	245,334-	241,674-	3,661-	99	169,246-	162,879-	6,368-	96
422505	RV Permits	25,783-	30,618-	4,835	119	18,590-	19,152-	562	103
422507	Food Service Permits	1,263,372-	1,207,676-	55,696-	96	805,632-	808,412-	2,780	100
422508	Wat Well Const Perm	146,747-	114,192-	32,555-	78	78,840-	96,750-	17,910	123
422509	Water Company Permits	29,941-	88,543-	58,602	296	21,850-	49,990-	28,140	229
422510	Air Pollution Permits	766,406-	642,645-	123,761-	84	608,864-	498,616-	110,248-	82
422511	ISDS Permits	234,031-	286,024-	51,993	122	165,195-	213,743-	48,548	129
422513	Special Event Permits	208,827-	173,378-	35,449-	83	168,108-	131,373-	36,736-	78
422514	Initial Applic Fee	104,711-	105,624-	913	101	55,800-	84,206-	28,406	151
*	Licenses and Permits	3,105,142-	2,981,803-	123,339-	96	2,148,652-	2,144,245-	4,407-	100
431100	Federal Grants	5,340,594-	4,120,734-	1,219,860-	77	5,651,096-	4,270,257-	1,380,839-	76
431105	Fed. Grants-Indirect	472,592-	386,023-	86,569-	82	461,750-	389,519-	72,231-	84
432100	State Grants	220,681-	135,856-	84,825-	62	211,364-	126,359-	85,005-	60
432105	State Grants-Indirect	17,396-	11,468-	5,928-	66	16,597-	13,423-	3,174-	81
432310	Tire Fee NRS 444A.090	450,000-	389,864-	60,136-	87	475,000-	447,633-	27,367-	94
432311	Pol Ctrl 445B.830	587,828-	745,724-	157,896	127	550,000-	573,910-	23,910	104
*	Intergovernmental	7,089,090-	5,789,669-	1,299,422-	82	7,365,806-	5,821,100-	1,544,706-	79
460162	Services O Agencies	19,000-	21,886-	2,886	115	39,417-	17,068-	22,349-	43
460173	Reimbursements - Reno								
460500	Other Immunizations	20,000-	62,760-	42,760	314	42,150-	39,999-	2,151-	95
460501	Medicaid Clinic Svcs	85,500-	190,492-	104,992	223	59,935-	132,727-	72,792	221
460503	Childhood Immunizations	200-	21-	179-	11	13,024-	174-	12,850-	1
460507	Medicaid Admin Claiming						115	115-	
460508	Tuberculosis	6,580-	5,986-	594-	91	7,000-	7,002-	2	100
460509	Water Quality	500-		500-		500-	710-	210	142
460510	IT Overlay	48,435-	37,650-	10,785-	78	39,025-	39,306-	281	101
460511	Birth Death Certific	515,000-	491,962-	23,038-	96	490,000-	507,539-	17,539	104
460512	Duplication Service		1,368-	1,368			592-	592	
460513	Other Health Service	75,753-	124,978-	49,225	165	60,908-	82,600-	21,692	136
460514	Food Service Certifi						1,176-	1,176	
460515	Medicare Reimbursement								
460516	Pgm Inc-3rd Prty Rec	66,000-	188,478-	122,478	286	16,394-	103,055-	86,661	629
460517	Influenza Immunization								
460518	STD Fees	25,000-	33,255-	8,255	133	17,200-	30,967-	13,767	180
460519	Outpatient Services	500-		500-		1,200-	41-	1,159-	3
460520	Eng Serv Health	168,844-	283,469-	114,625	168	120,960-	139,209-	18,249	115
460521	Plan Review - Pools	1,179-	16,845-	15,666	1,429	8,470-	18,379-	9,909	217
460523	Plan Review - Food S	81,584-	88,820-	7,236	109	56,150-	46,515-	9,635-	83
460524	Family Planning	40,000-	70,590-	30,590	176	35,000-	45,337-	10,337	130
460525	Plan Review - Vector	99,179-	86,930-	12,249-	88	82,842-	81,937-	905-	99
460526	Plan Review-Air Quality	122,695-	78,683-	44,012-	64	79,589-	62,428-	17,161-	78
460527	NOE-AQM	238,433-	281,703-	43,270	118	176,103-	155,292-	20,811-	88

Period: 1 thru 11 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%
460528	NESHAP-AQM	225,847-	195,526-	30,321-	87	153,862-	162,215-	8,353	105
460529	Assessments-AQM	106,866-	110,092-	3,226	103	81,614-	81,805-	191	100
460530	Inspector Registr-AQ	6,750-		6,750-		4,608-	1,656-	2,952-	36
460531	Dust Plan-Air Quality	334,771-	446,228-	111,457	133	257,784-	384,078-	126,294	149
460532	Plan Rvw Hotel/Motel		6,279-	6,279		2,530-	1,026-	1,504-	41
460533	Quick Start						251-	251	
460534	Child Care Inspection	21,169-	19,167-	2,002-	91	14,904-	15,552-	648	104
460535	Pub Accomod Inspectn	46,666-	39,177-	7,489-	84	33,060-	35,499-	2,439	107
460570	Education Revenue								
460723	Other Fees	197,528-	139,542-	57,986-	71	97,142-	80,745-	16,398-	83
*	Charges for Services	2,553,979-	3,021,885-	467,906	118	1,991,371-	2,274,764-	283,393	114
481150	Interest-Non Pooled		13-	13			41-	41	
484000	Donations,Contributions		5,000-	5,000		4,000-	4,000-		100
484050	Donation Fed Pgm Inc	16,050-	10,939-	5,111-	68	24,201-	14,366-	9,835-	59
484197	Non-Gov. Grants-Ind.	14,428-	12,945-	1,483-	90	11,367-	12,994-	1,627	114
485100	Reimbursements	46,084-	32,716-	13,368-	71	42,576-	31,084-	11,492-	73
485300	Other Misc Govt Rev		255-	255		35,000-	37,020-	2,020	106
*	Miscellaneous	76,562-	61,867-	14,695-	81	117,144-	99,503-	17,641-	85
**	Revenue	12,824,773-	11,855,224-	969,549-	92	11,622,973-	10,339,613-	1,283,360-	89
701110	Base Salaries	10,247,216	9,079,646	1,167,570	89	9,864,879	8,776,640	1,088,239	89
701120	Part Time	230,388	239,472	9,083-	104	314,723	204,735	109,987	65
701130	Pooled Positions	405,054	378,556	26,498	93	475,463	340,626	134,837	72
701140	Holiday Work	4,319	1,512	2,807	35	4,319	1,667	2,652	39
701150	xcContractual Wages								
701199	Lab Cost Sav-Wages								
701200	Incentive Longevity	164,408	81,562	82,846	50	165,730	85,172	80,558	51
701300	Overtime	68,241	69,270	1,029-	102	80,479	80,072	407	99
701403	Shift Differential	300	367	67-	122	287	217	69	76
701406	Standby Pay	38,000	29,437	8,563	77	38,000	28,069	9,931	74
701408	Call Back	5,000	1,539	3,461	31	5,000	3,822	1,178	76
701410	Detective Pay								
701412	Salary Adjustment	100,893		100,893		84,557		84,557	
701413	Vac Payoff Sick Term	82,416	55,571	26,845	67	84,423	160,577	76,154-	190
701414	Vacation Denied-Payoff		1,101	1,101-			3,744	3,744-	
701417	Comp Time	1,625	3,812	2,187-	235	0	14,130	14,130-	*0389
701419	Comp Time - Transfer		7,194	7,194-			4	4-	
701500	Merit Awards								
*	Salaries and Wages	11,347,860	9,949,041	1,398,819	88	11,117,860	9,699,477	1,418,383	87
705110	Group Insurance	1,634,991	1,429,933	205,058	87	1,755,795	1,480,723	275,072	84
705115	ER HSA Contribs	66,000	94,621	28,621-	143	529	71,645	71,116-	13548
705190	OPEB Contribution	1,305,189	1,196,423	108,766	92	1,181,460	1,083,005	98,455	92
705199	Lab Cost Sav-Benef								
705210	Retirement	2,979,795	2,640,286	339,509	89	2,907,355	2,545,905	361,450	88

Period: 1 thru 11 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%
705215	Retirement Calculation								
705230	Medicare April 1986	147,351	137,345	10,006	93	143,403	133,082	10,321	93
705240	Insur Budgeted Incr	48,610		48,610					
705320	Workmens Comp	97,239	88,931	8,309	91	93,193	87,273	5,919	94
705330	Unemply Comp	10,224	10,653	429-	104	13,751	11,230	2,521	82
705360	Benefit Adjustment	28,461		28,461		21,529		21,529	
*	Employee Benefits	6,317,860	5,598,192	719,668	89	6,117,014	5,412,863	704,151	88
710100	Professional Services	460,662	231,516	229,146	50	655,630	170,256	485,373	26
710101	Lab Testing Services						4,410	4,410-	
710105	Medical Services	9,121	4,965	4,156	54	9,971	5,896	4,075	59
710108	MD Consultants	58,936	43,369	15,567	74	61,210	49,869	11,341	81
710110	Contracted/Temp Svcs	53,610	68,291	14,681-	127	39,600	11,780	27,820	30
710119	Subrecipient Payments								
710155	Lobbying Services						300	300-	
710200	Service Contract	61,929	102,295	40,367-	165	91,731	54,674	37,057	60
710201	Laundry Services		1,621	1,621-					
710205	Repairs and Maintenance	13,645	12,967	678	95	14,843	9,035	5,808	61
710210	Software Maintenance	3,000	3,059	59-	102	12,319	2,942	9,378	24
710300	Operating Supplies	151,280	77,082	74,198	51	178,449	125,064	53,385	70
710302	Small Tools & Allow	1,435	134	1,301	9	1,435	1,266	169	88
710308	Animal Supplies	1,600	780	820	49	1,600	1,242	358	78
710312	Special Dept Expense		480	480-					
710319	Chemical Supplies	767,535	767,103	432	100	438,225	235,731	202,494	54
710325	Signs and Markers								
710334	Copy Machine Expense	26,066	16,735	9,331	64	35,875	18,405	17,470	51
710335	Copy Mach-Copies	4,044	6,806	2,762-	168	2,001	5,283	3,282-	264
710350	Office Supplies	36,398	27,891	8,507	77	42,667	34,665	8,002	81
710355	Books and Subscriptions	8,145	8,547	402-	105	15,690	6,772	8,918	43
710360	Postage	19,260	15,696	3,564	81	21,774	13,739	8,035	63
710361	Express and Courier	100	124	24-	124	370	424	54-	115
710391	Fuel & Lube	125		125		125		125	
710400	Pmts to O Agencies	140,650	172,750	32,100-	123	31,500	65,622	34,122-	208
710412	Do Not Use								
710500	Other Expense	27,606	16,720	10,886	61	105,780	10,887	94,893	10
710502	Printing	29,043	10,290	18,753	35	26,573	10,609	15,964	40
710503	Licenses & Permits	8,345	5,113	3,232	61	9,245	4,728	4,517	51
710504	Registration		1,430	1,430-			504	504-	
710505	Rental Equipment		1,812	1,812-		1,800	1,800		100
710506	Dept InsDeductible		300	300-			434	434-	
710507	Network and Data Lines	9,050	6,240	2,810	69	9,662	7,122	2,540	74
710508	Telephone Land Lines	35,611	32,676	2,935	92	36,606	32,420	4,186	89
710509	Seminars and Meetings	43,748	38,653	5,095	88	47,577	41,463	6,114	87
710512	Auto Expense	9,870	5,373	4,497	54	13,109	6,639	6,470	51

Period: 1 thru 11 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%
710514	Regulatory Assessments	20,000	14,885	5,115	74	20,000	13,672	6,328	68
710519	Cellular Phone	14,341	11,382	2,959	79	14,833	11,172	3,661	75
710529	Dues	32,129	33,553	1,424-	104	8,362	35,123	26,761-	420
710535	Credit Card Fees	51,157	48,765	2,392	95	52,157	26,148	26,009	50
710546	Advertising	167,119	103,075	64,044	62	149,712	199,469	49,758-	133
710551	Cash Discounts Lost		6	6-			9	9-	
710563	Recruitment		771	771-					
710571	Safety Expense	57,891	30,381	27,510	52	55,000	62,456	7,456-	114
710577	Uniforms & Special C	4,200	6,514	2,314-	155	5,657	10,040	4,383-	177
710585	Undesignated Budget	794,954		794,954		450,000		450,000	
710594	Insurance Premium	5,815	5,605	210	96	5,815	5,605	210	96
710600	LT Lease-Office Space	76,607	70,223	6,384	92	76,607	66,650	9,957	87
710620	LT Lease-Equipment								
710703	Biologicals	277,612	262,477	15,135	95	302,681	211,990	90,691	70
710714	Referral Services	6,780	6,328	452	93	6,780		6,780	
710721	Outpatient	114,985	69,136	45,849	60	108,555	75,708	32,847	70
710872	Food Purchases	2,744	966	1,778	35	2,994	1,484	1,510	50
711008	Combined Utilities	90,800	83,233	7,567	92	90,800	83,233	7,567	92
711010	Utilities								
711100	ESD Asset Management	40,091	38,808	1,283	97	47,382	42,000	5,382	89
711113	Equip Srv Replace	55,159	45,457	9,702	82	44,876	37,525	7,351	84
711114	Equip Srv O & M	64,486	65,191	705-	101	66,315	53,167	13,147	80
711115	Equip Srv Motor Pool	5,000		5,000		5,000	3,874	1,126	77
711116	ESD Vehicle Lease								
711117	ESD Fuel Charge	27,852	26,028	1,824	93	34,167	22,643	11,524	66
711119	Prop & Liab Billings	82,007	75,173	6,834	92	82,007	72,149	9,858	88
711210	Travel	168,871	92,579	76,292	55	183,341	69,556	113,785	38
711213	Travel-Non Cnty Pers		3,296	3,296-			2,148	2,148-	
711300	Cash Over Short		22	22-			42-	42	
711399	ProCard in Process								
711400	Overhead - General Fund	1,520,621	1,393,903	126,718	92	1,700,797	1,559,064	141,733	92
711504	Equipment nonCapital	83,270	77,434	5,835	93	75,392	198,235	122,843-	263
711508	Computers nonCapital	20,000	1,944	18,056	10				
711509	Comp Sftw nonCap	2,631	5,569	2,938-	212		3,910	3,910-	
*	Services and Supplies	5,767,936	4,253,522	1,514,414	74	5,494,596	3,800,966	1,693,630	69
781004	Equipment Capital	100,000	70,032	29,968	70	40,472	35,340	5,132	87
781007	Vehicles Capital								
781009	Comp Sftw Capital	25,000	25,374	374-	101	25,000	25,374	374-	101
*	Capital Outlay	125,000	95,406	29,594	76	65,472	60,714	4,758	93
**	Expenses	23,558,656	19,896,160	3,662,496	84	22,794,942	18,974,019	3,820,923	83
621001	Transfer From General	10,051,691-	9,258,620-	793,071-	92	10,002,381-	8,980,451-	1,021,930-	90
*	Transfers In	10,051,691-	9,258,620-	793,071-	92	10,002,381-	8,980,451-	1,021,930-	90
812230	To Reg Permits-230	100,271		100,271		58,081	58,081		100

Period: 1 thru 11 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%
814430 To Reg Permits Capit								
* Transfers Out	100,271		100,271		58,081	58,081		100
** Other Financing Src/Use	9,951,420-	9,258,620-	692,800-	93	9,944,300-	8,922,370-	1,021,930-	90
*** Total	782,463	1,217,684-	2,000,147	156-	1,227,669	287,964-	1,515,633	23-

RESOLUTION OF APPRECIATION

WHEREAS the Washoe County District Health District is charged with enacting and maintaining various sets of regulations pertaining to programs serving the citizens of the Health District, and;

WHEREAS the Regulations Governing Sewage, Wastewater, and Sanitation is a complex document which requires great expertise in its interpretation, intent, and objectives of maintaining high standards of individual sewage disposal system construction in the Health District, and;

WHEREAS the Sewage, Wastewater, and Sanitation Hearing Board has been established to hear matters relative to complying with these high standards and is composed of responsible community members meeting the requirements to serve on the Board which have volunteered to provide their invaluable assistance in matters of appeals, variances, and recommendations to the District Board of Health, and;

WHEREAS Michele C. Dennis, P.E. has faithfully served on the Hearing Board and rendered unwavering assistance in support of the standards expressed for septic system construction in the Health District;

THEREFORE the Washoe County District Board of Health wishes to convey by the way of the **RESOLUTION OF APPRECIATION** its thanks to **Michele C. Dennis, P.E.** for her dedicated service as a member of the Sewage, Wastewater, and Sanitation Hearing Board from October 1999 to October 2017.

Set forth this 28th day of June 2018

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

_____

Kitty Jung, CHAIR
Washoe County District Board of Health

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WHEREAS Steven H. Brigman, P.E. has faithfully served on the Hearing Board and rendered unwavering assistance in support of the standards expressed for septic system construction in the Health District;

THEREFORE the Washoe County District Board of Health wishes to convey by the way of the **RESOLUTION OF APPRECIATION** its thanks to **Steven H. Brigman, P.E.** for his dedicated service as a member of the Sewage, Wastewater, and Sanitation Hearing Board from October 1999 to October 2017.

Set forth this 28th day of June 2018

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Kitty Jung, CHAIR
Washoe County District Board of Health

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

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Staff Report
Board Meeting Date: June 28, 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 Proposed Revisions to the District Board of Health Regulations Governing Air Quality Management, Sections 020.040 (Civil Fines and Penalties) and 020.042 (Criminal Fines and Penalties).

SUMMARY

The Washoe County District Board of Health (Board) must adopt any changes to the District Board of Health Regulations Governing Air Quality Management (Regulations).

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

May 24, 2018. The District Board of Health adopted the Business Impact Statement 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 June 28, 2018 at 1:00 pm.

November 16, 2006. Section 020.040 (Civil Fines and Penalties) was last revised to increase the fine amounts that shall be levied for minor violations of these regulations to the current levels.

October 20, 1993. Section 040.042 (Criminal Fines and Penalties) was originally adopted and has not since been revised.

BACKGROUND

The review of the fines levied for minor violations resulted from discussions occurring at the District Board of Health Strategic Plan Retreat in 2016. Board members expressed concern the fines were not adequate to provide the necessary incentive to ensure compliance with the regulations. The review of regulations establishing the fines schedule was incorporated as an initiative supporting the goals and objective of the Health District's Fiscal Year (FY) 2017 Strategic Plan. Due to a staffing shortage in the enforcement section, the initiative was extended into the FY18 Strategic Plan.

During the review of the fine schedule, staff found the fine amounts were not adequate when compared to the costs associated with conducting business. An example is the cost of a water truck is approximately $800 per day which is significantly more than the initial violation fine amount of $250. The fine schedule was also compared to other air quality agencies in Nevada and the Western U.S. Clark County Department of Air Quality has a flat penalty amount of $2,000 for a violation of a regulations governing gasoline dispensing and indicated they are also reviewing their fine schedule.

The determination was made to revise the penalties for violations of Section 040.0030 (Dust Control) to not more than $1000 for a first violation and set a range of not less than $1000 to not more than $2000 for a second violation. Additionally, the penalty for a second visible emissions violation was reduced from $2500 to $2000 to comply with NRS 445B.640 which sets the limit for a minor violation penalty. Revisions to Section 020.042 (Criminal Fines and Penalties) are also proposed to correct the NRS references.

On January 10, 2018, the U.S. Environmental Protection Agency (EPA) published a review of their penalties in the Federal Register (Vol. 83, No. 7) in compliance with the Federal Civil Penalties Inflation Adjustment Act of 1990 (Amended 2015). This act requires EPA to review penalties every 4 years to reflect inflation, maintain the deterrent effect of penalties, and promote compliance with the law. As a delegated agency, AQMD is not required to meet the same requirements as EPA but it is strongly encouraged. As previously noted, the penalties in Section 020.040 have not been reviewed and adjusted since 2006.

Presentations were provided to the Nevada Chapter of the Associated General Contractors (March 20, 2018) and the Builders Association of Northern Nevada (April 19, 2018) as an advance notice of the proposed action. No significant comments were received at either meeting. The industry representatives expressed an understanding of why the proposed revisions were needed and did not provide any objections.

Public notice for the revisions to these Regulations was published in the Reno Gazette-Journal on April 23, April 27, and May 1, 2018. The Notice of Proposed Action and the proposed revisions to the regulations were also made available in the "Public Notices" section of the AQMD website (www.OurCleanAir.com). Public workshops were held on May 2nd at noon and at 5:30 pm, to address any questions or concerns, no industry representatives or members of the general public attended either workshop. The published Notice of Proposed Action included instructions that written comments must be submitted to the AQMD by May 4th; no comments were received by close of business.

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 proposed revisions to the District Board of Health Regulations Governing Air Quality Management, Section 020.040 (Civil Fines and Penalties) and 020.042 (Criminal Fines and Penalties).

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be:

"Move to approve and adopt the proposed revisions to the District Board of Health Regulations Governing Air Quality Management, Section 020.040 (Civil Fines and Penalties) and 020.042 (Criminal Fines and Penalties)."

020.040 CIVIL FINES AND PENALTIES (Amended 4/88, 10/20/93, 11/16/94; Revised 8/26/04, 11/16/06, *mm/dd/yy*)

A. Except as provided in Subsections B and C, a violation of any section of these regulations constitutes a major violation. Any violation of a permit condition shall be a major violation as specified in ~~s~~Section 030.2175 of these regulations.

B. Any person who commits a major violation of any section of these regulations, other than Sections 020.050 and 020.055, is guilty of a civil offense and may be required to pay an administrative fine of not more than $10,000.00. Each day of violation constitutes a separate offense. The District Board of Health may establish a compliance schedule as a part of any civil finding either in lieu of, or in addition to, monetary penalties. Any fines assessed may be held in abeyance pending fulfillment of any compliance schedule.

C. Any violation of Sections 040.030, 040.035, 040.040(A), 040.050, 040.051, 040.055, 040.080, or 050.001 of these regulations constitutes a minor violation unless the violation occurs on more than two (2) occasions during a period of twelve (12) consecutive months. In that event, the third (3rd) and any subsequent violations constitute major violations.

D. The following fines shall be levied for minor violations of these regulations:

	First Violation	Second Violation
Section 040.030 (Dust Control)		
A. Violation of Dust Permit Condition(s)	~~not less than 100~~ Not more than ~~250~~ *1000*	not less than ~~250~~ *1000* not more than ~~750~~ *2000*
B. Visual Emission Violation	~~not less than 500~~ not more than 1000	not less than 1000 not more than ~~2500~~ *2000*
Section 040.035 (Open Fires)	not more than 500	not less than 500 not more than 1000
Subsection A of Section 040.040 (Fire Training)	not more than 500	not less than 500 not more than 1000
Section 040.050 (Incinerator Emission)	not more than 1000	not less than 1000 not more than 2000
Section 040.051 (Certified Woodstoves)	not more than 500	not less than 500 not more than 1000
Section 040.055 (Odors)	not more than 1000	not less than 1000 not more than 2000
Section 040.080 (Gasoline Transfer)	not more than 1000	not less than 1000 not more than 2000

Section 040.200 (Diesel Idling)	not more than 500	not less than 500 not more than 1000
Section 050.001 (Emergency Episode)	not more than 1000	not less than 1000 not more than 2000

E. Administrative fines shall be levied by appropriate action of the District Board of Health and recorded in its official minutes. The evidence or information on which the District Board of Health bases its action may include any one or more of the following:

1. The recommendation of the Control Officer based on any Notice of Violation served on any person in accordance with these regulations, if that person has not appeared or requested a hearing before the Hearing Board.

2. The recommendation of the Hearing Board, based on its findings in connection with any appeal or other matter referred to the Board in accordance with these regulations.

3. Evidence presented before the District Board of Health by any person, public official, or representative of the District Board of Health or District Health Department, provided the person charged with violating any of these regulations has received reasonable notice (at least twenty (20) days in advance) of the hearing at which such evidence is to be presented and is provided an opportunity to present evidence in his defense at the hearing.

F. Unless the Board of Health bases its decision on the recommendations and/or findings of the Control Officer or the Hearing Board as set forth in Paragraphs 1 and 2 of Subsection E, the Board shall base its decision as to whether a violation of these regulations has occurred on the evidence presented before the Board pursuant to Paragraph 3 of that subsection. Irrelevant, immaterial or unduly repetitious evidence shall be excluded. Documentary evidence may be received in the form of authenticated copies or excerpts if the original is not readily available and, on request, parties shall be given an opportunity to compare the copy with the original. Each party may call and examine witnesses, introduce exhibits, cross-examine opposing witnesses on any matter relevant to the issues even though such matter was not covered in the direct examination, impeach any witness regardless of which party first was called to testify and rebut the evidence against him. The Board of Health may take notice of judicially cognizable facts and/or recognized technical or scientific facts within the Board's specialized knowledge. All decisions of the Board of Health respecting administrative fines shall be in writing or notice of the Board's decision shall be forwarded to the aggrieved party at his last known mailing address.

G. ~~If any person served with a Notice of Violation in accordance with these regulations is charged with committing a minor violation, he may voluntarily waive his right to appear before the Hearing Board and remit to the District Health Department within ten (10) days after service of the Notice of Violation an amount in accordance with the minimum prescribed for such violation set forth in Subsection D by cashier's check, certified check or money order made payable to the Washoe County District Health Department.~~ All ~~other~~ fines shall be levied by formal action of the District Board of Health. The Control Officer may suspend, deny or revoke any or all permits of a person who has failed to pay any fine that has been levied by the District Board of Health.

H. In those cases where it is determined by the District Board of Health that a violation of the Regulations has occurred, the Board at its discretion may choose to waive the fine for a first violation, levy any fine

providing it does not exceed the appropriate range limitation, require use of other mitigation methods or schedules of compliance and in emergency situations, require a Stop Work Order to be issued and/or any other combination of remedies to bring about compliance with the Regulations.

I. All administrative fines collected by the District Board of Health pursuant to this section shall be deposited in the school district fund of Washoe County.

J. All monetary fines assessed pursuant to violations of Sections 030.105 or 030.107 for improper asbestos containing material removal, shall be for an amount greater than the estimated savings obtained by the illegal removal.

020.042 CRIMINAL FINES AND PENALTIES (Adopted 10/20/93)

A. Any person who knowingly:

1. makes any false statement, representation or certification;

2. falsifies, tampers with, renders inaccurate or fails to install any required monitoring device or method;

3. alters, conceals, fails to file or maintain any required document;

4. fails to pay any fee;

5. violates any applicable requirement; or

6. violates the terms or conditions of any permit.

as required under NRS ~~445.401~~*445B.100* to ~~445.526~~*445B.450*, inclusive, or NRS ~~445.546~~ *445B.470* to ~~445.601~~*445B.640*, inclusive or any regulations adopted pursuant to those provisions shall pay a fine of not more than $10,000.

B. B. Each day of violation of the provisions of subsection A constitutes a separate offense.

Regional Emergency Medical Services Authority

A non-profit community service using no tax dollars

REMSA

FRANCHISE COMPLIANCE REPORT

MAY 2018

450 Edison Way • Reno, NV 89502-4117 • 775.858.5700 • fax 775.858.5726

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
December	4428	$5,139,837.20	$1,160.76	$1,142.82	$411.42
January	4239	$4,948,942.20	$1,167.48	$1,146.47	$412.73
February	3844	$4,582,675.00	$1,192.16	$1,151.87	$414.67
March	4157	$4,953,807.00	$1,191.68	$1,156.39	$404.74
April	3718	$4,419,460.40	$1,188.67	$1,159.36	$405.78
Totals	40370	$46,803,439	$1,159.36		

		1/1/18 3% increase
Allowed ground average bill:	$1,161.23	$ 1,196.07
Monthly average collection rate:	36.0%	
Monthly average collection rate rev3.1.18:	35%	

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%
Jan-18	5 Minutes 39 Seconds	93%	95%
Feb-18	5 Minutes 48 Seconds	92%	96%
Mar-18	5 Minutes 53 Seconds	91%	93%
Apr-18	5 Minutes 41 Seconds	93%	96%
May-18	5 Minutes 47 Seconds	91%	92%

Year to Date: July 2017 thru May 2018

Priority 1 System - Wide Avg. Response Time	Priority 1 Zone A	Priority 1 Zones B,C,D
5 Minutes 44 Seconds	92%	94%

Year to Date: July 2017 through May 2018

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
Jan-18	**P-1**	5:03	5:47	7:56
	P-2	5:06	5:59	7:28
Feb-18	**P-1**	5:07	5:52	8:03
	P-2	5:24	6:27	8:14
Mar-18	**P-1**	5:13	6:15	8:06
	P-2	5:32	6:11	8:20
Apr-18	**P-1**	5:08	5:49	7:52
	P-2	5:07	6:00	8:00
May-18	**P-1**	5:05	5:59	8:18
	P-2	5:15	6:29	8:21

Year to Date: July 2017 through May 2018

Priority	Reno	Sparks	Washoe County
P-1	5:05	5:53	8:03
P2	5:16	6:15	8:15

REMSA OCU INCIDENT DETAIL REPORT
PERIOD: 01/01/2018 THRU 05/31/2018

CORRECTIONS REQUESTED					
Zone	**Clock Start**	**Clock Stop**	**Unit**	**Response Time Original**	**Response Time Correct**
Zone A	5/1/2018 13:34	5/1/2018 13:41	1C26	0:06:38	0:06:38
Zone A	5/4/2018 14:39	5/4/2018 14:43	1C43	0:18:54	0:04:04
OUT OF SERVICE AREA	5/5/2018 16:38	5/5/2018 16:47	1C03	0:09:24	0:09:24
Zone A	5/7/2018 9:31	5/7/2018 9:32	1C21	-00:00:04	0:00:48
Zone A	5/10/2018 15:58	5/10/2018 15:58	1C05	-00:00:06	0:00:22
Zone A	5/11/2018 9:28	5/11/2018 9:29	1C17	-00:00:23	0:00:34
Zone A	5/11/2018 22:54	5/11/2018 23:06	1C30	-01:19:56	0:12:36
Zone A	5/11/2018 23:41	5/11/2018 23:43	1C29	0:02:38	0:02:38
Zone A	5/12/2018 19:43	5/12/2018 19:46	1C26	-00:01:06	0:03:29
Zone A	5/14/2018 20:45	5/14/2018 20:47	1C42	0:02:20	0:02:20
Zone A	5/16/2018 14:31	5/16/2018 14:39	1C30	-05:52:54	0:08:00
Zone A	5/16/2018 14:45	5/16/2018 14:51	1C26	-00:00:19	0:06:00
Zone A	5/17/2018 10:50	5/17/2018 10:51	1W03	-00:00:06	0:00:23
Zone A	5/17/2018 11:30	5/17/2018 11:33	1C20	0:02:47	0:02:47
Zone A	5/20/2018 14:57	5/20/2018 15:00	1C16	0:03:26	0:03:26
Zone A	5/20/2018 20:39	5/20/2018 20:41	1C30	0:01:46	0:01:46
Zone C	5/21/2018 18:15	5/21/2018 18:25	1M16	0:10:42	0:10:17
Zone A	5/22/2018 22:43	5/22/2018 22:44	1C08	0:10:51	0:00:30
Zone A	5/24/2018 10:45	5/24/2018 10:51	1X14	0:06:22	0:05:50
Zone A	5/24/2018 11:38	5/24/2018 11:40	1X14	0:03:19	0:02:36
Zone A	5/24/2018 13:07	5/24/2018 13:12	1X14	0:04:57	0:04:33
Zone A	5/24/2018 14:48	5/24/2018 14:53	1X14	0:05:56	0:05:29
Zone A	5/24/2018 18:37	5/24/2018 18:40	1X14	0:03:16	0:02:49
Zone A	5/26/2018 13:57	5/26/2018 14:02	1C17	0:05:09	0:05:09
Zone A	5/26/2018 22:33	5/26/2018 22:42	1C05	0:00:45	0:09:23
Zone A	5/28/2018 14:01	5/28/2018 14:07	1C42	1:45:23	0:05:05
Zone A	5/29/2018 3:49	5/29/2018 3:52	1C07	0:03:07	0:03:07
Zone A	5/29/2018 12:52	5/29/2018 12:52	1C44	-00:00:02	0:00:29
Zone A	5/29/2018 21:48	5/29/2018 21:51	1C12	0:02:08	0:02:08

UPGRADE REQUESTED						
Response Area	**Zone**	**Clock Start**	**Clock Stop**	**Unit**	**Threshold**	**Response Time.**
AR02_S_of_River	Zone A	5/22/2018 22:43	5/22/2018 22:44	1C08	0:08:59	0:00:30

EXEMPTIONS REQUESTED					
Incident Date	Approval	Exemption Reason	Zone	Response Time	Overage
05/04/18	Exemption Approved	MCI	A	0:10:47	0:01:48
05/04/18	Exemption Approved	MCI	A	0:11:39	0:02:40
05/08/18	Exemption Approved	Incorrect Address	A	0:10:23	0:01:24
05/16/18	Exemption Approved	Weather	A	0:15:08	0:06:09
05/16/18	Exemption Approved	Weather	A	0:23:44	0:14:45
05/16/18	Exemption Approved	Weather	A	0:09:29	0:00:30
05/16/18	Exemption Approved	Weather	A	0:09:50	0:00:51

GROUND AMBULANCE OPERATIONS REPORT
MAY 2018

1. **Overall Statics**
    a) Total number of system responses: 6443
    b) Total number of responses in which no transports resulted: 2331
    c) Total number of System Transports (including transports to out of county): 4132
2. **Call Classification**
    a) Cardiopulmonary Arrests: 1.4%
    b) Medical: 38.6%
    c) Obstetrics (OB): 0.7%
    d) Psychiatric/Behavioral: 10.8%
    e) Transfers: 11.5%
    f) Trauma – MVA: 7.7%
    g) Trauma – Non MVA: 24.1%
    h) Unknown: 5.2%
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: 358

Total number of above calls receiving QA Reviews: 1925

Percentage of charts reviewed from the above transports**:** 18%

REMSA EDUCATION
MAY 2018 MONTHLY COURSE AND STUDENT REPORT

Discipline	Total Classes	Total Students	REMSA Classes	REMSA Students	Site Classes	Site Students
ACLS	4	24	3	20	1	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	3	1	3	0	0
ACLS R	14	21	5	1	9	20
ACLS S	8	23	0	0	8	23
AEMT	0	0	0	0		
-	-	-	-	-		
	0	0	0	0	0	0
BLS	62	453	16	158	46	295
BLS I	0	0	0	0	0	0
BLS R	33	163	24	128	9	35
BLS S	17	44	0	0	17	44
B-CON	4	41	4	41	0	0
CE	7	53	7	53	0	0
EMAPCT	0	0	0	0	0	0
EMPACT I	0	0	0	0	0	0
EMR	2	8	2	8		
EMR R	0	0	0	0		
EMS I	0	0	0	0		
EMT	0	0	0	0		
EMT R	0	0	0	0		
FF CPR	3	4	1	0	2	4
FF CPR FA	0	0	0	0	0	0
FF FA	0	0	0	0	0	0
HS BBP	7	77	6	62	1	15
HS CPR	21	173	6	47	15	126
HS CPR FA	46	386	12	124	34	262
HS CPR FA S	0	0	0	0	0	0
HS CPR PFA	0	0	0	0	0	0
HS PFA S	0	0	0	0	0	0
HS CPR S	1	1	0	0	1	1
HS FA	3	14	3	14	0	0
HS FA S	0	0	0	0	0	0
HS K-12 CPR	34	317	0	0	34	317
HS K-12 CPR, AED, FA	8	40	0	0	8	40
HS PFA	0	0	0	0	0	0
HS Primeros Auxilios, RCP y DEA	0	0	0	0	0	0
HS Spanish	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	2	1	2	0	0
ITLS S	0	0	0	0	0	0
Kid Care	1	11	1	11	0	0
PALS	3	21	2	18	1	3
PALS I	0	0	0	0	0	0
PALS R	7	31	3	19	4	12
PALS S	1	2	1	1	0	0
PHTLS	1	2	1	2	0	0
PHTLS R	0	0	0	0	0	0
PM	1	15	1	15		
PM R	0	0	0	0		
Classes w/CPR		**CPR Students**		**REMSA CPR**		**REMSA CPR Students**
226		1592		60		468

COMMUNITY OUTREACH MAY 2018

Point of Impact		
05/19/18	Child car seat checkpoint hosted by The Children's Cabinet; 17 cars and 22 seats inspected.	10 Volunteers; 3 Staff
05/2018	Twelve office installation appointments; 12 cars and 14 seats inspected.	
Cribs for Kids/Community		
05/07/18-05/08/18	Attended Grant Writing Workshop in Carson City.	
05/10/18	Attended Washoe K-12 Education Foundation Luncheon.	
05/10/18	C4K Attended Statewide Safe Sleep Meeting.	
05/11/18	C4K held a booth at the Veteran`s Baby Shower.	25 Participants
05/13/18	C4K held a booth at Mom`s on the Run.	200 Participants stopped by booth
05/19/18	Participated as a technician during the child car seat checkpoint hosted by The Children's Cabinet	
05/23/18	C4K attended the Child Death Review`s Executive Committee meeting in Carson City.	
05/24/18-05/25/18	C4K held Train-the-Trainer for staff at the University Medical Center Children`s Hospital in Las Vegas.	18 Participants
5/30/18-05/31/18	C4K held Train-the-Trainer in Elko at the Family Resource Center.	12 Participants

REMSA

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Client 7299

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EMS System Report

May 1, 2018 to May 31, 2018

Your Score

92.78

Number of Your Patients in this Report

153

Number of Patients in this Report

6,498

Number of Transport Services in All EMS DB

147

REMSA
May 1, 2018 to May 31, 2018

Executive Summary

This report contains data from **153 REMSA** patients who returned a questionnaire between **05/01/2018** and **05/31/2018**.

The overall mean score for the standard questions was **92.78**; this is a difference of **0.03** points from the overall EMS database score of **92.75**.

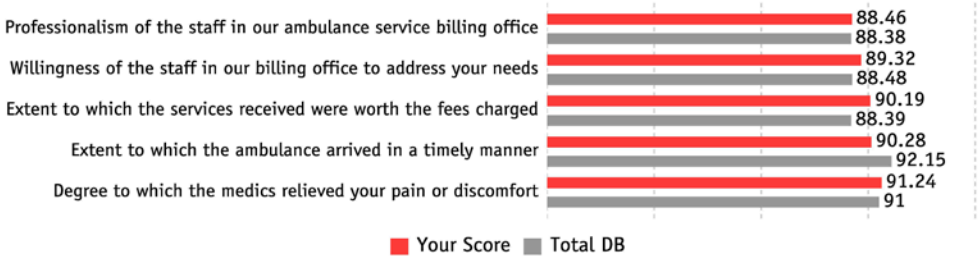
The current score of **92.78** is a change of **-1.40** points from last period's score of **94.18**. This was the **48th** highest overall score for all companies in the database.

You are ranked **13th** for comparably sized companies in the system.

84.82% of responses to standard questions had a rating of Very Good, the highest rating. **95.67%** of all responses were positive.

5 Highest Scores

5 Lowest Scores



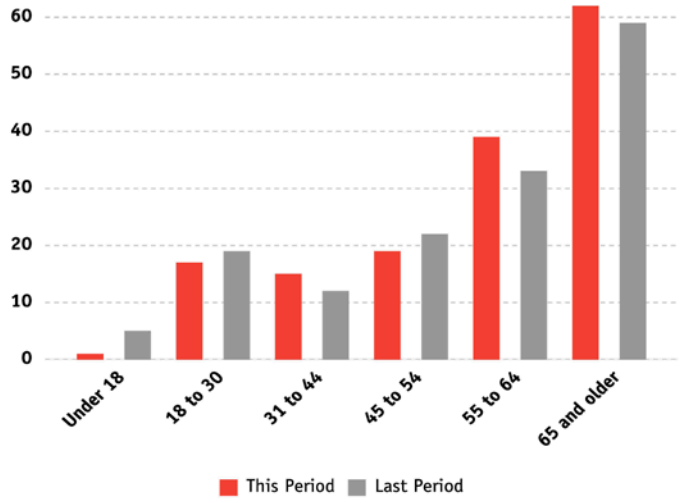
REMSA

REMSA
May 1, 2018 to May 31, 2018

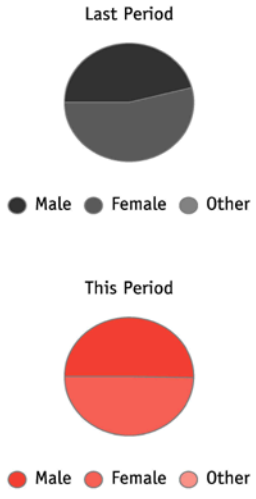
Demographics — This section provides demographic information about the patients who responded to the survey for the current and the previous periods. The information comes from the data you submitted. Compare this demographic data to your eligible population. Generally, the demographic profile will approximate your service population.

	Last Period				This Period			
	Total	Male	Female	Other	Total	Male	Female	Other
Under 18	5	3	2	0	1	0	1	0
18 to 30	19	12	7	0	17	9	8	0
31 to 44	12	5	7	0	15	3	12	0
45 to 54	22	13	9	0	19	9	10	0
55 to 64	33	14	19	0	39	25	14	0
65 and older	59	22	37	0	62	31	31	0
Total	150	69	81	0	153	77	76	0

Age Ranges



Gender



EMS SURVEY TEAM

REMSA

May 1, 2018 to May 31, 2018

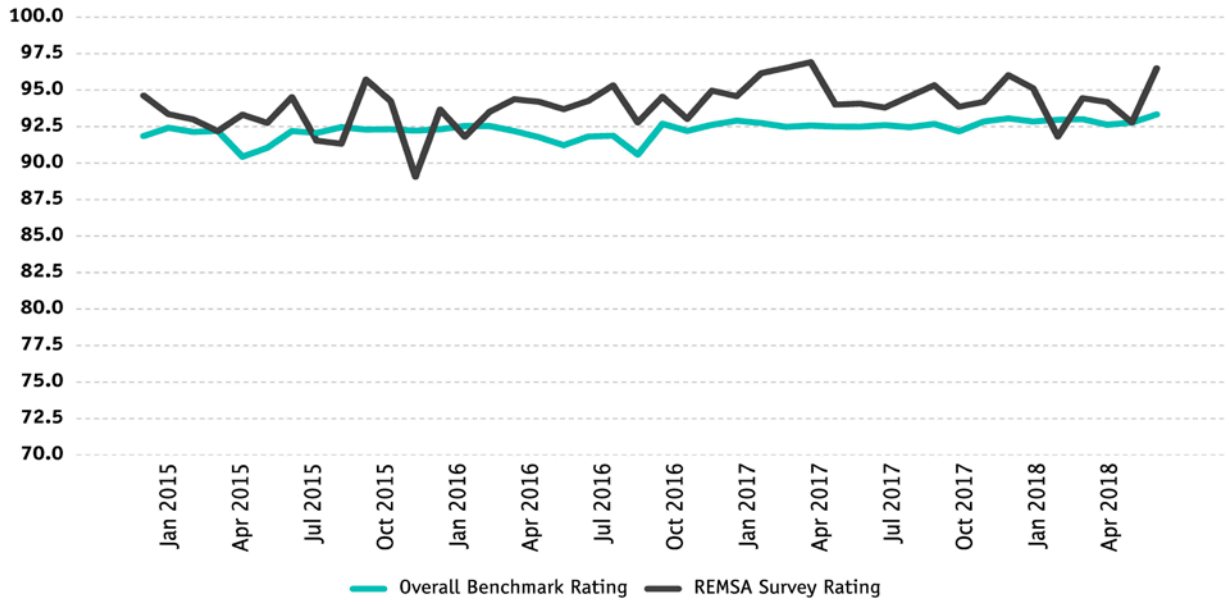
Monthly Breakdown

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.

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018
Helpfulness of the person you called for ambulance service	96.59	91.69	95.21	95.21	93.13	90.58	93.13	97.56	93.55	90.95	92.53	99.42	96.67
Extent to which you were told what to do until the ambulance	94.77	92.10	91.48	96.02	89.89	92.33	94.59	95.65	93.77	90.52	92.97	99.39	96.59
Extent to which the ambulance arrived in a timely manner	92.40	93.40	92.01	95.01	95.44	92.37	92.87	95.84	95.36	92.30	95.11	93.55	90.28
Cleanliness of the ambulance	95.17	97.11	96.04	96.57	99.09	96.82	96.12	98.26	96.49	93.00	96.01	94.53	93.72
Skill of the person driving the ambulance	96.01	95.42	95.49	96.40	96.44	96.82	95.26	96.96	96.12	93.93	95.43	95.63	93.77
Care shown by the medics who arrived with the ambulance	94.47	94.74	95.12	93.90	96.19	93.68	95.49	95.45	95.78	92.94	95.59	94.37	92.91
Degree to which the medics took your problem seriously	93.99	95.88	94.73	94.70	95.90	93.59	95.21	95.93	95.61	91.99	93.97	94.85	92.30
Degree to which the medics listened to you and/or your family	94.31	93.63	93.77	94.52	96.88	94.22	94.75	96.11	95.60	92.11	94.80	95.44	92.65
Extent to which the medics kept you informed about your	91.96	92.92	91.76	92.33	92.75	92.56	93.81	94.98	94.69	91.33	94.04	94.26	92.27
Extent to which medics included you in the treatment decisions	93.77	92.86	92.01	93.16	91.71	93.93	91.47	96.68	93.34	89.66	93.44	92.69	91.80
Degree to which the medics relieved your pain or discomfort	87.89	87.94	87.43	92.54	90.17	86.22	92.90	91.13	91.12	89.07	90.92	90.45	91.24
Medics' concern for your privacy	94.31	95.39	97.16	96.00	96.73	94.72	93.45	95.85	94.40	92.26	95.53	94.51	93.74
Extent to which medics cared for you as a person	94.29	95.74	95.40	95.20	96.95	94.54	94.51	96.41	95.85	92.30	94.24	95.28	94.11
Professionalism of the staff in our ambulance service billing	90.00	95.00	81.25	93.18	96.43	100.00	87.50	97.22	96.88	94.44	100.00	94.57	88.46
Willingness of the staff in our billing office to address your	90.00	87.50	84.50	87.50	100.00	98.08	87.50	96.88	96.43	93.75	100.00	95.24	89.32
How well did our staff work together to care for you	94.99	96.22	96.25	95.72	96.68	95.92	95.98	97.79	96.46	93.02	95.22	94.78	93.73
Extent to which the services received were worth the fees	90.72	78.61	87.92	88.24	83.63	85.47	89.39	91.20	91.67	84.95	89.98	85.38	90.19
Overall rating of the care provided by our Emergency Medical	95.52	94.78	94.94	94.54	95.94	94.97	94.82	97.66	96.10	92.23	94.55	93.82	93.50
Likelihood of recommending this ambulance service to others	95.79	94.93	93.55	96.46	97.34	96.87	95.29	97.68	96.78	93.44	95.47	94.92	93.83
Your Master Score	94.00	94.07	93.80	94.57	95.33	93.86	94.19	96.02	95.12	91.82	94.44	94.18	92.78
Your Total Responses	150	150	144	150	150	150	150	150	150	150	150	150	153

REMSA
May 1, 2018 to May 31, 2018

Monthly tracking of Overall Survey Score



REMSA GROUND AMBULANCE MAY 2018 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	03/08/18					
2	03/15/18	"Nothing they didn't listen to me."	"I wasn't happy with where they took me after I told them where I wanted to go. Take the patient to where they asked to go."		Assigned on 6.4.18 Ticket #5747	See result follow up below
3	03/15/18	"prompt and curious always makes sure some"				
4	03/19/18	"they were very kind to me and gave me the help I needed, I'm very thankful"				
5	03/19/18	"just everything, nothing was wrong"				
6	03/19/18	"overall they took really good care of me."				
7	03/20/18	"they got here fast, and took really good care of me"				
8	03/20/18	"the care is great but the fees charged are way too high"				
9	03/20/18	"it was all positive"				
10	03/20/18	"they just treated me with care and compassion. and were very professional"				
11	03/21/18	"knowing what to do and how to do it"	"My wife was laying in the ambulance naked without a blanket for shock given. I wish that had been dealt with differently. I personally had to go put a towel on her. I would also would have liked it if the medics listened to me more."			This PT was transported by another ambulance agency. PT was only transported by us for a flight transfer. Husband who wrote comments was not with her at the time
12	03/22/18	"the medic were good, they were good service, the medics stayed with me"	"have a none way to get people out of a small room if they are passed out"			
13	03/22/18	"well everything, they were there. they knew I would be more sick if I laid down and let me sit up. everything was just really great."	"nothing comes to mind"			
14	03/22/18	"you guys are always caring, you don't judge, and you do what you have to do. you calm them down and do what you have to do. you guys are ALWAYS great"				
15	03/22/18	"well I had a very positive experience, and they did everything well"				
16	03/22/18	"honestly everything was really great, they did everything they had to do."	"The only thing bad about this night, was that I was in so much pain and the firefighter were standing around me, and I just thought I was going to die."			
17	03/22/18	"the one thing that I can say for sure, is that they were very compassionate"				

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results after follow up
18	03/22/2018	"they were just wonderful, they had to carry me down the stairs. They did a great, and are very caring. they made sure to not move me too fast because my hips were out of place. I even pooped myself once and they acted like nothing happen and just did their job."	"nothing! I was totally 100%"			
19	03/23/18		"The nurses were clapping and talking about me as I left. and I asked the medic "" don't they know I know they're talking about me?"" he said they weren't. but I could hear them. The medic also didn't help me into the ambulance/ I should have been laying down"			
20	03/23/18		"I am slow in the head and they make fun of me and they say stuff to me insinuating things like I am dumb or that I don't have a brain. I am not being taken care of properly."	"I fell over on the bus in the aisle and the bus driver asked me to get off the bus stop at the stop"	Assigned on 5.5.18 Ticket #5637	See result follow up below
21	03/23/18	"Medic were amazing to me. My husband was very impressed too."				
22	03/23/18	"Medics were very professional. Well mannered and very caring"				
23	03/24/18	"The medics were all very polite, they did exactly what they should have. I am very happy with them!"				
24	03/25/18	"You guys were the SHIT!! If I could give them a pat on the back I would."				
25	03/25/18	"Thank you to the crew!! It was all a 10!"				
26	03/26/18	"They did great! One medic was very helpful."				
27	03/26/18		"The driver didn't know where she was going so she took a really long time"			
28	03/26/18	"they were good, treated me good."				
29	03/26/18	"they had to take me down from the 2nd floor to the ambulance- they did a great job- I was rocked a whole bunch. I would also like to give them a huge thank you!"				
30	03/27/18	"they just did everything well"	"wish they didn't act like I needed to take the ambulance- turns out I could have driven my truck."			
31	03/28/18	"they were very professional- they did what they had to do, and were very kind"				

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results after follow up
32	03/28/18	"just about everything that happened. I fell and couldn't get up. my wife couldn't get me up. they got me up right away- loaded me up and away we	"I think $22 a miles is a pretty high rate, I honestly couldn't believe it was that much."			
33	03/28/18	"they tired to stop the bleeding"				
34	03/28/18	"ohh they did great, they made me feel comfortable- this was my 1st time riding in an ambulance and they made me feel very at ease and just took great care of me"				
35	03/28/18	"their overall performance was great. they really did a great job"				
36	03/28/18	"just the care I guess. they just really cared."				
37	03/29/18	"They were perfect!"				
38	03/30/18	"they got here very quickly, helped my body that was on the ground quickly as well, and got me to the ER."				
39	03/30/18	"they took me down and got me checked out- made sure I was good"				
40	03/31/18	"they kept me comfortable, and relaxed"				
41	03/31/18	"ha-ha that's hard they did everything good!"				
42	03/31/18	"everything! all are all wonderful everyone of you!"				
43	04/01/18	"they were all very kind and caring."				
44	04/01/18	"I was pretty beat up and they just uh id there job\"				
45	04/01/18	"they stayed on the phone with me until the ambulance came- you guys just did a really good job"				
46	04/02/18	"they saved my life two times so they told me what was going on and talked me thru everything, and got me there safely- they did it was kindness and acr4ing"				
47	04/02/18	"they were great I would give them all fives"				
48	04/02/18	"they were really great- I had no problems with them"	"I did get a bill in the mail, but I have two insurances that should have covered it. and I did tell they about the insurances."			
49	04/02/18	"everything was fine"				
50	04/02/18	"they protected my privacy- had me sign a piece of paper saying they protected my privacy. they also tried to address my pain- but weren't given permission to give me meds and ended up in a lot of pain."	"stop being a afraid of opiates- cancer is very painful"			

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results after follow up
51	04/02/18	"I wanted to tell you that they were fantastic! everything they did was great- thank you"				
52	04/02/18	"everything they did was great- they were very caring and professional"				
53	04/03/18	"I had an excellent experience"				
54	04/03/18	"everything was fine- had an excellent experence"				
55	04/03/18	"I would say everything, by the time they came and got me- they were very concerned about how they got me out of the house and into the ambulance- tried to make me very comfortable and informed- got chilled and they gave me a blanket. I the staff at REMSA have always treated me so well. they have even been really good with my mom. I don't know how you could ask for anything more from them."				
56	04/04/18		"Not necessary"			
57	04/04/18	"took them a little while to get to me. overall more personal compassionate and better communication and concern"			6.4.18 Ticket#5748	6/7/18, I contacted the pt about his complaint and he told me he did not want to talk to me, I thanked him for his time.
58	04/05/18	"They were perfect, I was having a heart attack, I really appreciate their help."				
59	04/05/18	"They don't waste time getting here. God bless them for what they do. They have always been very good to me and my wife."				
60	04/05/18	"they got me there safe"	"I didn't think that the guys where very compassionate- I"		Assigned 6.5.18 ticket #5750	See result follow up below
61	04/06/18	"they did everything they took care of me."	"maybe be able to get here faster"			
62	04/06/18		"You should have gave me the option of going to the damn hospital if I wanted to, because it ended up costing me more money to go then it would have to not have gone. so I hate your company because of that. is that enough?"		Assigned 6.5.18 Tickets #5751	See result follow up below
63	04/06/18	"everything was great"				
64	04/07/18		"Take my health more seriously. I was asked many times if I wasnted to actually be taken to the hospital. I kept telling them yes, and when I got to the hospital was taken right to the ICU"		Assigned 6.5.18 Tickets #5752	6/7/18, I contacted the pt he told me he did not have a complaint, I thanked him for his time

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results after follow up
65	04/07/18	"they just did make sure to comfort me and got me where I needed to be- I wish it wasn't as expensive but it makes sense- and you don't have to wait- you get in right away"				
66	04/08/18	"they got me there very fast- they were also very caring and helped comfort me"				
67	04/08/18	"everything was great- the medics did an excellent job with getting here and taking care of me"				
68	04/09/18	"My overall experience was excellent. I have no complaints."				
69	04/09/18		"Better communication between medics and patients. Come to front of the house."			
70	04/10/18		"before judging people ask questions"			
71	04/10/18	"Well they got me there fast and were very professional. overall they gave me fantastic care."				
72	04/10/18	"they were professional, caring, and made sure to comfort me and my family- kept me very informed"				
73	04/10/18	"yes they were very good- no problem with them whatsoever"				
74	04/10/18	"everything that the medics did was good- they did their job"	"maybe just get here a little faster if possible"			
75	04/10/18	"they were very professional and showed excellent care- I'm very thankful"				
76	04/11/18	"they performed a ekg and told usher was having a massive heart attack and took him to the hospital and saved his life- I want to thank the two gals that came here in the ambulance they were great."				
77	04/11/18	"I have no complaints, everything from what I'm aware of was taken care of well"				
78	04/12/18	"showed up quickly and knew where to go"				
79	04/12/18	"overall care"				
80	04/12/18	"they were very kind- I had lost my phone at one point and the medics ended up looking everywhere for it- it was a couple days later and there was a knock at the door- the medic asked me my name and then handed me my phone. they are very caring and do excellent work"				

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results after follow up
81	04/15/18	"Calming and comforting when I couldn't breathe. Reassured that I was going to be okay"	"Always calm and helpful, wouldn't change a thing"			
82	04/15/18			"Did not call but pleased with how fast they arrived. Had to wait for fire truck but not medics fault"		
83	04/15/18	"The pt said she was chilled and the medics gave her a warm blanket and let her keep her sweater on. They also informed the hospital staff when they arrived that she felt chilled. She stated she was very grateful for that kindness and attention to detail."				
84	04/18/18	"they were really nice. they are super kind and act like gentalmen. when I get taken to the hospital I want to stay with them instead of seeing the doctor, because they are so nice"				
85	04/19/18	"the skill, how they fixed my arm and got me out of car- I don't remember that hurting at all- everything they did was great- I have nothing negative to say about them!"				
86	04/19/18	"I've already done this survey before, but I give you guys all 5. no complaints whatsoever"				
87	04/19/18	"they did everything that was right- I fractured my back and they helped me out of my bed and into the ambulance and got me where I needed to go"				
88	04/19/18	"the speed of them getting to me was fantastic! they were speedy!!"				
89	04/19/18	"everything was all good, thank you!"				
90	04/19/18	"ehh they did everything pretty well, everything seemed fine to me"				
91	04/20/18	"everything! I mean there's really nothing more I can say! everything was good"				
92	04/20/18	"I guess I would say getting my pain under control and moving me very gently"				
93	04/20/18	"just everything! overall care and"	"maybe better practice putting an IV in - they got it in the 1st time but had a hard time with it the 2nd time"			
94	04/20/18	"they're professional- thier attention to details, and they made it a fun trip. I think that everything you guys have done for me has been great"				
95	04/21/18	"they did all they could do- it was good"				

#	Date of Service	What Did We Do Well?	What Can We Do To Serve You Better	Description / Comments	Assigned to	Results after follow up
96	04/21/18	"they were here pretty quick and were really good"				
97	04/21/18	"they were awesome and listen to me"				
98	04/21/18	"the showed up in a timely matter- they were also professional- they are very good at their job"	"in my case; id say get their faster, not that they didn't get here fast, but by the time they did get here, they couldn't get me on the heart monitor fast enough"			
99	04/21/18	"they were absolutely perfect- truly wonderful both times"				
100	04/21/18	"they put me in the ambulance and I was laying on a cot and they took my vitals- then radio that they were going back to the hospital. everything was great"				
101	04/24/18	"They were all great"				
102	04/30/18	"They listened to me and they were caring."		"They were already there when I got there"		
103	04/30/18	"They arrived quickly considering how far away we live from town. Everything was good"		"Were unable to relieve pain on the way there"		
104	04/30/18	"Everything. They were taking care of me and watching me all the time. Every time I needed something they helped me"		"Didn't take long" "They gave me medication and I was fine"		
RESULTS AFTER FOLLOW UP						
2	03/15/18	6/6/18 1520, I left a message for the pt . 6/7/18 0938, I spoke with the pt , he was very nice and told me he did not choose RRMC as he has not been there in yrs and does not like that hospital. I apologized to him several times and told him I would follow up with the paramedic, also I am writing up a report. PT thanked me for calling him back. I will talk to Paramedic about the mistake.				
20	03/23/18	A message was left with the patient on 5/7/18 at 1615. The patient called back and we spoke at length about his experiences with REMSA. He was very nice but seemed confused about what occurred on the call in question, and it was difficult for me to keep him focused on the questions I was asking. He said the only thing specifically he remembered was that the male paramedic said "something to the effect of", "maybe you need a trip through the Taco Bell drive through for an oil change". He didn't know what that meant. The patient was otherwise complimentary of our crews and the service he has received in the past. I will contact the involved crew for their perspective on their next shift. 5.8.18 Today I spoke with Paramedic, who remembered the call. He said he and his partner took extra care with this patient due to his disability. He stated they both made an effort to not be condescending to the patient, and that he was "a really nice guy". Medic denied the comment about Taco Bell, and stated he doesn't know what the statement even means. Medic was surprised the patient complained because he felt both he and his partner provided excellent care.				
60	04/05/18	6/7/18 0950, I contacted the pt she asked me if I could call her back this afternoon. 6/8/18 1105, I spoke with the pt , she was very nice and told me she did not want to get anyone in trouble. PT felt the crew was very condescending, she felt she was having a stroke and they made her walk downstairs. She was very happy I called her back to talk about her concerns as I apologized several times.				
62	04/06/18	6/7/18 0958, I contacted the pt about the complaint he had from his transport on 4/6/18, he hung up on me. Reading the chart the crew did persuade PT to be transported as he had two syncopals and vomiting before REMSA arrived. He also had positive orthostatic changes on scene, pt was given 600 cc of fluid with improvement and 12 lead was completed.				

May 2018 Public Relations + Digital Media Highlights Report

District Board of Health

PUBLIC RELATIONS

Bleeding Control

REMSA's Bleeding Control class was highlighted on *Nevada Business Magazine*, KTVN, KOLO, *Medical Health News*, Facebook and Yelp.

1

May 2018 Public Relations + Digital Media Highlights Report

District Board of Health

PUBLIC RELATIONS

Nurse Health Line

REMSA's contract with South Lyon Medical Center to provide Nurse Health Line services was mentioned in the *Mason Valley News*.

Drones

The national Drone Pilot Program was picked up by many news outlets, due to wire releases on PR Newswire and the Associated Press. REMSA also garnered interest in coverage from the *RGJ*, *Las Vegas Sun* and *Northern Nevada Business Weekly*.

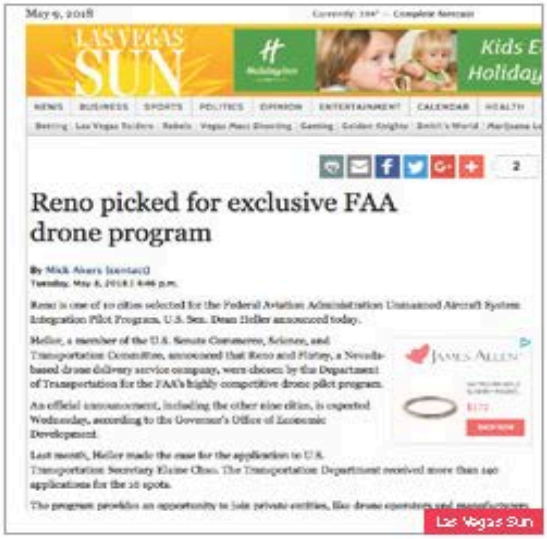
2

May 2018 Public Relations + Digital Media Highlights Report

District Board of Health

PUBLIC RELATIONS

Drones (Continued)



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PUBLIC RELATIONS

Nursing

During National Nurses Week, *The Daily Nurse* highlighted Kristine Strand RN, BSN, REMSA-Care Flight Clinical Services and Quality Manager, and Megan Meagher, RN, CFRvN, Care Flight Flight Nurse Truckee Base Supervisor, in "Why It's Great to be a Nurse in 2018."

EMS Week

Dean Dow, Chief Dave Cochran, Chief Chris Maples and Chief Charles Moore collaborated on an op-ed in the *RGJ* called, "Stronger Together: Local chiefs celebrate EMS week." The EMS Week video was also distributed on ThisIsReno.

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PUBLIC RELATIONS

Summer Safety

KTVN produced a segment on summer safety tips. Adam Heinz spoke about how to prepare for the heat.

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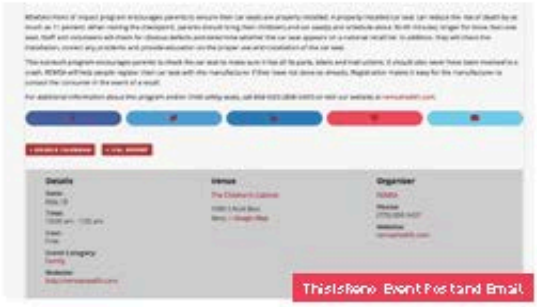
PUBLIC RELATIONS

Point of Impact

REMSA continues to be on calendar listings on ThisIsReno, KOLO and *Reno News & Review*.



7 Events To Check Out

- Kids Triathlon Series to Kick off in Sparks on May 19 – National Kids to Parks Day
- Sheriff Candidates Forum
- UNR Mod 2018 Best Ball Scramble Golf Tournament
- LOCAL 891 LIVE featuring Grace Hayes
- NITRO CIRCUS GOES NEXT LEVEL WITH ALL-NEW MOTO SHOW
- The Reno Jazz Orchestra presents ... The Music of Hans Holt
- REMSA Free Car Seat Check Point

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Strategic Initiatives

REMSA partnered with the Washoe County Health District to curb the misuse of the 9-1-1 system. A portion of the campaign has rolled out locally and includes a Facebook campaign, TV spots on KRNV, and RTC bus interior and tail ads. The advertisements direct the public to visit a webpage with educational information about when to use 9-1-1 and when to seek alternative services.

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Community Relations

Girl Scouts Tour REMSA Ground Operations and Center for Clinical Communications

On Thursday, May 24, Christine Barton, Manager, Center for Clinical Communications, and Scott Steele, Ground Operations Supervisor, welcomed a local Girl Scout Troop to tour REMSA. The girls are working toward earning their First Aid badge.

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COMMUNITY RELATIONS

Nevada Women's Fund Women of Achievement

On Thursday, May 24, the Nevada Women's Fund held its annual Salute to Women of Achievement luncheon. This year, Pam Boe, Chief Financial Officer, was recognized by Nevada State Bank and Chris Watanabe, Vice President of Business Services, was recognized by REMSA. The event celebrates some of the most passionate, dedicated, confident, energetic and successful women in our community. Congratulations, Pam and Chris!

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SOCIAL MEDIA HIGHLIGHTS

REMSA Social Media

We are thrilled with the results of social media efforts. We have met our 6 and 12-month likes and follower goals, and our reach trends are in the thousands based on the content we share. In particular, the video content developed and posted by REMSA has had outstanding performance. We have also increased likes and followers by re-engaging with individuals who have liked past posts on Facebook but have yet to like the REMSA or Care Flight pages by inviting them to like our pages.

Social media engagement is a critical element of a successful public relations program, and we plan to continue the momentum with engaging content and new ways of telling the REMSA story through these social channels while exploring others.

Facebook

- Likes to-date: 2,534 +201 likes from April 2018
- Followers to-date: 2,513 +258 followers from April 2018
- April posts: 41
- April post comments: 103
- April post shares: 289
- April post reactions: 1.97k

Top Posts By Reach

1. EMS Week RGJ Op-Ed
   - 4,417 people reached
   - 108 reactions, comments and shares

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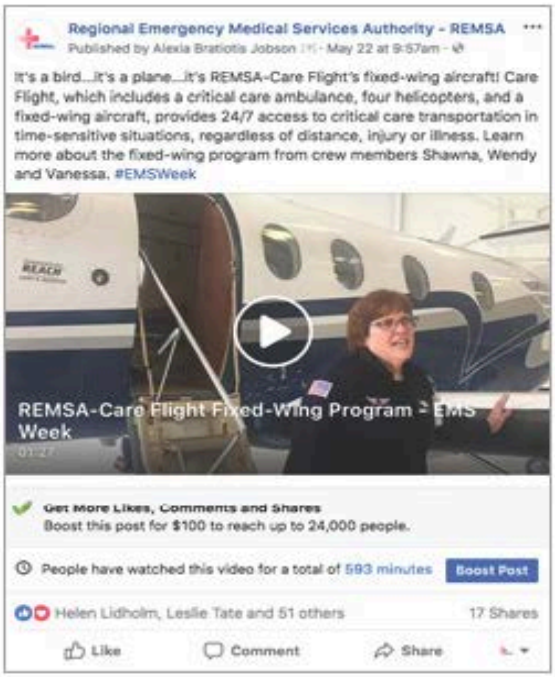
District Board of Health

SOCIAL MEDIA HIGHLIGHTS

Top Posts By Reach

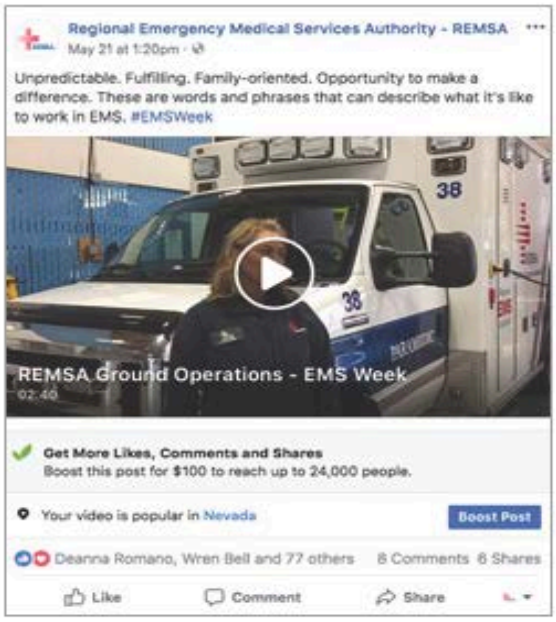
2. EMS Week Video

- 3,216 people reached
- 1,487 video views
- 171 reactions, comments and shares



3. EMS Week Video

- 2,276 people reached
- 1,165 video views
- 136 reactions, comments and shares



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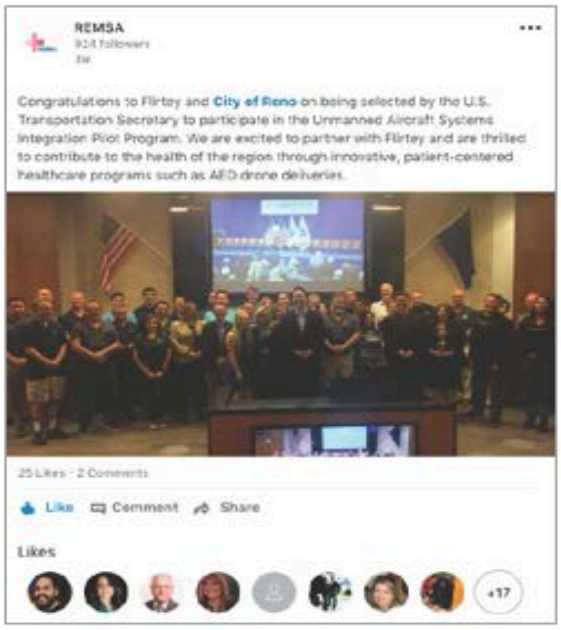
SOCIAL MEDIA HIGHLIGHTS

LinkedIn

- Followers to-date: 924 + 7 likes from April 2018
- Posts: 7
- Impressions: 3,889
- Clicks: 134
- Social Actions: 90

Top Post By Impressions



May Website Referral Sessions from Social Media

Website referral sessions from social media have increased 538% year over year. The increase in sessions in May can be attributed to Facebook and LinkedIn efforts.

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GOOGLE ANALYTICS

REMSA Google Analytics

We use Google Analytics to measure the various ways visitors come to the website. The best way we can measure how public relations is driving people to the REMSA website is to evaluate referral and direct traffic. Referral traffic is Google's method of reporting visits that came to your site from sources outside of its search engine, i.e. a partner website, news website, etc. Direct traffic are users who directly type your URL or visit through a bookmarked mechanism. Direct traffic can be related to brand awareness, as well.

Users coming from direct traffic year over year in the month of May increased by 34%. The bounce rate, which determines how many people visited the website without any interactions, decreased by 10% (a decrease is good) and the average number of pages viewed increased by 21%.

Overall Site Sessions in May (Year over Year Comparison)

Overall, the new website is performing great in all areas in Google Analytics:

- **Sessions:** 16% decrease year over year
- **Users:** 28% increase year over year
- **Pageviews:** 21% increase year over year
- **Pages / Session:** 45% increase year over year
- **Avg. Session Duration:** 2% increase year over year
- **Bounce Rate:** 10% decrease year over year

May 2018 Public Relations + Digital Media Highlights Report

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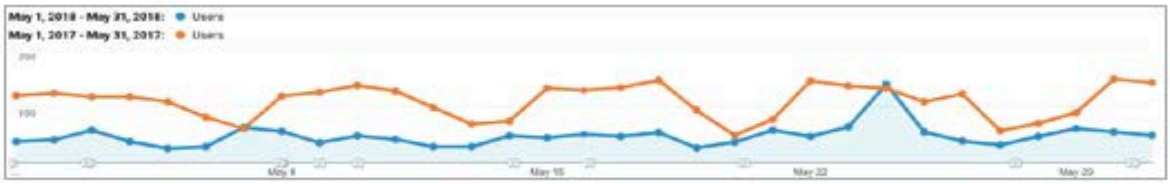
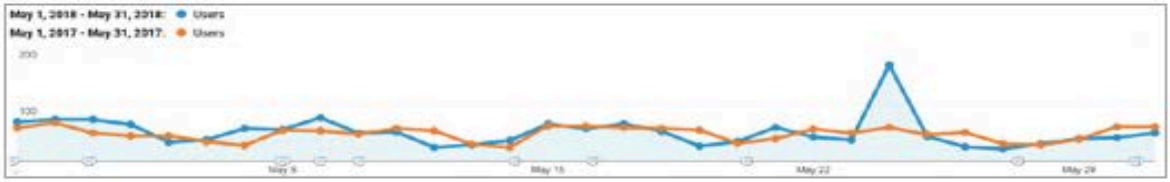
GOOGLE ANALYTICS

Referral Traffic:



Direct Traffic:



REMSA 2017- 2018 PENALTY FUND RECONCILATION AS OF APRIL 30, 2018

2017-18 Penalty Fund dollars accrued by month

Month	Amount
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	8,733.88
January 2018	7,279.84
February 2018	8,018.44
March 2018	8,407.16
April 2018	5,633.04
May 2018	
June 2018	
Total accrued as of 4/30/2018	$73,460.40

2017-18 Penalty Fund dollars encumbered by month

Program	Amount	Description	Submitted
Child Safety	$5,965.00	500 First Aid Kits for children's league sports	January-18
Pulse Point CPR/AED Phone Application	$10,000.00	PulsePoint Implementation Services - License will be billed upon installation	April-18
Total encumbered as of 4/30/2018	$15,965.00		
Penalty Fund Balance at 4/30/2018	$57,495.40		

REMSA INQUIRIES

MAY 2018

No inquiries for May 2018

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DD____RT_
DHO_____KD_
DA_____
Risk_____

Staff Report
Board Meeting Date: June 28, 2018

TO: District Board of Health

FROM: Brittany Dayton, EMS Coordinator
775-326-6043, bdayton@washoecounty.us

SUBJECT: Presentation, discussion and possible approval of revisions to the Multi-Casualty Incident Plan (MCIP).

SUMMARY

On an annual basis staff reviews either the Multi-Casualty Incident Plan (MCIP) or the Mutual Aid Evacuation Annex (MAEA) for possible revisions. During fiscal year 2017-2018 there were several updates to the MCIP, to include a new annex, the MCI Alpha Plan.

EMS staff would like to thank all of the regional partners who assisted the Health District throughout this process. The revisions to the MCIP could not have been completed without their input and subject matter expertise.

PREVIOUS ACTION

The MCIP was first presented to the District Board of Health in August 1986. Since then, staff has presented several updates to the plan. The DBOH last approved revisions to the MCIP on April 28, 2016.

BACKGROUND

During any declared multi-casualty incident (MCI) in Washoe County, the MCIP is activated and followed by first responders and healthcare facilities. The fiscal year 2017-2018 revision process focused on refining plan details and enhancing specific plan sections to be more robust.

In 2016 EMS Program staff attended the EMS Today conference and heard a presentation on the Paris terror attacks that occurred in November 2015. The presenter described their "Alpha/Red Plan" which was specifically for multi-location incidents and included alternate response strategies and strategically placed medical equipment throughout the city.

After the conference, EMS Program staff brought this idea to regional partners who began considering the idea of a specific plan for large-scale MCIs or incidents that occur in multiple locations in the county. Staff also presented the idea of law enforcement transports during a major disaster at a regional law enforcement chiefs meeting in July 2016. Staff received quality input and feedback and worked with legal to ensure this was a feasible idea during a declared disaster.

On June 29, 2017, EMS staff held an MCIP workshop with regional partners to brainstorm possible updates for this revision cycle. The meeting included personnel from ten regional agencies and the attendees developed a list of possible revisions. One of the primary discussion points was the development of a plan for major incidents that would have special response components to better respond to a large number of casualties.

Throughout the fiscal year, EMS Program staff held several additional meetings to update the regional partners on the revisions and determine if any other modifications should be included. Additionally, a subcommittee of first responders and healthcare personnel was created to assist in the development of the MCI Alpha Plan.

In January 2018, the EMS Coordinator organized a regional fire, EMS and law enforcement tabletop exercise that focused on on-scene coordination during an MCI. The objective of the tabletop was to identify possible planning gaps for the revision of the MCIP. Over the three days, 37 individuals from fire, EMS and law enforcement agencies attended. Based off exercise feedback, the MCIP was revised to include MCI levels. Agencies also expressed a desire to conduct regional trainings on multi-casualty incidents on an annual basis.

Additionally, the Inter-Hospital Coordinating Council (IHCC) requested that the MCIP include information on the care and response to pediatric patients during an MCI. The plan revisions reflect this request.

On April 17, 2018 EMS staff held a workshop where the final draft of the MCIP and the Alpha Plan were distributed to the regional partners for review and input prior to the possible approval of the DBOH. The EMS Coordinator also provided a final opportunity for input on the MCIP and MCI Alpha Plan where regional agencies could review all revisions and provide final suggestions by May 30, 2018.

In addition to the review processes for the plan, there were two MCI declarations during the review period (February and May). Prior to the After-Action Review meetings, EMS staff provided participants with the draft plan to review for possible changes. Regional partners identified the value of the proposed changes and made additional suggestions.

The following list includes all revisions made this fiscal year:

- Updated formatting and organization of the MCIP
- Pre-alert verses activation flow chart
- Establishment of MCI levels
- Verbiage change of MCI declaration to be anticipated transports
- Addition of a patient tracking section
- Creation of a patient considerations section (burn patients, pediatrics and individuals with access and functional needs)
- Revisions to the out-of-county MCI process

- Change to the mass gathering mitigation section (changed from 2,500 to 1,500 attendees/participants)
- Updated MCI resource lists
- Development of large scale incidents plan (MCI Alpha Plan)

FISCAL IMPACT

There is no fiscal impact should the DBOH approved the revisions to the MCIP. The EMS Program collaborated with Public Health Preparedness and IHCC to secure grant funding to purchase the medical supplies for the Alpha Plan kits.

RECOMMENDATION

Staff recommends the DBOH approve the proposed MCIP; and if approved, authorize the Chair to execute with an effective date of October 1, 2018, which will allow for training on the annex, the MCI Alpha Plan.

POSSIBLE MOTION

Should the DBOH agree with staff's recommendation, a possible motion would be:
"Move to approve the fiscal year 2017-2018 revisions to the MCIP, effective October 1, 2018."

Multi-Casualty Incident Plan (MCIP)

Fiscal Year 2017-2018 Revisions

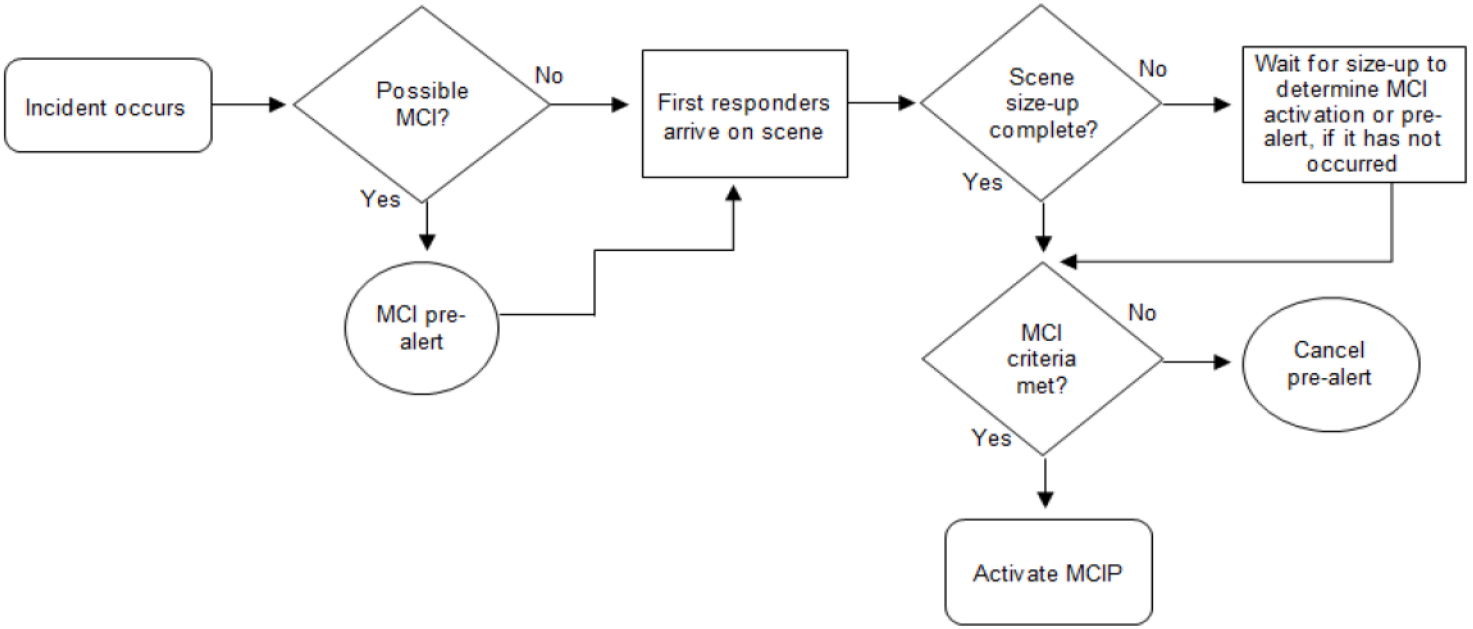
MCIP Revisions Overview

- Updated formatting and organization of the MCIP
- Pre-alert/activation flow chart
- Establishment of MCI levels
- Verbiage change of MCI declaration to be anticipated transports
- Addition of a patient tracking section
- Creation of a patient considerations section (burn patients, pediatrics and individuals with access and functional needs)

MCIP Revisions Overview

- Revisions to the out-of-county MCI process
- Change to the mass gathering mitigation section (changed from 2,500 to 1,500 attendees/participants)
- Updated MCI resource lists
- Development of large scale incidents plan - MCI Alpha Plan

Pre-Alert/Activation Flow Chart



MCI Criteria – activation of the MCIP and notification to the regional healthcare facilities by the Medical Dispatch Center will occur when 10 or more patients are anticipated to be transported. However, activation may occur if there are fewer than 10 patients depending on factors like the location of the incident, the number of critical patients, or the involvement of hazardous materials, etc.

MCI Levels

MCI Type	Number of Victims	Description
Level 3	10-40	Minor incident involving 10-40 surviving persons. Will stress local resources for a short period of time.
Level 2	41-100	Major incident involving 41-100 surviving persons. Will tax Washoe County resources for moderate period of time.
Level 1/Alpha	>100	Catastrophic casualty incident involving greater than 100 surviving persons. Will tax regional resources for an extended time; the Alpha MCI plan should be activated.

The above table is a guideline for activation that will assist responders in knowing the general size of the incident. There are instances where an MCI could be small, but the critical nature of patient conditions could have a larger impact on resources.

MCI Declarations

- Two MCI occurred during the review period
  - Car accidents in February and May
- These incidents prompted discussion about the declaration "trigger"
- Changed from 10 victims simultaneously involved to 10 or more patients are anticipated to be transported

Patient Tracking Section

- Patient tracking is a key element of an MCI response:
  - The DMS patient receipt holders are sent to the Medical Services Unit every 10 patients.
  - Data is entered into a locked down board on WebEOC.
  - EMS and patient information may be used for reunification.

Patient Considerations

- Pediatric Patients
- Burn MCIs
- People with Access and Functional Needs (AFN)

MCI Alpha Plan

- Goal: provide a framework for an interoperable response by pre-hospital and healthcare agencies to effectively and safely manage large-scale events and/or incidents in multiple locations.

MCI Alpha Plan

- Response Components:
  - Police transports
  - MCI medical supplies
  - Healthcare response

Implementation

Staff recommends approval of the revisions to execute effective October 1, 2018

- Allows for training personnel on the MCIP changes and the new MCI Alpha Plan.

Regional Partners

- ED Consortium
- Inter-Hospital Coordinating Council
- Incline Village Community Hospital
- Northern Nevada Access and Functional Needs Workgroup
- Northern Nevada Adult Mental Health Services
- Northern Nevada Medical Center
- North Lake Tahoe Fire Protection District
- REMSA and CareFlight
- Reno Fire Department
- Reno Police Department
- Renown Regional and South Meadows Medical Centers
- Reno-Tahoe Airport Authority
- Saint Mary's Regional Medical Center
- Sparks Fire Department
- Sparks Police Department
- Truckee Meadows Fire Protection District
- VA Sierra Nevada Healthcare System
- Washoe County Emergency Management
- Washoe County Sheriff's Office

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Washoe County District Board of Health
Multi-Casualty Incident Plan

Original MCIP Effective 8/86
Revisions on January 20, 1987
Revisions on March 17, 1989
Revisions Approved by the DBOH on May 20, 1992
Effective July 1, 1992
Revisions Approved by the DBOH October 27, 2005
Effective December 1, 2005
Revisions Approved by the DBOH January 24, 2008
Revisions Approved by the DBOH on December 19, 2013
Effective January 1, 2014
Revisions Approved by the DBOH on April 28, 2016
Effective July 1, 2016

Record of Plan Changes and Updates

CHANGE RECORD	DATE OF CHANGE	DATE ENTERED	TYPE OF CHANGE	CHANGE MADE BY
	8/86	8/86	Original Plan Publication	DdeCrona
1	1/28/87	1/28/87	Selected Segments	DDeCrona
2	3/17/89	3/17/89	ICS and Coroner	SAB, DDC
3	5/92	5/92	Total Plan Revision	WCDBH
4	12/1/05	12/1/05	Plan Revision	WCDBH
5	1/24/08	1/24/08	Smart Tag and Triage	WCDBH
6	1/1/14	12/16/13	Plan Revision - DMS Triage Tags	WCHD
7	7/1/16	4/14/16	Overall Plan Revisions	WCHD
8	10/1/18	6/2017-5/2018	Pre-alert/activation, on-scene coordination, pediatric/AFN section, MCI levels, out of county MCIs, resources update, formatting and Alpha Plan development	WCHD

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APPENDICES

PLAN ANNEXES

MUTUAL AID EVACUATION (MAEA) ANNEX

FAMILY SERVICECENTER (FSC) ANNEX

MCI ALPHA PLAN

INTRODUCTION TO THE MULTI-CASUALTY INCIDENT PLAN

A Multi-Casualty Incident (MCI) is defined as a single geographically focused event, which produces casualties of a sufficient number and severity that special operations and organizations are required at the scene. These resources respond for the purpose of hazard mitigation, triage, treatment and transportation of victims.

MCIs present emergency workers with special problems. Unlike other large-scale incidents for which the Incident Command System (ICS) was initially developed, MCIs primarily involve human casualties. These incidents require organizational and management skills not routinely used during the course of the normal workday.

Because of these special characteristics, the following county plan has been developed. This plan provides the guidelines necessary to effectively, efficiently and safely manage MCIs in Washoe County.

Among the special characteristics encountered during MCIs are the need for coordination between multiple responding agencies and organizations; the need to manage the scene so that appropriate resources are focused on individual patients; and the need for flexibility and creativity, because no two MCIs are exactly alike (location, time of day, patient count, responding personnel, etc.). The final key characteristic is that all **MCIs are evolutionary** in nature: MCIs have a beginning, middle and an end.

In the earliest stages of an MCI, there may be too few resources, compared to need. The inclination is to provide direct, hands-on patient care. However, the critical need is to establish a scene management structure, so that when additional help arrives, it may be efficiently and effectively deployed. During the middle stages of an MCI, there are generally enough resources. Scene management is responsible for effective assignment of these resources. The final stage of an incident is the recovery and demobilization. No longer is there any excitement or particular sense of urgency.

Due to the need for coordination between multiple responding agencies and organizations, the Multi-Casualty Incident Plan (MCIP) adopts the ICS. The cornerstone of the ICS is the development of an incident-specific management structure. The Incident Commander (IC) will establish an on-scene organization to manage the activities of responding emergency workers and to coordinate with off scene agencies. Those responding, regardless of agency or organization affiliation, should expect to participate as assigned within this on scene organization. Depending on the size and duration of the incident, the IC may directly supervise operations or delegate this responsibility to an Operations Chief. The field operations will fall within the responsibility of Operations. It is important that medical personnel, treatment areas and medical management be easily identifiable. The MCIP describes the types of functions that may likely be performed during medical operations.

Of special note, an MCI may require the implementation of various specialty Branches within the ICS structure. While other incident activities and Branches may be necessary, such as traffic control, fire suppression and the like, the Medical Branch is focused on medical management of the injured. The key positions within the Branch should be filled by the most qualified, available personnel on scene.

The need to manage the scene rather than focus directly on individual patients is one of the most difficult concepts for responding workers to implement. In order to best serve the patients, many activities must be conducted that have little or no direct patient contact. These activities might include communications, record keeping, personnel, equipment and supply staging/logistics, scene security, public information and other tasks as determined by the IC.

The essential purpose of response to an MCI is to administer to the needs of the patients and the community, to mitigate suffering and to minimize loss of life. No plan can fully prepare for all of the variations that can occur during an MCI. It is the responsibility of the IC and all responding personnel to be aware of the resources available and to make effective use of those resources. It must be remembered that the MCIP only provides a framework, or a guideline. On scene management must be flexible and creative to meet the needs of the entire incident.

It is most important for the first arriving units to be aware of the critical nature of the initial phase of an MCI response. The activities and effectiveness of all additional responding personnel will be affected by the initial responders' ability to effectively activate the MCIP.

Initial size-up deserves special attention, because it has been found that the successful operation of an MCI is often linked to the accuracy of the reports provided by the first-in responders to the scene. At a minimum, the senior official first arriving becomes the initial IC and should identify and report the following to their own dispatch center. This information should be relayed to all responding agencies' dispatch centers:

- The establishment of command and name of the incident
- The identity of the IC
- The exact location of the incident
- The exact location of the Command Post
- The type and cause of the incident
- An estimate of the number of casualties
- An estimate of the condition of casualties
- An estimate of additional resources needed
- The appropriate routing to the incident
- The identification of special hazards, if any
- The exact location of the initial staging area

The second responsibility of the initial IC is to begin to delegate duties to designated people, and to develop an incident action plan (IAP) that includes some of the following:

- Extrication/rescue
- Safety of personnel and scene safety
- Triage
- Treatment
- Transport
- Staging
- Security

- Communications
- Record keeping

Additionally, it is crucial to be aware that command will likely change over the course of the incident. Incident Command will most likely be passed to a more senior officer when that person arrives. Any time there is a change in the command structure, it is imperative that the exchange take place face to face, that a briefing is conducted to bring the new IC up to date, and that the identity of the new IC be communicated to the dispatch centers and the members of the command structure already in operation. This same dynamic of face-to-face briefing and reporting of the change in responsibility applies to any other change that may occur throughout the organization during the course of the incident.

Finally, experience has shown that the following areas are critical to a positive outcome of an MCI:

- Establish a single, unified incident command as soon as possible, with a single, fixed Command Post
- Establish staging immediately
- Provide accurate initial information
- Request additional resources early
- Delegate authority for major functional areas
- Clearly identify major command personnel
- Provide effective progress reports to command personnel
- Command management personnel do not become involved in physical tasks
- Triage and tag all patients
- Provide adequate safety precautions
- Treat patients in a designated treatment area
- Establish an adequately sized treatment area
- Keep command personnel updated on available manpower
- Alert and keep dispatch and healthcare facilities updated
- Plan for medical supply needs
- Assess and utilize non-traditional resources
- Designate a common radio channel for disaster operations (ICS 205)

The MCIP is designed to provide the community with the Washoe County District Board (DBOH) of Health's policies and guidelines for response to an MCI. It is encouraged that the plan be used as a training document for all emergency responders.

"Qualified" as used in this document shall be understood to mean:

A person who has attained the appropriate level of training and experience for specific positions, as determined in the Training Section of the MCIP.

It must be further understood that the IC has the ultimate authority and responsibility to fill the ICS positions to the best of his/her ability with available personnel on scene during the incident.

Brian Taylor
Chairman, Inter-Hospital Coordinating Council

Date

Kitty Jung
Chairwoman, District Board of Health

Date

1. PLAN BASIS

1.1 Purpose

The Washoe County DBOH is committed to providing necessary emergency medical care to all patients in an MCI. The goal of this plan is to provide procedural guidelines for rapid and effective patient assessment/triage, treatment and transportation to appropriate care facilities.

The majority of medical emergencies in this area are handled by a single first response agency and an ambulance unit. In some instances, there is a need for additional assistance even in routine incidents.

The plan establishes a mechanism to organize and mobilize emergency medical resources within Washoe County.

1.2 Planning Concept

Emergency medical services (EMS) personnel responding to an MCI must coordinate with a variety of agencies. Therefore, this plan will utilize the ICS to integrate these agencies. EMS personnel should have formal training in the ICS to facilitate this plan.

This plan acknowledges that there are local variations in pre-hospital medical management systems in the outlying areas of Washoe County in Incline Village and Gerlach.

This plan acknowledges existing mutual aid agreements (MAAs) between public and private agencies inside and outside Washoe County and the State of Nevada. Regional Emergency Medical Services Authority (REMSA) has a mutual aid agreement with surrounding agencies to provide EMS personnel, resources and facilities for emergency medical care to each other during an incident that requires the combined resources of additional agencies. The Nevada Intrastate Mutual Aid System, North Lake Tahoe Fire Protection District (NLTFPD)/REMSA agreement and Lake Tahoe Fire Chief's agreements also address automatic aid or mutual aid regarding the sharing of ambulance resources.

1.3 Plan Development and Revisions

The MCIP is formally developed and reviewed by the Inter-Hospital Coordinating Council (IHCC).

The plan is reviewed by regional partners that could be affected by an MCI for revision recommendations.

The formal recommendations of these agencies are presented to the DBOH through WCHD staff. The DBOH has the final authority for formal approval of the MCIP.

The MCIP supports the Reno, Sparks and Washoe County Emergency Management Plans, each of which designates the District Health Officer (DHO) to coordinate EMS in a widespread disaster. The MCIP also supports the following regional plans:

- Disaster Behavioral Health Annex of the Regional Emergency Operations Plan
- Medical and Weapons of Mass Destruction Annexes of the Regional Hazardous Materials Emergency Management Plan
- Washoe County Recovery Plan

The Washoe County Office of Emergency Management and Homeland Security and the Emergency Managers of the City of Reno and the City of Sparks provide disaster consulting services to the DBOH on an ongoing basis, and provide support services to the Board in concert with the Washoe County Health District (WCHD) EMS Oversight Program staff.

1.4 Inter-Hospital Coordinating Council

The IHCC meets monthly to prepare for, respond to, mitigate, and recover from the medical impacts of emergencies. On an ongoing basis, the IHCC provides input to WCHD staff on the effectiveness of proposed revisions to the MCIP.

1.5 Washoe County District Health Officer Responsibilities

- Designates a person in the WCHD to assist with medical disaster planning.
- Coordinates post-incident debriefings of MCIs involving 10 or more victims or smaller incidents at the request of incident command personnel or medical agencies.
- Ensures the MCIP is efficient, effective, meets the needs of Washoe County in an MCI and is consistent with other jurisdictional, regional and State disaster plans.
- Solicits input from both public and private agencies during plan development and/or revisions, and ensures distribution of the plan to EMS and public safety agencies.
- Provides trained staff to coordinate medical response and support medical functions at medical dispatch centers during out-of-county emergencies that impact the Health District; in the Health District Operations Center; and in the Medical Operations Unit of jurisdictional Emergency Operations Centers (EOCs) if such operations centers are activated during larger events.

1.6 Emergency Operations Center Interface

The WCHD, as the arm of the Washoe County DBOH, is the governmental agency responsible for coordinating public health issues during an emergency.
During most MCIs, WCHD staff does not routinely respond to the field, although Hazardous Materials Program staff may respond to an MCI that is related to hazardous materials release. Staff gathers data after the event and coordinates incident debriefings with the Incident Commander(s).

In larger events, such as a plane crash, or prolonged events that require the involvement of State and/or Federal agencies, such as floods, a local jurisdictional or Regional Emergency Operations Center (REOC) may be opened. The WCHD, working with the local jurisdictions, has committed to fill both a Health and Medical position under the Operations Section in the REOC.

If necessary, the WCHD will also open an internal Department Operations Center to coordinate department resources and responses to the public health impacts of disasters. Monitoring and supporting the community's EMS agencies and medical resources, as well as providing patient tracking functions for the area healthcare facilities are only a few of the public health focused tasks. The WCHD may share patient tracking information with the Northern Nevada Chapter of the American Red Cross and other agencies that have specific exemptions to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which allow disclosure of protected health information.

1.7 Critiques / Plan Revisions

Incident critiques, i.e., a comprehensive review of actual incidents, have generally proven to be a beneficial means of focusing attention on the MCIP and operational effectiveness.

Incident critiques will be held following each MCI and will be open to both the incident's participants and others as approved by the agency of jurisdiction.
Periodically, the IHCC will host a general review of the plan's utilization and proposed revisions. Representatives from Fire, EMS, emergency managers, public health and healthcare will be invited to participate.

Tabletops and field exercises are also excellent continuing education opportunities.

2. MCI MITIGATION

2.1 Mass Gathering Guidelines

The following provisions are suggested guidelines and are meant for advisory purposes only. The original Washoe County Mass Gathering Guidelines were enacted by the DBOH in 1991, but recent actions during the 2013 and 2015 sessions of the Nevada Legislature supersede the Washoe County Guidelines. Therefore, the following information should only be used for MCI mitigation purposes during special events.

A mass gathering may be defined as a situation or event during which crowds gather and there is a potential for a delayed response to emergencies because of limited access or other features of the environment or location.

The general guideline for any mass gathering event larger than 1,500 people per day is access to an Advanced Life Support (ALS) ambulance within eight (8) minutes

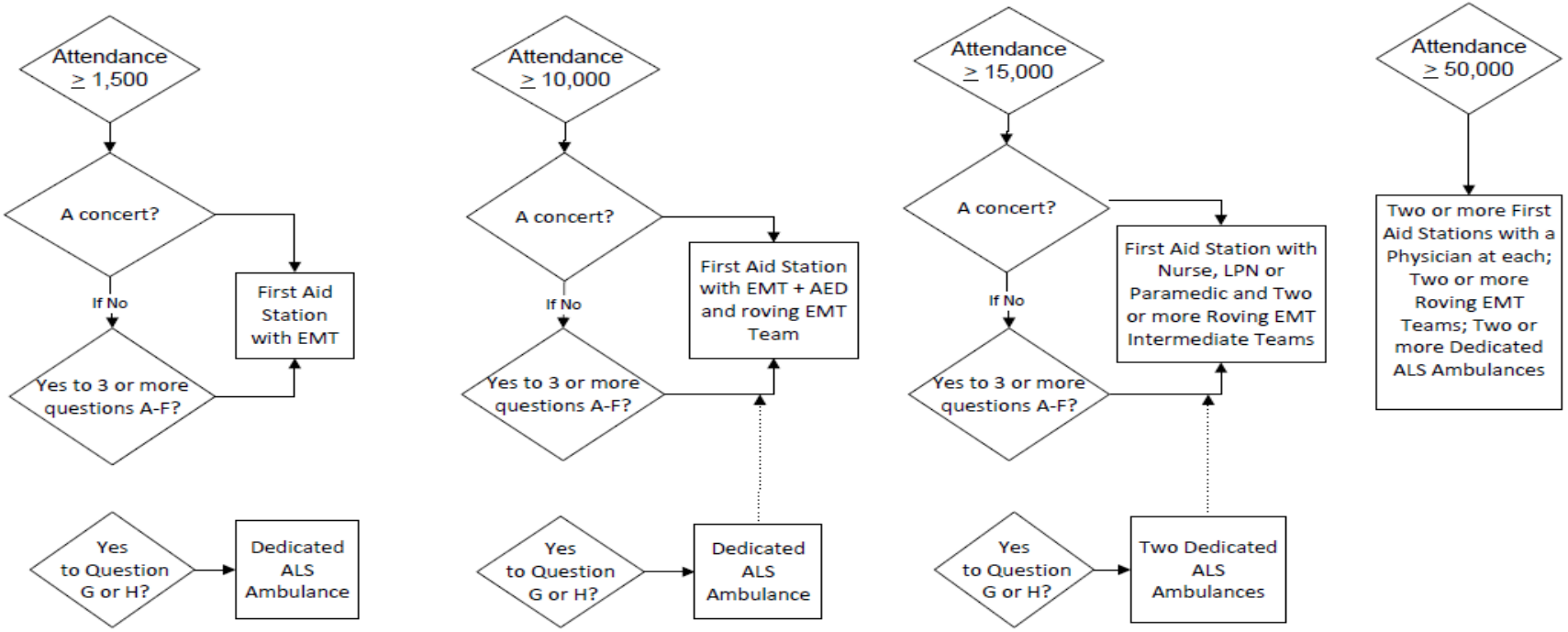
or one (1) dedicated ALS ambulance, and on-scene medical personnel of various levels suitably equipped, which may vary depending on the factors evaluated. Other factors should be considered, which are based on published standards and are identified to be important to provision of EMS coverage at a specific event. The minimum factors to be considered are listed below.

The EMS Coverage Analysis Flow Chart (Section 2.2) is based on a review of literature regarding EMS at mass gatherings. The flow chart is based on both the size of an event and variables that may result in an increased need for medical care for an event of 1,500 people or more. For events involving fewer than 1,500 people that do not meet the risk factors, it is recommended that the local EMS/ambulance providers be provided information on ingress/egress plans and traffic issues that may result from the event. This allows the first responders to plan for and monitor impacts of the event on the EMS system, while continuing to maintain rapid responses to patients throughout the community.

The following mitigation strategies for EMS medical coverage are also recommended for all events of at least 1,500 people:

- EMS personnel should be on site whenever event personnel, spectators or participants are on scene, including set up and take down activities.
- If dedicated ambulances are utilized, they should be co-located with the first aid tent whenever possible.
- Hand washing facilities for medical aid station personnel should be separate from general public facilities.
- Handicapped accessible Sani-Huts or ADA-approved fixed facility restrooms should be available near the medical aid stations so patients can access them.
- If first aid stations are utilized, disposal of biological waste should be addressed in the event plan.
- For venues that are a considerable distance from the closest healthcare facility, pre-planning for landing a medical helicopter should be included.
- Plans for compliance with HIPAA provisions should be developed for patient care records that include patient identifiers.
- For events greater than 15,000 people, MCI response operations and command structure concepts should be included in the event planning process

2.2 EMS Coverage Flow Chart



QUESTIONS

A. High-risk activities such as sports, racing, etc.?
B. Environmental hazards or extremes of heat or cold?
C. Average age of crowd less than 25 or greater than 50?
D. Crowd includes large numbers of persons with acute or chronic illnesses?
E. Crowd density presents challenges for patient access or transfer to ambulance ?
F. Alcohol to be sold at the event, or a history of alcohol or drug use by the crowd at prior events?
G. Past history of significant number of patient contacts at the event or patients transported to area hospitals?**
H. Event greater than 5 miles from the closest hospital?

** Significant is defined as (1) the number of patient contacts is ≥ 0.7% of the total number of attendees, or (2) transport rate to hospital by ambulance or private vehicle is ≥ 15% of total patient contacts

DEFINITIONS

First Aid Station: Fixed location on site staffed by at least one Emergency Medical Technician or a person with a higher skill level capable of providing emergency medical care within their proscribed scope of practice.

Roving EMT Team: team of two or more personnel at the basic or EMT Intermediate level with treatment supplies to provide emergency medical care.

Dedicated ALS Ambulance: An Advanced Life Support ambulance staffed by a Paramedic and Intermediate EMT, or personnel with a higher skill level, and capable of providing transport of patients, but which will immediately respond back to the event site.

3. OPERATIONAL CONCEPTS

3.1 Medical Response

In a medical disaster, resources are typically the limiting factor. The number of victims, nature of critical injuries and current resources will interplay to stress the medical system. In smaller incidents, resources within the county may be the only resources required.

As the magnitude of the incident increases, out of county resources from neighboring jurisdictions, and in some cases, State and Federal agencies' resources may be required. Therefore, the use of Memorandums of Understanding (MOUs) and MAAs will be employed.

3.2 MCI Pre-Alerts, Notifications and Activations

MCI Pre-Alerts

When there is an incident that has the potential to be an MCI, but the exact details are unknown, the Medical Dispatch Center or a responding agency may initiate an MCI pre-alert. This is a notification only, but agency notifications required for an actual MCI should be followed. Agencies are encouraged to conduct business as usual until they are notified by the Medical Dispatch Center that an MCI has been declared, or that the pre-alert has been cancelled.

Healthcare facilities will begin gathering information on their capacities should the pre-alert become an actual MCI.

For pre-alerts that are initiated for incidents outside of Washoe County, but may impact EMS or healthcare resources within Washoe County, the Medical Dispatch Center, as further information is obtained, will determine if a pre-alert should be cancelled or an MCI declared.

If there is a delay in determining if the pre-alert is to be cancelled or an MCI declared, the Medical Dispatch Center will update the Public Safety Answering Points and healthcare facilities at least every hour. When a decision to cancel or declare an MCI is made, all notified agencies will be contacted regarding the status of the incident.

Notifications

After the initial activation of the EMS system and healthcare notification, the following two officials must be notified by the Medical Dispatch Center:

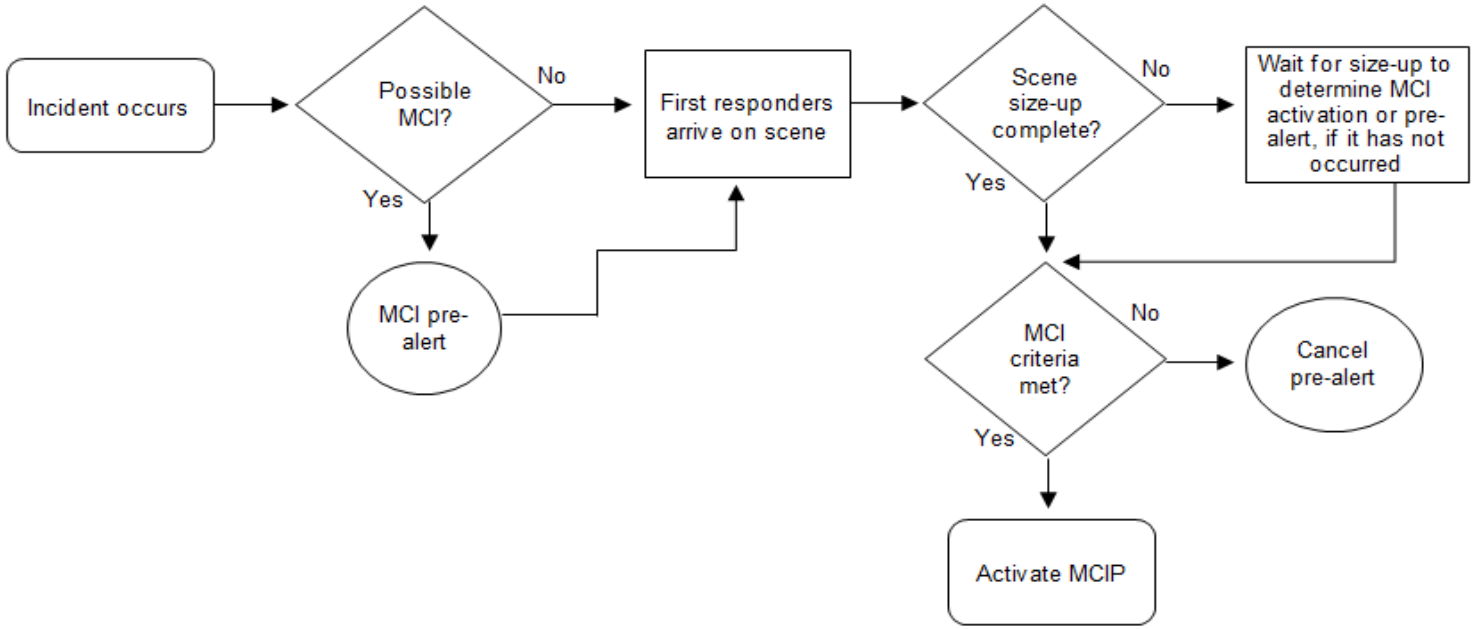
- The Washoe County DHO or his /her designee.
- Washoe County Emergency Manager or his /her designee.

The Nevada Division of Emergency Management (DEM) will be alerted by the Washoe County Office of Emergency Management and Homeland Security of impacts to the county. This alert provides for the ability to request additional out-of-county resources to respond and support the event.

Activating the Medical System within Washoe County

Timely activation is a key element in securing an appropriate medical response. Activation will begin upon the request of the first responding unit on scene. In the case of larger events, units still enroute may declare an MCI before they arrive on the scene.

In general, activation of the MCIP and notification to the regional healthcare facilities by the Medical Dispatch Center will occur when 10 or more patients are anticipated to be transported. However, activation may occur if there are fewer than 10 patients depending on factors like the location of the incident, the number of critical patients, or the involvement of hazardous materials, etc.



MCI Criteria – activation of the MCIP and notification to the regional healthcare facilities by the Medical Dispatch Center will occur when 10 or more patients are anticipated to be transported. However, activation may occur if there are fewer than 10 patients depending on factors like the location of the incident, the number of critical patients, or the involvement of hazardous materials, etc.

First responders can use the following disaster response levels to indicate the size of the MCI to dispatch and other responders:

MCI Type	Number of Victims	Description
Level 3	10-40	Minor incident involving 10-40 surviving persons. Will stress local resources for a short period of time.
Level 2	41-100	Major incident involving 41-100 surviving persons. Will tax Washoe County resources for moderate period of time.
Level 1/Alpha	>100	Catastrophic casualty incident involving greater than 100 surviving persons. Will tax regional resources for an extended time; the Alpha MCI plan should be activated.

The above table is a guideline for activation that will assist responders in knowing the general size of the incident. There are instances where an MCI could be small, but the critical nature of patient conditions could have a larger impact on resources.

3.3 Out of County Emergencies

When out of county MCIs occur and Washoe County agencies are contacted for transport or receiving patients, the agency initially contacted will immediately notify the Medical Dispatch Center.

The Medical Dispatch Center will be responsible for notifying all agencies regarding the out of county MCI. The Medical Dispatch Center will contact out of county agency(s) to redirect any further medical incident communications to Washoe County through them, and the Medical Dispatch Center will coordinate information dissemination about the incident within the Washoe County EMS system.

Activation of the Washoe County MCIP will be based on initial information, request of the out of county agency, or at the request of healthcare partners.

The Medical Dispatch Center will brief the DHO or his/her designee on the incident. If requested, the DHO or his/her designee can assume the role of agency liaison. If acting as a liaison the DHO or designee may conduct the following:

- Coordinate operational and logistical activities along with the assistance of the Medical Dispatch Center to centralize communications.

- Communicate healthcare facilities capability information within Washoe County, obtained by the Medical Dispatch Center, to the Incident Commander in the out of county jurisdiction. If patients have been transported to a local acute care healthcare facility outside of Washoe County, the facility capacity information within Washoe County will be shared with the out of county Hospital Incident Commander, who may make that information available to attending physician(s).
- Notify the Nevada DPBH of the public health impacts within the WCHD, and identify himself/herself as the authorized point of contact for public health issues within the WCHD until a community EOC or Washoe County Health District Operations Center may be activated.
- Depending on the incident circumstances, the on duty officer for the Nevada DEM may assume medical resource coordination duties for the incident outside Washoe County. In that case, the Washoe County DHO or his/her designee will notify DEM of his/her role and will act as a liaison with DEM and other state agencies, the out of county Incident Commander and Washoe County EMS/ambulance services and healthcare facilities regarding MCIP matters within Washoe County.
    - If multiple military or civilian helicopter ambulances respond into Washoe County, the DHO or his/her designee will coordinate with DEM, the local Hospital Incident Commander(s) and CareFlight regarding appropriate landing zones (LZ) based on patient severity and other factors. In general, unless there is a pre-existing landing agreement with a healthcare facility, helicopters will land at the Reno-Tahoe International Airport, and the patients will be transported by ambulance to facilities within Washoe County. Law enforcement and Fire agencies within Washoe County may be requested to provide operational and logistical support issues regarding air operations, closure of streets, night lighting, and security of LZs.

The goal is to ensure that patients receive the best possible care via ground, helicopter and fixed wing ambulances, and that patients are disbursed safely and expeditiously to appropriate healthcare facilities within Washoe County.

3.4 Mutual Aid and Other Resources

The IC, in coordination with Medical Branch, will request out of county resources through ICS with the use of existing MOUs and MAAs. Only with the approval of the Incident Commander or designee may the Medical Branch Director initiate a mutual aid response by alerting or requesting additional medical resources directly from the scene. Medical mutual aid resources committed to the scene of an incident will come under the direction and control of the Medical Branch Director or Incident Commander, as assigned.

At any incident or event, the situation must be assessed and response planned. Resources must be organized, assigned and directed to accomplish the incident objectives.

Usually, incidents have an initial commitment of resources assigned. As incidents grow in size and/or complexity, more tactical resources may be required and the Incident Commander may augment existing resources with additional personnel and equipment. All resources should be requested via single-point ordering through the on-scene IC.

3.5 Transition and Implementation of Medical Resources

Upon arrival at any MCI, the EMS provider(s) must make a rapid change from "one-on-one/one-on-few" direct patient care to the role of "one-on-many" facilitator and leader within the ICS.

The first arriving ambulance must first make immediate contact with the Incident Commander, if activated, or the government response agency official having jurisdiction at the scene who may be present. The purpose is twofold:

- To protect the arriving ambulance personnel from harm, such as accidentally entering an unsafe environment, and
- To coordinate activities between ambulance personnel and the jurisdictional agency having authority over the incident.

Medical operations must be based on up-to-the-minute information. This begins the process of a medical size-up. On MCIs, the role of initial responder may not be direct patient care.

The first arriving ambulance should provide an initial size-up report to the Medical Dispatch Center as described on page 6.

In the case of hazmat related incidents, refer to the Medical Annex of the Regional Hazardous Materials Emergency Response Plan for additional MCI size-up information.

3.6 Implementation of Medical Role

The arrival of a qualified person on scene, at the direction of the Incident Commander, will establish the Medical Branch Director position. This results in transfer of overall direction and coordination of the Medical Branch from the Incident Commander to the Medical Branch Director.

The Medical Branch Director will assume all other Branch duties until suitable staffing is available and assigned. The best use of ALS providers is direct patient care, unless they are needed in other positions of the ICS to complete an effective working structure.

Additional ambulances must be prepared to rapidly load and transport, or be assigned roles within the medical operations. Incoming ambulances must monitor assigned EMS frequencies to ensure that they receive current information and instructions, and should report to the ambulance staging area, or other location, as directed by the Medical Dispatch Center.

As the Medical Branch is established and additional medical intelligence is gathered all information should be provided to the Medical Dispatch Center to keep dispatch personnel well-informed of the situation, so they can advise the healthcare facilities and other reporting agencies.

Delaying transport should be avoided if ambulances are available, victims are packaged for transport, and healthcare facilities are available to receive and care for the victims. The priority is to transport immediate (red) patients first. Departures and destinations should be properly coordinated and recorded.

Line EMS personnel should be relieved from medical management roles as qualified personnel arrive. Medical management roles should be filled by those not essential to patient care, when applicable.

3.7 Healthcare Facilities Role in MCI

The Medical Dispatch Center will immediately notify the healthcare facilities within the county in an MCI activation or in a pre-alert situation. The Emergency Department Charge Nurse at Renown Regional Medical Center, Renown South Meadows, Northern Nevada Medical Center, Saint Mary's Regional Medical Center, and the Administrator on Duty at VA Sierra Nevada Health System will be notified. Depending on the location of the incident and the number of patients, the Medical Dispatch Center shall also notify Incline Village Community Hospital for a patient care capacity inventory.

Healthcare facilities in the county should consider activating their own Emergency Management Plan.

It is recommended that each healthcare facility develop internal guidelines to identify how many patients and what type the facility can accept in a disaster or multi-casualty situation. The following criteria should be considered:

- Number of available beds and number of beds the facility is able to open/add
- Available number of monitors in the Emergency Department
- The number of available operating rooms/teams
- Physician staffing (particularly in the Emergency Department)
- Nurse staffing

To assist the Medical Dispatch Center, emergency department baseline capacity numbers have been documented by the area healthcare facilities, so that the Medical Dispatch Center can begin dispersing patients via the process noted throughout section 3. It is the responsibility of the area facilities, through the IHCC, to periodically update those emergency department baseline capacity numbers to ensure they remain current.

The ambulance transport agency(s) will begin transporting patients using the emergency department baseline capacity numbers as a guide. The ambulance transport agency(s) will update the healthcare facilities as additional information becomes available as to the number and types of patients the facilities may expect to receive.

Each facility is responsible for updating the Medical Dispatch Center if there is a change in capacity to receive patients in comparison to the baseline capacity numbers below:

Emergency Department Baseline Capacity 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 numbers: 25 reds, 50 yellows and 108 greens

In larger events, there is the potential that green patients may tie up critical resources dedicated to the more critical red or urgent yellow patients. It is each facility's responsibility to notify the Medical Dispatch Center when they are considering the transfer of green patients to their affiliated urgent care centers, or if they wish to divert green patients from the scene to their affiliated urgent care center, whom they have pre-alerted.

Within the Truckee Meadows region of Washoe County, the first six most critical patients will be transported to the Trauma Center at Renown Regional Medical Center. Additional patients will be distributed to the healthcare facilities based on available patient care capacity. (State Trauma Destination Guidelines do not apply.) Facilities will prepare to accept patients as assigned. The Medical Branch Director through the Medical Dispatch Center will update the healthcare facilities as patient numbers are confirmed and notify the appropriate agencies when all patients have been transported.

Healthcare facilities distant to the scene will prepare to provide manpower, equipment and supplies as requested by the Medical Dispatch Center. These facilities may be activated under MAAs.

Due to safety and logistical issues, the landing of helicopters at hospital helipads during an MCI will be limited to those agencies that have pre-approved agreements with the medical facilities. All other helicopters will be directed by the Medical Dispatch Center to land at the Reno-Tahoe International Airport, and the Medical Dispatch Center will make arrangements for those patients to be transferred to the area facilities by ambulance.

Currently there are no formal agreements in place for hospitals to utilize urgent care centers to receive walking wounded. However, the use of urgent care centers or community clinics can increase the capacity of the health care system to provide expedient care to non-critical patients in a large incident. The WCHD, with the support of the acute care hospitals, will explore the development of written agreements with specific urgent care centers or clinics in the future.

See Appendix G for a map of locations of the acute care facilities with emergency departments in Washoe County.

3.8 Communications

Medical Nets/Landline Communication Systems

The Medical Branch must maintain communications with the Command staff and should determine the method of communication during the initial briefing. See below for a possible pre-built ICS 205 radio communications plan.

The Medical Dispatch Center will assign a channel or channels on MED NET frequencies for communications for the following responders:

- Medical scene operations
- Medical Branch Director to Medical Dispatch Center
- Medical Dispatch Center to healthcare facilities

The DHO has pre-designated FCC dedicated frequencies for facility to facility, and facility to WCHD if local landlines and cell phone capabilities are compromised, and redundant communication methods are required.

Federal grants allowed additional redundant communications through 800 MHz radios via a WCHD talk group when the radios were purchased for the area healthcare facilities and REMSA.

Amateur ham radio communications resources may also be activated to augment medical communications. Ham radio resources are activated through the Washoe County Emergency Manager.

Ambulance/Scene Communication

When the MCIP is activated, the Medical Dispatch Center will notify all local and incoming ambulance units of the activation that standing orders will be utilized to their fullest during disaster status, and that ambulances will not call individual patient reports to the healthcare facilities, but will brief the Medical Dispatch

Center. The ambulance personnel will only contact the facility with a brief description of the illness, injury or triage category of the victim and ETA.

The Medical Dispatch Center will assign ambulances responding to a request for mutual aid to the proper channel for scene operations.

Communication from the scene to the jurisdictional EOC or REOC will occur through Incident Command communication system designated tactical frequencies. The EOC may not be activated for all MCIs.

Disaster medical communication will take priority over all non-disaster related emergency medical transmissions, except for those patient emergencies that need immediate medical direction beyond written protocols.

Inter-Facility Communication

Landlines should be utilized for inter-hospital operations, if possible, in order to reduce radio traffic and interference.

Communication from the EOC to the scene and healthcare facilities may utilize the MED NET channels.

Medical Dispatch Center

The Truckee Meadows area is served by a Medical Dispatch Center capable of coordination of all emergency medical communications.

In the outlying areas of Washoe County in Incline Village and Gerlach, the Washoe County Sheriff's Office Public Safety Answering Point (PSAP) will be utilized for communication coordination with the Medical Dispatch Center.

In the event of any questions regarding medical channel frequency assignment, hospital destination, etc., the final authority for resolution will rest with the Medical Dispatch Center.

The Medical Dispatch Center will be released from MCI status by the Medical Branch Director, if approved by the Incident Commander, and in turn will communicate with all involved parties that routine medical status will be reinstituted.

Additional Communication Resources

If the political subdivision(s) EOC is activated, select radios may be placed in service to provide communication links between the incident scene, the EOC and supporting agencies.

On a limited basis, some agencies can provide portable phones and "Fastpack" communications to the incident scene.

During an emergency, cooperation is paramount to achieve the maximum use of the communications system. Messages can be cut short if an operator does not listen to the traffic and overrides another transmission. Radio frequencies are subject to atmospheric interferences, reducing the use of some radios.

In the event of a major disaster within Washoe County, the County local government radio network and Amateur Radio Emergency Service (ARES) ham radio operators may be dedicated for supplementary emergency communications.

Acute care facilities in Washoe County are equipped with ARES radio equipment and have appropriately licensed staff as a supplemental communications resource.

Additional communication resources should be initiated by the Incident Commander from whoever owns or manages the resource.

Incident Radio Communications Plan (ICS 205)

ICS 205 provides information on radio frequency or trunked radio system talkgroup assignments for each operational period. In the initial response to an MCI, agencies will likely use a command channel and several tactical channels, which will be determined by the initial IC.

In most incidents communications is identified as a challenge for responding personnel. In an effort to overcome this barrier regional Fire, EMS and Law Enforcement developed the following ICS 205 for pre-planned radio communication to be used for extended incidents (MCI lasting more than 12 hours). It is understood that this is only a guideline for the beginning of an incident and the communications plan could expand or change, as appropriate.

INCIDENT RADIO COMMUNICATIONS PLAN		**1. Incident Name**	**2. Date/Time Prepared**		**3. Operational Period Date/Time**
4. Basic Radio Channel Utilization					
System/Cache	**Channel**	**Function**	**Frequency/Tone**	**Assignment**	**Remarks**
800 MHz	PS Fire 1	Command	WCRCS	PSAP Dispatch to Comm	Coordinated with PSAP
800 MHz	PS Fire 2	Tactical	WCRCS	Comm to Responders	Coordinated with PSAP
800 MHz	PS LE 1	Tactical	WCRCS	Comm to Responders	Coordinated with PSAP
800 MHz	PS LE 2	Command	WCRCS	PSAP Dispatch to Comm	Coordinated with PSAP
Med Radios	Mednet 3	EMS	UHF	Field to REMSA Dispatch	Subject to change depending on location
Med Radios	Mednet 8	EMS	UHF	REMSA Dispatch to hospitals	Subject to change depending on location
800 MHz	WC HDSUP	Command	WCRCS	Comm to WCHD	
VHF	NevCord 1	Air Resources	VHF	Air ambulance responders to ground crews	
800 MHz	PS Event 2	Tactical/Comm	WCRCS		
800 MHz	PS Event 3	Tactical/Comm	WCRCS	Optional – Comm to Responders	
5. Prepared by (Communications Unit)					

3.9 Special Incident Considerations

Incident Command/Command Post Functions

At the onset of an emergency incident involving more than one agency, a Command Post should be established. It represents the command and direction elements for monitoring and controlling operations. Representatives from each agency should function within the Command Post, which should be easily identifiable.

The communication element of the command post serves as the nerve center for maintaining coordination and control. In order to obtain this service, it might require each agency to position one of their mobile units in the vicinity of the command post to provide this coordination of communications.

A large incident might necessitate the incident to be split into geographically distinct divisions.

The Incident Commander, through his/her Public Information Officer (PIO), is responsible for media relations. Medical personnel on scene approached by media must refer them to Command personnel, unless otherwise authorized and directed.

The Incident Commander may request a weather forecast from the Reno National Weather Service (NWS) Reno.

Staging Areas

The designation of a staging area is of major importance in maintaining organization and control of an emergency incident scene. This area should be located as near as possible to the periphery of the incident zone. All responding vehicles and personnel not having prior assignments should be directed to the staging area(s). In a large medical incident, ambulance staging may be separate from incident staging, and units may be directed to respond to either area by the Medical Dispatch Center.

Vehicles must be systematically parked and keys left in the vehicle.

Volunteers and self-deployed workers, including off duty firemen and law enforcement personnel, may arrive at the scene during a major incident. These persons must be referred to the staging area, where they should be organized for proper utilization and coordination.

Refueling of emergency vehicles is essential during a prolonged incident.

Food and Shelter

Food and drinks for incident personnel will be coordinated through the Incident Commander and, generally, provided by the American Red Cross and/or Salvation Army.

The American Red Cross and/or Salvation Army vehicles should report to staging to be directed to appropriate areas of need.

Mass shelters or evacuation shelters will generally be established by the American Red Cross in coordination with the Incident Commander.

Rescue and Extrication

In a large event, the initial extrication of the injured may be initiated by lay persons entering the disaster zone prior to the arrival of trained personnel. Law enforcement, fire or other trained official rescue units should assume control over all extrication efforts by establishing the rescue/extrication group.

Air Space Security

Air space security is an important consideration for any incident aircraft. The Incident Commander or designee will secure and control air space as appropriate for the incident.

Deceased

The Medical Branch Director through the Medical Dispatch Center is responsible for notifying the Washoe County Medical Examiner/Coroner's Office (WCMECO) if there are deceased patients at the scene. Except by the specific authorization of the WCMECO or an authorized representative, no photographing, removal of clothing or effects, or handling of bodies or parts is allowed in any manner whatsoever, except that which is necessary for preservation of lives and the safety of others or to safeguard the remains of the deceased.

All removal or covering of bodies, except which is necessary for the removal of other injured victims or to keep the bodies from public eye, will be accomplished under the direction of the WCMECO. If possible, mark the position of the body or body parts before moving.

If healthcare facilities identified deceased patient(s), they may share information with bona fide family members unless prohibited by law enforcement agencies. Unidentified patients who expire at healthcare facilities will be turned over to the WCMECO.

The facilities may wish to advise inquiring family members that there are patients who still have not been identified, some of whom are deceased, and advise them that they may wish to gather identifying information about birthmarks, surgical scars or dental records to assist the WCMECO in identification.

The healthcare facilities may also wish to advise them of the WCMECO's phone

number and the location of the American Red Cross Disaster Welfare Inquiry Center, the Family Service Center (FSC) or community Family Assistance Center (FAC), if these resources have been activated.

Litter Bearers

Initially, there may be an insufficient number of litters, backboards, litter stands, and trained litter bearers. Volunteer litter bearers may be recruited and the litters, backboards and stands may be transported to the scene.

Four person litter teams should be used. Infection control measures should be followed, including the wearing of gloves and other appropriate personal protective equipment as indicated by the site safety plan.

Non-ambulatory victims should be immobilized on backboards or restrained on litters.

Ambulances and Transporters

The Medical Branch is charged with directing all activities of patient transport vehicles, including their ingress and egress routes.

Place the immediate/red treatment area closest to the ambulance access point.

In a large MCI, the method of transportation for minor/green patients may be of a type that cannot be used for the transportation of immediate and delayed patients, i.e., buses with fixed seats.

Healthcare facilities may be requested to restock ambulances as they arrive with individual medical supplies, depending on the availability of supplies within the Emergency Departments.

If major supplies are needed on scene, requests for medical supplies will come from the Field Medical Supply Coordinator and will be requested through the Hospital Liaison Officer or Hospital Incident Commander.

It is the healthcare facility's responsibility to facilitate disposition of the patients upon arrival and to release ambulances as soon as possible.

Ambulance personnel will transport patients to the facility designated by the Patient Transportation Group Supervisor (PTGS). Changes enroute may only be authorized by the Medical Dispatch Center and should be documented appropriately.

The Air Operations Branch Director reports to the Operations Section Chief in a larger incident response and supervises all air operations.
In smaller incidents, the Air Operations Branch Director position can be filled if the location or complexity requires the use of multiple EMS aircraft; in this case

they can report to the Incident Commander or designee. Air Ambulance Coordinator work under the Air Operations Branch Director and coordinate EMS aircraft and patient flow in and out of the incident with the PTGS.

In a large incident that utilizes additional non-EMS aircraft, the Air Operations Branch Director will coordinate to ensure continuity and safety between all aircraft.

If patients are evacuated by helicopter, a landing zone should be established – as near as practicable to the patient pick-up area, unobstructed to approach and departure, yet distant enough from the treatment units to avoid excessive noise and blown debris.

Documentation

Record keeping/documentation at the scene should be accomplished through use of the disaster scene forms and triage tags.

Documentation at the facilities and definitive treatment area should be in accordance with the individual policies and procedures of each agency, but should be done to allow coordination between scene and definitive treatment areas (i.e. inclusion of the triage number off the field triage tag).

Each agency and facility involved in the incident should have a system for issuance and accountability of equipment and supplies.

Medical Dispatch Center personnel will maintain documentation of agency notifications and facility capabilities.

At a minimum a Unit Log 214 will be completed by all dispatch personnel involved in the incident to document key communications with incident personnel and other agencies off scene.

Rehabilitation/Stress Management

Due to the stressful nature of responding to a disaster, all incident personnel should realize that their natural coping defenses may be inadequate, and they should seek help for themselves and other incident personnel, as needed, from incident management (See Appendix I).

Due to physical and mental fatigue and the adverse environmental conditions of disasters, all incident command supervisors should monitor their personnel for rehabilitation needs and notify the Incident Commander or designee for appropriate restoration of personnel.

The Washoe County Regional Emergency Operations Plan (REOP), Disaster Behavioral Health Annex establishes a mechanism for jointly managing behavioral health for emergency incidents and events impacting one or more of

the participating jurisdictions. The Annex is a streamlined guide for quickly obtaining behavioral health resources in an organized manner. It focuses on Washoe County regional actions and State of Nevada DPBH support resources.

The MCIP provides optional resources for responders in Appendix I, however it is highly recommended that each individual agency develop and maintain a mental health and stress management response plan for their employees.

Demobilization
During the demobilization process, all incident personnel must check out through their command supervisor or designee before being released from incident duty.

4. TRIAGE AND TREATMENT

4.1 Triage Procedure

Triage is defined as the sorting of, and allocation of treatment to, multiple patients and disaster victims according to a system of priorities designed to maximize the number of survivors. The function of triage is most useful and needed in large disaster settings where local resources are overwhelmed.

Triage is performed by the assigned team(s), whose knowledge of triage will allow them to quickly evaluate and place the victim into an appropriate category. The Simple Triage and Rapid Treatment ("START") is the initial triage procedure for MCIs in Washoe County.

The START Flow Chart and Pediatric JumpSTART Flow Chart are located in Appendix B to provide the rescuer with a quick reference guide for triage in the field.

"START" was developed as a method of triaging patients in an MCI quickly and efficiently. START focuses on the following goals: simple to use, does not require any special skills, rapid, provides minimal stabilization, does not require specific diagnosis, and is easy to learn and teach. The START method utilizes four assessment tools to evaluate and categorize patients. These tools are: the ability to walk, ventilate, perform, and reason. Also known as "30-2-Can Do."

4.2 Additional Triage Guidelines

With the institution of the initial ribbon triage system (12/19/13), colored ribbons (surveyor tapes) are used to mark a patient's acuity level during initial triage. Triage tags are used for secondary triage in the treatment areas or are applied to victims during ambulance loading if treatment areas have not been established. Once all victims are marked with ribbons, triage personnel will have a count of victims as well as their acuity level, which they will report to the Triage Unit Leader. This information should be reported immediately through

the ICS structure to the Incident Commander and Medical Unit Leader.

Victims should be moved to the appropriate treatment areas for treatment, reassessment and transportation beginning with victims marked as immediate/red.

Victims' medical conditions will not be static throughout the event. Therefore, it should be noted that triage is a continuous process.

The START method will not be used to reassess patients in the treatment areas. Traditional methods will be used to further assess the patient based on diagnostic criteria (see section 4.4).

Patients who are marked as non-salvageable/black should not be moved until the WCMECO has reviewed the victim and has approved movement to the morgue area. The exception to this rule would be if a body was impeding triage, movement or treatment of a salvageable patient.

In general, cardiopulmonary resuscitation of patients should not be initiated unless staffing allows for immediate treatment of all immediate/red and delayed/yellow patients.

4.3 Triage Ribbons and Tags

The colors red, yellow, green, and black correspond to the colors on both the initial triage ribbons and triage tag.

Note: The ribbons use the same color scheme but utilize a black and white striped ribbon instead of black for improved night visibility.

Triage ribbons are dispensed from a waist pack that contains four rolls (red, yellow, green and black & white). Ribbons are used for initial triage by triage team members. Triage tags are used in the treatment areas for secondary triage and patient accountability.

The all-risk DMS Triage Tag utilizes colored tear-off receipts to indicate victim's acuity levels during secondary triage.

- If a patient is determined to be in minor condition, using the START method (see START Flow Chart and Pediatric JumpSTART guideline in Appendix B), the pink contamination strip is removed to confirm the patient is not contaminated and the green receipts are left in place indicating the patient is MINOR acuity.
- If the patient is determined to be in delayed condition, the pink and green receipts are removed leaving both yellow receipts in place indicating the patient is DELAYED acuity.

- If the patient is determined to be in immediate condition, the pink, green and yellow receipts are removed leaving both red receipts in place indicating the patient is IMMEDIATE acuity.
- If the patient is determined to be in a non-salvageable condition, all receipts except for the black MORGUE receipts are removed.
- Triage unit personnel should maintain the numbers they have triaged and their color codes so that a count of patients, and their priorities, can be reported to the Triage Unit Leader. Each ribbon dispenser contains a card to help triage personnel keep track of patients triaged.
- Once patients arrive in treatment areas, and triage tags are applied, appropriate patient information regarding vital signs, Glasgow score, injured areas, and treatment notes may be noted as time allows.
- Triage tag transportation receipts located on top of the tag contain the patient's triage tag number and will be retained at the scene prior to transport. Healthcare facilities should cross reference patient account numbers on charts with field triage tag numbers; upon removal, tags should be kept by the facility for future quality improvement purposes.

4.4 Reassessment in Treatment Areas

In general, sorting of patients relates to how quickly treatment must be delivered to ensure survivability. Triage categories are traditionally defined as:

- Immediate/red – critical; life threatening; may survive if care is received within thirty minutes (30).
- Delayed/yellow – serious; may be life threatening; may survive if care is received in thirty minutes (30) to several hours.
- Minor/green – not considered life threatening; care may be delayed hours or days; this group may be referred to as the walking wounded.
- Deceased/black – fatally wounded, or clinically dead.

START triage of victims is designed for rapid assessment. Once patients are assigned to treatment areas, they should be reassessed using primary and secondary surveys. The guidelines on the following page are to be used to decide the priority of treatment and transport after patients arrive in the treatment areas and are reassessed based on diagnostic categories.

Triage tags on victims in the treatment areas should be reclassified as appropriate following reassessment, and patients should be moved to the appropriate treatment area if there is a change. If the patient is moved to a lower priority of treatment, remove the colored receipts to reflect the new priority color.

Patients will be transported from the treatment areas according to the directives of the PTGS on reassessment categories provided by the Treatment Dispatch Manager.

Reassessment in Treatment Areas by Diagnostic Categories

First Priority – Immediate/Red

- Airway problems of any type
- Most types of chest wounds
- Deteriorating vital signs
- Suspected internal hemorrhage
- Severe uncontrolled external bleeding
- Head injuries with decreasing level of consciousness
- Partial and full-thickness burns of 20%-60% of body surface
- Medical conditions with deteriorating vital signs, altered level of consciousness, or severe breathing problems

Second Priority – Delayed/Yellow

- Open fractures
- Multiple fractures
- Spine injuries
- Large lacerations
- Partial and full-thickness burns of 10%-20% of body surface
- Medical conditions manifested by abnormal vital signs or severe pain consistent with a life threatening condition
- Injuries or conditions involving circulatory compromise to an extremity

Third Priority – Minor/Green

- Minor burns
- Closed fractures
- Sprains and strains
- Minor lacerations
- Abrasions and contusions

Deceased/Expectant – Black

- Obviously dead
- Probably fatal injuries, such as severely crushed heads or full-thickness burns of 80%-100% of body surface
- Cardiac arrests

5. PATIENT CONSIDERATIONS

5.1 Patients with Burns

Nationally there are not enough designated burn care beds or burn centers to manage a surge of pediatric and adult burn patients. Current practice recommends transfer of seriously burned patients to burn centers for specialized care; however, these resources will be quickly overwhelmed by an incident that results in large numbers of burn victims, either pediatric or adult.

In the event a disaster occurs in which there is a surge of burn patients, it is not possible for local facilities to provide specialized burn care for affected patients because Washoe County does not have any burn centers. If a burn MCI should occur, some local healthcare facilities may need to accommodate and care for burn patients until specialized burn care resources/beds become available. It is likely those healthcare facilities will be caring for the burn patients for several days until safe discharge or transfer to a tertiary care facility.

Healthcare facilities in Washoe County need to be aware that many burn patients will be critically ill and require time/resource/labor intensive care:

- Initial resuscitation in EDs
- Fluid managements
- Airway control/ mechanical ventilation
- Surgical debridement/ escharotomy/ grafting
- Pain control
- Infection control

If a burn MCI occurs, Washoe County local responders will use the Western Region Burn Mass Casualty Incident (BMCI) Response Plan to get necessary care for burn patients.

Western Region Burn Mass Casualty Incident (BMCI) Response Plan
The American Burn Association (ABA) designated Western Region[1] encompasses Burn Centers located west of Montana, Wyoming, Colorado and New Mexico, including Alaska and Hawaii.
• For a BMCI occurring anywhere within the Western region of the United States the Western Region Burn Disaster Consortium serves as a communications and coordination center to support Burn Center(s) with burn bed census and/ or patient triage and transfer. • A BMCI is defined as any incident where capacity and capability significantly compromises patient care, as identified in accordance with individual BC(s), state, regional or federal disaster response plans.

Requesting Assistance from the Western Region Burn Disaster Consortium (WRBDC)for BMCI Response and Coordination	
Upon request by a referring BC(s) the WRCC: • Conducts a bed census of Western region BCs using the Utah Notification and Information System(UNIS) Burn Provider Group • Supports and assists with regional efforts for patient triage and transfer if requested	Agencies requesting assistance include: • Western Region BCs • Affected ABA BCs • ABA Regional Coordinator(s) • ABA Central Office • Department of Health & Human Services (DHHS) or designee
To request WRBDC assistance contact: • The University of Utah Burn Center 24/7 line at **801-581-2700** • Burn Medical Coordination Center (BMCC) 24 hour Emergency Hotline at **866-364-8824**	Upon notification WRBDC: ○ Activates the regional burn disaster plan ○ Conducts burn bed census of non-affected Western region burn centers for 02,12, 24 hour intervals ○ Coordinates requests for patient transfer between referring and receiving BC(s)

Definitions

1. Western Region (WR) - one of five American Burn Association-designated regions. Refer www.ameriburn.org Homepage for a map of all regions.
2. Western Region Burn Disaster Consortium (WRBDC) - a Utah-based consortium of 26 burn centers,13 of which are verified, who have joined together to support disaster response efforts for one another throughout the Western Region.
3. Western Region Burn Coordination Center (WRBCC) - one of 2 centers located throughout the West with redundant communication technologies to support disaster response efforts for burn centers. These centers are Utah and Colorado.

5.2 Pediatric Patients

Children are a highly vulnerable segment of the population and can often be victims of disasters or multi-casualty situations. When planning for MCIs children tend to be forgotten, or simply included in the general population of a region's plan. However, children are a group with distinct needs. There are a number of challenges prehospital providers may face when caring for children during a multi-casualty incident because:

- The physiology of children differs from adults,
- Children are particularly vulnerable in a disaster,

- Separation from parents or caregivers may occur;
- And protocols developed for adults may not work well for children.

A large number of pediatric patients with either physical or psychological injuries could easily overwhelm the existing pediatric resources for Washoe County healthcare facilities. To accommodate the initial stabilization and treatment of these victims, the EMS system must have pediatric protocols in place and take these patients to a hospital that has the resources for adequate pediatric care. In addition, hospitals should have surge plans in place for response to an MCI, with the aim of increasing the pediatric bed capacity.

The following assumptions should be considered during a pediatric disaster:

- Pediatric care, not normally available at some hospitals, may have to be provided during a disaster until transfer to definitive care can be arranged. Healthcare providers, not used to caring for critically ill or injured pediatric patients may have to provide initial stabilization and continued care, until the patient can be transferred.
- Pediatric patients are not little adults and, as such, the extent and intensity of care and resources required will vary significantly within the targeted population. This is critical in assessing existing pediatric resources as it relates to the development of pediatric preparedness plans. Hospitals without pediatric services such as pediatric critical care or a pediatric trauma service may need guidelines and recommendations to provide protection, treatment and acute care for pediatric patients in disasters.
- Healthcare providers need access to pediatric-specific training, guidance, exercises and supplies.

An MCI involving a large number of children is likely a worst case scenario for many prehospital providers, but it is necessary for providers to know the variances between children and adults to provide effective care during an MCI. The following sections include information on pediatric physiology and care recommendations for providers to consider when on-scene of an MCI with multiple pediatric patients.

Pediatric Physiology

There are numerous physiological vulnerabilities that can pose a challenge for responders when then arrive on an MCI including:

- Children's heads are proportionally much larger than their bodies, making them more susceptible to head injuries from blunt trauma.
- Children's organs are also proportionally larger and are not as well protected by the rib cage and abdominal musculature.
- During an MCI, children will typically suffer from respiratory problems rather than something cardiac-related, which is different than adults. It is important for the prehospital provider to be aware that the most common cause of

cardiac arrest in a child is the inability to establish or maintain a patient airway or the inability to oxygenate or ventilate a child.

- Children have faster respiratory and heart rates and a proportionally greater body surface area for their body mass. These factors places children at higher risk for airborne chemical and biological agents since their bodies absorb toxins at a faster rate.
- Some toxic agents cause vomiting and diarrhea, which dehydrates children more rapidly than adults, since children have smaller reserves.
- Children have a higher metabolic rate; therefore they have a different response to both the toxins and the medications you may use to treat them.
- Children have different mental and psychological needs, especially in a disaster setting. Most children lack a sense of self-preservation, and do not have the cognitive skills or physical ability to react appropriately to signs of danger or instructions for help.
    - Additionally, they have fewer coping skills than most adults and do not always follow directions well.

Despite all of these factors, children have great potential for resiliency when treated appropriately. Below are pediatric care recommendations for Washoe County agencies responding to a pediatric MCI.

Children with Intellectual and/or Developmental Disabilities: Roughly 20% of the population of the United States has some form of disability. Therefore, there is likelihood that individuals with intellectual and/or developmental (I/DD) could be involved in any type of MCI. There are a few important things for prehospital providers to know if individuals with I/DD are involved in an incident.

- Look for medic alert bracelets and care plans.
- Some individuals with I/DD are dependent on medications given at specific times during the day.
- Some individuals with I/DD are dependent on ventilators and other electrical equipment and may need to recharge batteries.
- If a child is non-communicative and has no family/care provider with them, providers will need to meet the needs of the child.

Psychological: Pay attention to children's emotional state. Responders may need to take a few extra seconds to calm a child in order to get them to cooperate.

Children continue to be susceptible to environmental problems like respiratory disease, contaminated water, malnutrition and dehydration and abuse. The stress hormones released can have profound impact on both the child's immediate health, as well as their long-term development; the psychological impact of an MCI will certainly have long-lasting implications as well.

As much as possible, try to create a sense of safety and well-being. For younger children, provide simple explanations for what happened and avoid excess details.

Older kids will usually benefit from a slightly more detailed explanation, perhaps emphasizing everything groups are doing to help fix the situation and prevent further mishap.

5.3 Patients with Access and Functional Needs (AFN)

The definition Federal Emergency Management Agency (FEMA) uses for individuals with AFN, which is consistent with the definition in the agency's National Response Framework is, "Populations whose members may have additional needs before, during, and after an incident in functional areas including but not limited to: maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include:

- those who have disabilities;
- live in institutionalized settings;
- are elderly;
- are children;
- are from diverse cultures;
- have limited English proficiency or are non-English speaking;
- Or are transportation disadvantaged."

During an MCI involving AFN patients, the IC will need to coordinate the utilization of medical facilities and the procurement, allocation, and distribution of medical personnel, supplies, and accessible communications, specialized equipment to meet the needs of people with disabilities and other access and functional needs and other resources.

Hospitals in Washoe County should address access and functional needs populations in their individual emergency response plans, including but not limited to communication, mobility, behavioral and mental health, and age-related issues.

6. PATIENT TRACKING

When a disaster occurs in Washoe County trained WCHD personnel will respond in their applicable roles. Specifically for an MCI response, WCHD staff will respond and conduct patient tracking for the incident through the Medical Services Unit Leader position in the EOC. Patient tracking is a key element of MCI response and requires significant coordination between EMS, the WCHD and the healthcare system.

The on-scene Patient Transportation Group Supervisor is required to submit the DMS transport receipts/patient receipt holders to the Medical Services Unit every 10 patients. The Medical Services Unit personnel inputs this information into a locked down WebEOC board, only accessible by public health and hospitals.

The patient information from EMS along with the additional data from the receiving facilities assists with reunification of family members and individuals involved in the incident.

7. TRAINING

MCIs are not everyday occurrences. Additionally, the nature of the work demanded of the emergency responders is different from routine roles.

To be properly prepared for the unusual, it is necessary to have specific training in the theory and tactics that will be employed during an MCI.

While many agencies may be called on during an MCI, the bulk of the responsibility for patient care, treatment, transport, and safety generally lies with the responding Fire and EMS personnel, Medical Dispatch Center and the healthcare facilities. The following training guidelines outlined in this plan focus on these responders.

7.1 Ambulance Personnel Training

EMS personnel must be knowledgeable about the purpose and operation of the ICS and about the MCIP.

EMS managers must be trained to actively assume responsibilities within this plan and, therefore, in the ICS structure as managers, e.g., at the Unit, Group or Branch level.

All ambulance operational personnel should receive formal training in ICS and the MCIP. Specifically, all ambulance operational personnel should receive training as detailed in the following:

- ICS 100 (prerequisite)
- MCI basic training objectives:
    - Define a multi-casualty incident and the role and authority of the DBOH in developing the MCIP
    - Itemize the information to be gathered in an initial MCI size-up
    - List the activation criteria and the agencies that will be notified in an MCI pre-alert or MCIP activation, and explain why those agencies are notified
    - Explain the role in establishing incident command that is assumed by the first-in ambulance if no other agencies have arrived on scene
    - Describe the ICS medical organizational structure and how it may develop from an initial response level, to a reinforced response level, to a full response level, and a escalated branch response level
    - Explain how face-to-face reporting to the Incident Commander or lead jurisdictional agency by the first arriving medical personnel on scene can improve the outcome of an MCI

- Demonstrate the ability to select the appropriate START triage criteria, perform limited treatment interventions and carry out ongoing reassessment for simulated patients
- Describe the four-color categories in the triage tagging system, their significance regarding priority of transfer to treatment areas, and their significance in selecting patient transportation methods.
- Explain why it is important to immediately notify healthcare facilities in an MCI or hazardous materials incident that involves potential patients
- Describe the positive outcomes for patients when patients are disbursed appropriately to the area hospitals
- Describe the communication role of Medical Dispatch Center with on scene personnel, the healthcare facilities, the PSAPs, and other agencies
- Describe the factors in making a decision to request out of county hospitals or ambulance resources and the chain of command that is used
- List and describe the purpose of the documentation forms utilized by medical branch personnel

7.2 Medical Dispatch Personnel

Medical Dispatch Center personnel, in addition to 7.1, should receive training in Medical Dispatch MCI coordination objectives:

- List the priority of agencies and individuals to be notified by medical dispatch during an MCI
- List the baseline capacity numbers; describe the criteria used by the facilities to update those numbers, and the role of dispatch in monitoring those numbers during an MCI
- Demonstrate the procedures used to notify appropriate area healthcare facilities and other agencies, and the record keeping used by dispatchers to monitor capacities, ICS Unit Log 214, and the Hazardous Materials Spill Emergency Information Form
- Describe the methods, resources, and procedures used in medical communications in an MCI, including patient reports to the receiving healthcare facilities
- Describe the possible causes of communication failure and at least two back-up methodologies that could be used during those failures
- Explain the protocol for ambulances to provide patient reports during an MCI
- Describe the use of urgent care centers in large MCIs
- Describe the communication challenges presented by using urgent care centers in large MCIs

- Demonstrate the role of medical dispatchers in coordinating communications between Medical Branch personnel, the healthcare facilities and other agencies
- Demonstrate the coordination of out of county ambulance vehicles
- Demonstrate a system to track assignment of patients to facilities based on capacity, and updating of capacities
- Demonstrate the medical dispatcher's role in MCI record keeping
- Demonstrate out of county incident notifications and WCHD interface procedures
- Demonstrate MCI record keeping procedures within dispatch

7.3 ICS Management Position Training

All ambulance personnel who may assume ICS management positions at the unit leader level or above should receive additional training as detailed below:

- ICS 200 (prerequisite)
- MCI advanced training objectives:
  - List at least 10 items critical to the positive outcome of an MCI
  - Demonstrate the ability to assign appropriate personnel to the Medical Branch based on the various levels of response
  - Demonstrate the ability to brief lead Medical Branch personnel on the IAP and safety issues, give them their Medical Branch vest, and assign them specific responsibilities and reporting duties
  - Describe how to select, staff and equip appropriate treatment areas in a simulated event and to verbalize the factors that are important during treatment to improve patient outcome
  - Demonstrate the ability to select an appropriate ambulance staging location considering optimum ingress and egress routes and safety issues
  - Describe the role of the Medical Examiner/Coroner in caring for deceased persons, when it may be appropriate to move deceased patients, and how the morgue manager would request law enforcement/coroner involvement in an incident
  - Demonstrate the ability of the Medical Branch Director or Medical Group Supervisor to establish a variety of communication links during an MCI, both up and down the chain of command, and to delegate the appropriate communication responsibilities to on scene staff and to the Medical Dispatch Center
  - Verbalize the personal protective equipment and safety concerns that the Medical Branch Director or his/her designee may be responsible to address in an IAP

- Describe the rationale and process for requesting out of county facilities or ambulance resources
- Demonstrate the ability to use secondary (reassessment) triage criteria based on diagnostic categories that are to be used by ambulance personnel in the treatment areas
- Describe at least three medical branch challenges should an incident occur in Incline Village or a rural part of Washoe County
- Demonstrate the ability to interface with the HICS structure in a hospital evacuation
- Describe additional medical equipment available through the Reno-Tahoe Airport Authority of Washoe County and other agencies, and the process for requesting such resources
- Describe the role of the Medical Branch Director or his/her designee in demobilizing both on scene and off scene resources activated during an MCI
- Verbalize the role of an the ambulance transport agency representative in unified command
- Explain the role of the WCHD staff during out of county incidents and the role of the WCHD medical representative in an EOC for coordinating medical issues, monitoring medical capabilities, and tracking patients in a large MCI
- Describe the responsibility of the medical branch personnel to supply a copy of all MCI forms to the Incident Commander and to the WCHD at the completion of the incident, and to participate in an MCI debriefing

7.4 Fire Personnel Training

Fire personnel who provide emergency services must be knowledgeable about the purpose and operation of the ICS and the MCIP.
Fire command personnel must be trained to actively assume responsibilities within this plan and, therefore, in the ICS structure as managers, e.g., Unit, Group or Branch level or as the Incident Commander.

All fire operation personnel should receive formal training in ICS and the MCIP. Specifically, all fire operational personnel should receive training as detailed in the following courses:

- ICS 100 (prerequisite)
- See MCI basic training objectives in section 7.1

All fire personnel who may assume ICS management positions should additionally receive training as detailed in the following courses:

- ICS 200 (prerequisite)

- See MCI advanced training objectives in section 7.3

7.5 Executive Level Training

While executive personnel may not directly respond to an incident, or use operational elements identified in the MCIP, it is necessary for supervisory staff to have an understanding of the plan. The WCHD will offer annual executive level training for healthcare, fire, EMS, emergency managers, RTAA, public health, WCMECO or any other personnel interested in having a high-level training on MCI response and management in Washoe County.

7.6 Allied Agency Training

The nature of an MCI generally calls for the involvement of additional agencies and organizations other than Fire and the EMS/ambulance provider. These additional agencies are encouraged to participate in as much training relating to the response to a multi-casualty incident as possible.

Agencies that would likely have particular interest in and benefit from MCI training include:

- Volunteer fire departments
- Law enforcement
- Healthcare facilities
- Service organizations, such as the American Red Cross and the Salvation Army
- Emergency Managers

Organizations that would benefit from an introduction to multi-casualty incident operations include:

- Utilities
- Public works
- Public transportation
- Any facility that houses or operates with hazardous materials
- Any facility that regularly houses large numbers of people
- Organizations that provide medical care at mass gatherings

7.7 EMS Field Management Personnel Function and Selection

At the time any of the key medical personnel positions listed below are assigned, it is imperative that the personnel being assigned is given:

- The appropriate vest for the position
- The appropriate position check list
- Means of communication to be utilized during the incident

The person in charge of EMS Field Operations in an initial and reinforced level of response is the Medical Group Supervisor. Overall command of EMS field operations in a full response would be delegated to the Medical Branch Director.

The EMS field organization builds from the top down with responsibility and performance placed initially with the Medical Group Supervisor. The specific organizational structure established for any given incident will be based upon the management needs of the incident. If one individual can simultaneously manage all major functional areas, no further organization is required. If one or more of the areas requires independent management, an individual should be named to be responsible for that area. In a small MCI, or in the early phases of a large MCI, the Medical Group Supervisor may also need to serve as Patient Transportation Group Supervisor and coordinate communication with the Medical Dispatch Center to organize patient disbursement. Additional personnel may include, but are not limited to: Triage Unit Leader, Treatment Unit Leader and Medical Supply Coordinator.

7.8 Key Medical Personnel

Medical Branch Director

The Medical Branch Director is responsible for implementation of the IAP when the Medical Branch is implemented and reports to the Operations Section Chief. The Medical Branch Director then assumes supervision of and provides direction to the Medical Group Supervisor and the Patient Transportation Group Supervisor.

Medical Group Supervisor

The Medical Group Supervisor shall be the first qualified responder for the position on the scene and, in accordance with local policy, may be law enforcement, fire or private provider personnel. The initial Medical Group Supervisor may be the Incident Commander or his/her designee.

The Medical Group Supervisor will report to the Incident Commander (or his/her designee). If an Incident Command has not been established (early in an MCI), the Medical Group Supervisor will coordinate operations with fire and law enforcement until an Incident Commander is assigned.

The Medical Group Supervisor (or Medical Branch Director if assigned) will be responsible for overall medical scene control and should not be directly involved in patient care unless he/she is the only rescuer at the scene for extended lengths of time. The Medical Group Supervisor will utilize the Medical Branch Worksheet MCM Form 402 and the ICS Unit Log 214 when

appropriate.

The Medical Group Supervisor will appoint personnel depending upon the needs of the incident, which may include Triage Unit Leader, Treatment Unit Leader and Medical Supply Coordinator. Personnel can be placed in charge of several areas, if this is the best utilization of available resources.

Triage Unit Leader

The Triage Unit Leader (basic life support preferred) will coordinate the triage of all patients. After all patients have been triaged and marked with ribbons, this person will supervise the movement of patients to a treatment area. The Triage Unit Leader may assign triage personnel and a Morgue Manager as needed. This person will remain at the triage area and will report to the Medical Group Supervisor.

Treatment Unit Leader

The Treatment Unit Leader (ALS preferred) is responsible for on scene emergency medical care of victims in the treatment area, and supervision of the movement of those patients to the ambulances. This person will be located at the treatment area and will report to the Medical Group Supervisor. Treatment Managers may be assigned by the Treatment Unit Leader to the immediate/red, delayed/yellow and minor/green treatment areas as needed. The Treatment Unit Leader may also assign a Treatment Dispatch Manager to coordinate communication with the Patient Transportation Group Supervisor (PTGS).

Medical Supply Coordinator

The Medical Supply Coordinator shall acquire and maintain control of appropriate medical equipment and supplies from units assigned to the incident or that arrive from other locations.

Patient Transportation Group Supervisor (PTGS)

The PTGS will establish and maintain communications with the Medical Dispatch Center and coordinate patient loading into ambulances and EMS aircraft as determined by the Treatment Unit Leader(s). The function of the PTGS may be filled concurrently by the Medical Group Supervisor in the event there are not enough qualified personnel available. The PTGS may assign the following personnel as necessary: Medical Communications Coordinator, Air Ambulance Coordinator and the Ground Ambulance Staging Manager.

Medical Communications Coordinator

The Medical Communications Coordinator shall establish and maintain medical communications with the Medical Dispatch Center and shall select the mode of transport and patient destination based upon the direction of the Medical Dispatch Center.

Air Ambulance Coordinator

The Air Ambulance Coordinator shall establish and maintain safe landing zones, communications and flow/tracking of patients and EMS/rescue helicopters/fixed wings in and out of the incident area. The Air Ambulance Coordinator can report to the PTGS on small incidents or the Air Operations Branch Director on larger incidents.

Ground Ambulance Staging Manager

The Ground Ambulance Staging Manager is responsible for the coordination of incoming personnel and equipment. The Ground Ambulance Staging Manager shall use the “Ambulance Staging Resource Status Log” to track ambulance availability and activities. This person will organize ambulances (or other medical transportation vehicles), medical equipment and medical personnel and dispatch them to duties at the request of the PTGS. This person will be located at the staging area and will report to the PTGS.

7.9 Modular Development of Medical Branch

The specific organizational structure established for any given incident will be based upon the management needs of the incident. If one or more of the areas require independent management, an individual should be assigned and briefed to be responsible for that area.

The Medical Branch field organization is modular and is built as needed. The following pages show organizational structures that could be developed in the following four different levels of response:

- Initial Response
- Reinforced Response
- Full Branch Response
- Escalated Response

In the “Initial” and “Reinforced Response” levels, responsibility and performance is placed initially with the Medical Group Supervisor.

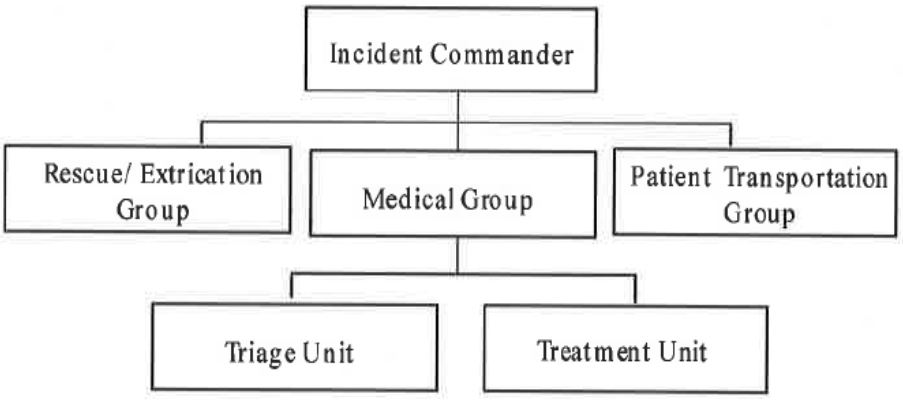
The Medical Group Supervisor (or Medical Branch Director if assigned) will be responsible for overall medical scene control.
If one individual can simultaneously manage all major functional areas, no further organization is required. In a small MCI, or in the early phases of a large MCI, the Medical Group Supervisor may also need to serve as the PTGS and coordinate communications with the healthcare facilities and patient destination.

8. ICS ORGANIZATIONAL CHARTS

While the IC has ultimate responsibility for all activities on the incident ground, through the use of the ICS structure, the IC should delegate tasks for completion to the functional area officers. The modular design of ICS allows the IC to establish ICS positions on an as needed or projected need basis. Therefore, organizational development will vary from incident to incident.

Below are examples of ICS organizational charts for initial, reinforced, full and escalated responses.

Incident Command Organizational Chart for an Initial Medical Response

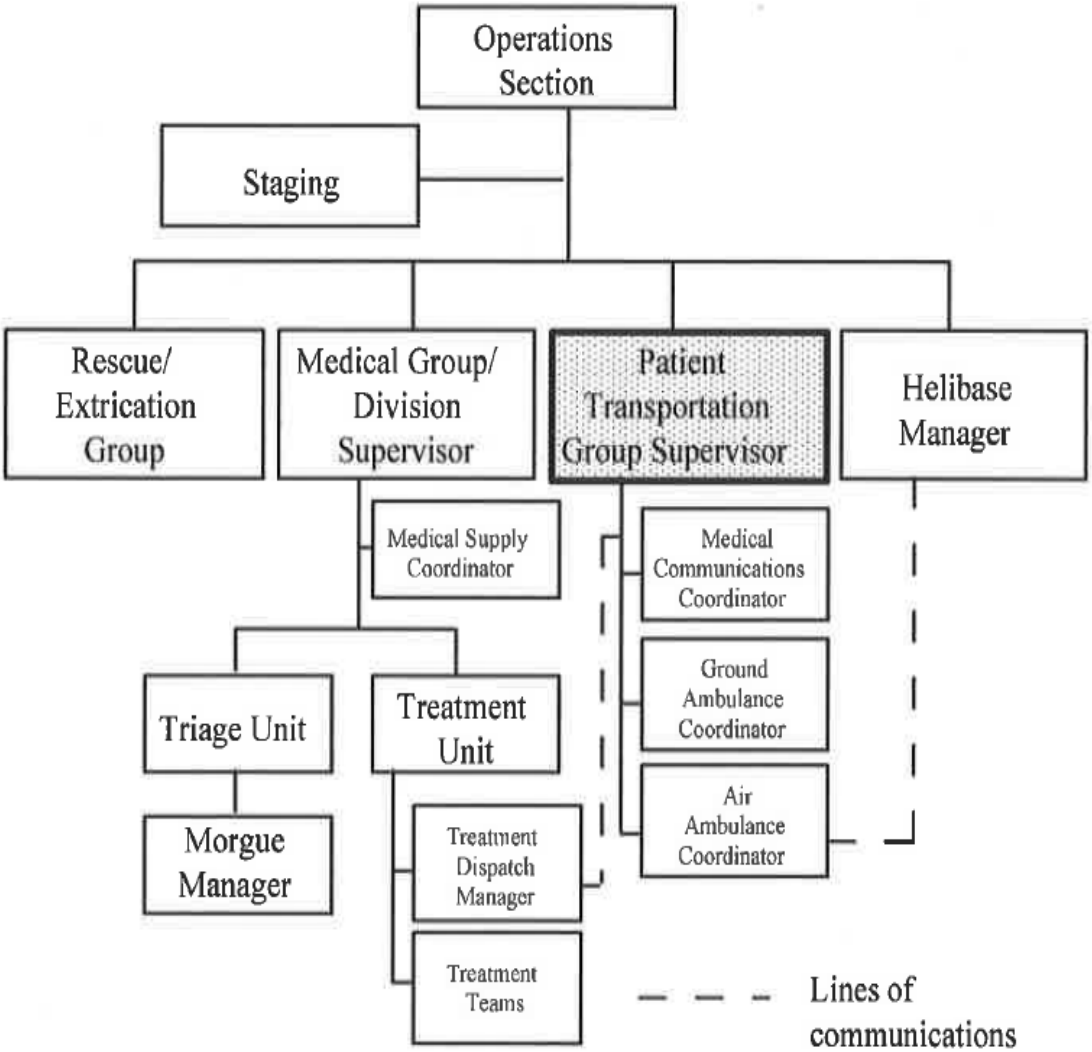


The first arriving unit or officer will establish command until arrival of a higher ranking officer. Upon arrival of a higher ranking officer, they will be briefed by the on-scene Incident Commander. The higher ranking officer will then assume command. This transfer of command is to be announced. The officer being relieved of command responsibilities will be reassigned by the new Incident Commander.

The IC normally establishes the Rescue/Extrication Group position early in the incident. It is often assigned to the first resource in the area.

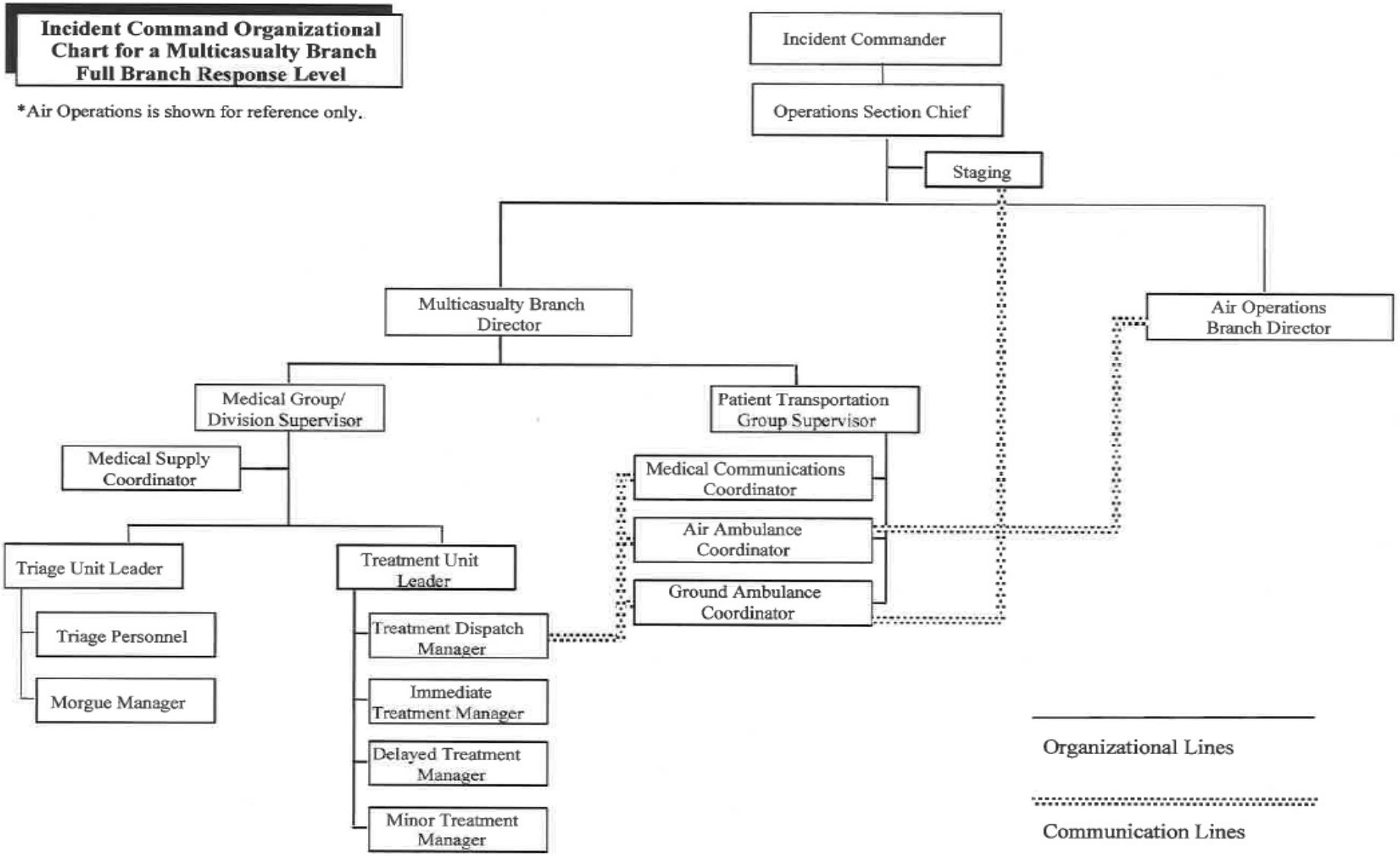
The Medical Branch Group Supervisor may be required to also serve as Patient Transportation Group Supervisor during small incidents, or in the initial phase of large incidents.

Incident Command Organizational Chart for a <u>Reinforced</u> Medical Response

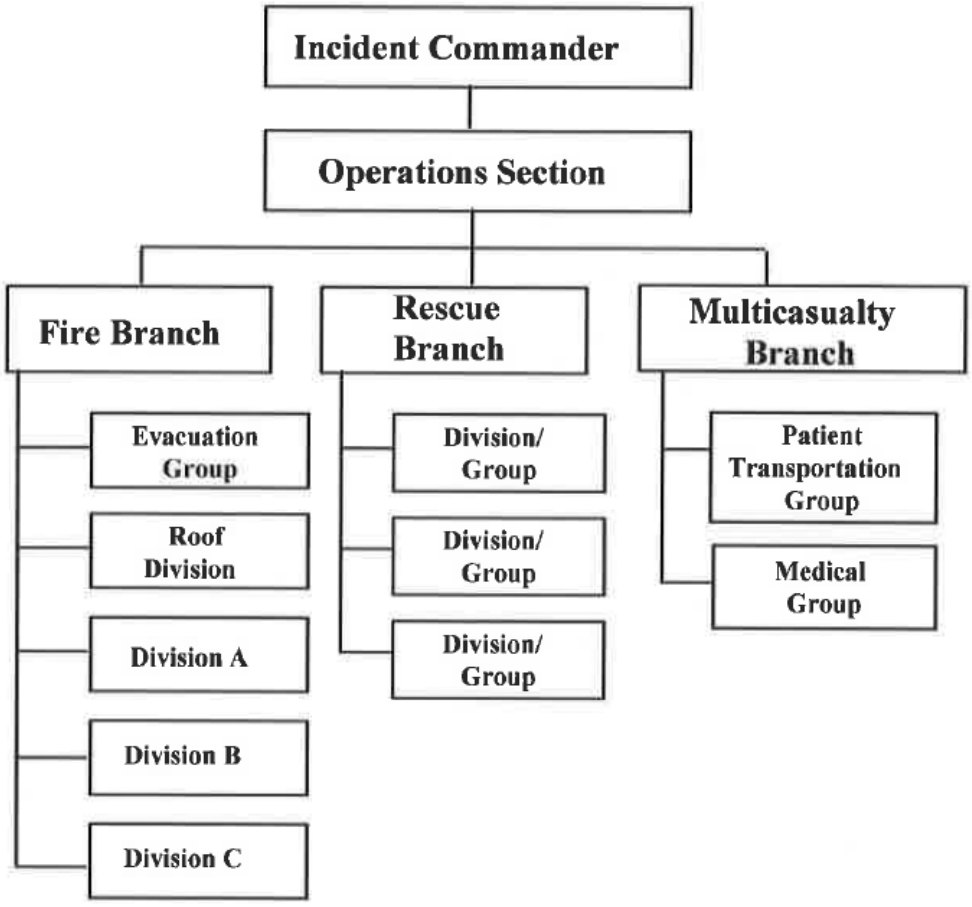


A reinforced response may be initiated when it is determined that the initial response resources will be insufficient to deal with the size or complexity of the incident.

Incident Command Organizational Chart for a Full Medical Response



Incident Command Organizational Chart for an <u>Escalated</u> Medical Response



Divisions or Groups are tactical level management units that organize responders. As an incident escalates the Incident Commander should consider using Division/Groups. Divisions represent geographic operations, and groups represent functional operations.

Divisions are the organization level having responsibility for operations within a defined geographic area. The division level is organized by signal resources, task force, or the strike team and the branch. Groups are the organization level having responsibility for a specified functional assignment at an incident (ventilation, salvage, water supply, etc.)

APPENDIX A - MEDICAL BRANCH ICS JOB DESCRIPTIONS

Rescue/Extrication Group

Definition:	First medical qualified personnel/unit
Supervised by:	Incident Commander
Function:	Conduct rescue of entrapped victims and/or assist with primary care of patients and coordinate initial patient triage and/or treatment.

DUTIES:

1. Check in and obtain briefing from IC.
2. Report to designated on scene location.
3. Implement assigned incident objectives.
4. Coordinate with treatment unit (if assigned) for patient care during the rescue operations.
5. Determine resources needed to extricate patients.
    - Rescue tools
    - Backboards
    - Personnel
    - Relief personnel
6. Communicate resources requirements to the IC.
7. Provide tactical direction and supervision to assigned resources.
8. Ensure safety of members operating in the area.
9. Coordinate patient transport to triage/treatment area.
10. Provide IC with frequent and timely progress reports
11. Maintain incident documentation.

OPERATIONAL CONSIDERATIONS:

1. Where possible, critical patients should be extricated, triaged and delivered to the treatment area ahead of the more stable patients.
    - There must be interface with the Triage Unit Leader.
2. The Recuse/Extrication Group will be within the hazard zone with potential risks to personnel and patients; appropriate action should occur to provide safeguards.

Medical Branch Director

Definition:	Qualified Medical Branch Director
Supervised By:	Operations Section Chief
Subordinates:	Group/Division Supervisors
Radio Designator:	Medical Branch Director
Function:	The Medical Branch Director is responsible for the implementation of the Incident Action Plan within the Branch. This includes the direction and execution of Branch planning for the assignment of resources within the Branch.

DUTIES:

1. Check in and obtain briefing from Operations Section Chief.
2. Review Group/Division assignments for effectiveness of current operations, and modify as needed.
3. Provide input to Operations Section Chief for the Incident Action Plan.
4. Supervise Branch activities.
5. Report to Operations Section Chief on Branch activities.
6. Maintain Medical Branch Worksheet (MCM 402) and Unit Log (ICS Form 214).

Air Operations Branch Director

Definition:	Qualified Group Supervisor
Supervised By:	Operations Section Chief
Subordinates:	Air Ambulance Coordinator
Radio Designator:	Air Operations
Function:	Ordering and coordination of medical air resources to and from an incident. Coordinate, support and oversee landing zones, airports, airstrips or any designated aircraft staging areas.

DUTIES:

1. Check in and obtain briefing from Operations Section Chief.
2. Establish communications with Patient Transportation Group Supervisor, LZ Coordinator, Fixed Wing Coordinator and designated dispatch center.
3. Designate LZs, airports, airstrips or aircraft staging areas where appropriate.
4. Ensure designated aircraft dispatch center(s) are aware of aircraft operating in the area and safely coordinate with incident aircraft in and out of the area.
5. Ensure incident EMS helicopters have proper frequencies and destination coordinates.
6. Ensure incident fixed wing aircraft have adequate transportation to and from the aircraft.
7. Coordinate air resource utilization during a large scale incident.
8. Maintain Unit Log (ICS 214).
9. Ensure LZ Coordinator and Fixed Wing Coordinator spreadsheets are maintained and accounted for at end of incident.

OPERATIONAL CONSIDERATIONS:

1. Security for LZs, airstrips or other non-secured aircraft staging areas
2. Fire/rescue standby at LZ’s and aircraft areas of operations
3. Contacting local FBO(s) to facilitate aircraft refueling operations
4. Consider providing incident helicopters with ICS Form 205 (Radio Communications Plan) for incident air operations frequencies
5. Logistics/rehab needs of air medical crews and pilots. Monitor pilot duty times and plan accordingly

Medical Group/Division Supervisor

Definition:	Qualified Group/Division Supervisor
Supervised By:	Branch Director
Subordinates:	Triage Unit Leader, Treatment Unit Leader, Medical Supply Coordinator
Radio Designator:	Medical Group/Division Supervisor
Function:	Establish command, and control and activities within a Medical Group in order to assure the best possible emergency medical care to patients during an MCI.

DUTIES:

1. Check in and obtain briefing from Medical Branch Director or Operations Section Chief.
2. Participate in Medical Branch/Operations Section planning activities.
3. Establish Medical Group/Division with assigned personnel; request additional personnel and resources sufficient to handle the magnitude of the incident.
4. Designate Unit Leaders and treatment areas as appropriate.
5. Isolate morgue from all treatment areas and contact Medical Dispatch Center to ensure that the Medical Examiner/Coroner's office is notified.
6. Separate minor/green treatment area from immediate/red and delayed/yellow treatment areas.
7. Request law enforcement/coroner involvement as needed.
8. Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, ambulances, helicopter, and other methods of patient transportation.)
9. Establish communications and coordination with Patient Transportation Group Supervisor, and coordinate support and tactical communication methods as needed for the Medical Branch.
10. Ensure activation of hospital alert system, local EMS/health agencies.
11. Direct and assign on scene personnel from agencies such as Medical Examiner/Coroner's Office, American Red Cross, law enforcement, ambulance companies, county health agencies, and hospital volunteers.
12. Ensure proper security, traffic control, and access for Medical Group/Division areas.
13. Direct medically trained personnel to the appropriate Unit Leader.
14. Maintain Medical Branch Worksheet (MCM 402) and Unit Log (ICS Form 214) when appropriate.

Medical Group/Division Supervisor *(continued)*

OPERATIONAL CONSIDERATIONS:

1. Group command location
    a. Safe area remote from triage/treatment areas with law enforcement perimeter control
    b. Adjacent to Patient Transportation Group Supervisor's location when possible
2. Ambulance traffic pattern and patient loading areas
3. Treatment areas – consider isolating from each other
    a. Immediate
    b. Delayed
    c. Minor
4. Morgue – consider security and remoteness

Triage Unit Leader

Definition:	Qualified Unit Leader
Supervised by:	Medical Group/Division Supervisor
Radio Designator:	Triage Unit Leader
Subordinates:	Triage Personnel/Litter Bearers and Morgue Manager
Function:	Assume responsibility for providing triage management and movement of patients from the triage area. When triage has been completed, the Unit Leader may be reassigned as needed.

DUTIES:

1. Check in and obtain briefing from Medical Group/Division Supervisor.
2. Develop organization sufficient to handle assignment.
3. Inform Medical Group/Division Supervisor of resource needs (see list in plan).
4. Implement START triage process.
5. Coordinate movement of patients from the triage area to the appropriate treatment area (in general, patients tagged red should be moved first).
6. Give periodic status reports to Medical Group/Division Supervisor.
7. Maintain security and control of the triage area.
8. Establish morgue (deceased casualty area) and liaison with Medical Examiner/Coroner.
9. Maintain Unit Log (ICS 214).

OPERATIONAL CONSIDERATIONS:

1. SAFETY SHALL BE OF PARAMOUNT CONSIDERATION
    a. Assess resource needs
    b. Command
    c. Communications
    d. Personnel
    e. Equipment/supplies
    f. Relief units
2. Inform Medical Group/Division Supervisor of minimum needs
3. Consult with Triage Personnel
4. Give job assignments
    a. Safety
    b. Records
    c. First-aid personnel
    d. Transporters
5. Establish morgue location*

*Note: Do not allow deceased patients to be moved from their original locations unless absolutely necessary. If possible, take pictures and mark location of deceased. This information is essential to the WCMECO. Upon arrival of the WCMECO, the Medical Examiner/Coroner will take charge of all related functions in the morgue area.

Triage Personnel

Definition:	Medical qualified personnel
Supervised by:	Triage Unit Leader
Function:	To triage patients on-scene and assign them to appropriate treatment areas.

DUTIES:

1. Check in and obtain briefing from Triage Unit Leader.
2. Report to designated on scene triage location.
3. Use START method to triage injured patients. Classify patients while noting injuries and vital signs (if taken). Track the number of patients triaged and their priorities to provide report to the Triage Unit Leader.
4. Move patients to proper treatment areas (in general, patients marked red should be moved first).
5. Provide appropriate medical treatment (ABC's) to patients prior to movement as incident condition dictates.

Treatment Unit Leader

Definition:	Qualified Unit Leader
Supervised by:	Medical Group/Division Supervisor
Subordinates:	1. Treatment Dispatch Manager 2. Immediate Treatment Manager 3. Delayed Treatment Manager 4. Minor Treatment Manager
Radio Designator:	Treatment Unit Leader
Function:	Assume responsibility for treatment, preparation for transport, and coordination of patient treatment in the Treatment Areas. Direct movement of patients to loading location(s).

DUTIES:

1. Check in and obtain briefing from Medical Group/Division Supervisor.
2. Develop organization sufficient to handle assignment.
3. Direct and supervise Treatment Dispatch Manager, immediate, delayed, and minor treatment areas.
4. Coordinate movement of patients from triage area to treatment areas with Triage Unit Leader.
5. Request sufficient medical caches and supplies as necessary.
6. Establish communications and coordination with Patient Transportation Group.
7. Ensure continual reassessment of patients throughout treatment areas.
8. Direct movement of patients to ambulance loading area(s).
9. Give periodic status reports to Medical Group/Division Supervisor.
10. Maintain Unit Log (ICS 214).

OPERATIONAL CONSIDERATIONS:

1. Assess resource needs
   a. Command
   b. Communications
   c. Equipment/supplies
   d. Medical Teams
   e. Relief Personnel
2. Give job assignments
   a. Treatment Managers
   b. Treatment Dispatch Manager
   c. Records
   d. Security
3. Standing orders

Treatment Dispatch Manager

Definition:	Qualified Person
Supervised by:	Treatment Unit Leader
Subordinates:	As needed
Radio Designator:	Treatment Dispatch Manager
Function:	Responsible for coordinating with Patient Transportation Group, the transportation of patients out of the treatment area.

DUTIES:

1. Check in and obtain briefing from Treatment Unit Leader.
2. Establish communications with the immediate, delayed and minor Treatment Managers.
3. Establish communications with Patient Transportation Group.
4. Verify that patients are prioritized for transportation.
5. Advise Medical Communications Coordinator of patient readiness and priority for transport.
6. Coordinate transportation of patients with Medical Communications Coordinator.
7. Assure that appropriate patient tracking information is recorded.
8. Coordinate ambulance loading with Treatment Manager and ambulance personnel.

OPERATIONAL CONSIDERATIONS:

1. Assess Resource Needs
   a. Communications
   b. Equipment/supplies
   c. Recorders and other personnel
2. Generally, the most critical patients should be transported first
3. Give job assignments

Immediate Treatment Manager

Definition:	Qualified Manager
Supervised by:	Treatment Unit Leader
Subordinates:	Medical Teams
Radio Designator:	Immediate Treatment Manager
Function:	Responsible for treatment and reassessment of patients assigned to immediate treatment area.

DUTIES:

1. Check in and obtain briefing from Treatment Unit Leader and brief subordinates.
2. Request or establish Medical Teams as necessary.
3. Assign treatment personnel to patients received in the immediate treatment area.
4. Ensure treatment of patients triaged to the immediate treatment area.
5. Assure that patients are prioritized for transportation.
6. Coordinate transportation of patients with Treatment Dispatch Manager.
7. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
8. Assure that appropriate patient information is recorded.

OPERATIONAL CONSIDERATIONS:

1. Assess resource needs
    a. Command
    b. Communications
    c. Equipment/supplies
    d. Medical teams
    e. Relief personnel
2. Generally, the most critical patients should be transported first
3. Give job assignments
    a. Patient care
    b. Transporters/ambulance loading
    c. Records
    d. Security (coordinate with Logistics Section)
4. Standing orders

Delayed Treatment Manager

Definition:	Qualified Manager
Supervised by:	Treatment Unit Leader
Subordinates:	Medical Teams
Radio Designator:	Delayed Treatment Manager
Function:	Responsible for treatment and retriage of patients assigned to Delayed Treatment Area.

DUTIES:

1. Check in and obtain briefing from Treatment Unit Leader and brief subordinates.
2. Request or establish Medical Teams as necessary.
3. Assign treatment personnel to patients received in the delayed treatment area.
4. Ensure treatment of patients triaged to the delayed treatment area.
5. Assure that patients are prioritized for transportation.
6. Coordinate transportation of patients with Treatment Dispatch Manager.
7. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
8. Assure that appropriate patient information is recorded.

OPERATIONAL CONSIDERATIONS:

1. Assess resource needs
    a. Command
    b. Communications
    c. Equipment/supplies
    d. Medical teams
    e. Relief personnel
2. Generally, the most critical patients should be transported first
3. Give job assignments
    a. Patient care
    b. Transporters/ambulance loading
    c. Records
    d. Security (coordinate with Logistics Section)
4. Standing orders

Minor Treatment Manager

Definition:	Qualified Manager
Supervised by:	Treatment Unit Leader
Subordinates:	Treatment Teams
Radio Designator:	Minor Treatment Manager
Function:	Responsible for reassessment of patients assigned to minor treatment area

DUTIES:

1. Check in and obtain briefing from Treatment Unit Leader and brief subordinates.
2. Request or establish Medical Teams as necessary.
3. Ensure minor treatment area is removed from all areas of active operations, including other treatment areas, morgue and impact area.
4. Assign treatment personnel to patients received in the minor treatment area.
5. Ensure treatment of patients triaged to the minor treatment area.
6. Assure that patients are prioritized for transportation.
7. Coordinate transportation of patients with Treatment Dispatch Manager.
8. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
9. Assure that appropriate patient information is recorded.
10. Coordinate volunteer personnel/organizations through Agency Representatives and Treatment Unit Leader.

OPERATIONAL CONSIDERATIONS:

1. Assess resource needs
    a. Command
    b. Communications
    c. Equipment/supplies
    d. Medical teams
    e. Relief personnel
2. Generally, the most critical patients should be transported first
3. Give job assignments
    a. Patient care
    b. Transporters/ambulance loading
    c. Records
    d. Security (coordinate with Logistics Section)
4. Standing orders

Medical Teams

Definition: Qualified Personnel with Supervision

Supervised by: Assigned Manager/Unit Leader

Composition: Medical Teams

Type I: 2 ALS responders, 3 BLS responders
Type II: 2 ALS responders
Type III: 3 BLS responders

NOTE:

Medical Team Type refers to qualification of personnel only. It does not refer to means of transportation, equipment or ability to transport patients. “ALS Company” or “BLS Company” includes qualified personnel and appropriate equipment to qualify as an ALS or BLS Company.

DUTIES:

1. Receive briefing.
2. Perform triage and treatment as assigned.
3. Record patient information on triage tags.
4. Report changes in patient status to appropriate assigned Manager/Unit Leader

Patient Transportation Group Supervisor

Definition:	Qualified Group Supervisor
Supervised by:	Medical Branch Director
Subordinates:	Medical Communications Coordinator, Landing Zone (LZ) Coordinator and Ground Ambulance Manager
Radio Designator:	Patient Transportation Group Supervisor
Function:	Coordination of patient transportation and maintenance of records relating to patient identification, injuries, mode of off incident transportation and destination.

DUTIES:

1. Check in and obtain briefing from the Medical Branch Director (if activated) or Operations Section Chief.
2. Establish communications with hospital(s) through the Medical Dispatch Center.
3. Designate an ambulance staging area(s).
4. Direct the transportation of patients as determined by Treatment Unit Leader(s).
5. Assure that patient information and destination is recorded.
6. Establish communications with Ambulance Staging Manager(s) and LZ Coordinator.
7. Request additional ambulances, as required.
8. Notify Ambulance Staging Manager(s) of ambulance requests.
9. Coordinate requests for air ambulance transportation through the Air Operations Branch Director.
10. Establish air ambulance Heli-spot with the Medical Branch Director and Air Operations Branch Director.
11. Maintain Patient Transportation Summary Worksheet (MCM 403) or DMS Triage Tag Transportation Receipt Holder and Unit Log (ICS 214).

OPERATIONAL CONSIDERATIONS:

1. Manage the location for patient transportation function.
2. Develop an ambulance traffic pattern to avoid confusion
3. Security (coordinate with Logistics)

Medical Communications Coordinator

Definition:	Qualified Coordinator
Supervised by:	Patient Transportation Group Supervisor
Subordinates:	Transportation Recorder and personnel as required
Radio Designator:	Medical Communications Coordinator
Function:	Maintain communications with the hospitals and/or other medical facilities through the Medical Dispatch Center to assure proper patient transportation and destination. Coordinate information through Patient Transportation Group Supervisor.

DUTIES:

1. Check in and obtain briefing from Patient Transportation Group Supervisor.
2. Establish communications with Medical Dispatch Center.
3. Determine and maintain current status of hospital/medical facility availability and capability through Medical Dispatch Center.
4. Receive basic patient information and injury status from Treatment Dispatch Manager.
5. Communicate hospital availability to Treatment Dispatch Manager.
6. Coordinate patient off-incident destination with Medical Dispatch Center.
7. Coordinate patient transportation needs to Ambulance Staging Manager and Air Operations Branch Director based upon requests from Treatment Dispatch Manager.
8. Maintain Patient Transportation Summary Worksheet (MCM 403) and Unit Log (ICS 214).

OPERATIONAL CONSIDERATIONS:

1. Maintain close coordination of efforts and liaison with the Treatment Dispatch functions
2. Provide medical input into the decision-making process
3. Anticipate potential patient numbers and consider requesting additional resources
4. Standing orders

Ground Ambulance Staging Manager

Definition:	Personnel as assigned
Supervised by:	Patient Transportation Group Supervisor
Subordinates:	Personnel as required
Radio Designator:	Ground Ambulance Staging Manager
Function:	Manage the Ground Ambulance Staging Area and dispatch ambulances as requested

DUTIES:

1. Check in and obtain briefing from Patient Transportation Group Supervisor.
2. Establish appropriate staging area for ambulances.
3. Establish routes of travel for ambulances for incident operations.
4. Establish and maintain communications with the Medical Communications Coordinator.
5. Provide ambulances upon request from the Medical Communications Coordinator.
6. Maintain records as required.
7. Assure that necessary equipment is available in the ambulance for patient needs during transportation.
8. Establish immediate contact with ambulance agencies at the scene.
9. Request additional transportation resources as appropriate.
10. Provide an inventory of medical supplies available at ambulance staging for use at the scene.
11. Maintain Ambulance Staging Resource Status Log (MCM 404).

OPERATIONAL CONSIDERATIONS:

1. Assess resource needs
    a. Command
    b. Communications
    c. Equipment/supplies
    d. Apparatus
    e. Personnel
    f. Relief personnel
    g. Law enforcement

Air Ambulance Coordinator

Definition:	Personnel as assigned
Supervised by: **1.15**	Patient Transportation Group Supervisor (less complex), Air Operations Branch Director (more complex)
Subordinates:	As required
Radio Designator:	Air Coordinator
Function:	Designated ground contact for incident EMS/rescue helicopters/fixed wing units. Coordinates patient transport and destinations by air units, through the Patient Transport Group Supervisor.

DUTIES:

1. Check in and obtain briefing from Patient Transportation Group Supervisor (low complexity) or Air Operations Branch Director (higher complexity).
2. Establish and maintain a secure landing zone(s) LZ(s)/staging area(s).
3. Establish communications with Patient Transportation Group Supervisor, Air Operations Branch Director (if applicable), designated dispatch center(s)
4. Provide LZ lighting, marking and hazard identification as appropriate.
5. Establish and maintain air to ground communications with all assigned incident response helicopters.
6. Coordinate all takeoffs/landings with incident response helicopters and/or fixed wing units.
7. Maintain safe spacing between aircraft in the LZ.
8. Act as liaison between helicopter crews, Patient Transportation Group Supervisor, IC or designee(s).
9. Document and maintain all aircraft arrival/departures, destinations and patients on Air Ambulance Coordinator Spreadsheet (MCM 405). Maintain Unit Log (ICS 214).

OPERATIONAL CONSIDERATIONS:

1. Additional need for barriers/security for LZ
2. Fire/rescue standby at LZ for crash/rescue
3. Contact local FBOs for fuel availability
4. Consider having a list of coordinates for local hospitals and FBOs
5. Water down LZ if conditions warrant
6. Consider facilities/logistical needs for long-term operations

Medical Supply Coordinator

Definition:	Qualified personnel as assigned
Supervised by:	Medical Group/Division Supervisor
Subordinates:	Personnel as required
Radio Designator:	Medical Supply Coordinator
Function:	Acquire and maintain control of appropriate medical equipment and supplies from units assigned to the Medical Group.

DUTIES:

1. Check in and obtain briefing from Medical Group/Division Supervisor.
2. Acquire, distribute and maintain status of medical equipment and supplies from units assigned to the Medical Group.
3. Request additional medical supplies (medical caches).
4. Distribute medical supplies to treatment and triage units.
5. Maintain Unit Log (ICS 214).

If Logistics Section is established, this position would coordinate with the Supply Unit Leader.

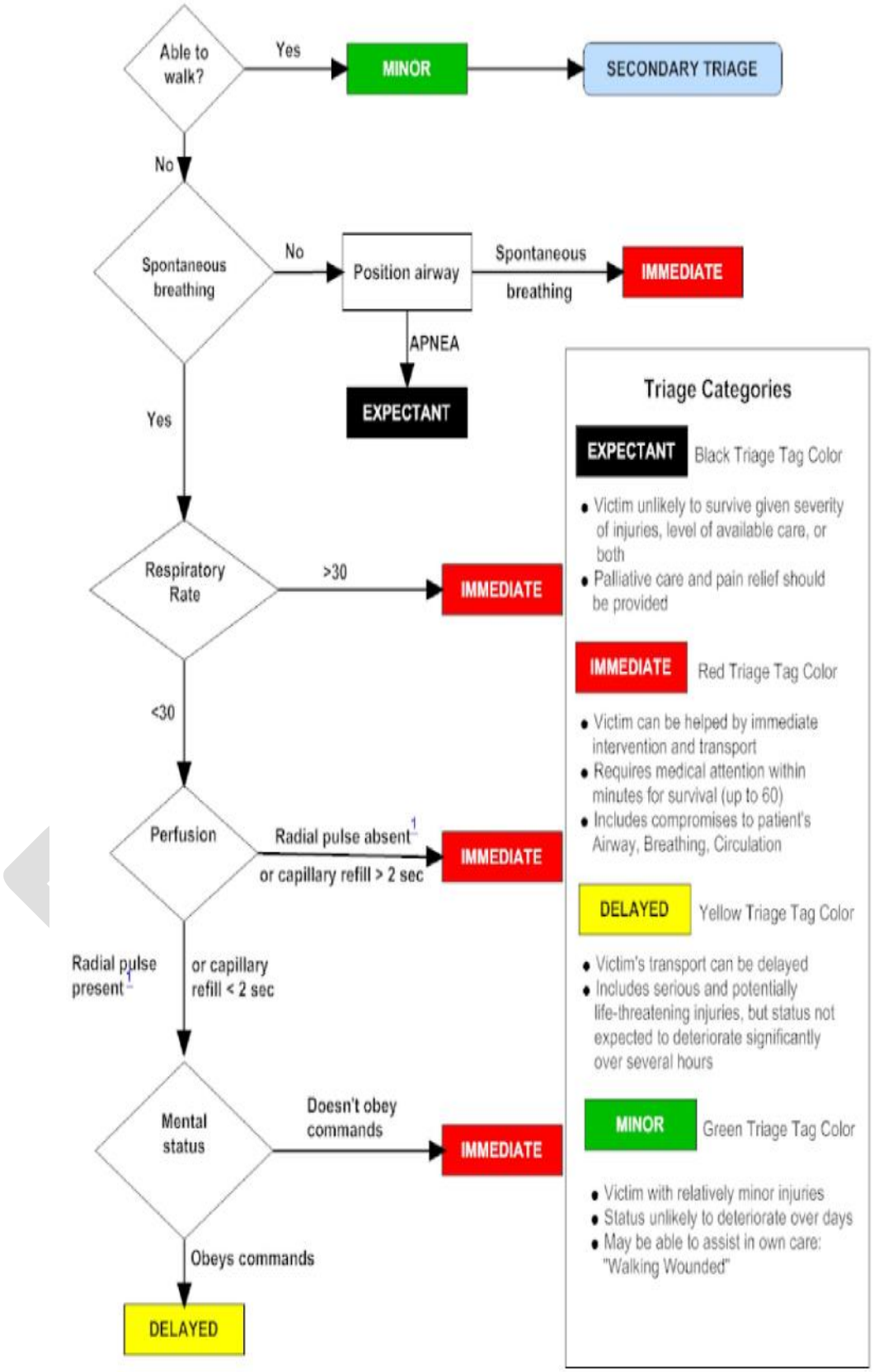
Morgue Manager

Definition:	Qualified personnel as assigned
Supervised by:	Triage Unit Leader
Subordinates:	Personnel as required
Radio Designator:	Morgue Manager
Function:	Assume responsibility for morgue area activities until relieved of that responsibility by the Washoe County Medical Examiner and Coroner's Office.

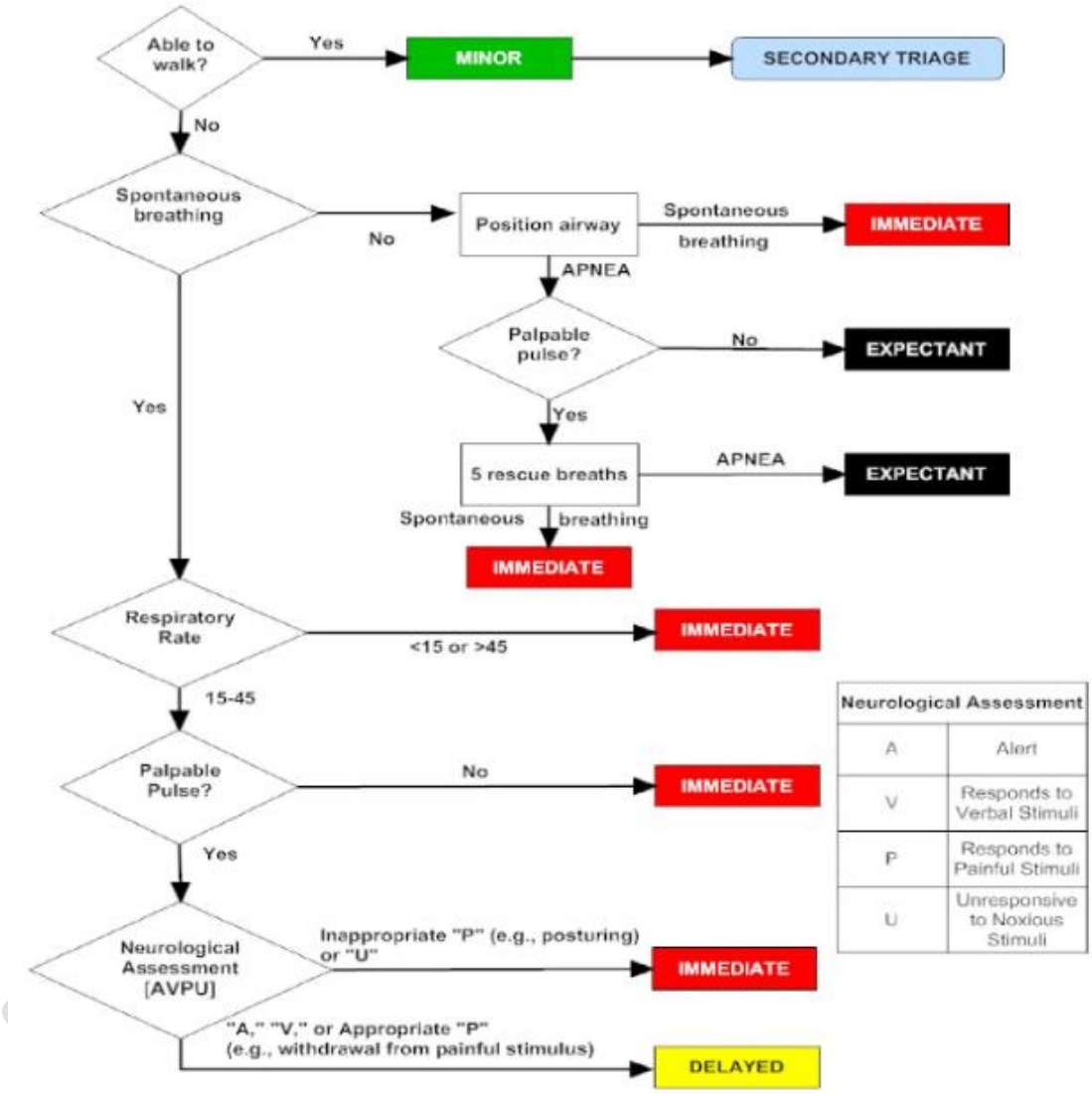
DUTIES:

1. Check in and obtain briefing from Triage Unit Leader. Verify that the WCMECO has been notified.
2. Assess resource/supply needs and order as needed.
3. Coordinate all morgue area activities.
4. Keep area off limits to all unauthorized personnel, including media photographers.
5. Coordinate with law enforcement and assist the WCMECO as necessary.
6. Keep identify of deceased persons confidential.
7. Maintain records, including deceased identity (if available), where the deceased was found, etc.
8. Establish incident morgue location if necessary.
9. Advise Triage Unit Leader of location.
10. Ensure orderly transfer of authority to WCMECO representative when feasible.

APPENDIX B – START FLOWCHARTS and DMS TRIAGE TAG SYSTEM



JumpSTART FLOWCHART (PEDIATRIC)



Use JumpSTART if the Patient appears to be a child.

Use an adult system, such as START, if the patient appears to be a young adult.

Triage Categories

EXPECTANT Black Triage Tag Color

- Victim unlikely to survive given severity of injuries, level of available care, or both
- Palliative care and pain relief should be provided

DELAYED Yellow Triage Tag Color

- Victim's transport can be delayed
- Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours

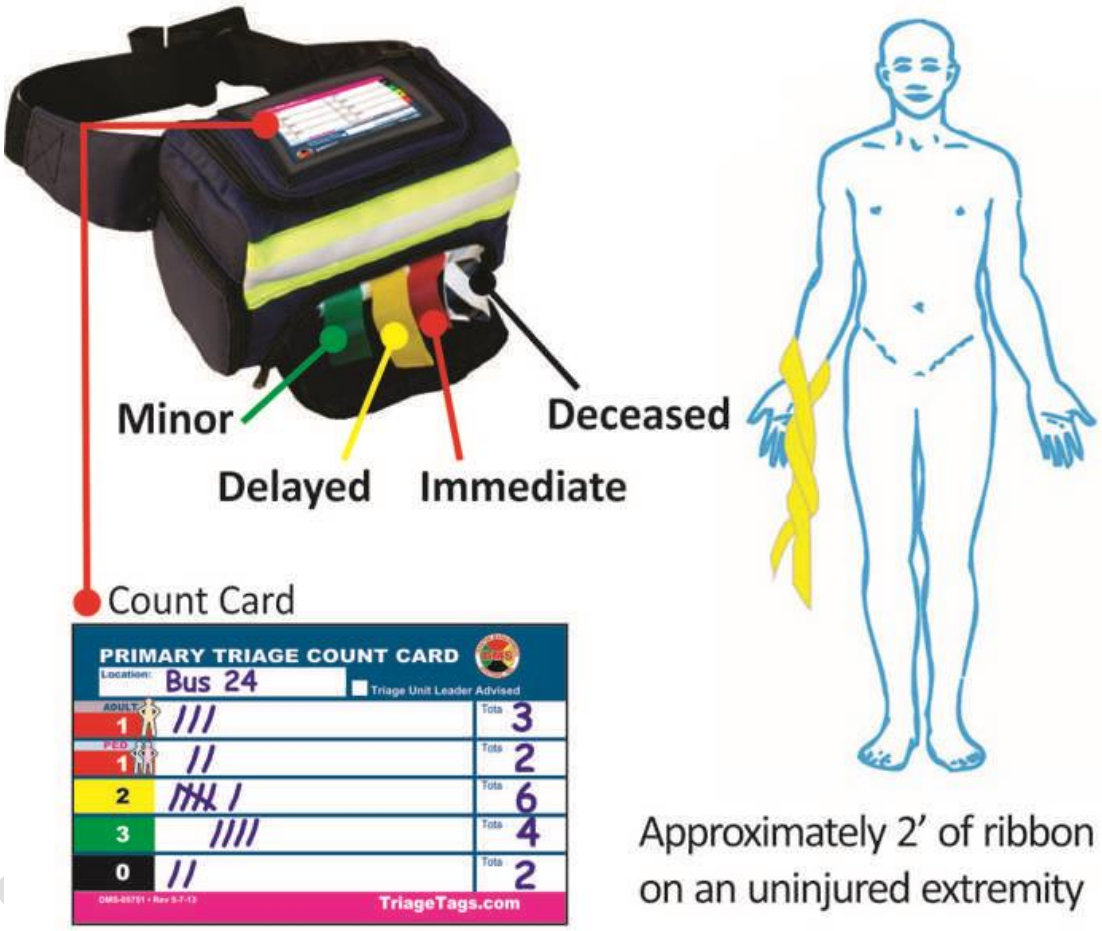
IMMEDIATE Red Triage Tag Color

- Victim can be helped by immediate intervention and transport
- Requires medical attention within minutes for survival (up to 60)
- Includes compromises to patient's Airway, Breathing, Circulation

MINOR Green Triage Tag Color

- Victim with relatively minor injuries
- Status unlikely to deteriorate over days
- May be able to assist in own care: "Walking Wounded"

DMS TRIAGE TAG SYSTEM



INITIAL TRIAGE

Casualty Area

1. Perform START/JumpSTART to Determine Initial Triage Category
2. Pull off Approx. 2 Feet of the Proper Colored Ribbon
3. Tie Ribbon to the Patient's Wrist or Ankle

4. Indicate Patient Count on Card

5. Totals from Count Cards are Verbally Provided to the Triage Unit Leader

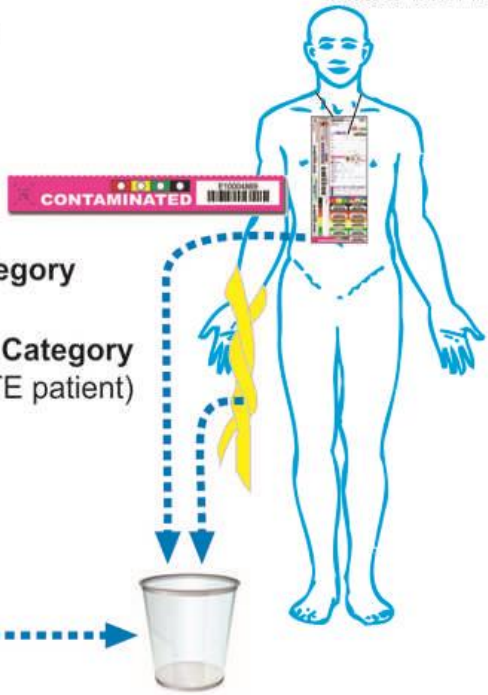
6. Triage Unit Leader will Tally Counts on Triage Count Worksheet and Report Count

SECONDARY TRIAGE

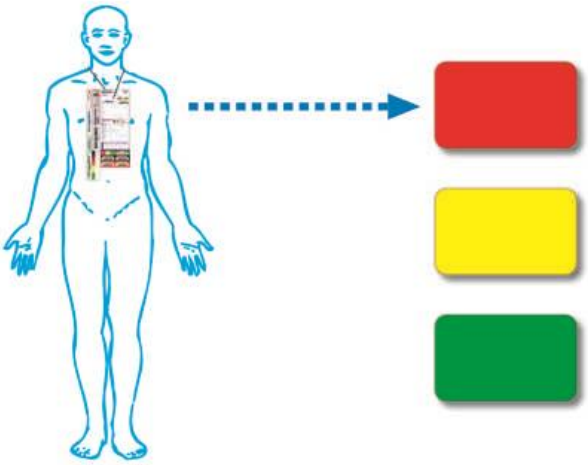
Entrance to the Treatment Area

DMS-05785 • rev. 12-7-12

1. Discard Primary Triage Ribbon
2. Apply Triage Tag to Patient
3. Discard Contamination Strip
4. Determine Patient's Triage Category
5. Discard Receipts below Triage Category
   (example shown is an IMMEDIATE patient)



6. Move Patient to the Proper Treatment Area

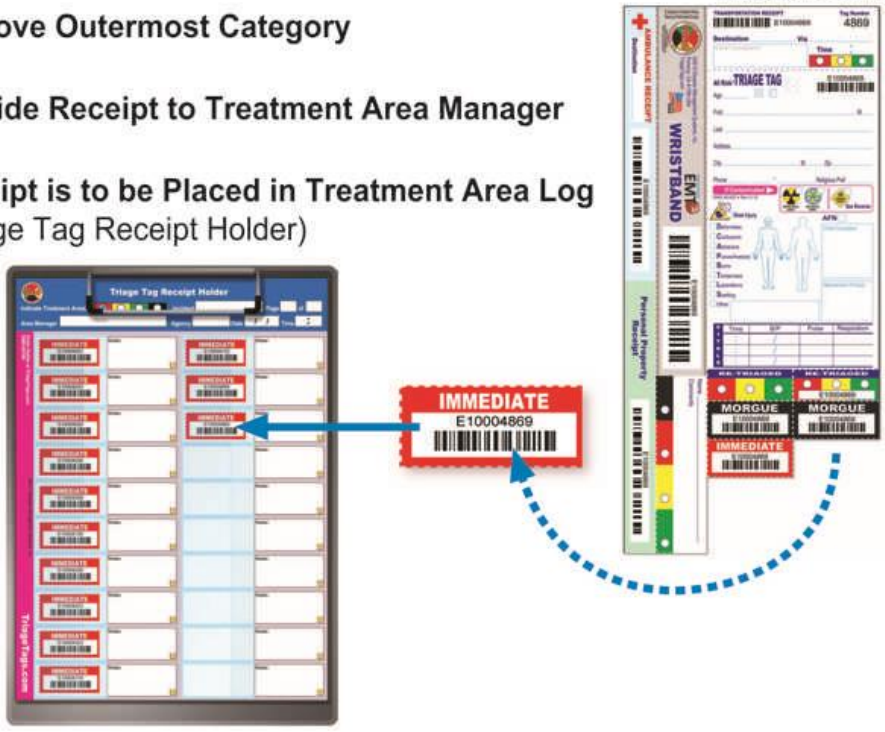


PATIENT TREATMENT

Treatment Areas

DMS-05785 • rev. 12-7-12

1. **Remove Outermost Category**
2. **Provide Receipt to Treatment Area Manager**
3. **Receipt is to be Placed in Treatment Area Log**
   (Triage Tag Receipt Holder)



1. **Enter Patient's Personal Information as Time Permits**
2. **Complete Patient Condition Section of Tag**
3. **Record Any Treatment Provided Whenever Possible**

Patient Information (Tag Front)

Patient Condition (Tag Front)

Treatment Provided (Tag Back)

TRANSPORTATION

Ambulance Loading Area

DMS-05785 • rev. 12-7-12

1. Remove the Transportation Receipt
2. Complete Required Information
3. Fill in the Proper Category Circle

4. Place the Transportation Receipt into Log
(Transportation Receipt Holder)

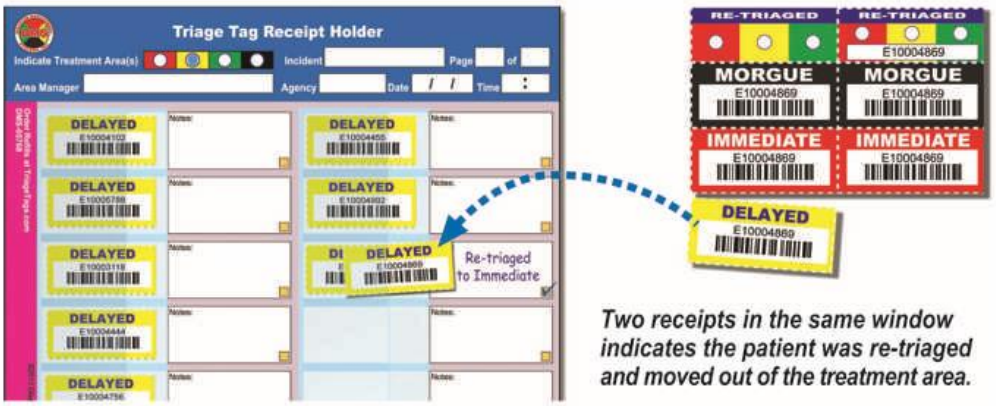
1. Remove the Ambulance Receipt
2. Give Receipt to Transporting Agency

RE-TRIAGE • Patient Degrades

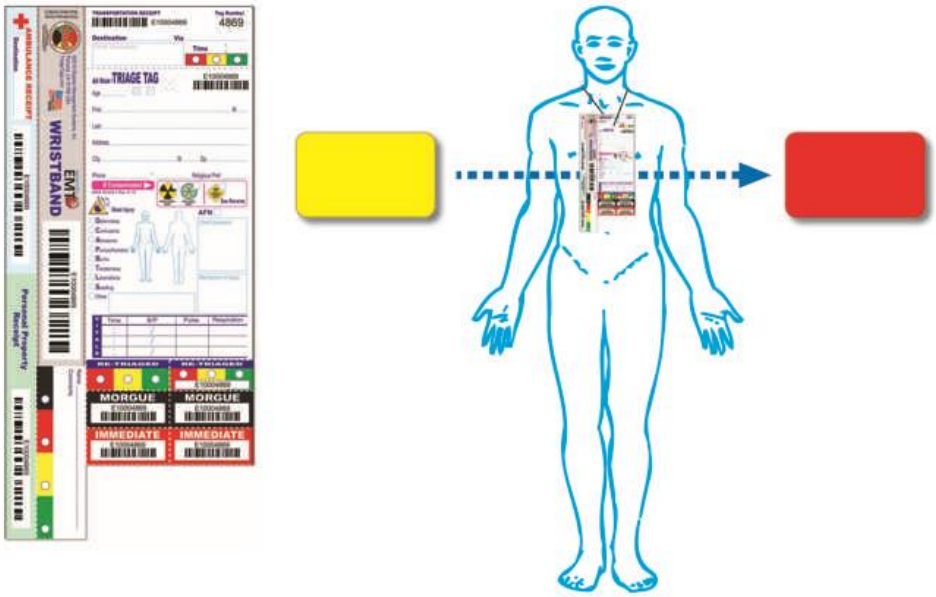
Delayed to Immediate Example

DMS-05785 • rev. 12-7-12

1. Remove remaining current acuity receipt from triage tag
2. Place receipt in Treatment Log on top of original patient receipt
3. Note in Treatment Log patient was re-triaged



4. Move patient to the new Treatment Area

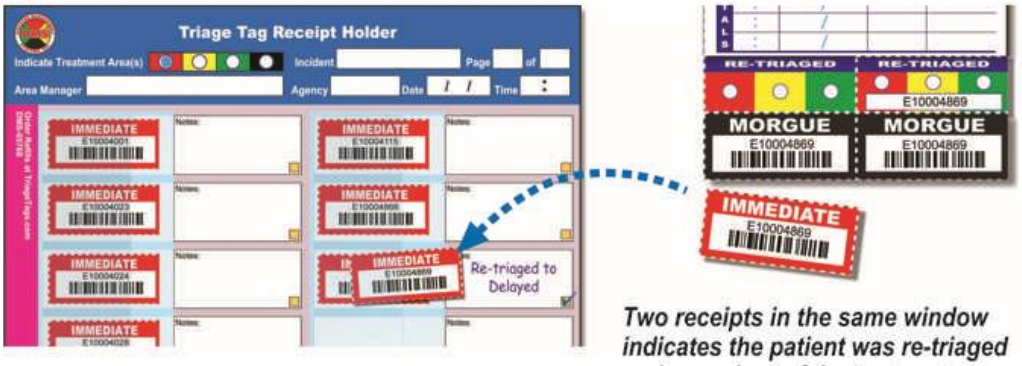


RE-TRIAGE • Patient Improves

Immediate to Delayed Example

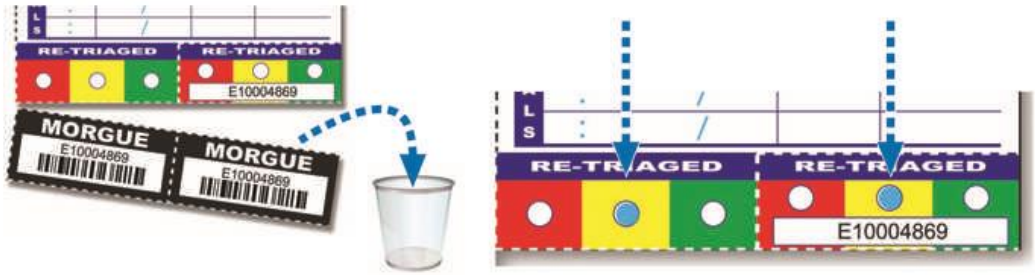
DMS-05785 • rev. 12-7-12

1 Place receipt in Treatment Log on top of original patient receipt.

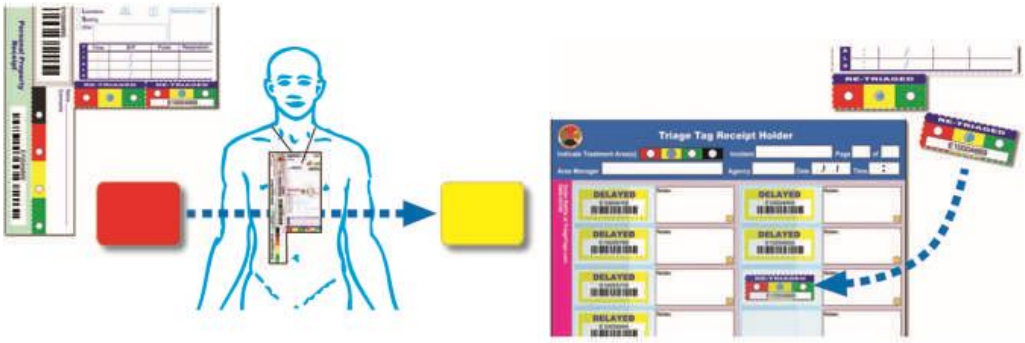


Two receipts in the same window indicates the patient was re-triaged and moved out of the treatment area.

2 Neutralize tag by discarding all receipts thru Morgue. Indicate new acuity on both re-triage receipts.



3 Move patient to indicated treatment area. A re-triage receipt is used by the new Area Manager for patient accountability.



APPENDIX C - WESTERN REGION BURN MASS CASUALTY INCIDENT RESPONSE PLAN

If a burn MCI occurs, Washoe County local responders will use the Western Region Burn Mass Casualty Incident (BMCI) Response Plan to get necessary care for burn patients.

Western Region Burn Mass Casualty Incident (BMCI) Response Plan
The American Burn Association (ABA) designated Western Region[1] encompasses Burn Centers located west of Montana, Wyoming, Colorado and New Mexico, including Alaska and Hawaii.
• For a BMCI occurring anywhere within the Western region of the United States the Western Region Burn Disaster Consortium serves as a communications and coordination center to support Burn Center(s) with burn bed census and/ or patient triage and transfer. • A BMCI is defined as any incident where capacity and capability significantly compromises patient care, as identified in accordance with individual BC(s), state, regional or federal disaster response plans.

Requesting Assistance from the Western Region Burn Disaster Consortium (WRBDC)for BMCI Response and Coordination	
Upon request by a referring BC(s) the WRCC: • Conducts a bed census of Western region BCs using the Utah Notification and Information System(UNIS) Burn Provider Group • Supports and assists with regional efforts for patient triage and transfer if requested	Agencies requesting assistance include: • Western Region BCs • Affected ABA BCs • ABA Regional Coordinator(s) • ABA Central Office • Department of Health & Human Services (DHHS) or designee
To request WRBDC assistance contact: • The University of Utah Burn Center 24/7 line at **801-581-2700** • Burn Medical Coordination Center (BMCC) 24 hour Emergency Hotline at **866-364-8824**	Upon notification WRBDC: ○ Activates the regional burn disaster plan ○ Conducts burn bed census of non-affected Western region burn centers for 02,12, 24 hour intervals ○ Coordinates requests for patient transfer between referring and receiving BC(s)

Definitions

1. Western Region (WR) - one of five American Burn Association-designated regions. Refer www.ameriburn.org Homepage for a map of all regions.
2. Western Region Burn Disaster Consortium (WRBDC) - a Utah-based consortium of 26 burn centers,13 of which are verified, who have joined together to support disaster response efforts for one another throughout the Western Region.
3. Western Region Burn Coordination Center (WRBCC) - one of 2 centers located throughout the West with redundant communication technologies to support disaster response efforts for burn centers. These centers are Utah and Colorado.

Courtesy of the
American Burn Association
Advanced Burn Life Support (ABLS)
Learn more about the ABA and ABLS at **www.ameriburn.org**

Burn Center Referral Criteria

A burn center may treat adults, children, or both.

Burn injuries that should be referred to a burn center include:

1. Partial thickness burns greater than 10% total body surface area (TBSA).
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
3. Third degree burns in any age group.
4. Electrical burns, including lightning injury.
5. Chemical burns.
6. Inhalation injury.
7. Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
8. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
9. Burned children in hospitals without qualified personnel or equipment for the care of children.
10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

Excerpted from Guidelines for the Operation of Burn Centers (pp. 79-86), Resources for Optimal Care of the Injured Patient 2006, Committee on Trauma, American College of Surgeons

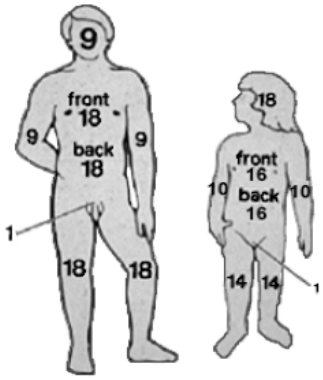
Severity Determination

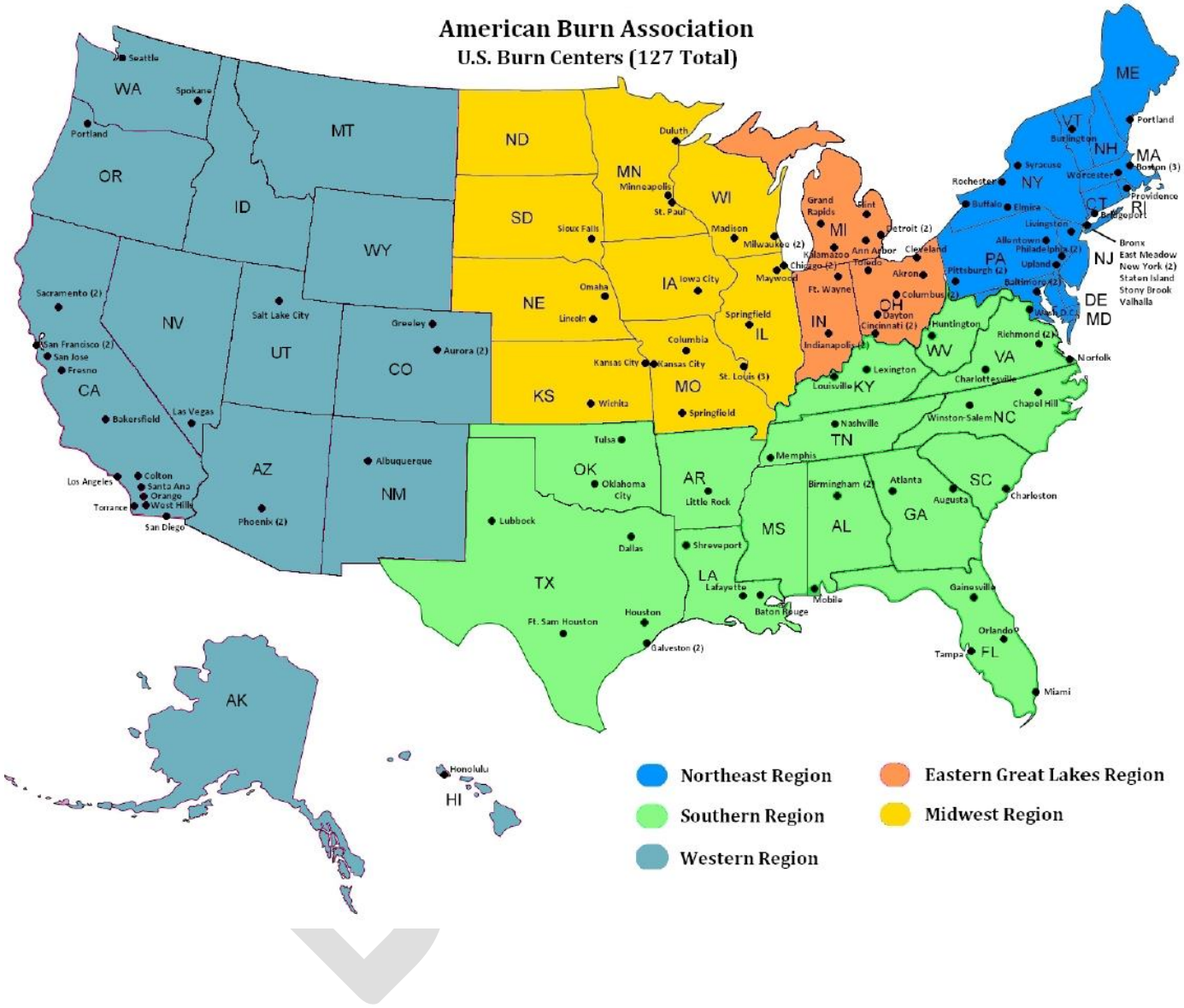
First Degree (*Partial Thickness*)
Superficial, red, sometimes painful.

Second Degree (*Partial Thickness*)
Skin may be red, blistered, swollen. Very painful.

Third Degree (*Full Thickness*)
Whitish, charred or translucent, no pin prick sensation in burned area.

Percentage Total Body Surface Area (TBSA)




American Burn Association
U.S. Burn Centers (127 Total)
Seattle
Spokane
Portland
WA
OR
ID
MT
WY
ND
SD
MN
Minneapolis
Duluth
WI
Madison
Milwaukee (2)
Sioux Falls
NE
Omaha
Lincoln
IA
Iowa City
Maywood
Chicago (2)
Springfield
IL
Columbia
Kansas City
Kansas City
St. Louis (3)
MO
Springfield
KS
Wichita
Grand Rapids
Flint
MI
Detroit (2)
Kalamazoo
Ann Arbor
Toledo
Cleveland
Akron
Ft. Wayne
Indianapolis (2)
IN
OH
Columbus (2)
Dayton
Cincinnati (2)
Huntington
Louisville
KY
Lexington
WV
Richmond (2)
VA
Norfolk
Charlottesville
Chapel Hill
Winston-Salem
NC
Nashville
TN
Memphis
Tulsa
OK
Oklahoma City
AR
Little Rock
Birmingham (2)
Atlanta
Augusta
SC
Charleston
MS
AL
GA
Shreveport
LA
Lafayette
Baton Rouge
Mobile
Gainesville
Orlando
Tampa
FL
Miami
Lubbock
Dallas
TX
Ft. Sam Houston
Houston
Galveston (2)
Sacramento (2)
San Francisco (2)
San Jose
Fresno
CA
Bakersfield
Las Vegas
NV
Salt Lake City
UT
Greeley
Aurora (2)
CO
Albuquerque
NM
Los Angeles
Colton
Santa Ana
Orange
Torrance
West Hills
San Diego
Phoenix (2)
AZ
AK
Honolulu
HI
ME
Portland
VT
Burlington
NH
MA
Boston (3)
Worcester
Syracuse
Rochester
NY
Buffalo
Elmira
Providence
CT
RI
Bridgeport
Livingston
Bronx
Allentown
Philadelphia (2)
NJ
East Meadow
Upland
New York (2)
Pittsburgh (2)
PA
Staten Island
Stony Brook
Baltimore (2)
Valhalla
DE
MD
Northeast Region
Eastern Great Lakes Region
Southern Region
Midwest Region
Western Region

APPENDIX D – PEDIATRIC MCI CONSIDERATIONS

Pediatric Care Recommendations

Decontamination: The agency responsible for decontamination will need an altered decontamination protocol, more communication, more personnel and specialized, smaller equipment when multiple children are involved in an MCI. Agencies should consider the following:

1. Set up a pediatric-specific decontamination station, with higher volume/lower pressure warm water. Consider family stations, which will keep families together and provide additional adult support to help get the children through the process.
2. Consider having isolette incubators, warmers and smaller gowns for the children after they have been decontaminated. Since children have a larger body surface area, they are at greater risk for hypothermia.

Additionally EMS responders and healthcare personnel should consider the following guidelines for children involved in an incident that requests decontamination:

- Avoiding separation of families during decontamination, especially under conditions that involve large numbers of patients in a chaotic situation; however, medical issues take priority.
- Older children may resist or be difficult to handle due to fear, peer pressure and modesty issues (even in front of their parents or caregivers).
- Since parents or caregivers may not be able to decontaminate both themselves and their children at the same time, decontamination (“hot zone”) personnel may be needed to assist them.
- Incorporating high -volume, low-pressure water delivery systems (e.g., handheld hose sprayers) that are “child- friendly” into the hospital decontamination showers.
- Risk of hypothermia increases proportionally in smaller, younger children when the water temperature in the decontamination shower is below 98°F.
- Attention to airway management, is a priority in decontamination showers.

The smaller the child, the bigger the problem regarding any of the above considerations (hypothermia, airway management, the ability to effectively decontaminate the child) and the separation of families.

Triage: Different triage and treatment protocols are needed for children compared to adults. “Walk to the sound of my voice” will not be an effective method for pre-ambulatory kids, or those with special needs. It will likely take you longer to assess children, even if they are triaged as green.

Airway: The MCIP uses JumpSTART for pediatric patients (less than 8 years old), which call for a few rescue breaths in children who have a pulse but aren’t breathing; if

the rescue breaths restore spontaneous respirations, the child gets triaged to the "urgent" or red category, rather than the expectant (black) category.
It will be impractical to intubate every child in an MCI - consider planning for oro- or nasopharyngeal airway, or laryngeal mask placement, and positioning young patients on their left side with a leg bent to keep them from rolling over, as quick ways to secure the airway and assist with breathing.

The focus for prehospital airway management in the disaster situation should be on positioning and bag valve mask ventilation rather than on invasive techniques. Positioning the child's airway appropriately can be a lifesaving intervention. Another important intervention that is often overlooked in the prehospital setting is appropriate suctioning of the child's airway. Because of the smaller diameter of the airway, it can easily be compromised (or even occluded) by secretions, especially in the event of chemical exposure.

Drug Dosage/Delivery: Responding agencies may need to place an intraosseous device for vascular access, rather than spending the time trying to find an IV on a child's small veins.

It is also important to remember that drugs are dosed differently for adults and children. An antidote auto-injector appropriately sized for an adult may be far too much for a small child. Consider adding a quick-reference card in your pediatric kits to ensure rapid calculation of key pediatric dosages on-scene.

Use weight based dosage for all medications and equipment:

- Weigh the patient and dose according to weight "Gold Standard"
- Use a length-based tool (Broselow tape) for weight estimation if you cannot weigh the child
- Use an age-predicted weight estimation chart as a last option because it is the least accurate

APPENDIX E – MEDICAL RESOURCE MANAGEMENT

The following MCI resource guide is not all-inclusive. Some other examples of resources that may be needed are: clergy, megaphones, interpreters, and multiport oxygen cascades, etc.

Personnel Resources (Public service agencies should be the first utilized)

Law Enforcement

- Nevada Highway Patrol
- Reno Police Department
- Sparks Police Department
- University of Nevada, Reno/Truckee Meadows Community College Police
- Washoe County Sheriff's Office
- Hasty Team
- Jeep Squadron
- Search and Rescue

Fire Agencies – this will include special purpose teams, e.g., Swift water rescue, Hazmat, etc.

- Airport Authority of Washoe County
- Bureau of Land Management (BLM)
- Nevada Air National Guard Fire Department (NANG)
- Nevada Division of Forestry
- North Lake Tahoe Fire Protection District
- Reno Fire Department
- Sparks Fire Department
- Truckee Meadows Fire Protection District
- United States Forest Service (USFS)

Ambulance Services – Washoe County

- Gerlach Volunteer Fire Department
- Pyramid Lake Fire Rescue EMS
- American Medical Flight - ALS
- North Lake Tahoe Fire Protection District - ALS
- Truckee Meadows Fire Protection District – ALS
- Reno Fire Department
- REMSA – ALS
- CareFlight – ALS
- REACH/Summit Air Medical Services

Ambulance Services - In proximity to Washoe County

- Banner Churchill Ambulance, Fallon - ALS
- Cal Star - Rotary
- REACH/Summit - Rotary
- North Lyon County Fire Protection District - ALS
- Central Lyon County Fire Protection District - ALS

- Carson City Fire Rescue - ALS
- South Lake Tahoe Fire Protection District - ALS
- Storey County - ALS
- Tahoe Douglas Fire Protection District - ALS
- East Fork Fire Protection District - ALS
- REACH/Summit Fixed Wing Air Ambulance, Elko
- Federal Fire - NAS Fallon - ILS

Other Sources

Hospitals (See Appendix G for map of locations of hospitals in Washoe County)

- Saint Mary's Regional Medical Center
- Northern Nevada Medical Center
- VA Sierra Nevada Health Care System
- Renown Regional Medical Center
- Renown South Meadows
- Incline Village Community Hospital

Military Organizations

- Marine Corps Mountain Warfare Training Center (Pickle Meadows, California)
- Naval Air Station (NAS), Fallon
- Nevada Air National Guard
- Nevada Army National Guard
- Sierra Army Ammunition Depot, Herlong
- U.S. Army Reserve

Free-Standing Clinics

- Washoe County Health District Clinics
- Industrial Occupational Health Clinics
- Urgent Care Centers
- UNR Clinics at the Medical School and Orvis School of Nursing
- Washoe County Clinic
- Health Access Washoe County

Nearby Out-of-County Ambulance/Personnel (Resources must be requested through the Incident Commander - this list may not include all possible resources.)

- Public Service Agencies
- Loyalton Volunteer Ambulance
- Portola Volunteer Ambulance
- Central Lyon County Fire Protection District
- Stagecoach Volunteer Ambulance
- North Lake Tahoe Fire Protection District
- Truckee Fire Department – ALS

Sources for General Medical Support Personnel - Existing Medical Staff

- Skilled Nursing and Long term Care facilities
- Health department and school nurses
- Hotel security officers

- Mental health hospitals
- Physician/dental offices
- Red Cross – Disaster Health Services

Training Institutions

- Truckee Meadows Community College
  - EMS Program—First Responders, EMT, Intermediate EMT and Paramedic Students
  - Nursing and Nursing Assistant Programs
- University of Nevada Reno
  - Advanced First Aid Training
  - Athletic Trainer Program
  - Medical School
  - Orvis School of Nursing
- REMSA Center for Pre-hospital Education
  - EMS Program – First Responder, Basic, Intermediate, and Paramedic students
  - Life Support Program – Cardiac, Pediatric and Trauma
  - EMS Refresher and Transition Courses

Out-of-County Training Institutions

- Feather River Community College - EMT
- Sierra Nevada College - EMT
- Western Nevada College - Nursing / EMT
- Lake Tahoe Community College - Fire Science and EMT
- Sierra College, Tahoe Truckee Campus - EMT

Non-ambulance Transportation Resources

Local Sources for Supine Patients

- Hospital/ Skilled Nursing/Long Term Care Specialty Vans
- Med Express
- Mortuaries
- VA DUV

Other Resources for Victims Able to Sit

- AME Medical Supplies
- Car Lots
- Casino Shuttle Buses
- RTC/CitiFare
- Forest Service and NDF Trucks
- Military Buses and Trucks
- Moving Vans
- Police Cars
- Private Bus Lines (i.e., Greyhound, Sierra Stage)
- Retirement Home Wheelchair Cars
- School Buses
- Taxicabs
- UPS Trucks

Equipment and Medical Supply Sources

Ambulance and Treatment Supply Sources

- Airport Authority Fire Vehicle (120 Backboards)

- Hospitals
- Medical Supply Houses
- Truckee Meadows Community College
- Truckee Meadows Fire Protection District MCI Trailer

General Medical Support Supplies

- Hospitals
- Medical Clinics
- Medical and Dental Offices
- Military
- Pharmacies and Drug Stores
- Supermarkets
- Veterinarian Offices

Communication Equipment Sources

- Hospitals
- Military
- Parks Communication
- Public Service Agencies
- Public Utility Companies
- ARES
- Sierra Electronics
- Sierra Nevada Amateur Radio Society
- TMFPD Mobile Command Post
- TMFPD Radio Cache
- Telephone Companies – land line and cellular
- Washoe County Telecommunications Office
- Washoe County Sheriff's Office Mobile Command Post

Airport Authority of Washoe County Medical Supply Lists

MASS CASUALTY TRAILER

Item Description(s)	Amount
Container of Airport MCI Position Vests (18 various MCI Position vests)	1
START Triage Packs (fanny packs); Blue	2
8 MCI Position Go-Kit (clipboard pack)	1
Backboards w/ straps	60
First Aid Kit General Purpose	1
Canopy 10'x50'	1
Green, Yellow, Red, Black treatment area bags/totes	1 each
Cardboard headblocks/headhuggers	77
Oxygen Bags	17
Emergency Blankets: light weight, orange	60
Cardboard splints 18" long	35
Cardboard splints 24" long	29
Garbage Can metal 30 gallon	1
Wool Blankets	60

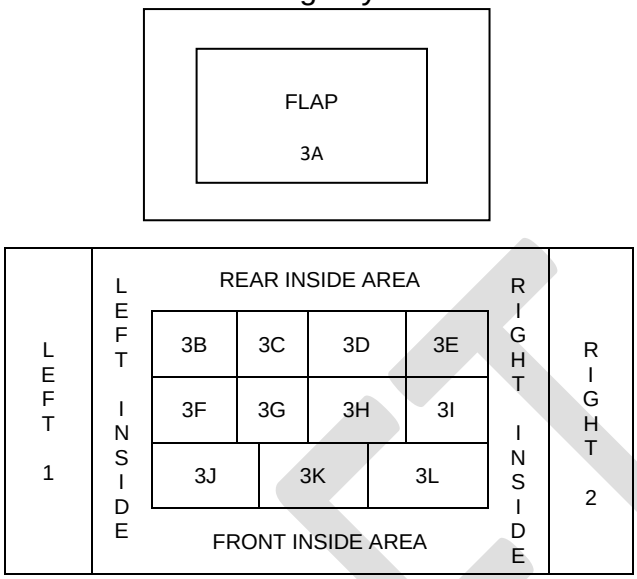
Airport Authority MCI Position Vests

Vest Position	Amount
Medical Coordinator & clipboard	1
Medical Group Supervisor & clipboard	1
Medical Supply & clipboard	1
Morgue	1
Medical Branch Director & clipboard	1
Patient Transportation Group Supervisor & clipboard	1
Recorders and tablets	4
Immediate Treatment Manager	1
Immediate Treatment Personnel	4
Delayed Treatment Manager	1
Delayed Treatment Personnel	4
Treatment Unit Leader & clipboard	1
Minor Treatment Personnel	5
Triage Unit Leader & clipboard	1
Triage Unit Personnel	4

AIRPORT AUTHORITY FIRE DEPARTMENT

Airport MCI Bag Inventory Sheet

MCI Bag Layout



Location	Compartment #	Description of Item	Quantity
Left Compartment	1	8"x10" Combine Dressings	6 Each
		5"x9" Combine Dressings	4 Each
		4"x4" Universal Dressings	10 Each
Right Compartment	2	10"x30" Trauma Dressings	4 Each
Main Compartment	Left Inside Area	54"x80" Disposable Emergency Blanket - Yellow	1 Each
	Right Inside Area	54"x80" Disposable Emergency Blanket - Yellow	1 Each
	Front Inside Area		
		60"x96" Sterile Burn Sheet	1 Each
		Flat SAM Splints - Orange	2 Each
	Rear Inside Area	60"x96" Sterile Burn Sheet	1 Each
	FLAP 3A	7%" Paramedic Shears - Orange	2 Each
		5%" Locking Forceps - Stainless Steel	1 Each
		AA Mini-Mag Light - Black	1 Each
	3B	250 ml .9% Sodium Chloride Solution	1 Each
	3C	Berman Oral Airway Kit - Complete	1 Each
	3D	36"x36"x51" Triangular Bandages	4 Each
	3E	1" Zonas Tape	2 Each
		3" Zonas Tape	2 Each
	3F	250 ml .9% Sodium Chloride Solution	1 Each
	3G	Wooden Tongue Depressors	4 Each
		1" Band-Aids	10 Each
	3H	MDI CPR Micro shields - X-Large	2 Each
	31	4"x4" Water Gel Burn Dressings	2 Each
	3J	4.5" Kling or Kerlix Bandage Rolls	4 Each
	3K	Adult Blood Pressure Cuff (w/zippered case)	1 Each
	3L	22" Sprague Stethoscope (w/additional ear piece kit)	1 Each
	Sitting on Top in Ziploc Bags	Bio-Hazard Kits: 1 pr. Gloves, 1 gown, Safety Glasses, 2 Vionex Wipes, 2 Infections Waste Bags, Medical Dust/Mist Mask	2 kits

Reno-Tahoe International Airport Authority Medical Supply Lists
Mass Casualty Truck, Fire 6

Location	Item Description(s)	Amount
CAB		
Left door	Reno/Sparks Community Area Road & Street Map	1
	International vehicle operator's manual	1
Under seat	ABC 2.5 lb. extinguisher	1
	First Aid kit, (general purpose)	1
Behind seat	Hook rods for awning	2
Sun visor	Outside gates & Fire House overhead controllers	1 each
Right door	Emergency Response Guidebook 2016	1
Center	Tower radio, Technisonic model TIL-90-6R, s/n 9381, red tag 30763	1
LEFT SIDE		
Compartment 1		
Top shelf	Water Cases	2
	Caution Tape roll	1
	Light Sticks: Red, Yellow, Green. Located in blue plastic bin	12 each
	START Triage Packs (fanny packs); Blue	5 each
	8 MCI Position Go-Kit (clipboard pack)	1
	START Triage Tags	120
Mid Shelf	Tape rolls: Red, Yellow, Green.	2 each
	Flare Alert light beacon/pucks kit. Contains: 5x White, 2x Red, 2x Yellow, 2x Green, 3x Orange Marshal Wands w/ 3 conversion adaptors	1
	Smoke Alarm	1
	Extension Cords	2
	Swat-T tourniquets (box of)	100
Lower Shelf	Chock	1
	Roll out tray – Honda EM 5000s Generator s/n EA7-1205409	1
Compartment 2		
	Trauma Bags (see below for bag inventory)	25
	Oxygen Bags (see below for bag inventory)	23
Compartment 3		
	Wool blankets	30
	Emergency Blankets: medium weight, yellow	50
	Emergency Blankets: light weight, orange	59
	Green, Yellow, Red, Black treatment area bags/totes	1 each
	Green, Yellow, Red, Black treatment area signs	1 each
	30 gallon biohazard barrels: red	2 each
	Biohazard bags/can liners	1 roll
Compartment 4		
	Backboards w/ straps (total count of walkthrough compartment)	109
	Cardboard headblocks/headhuggers	60
	Step ladder	1

Reno-Tahoe International Airport Authority Medical Supply Lists
Mass Casualty Truck, Fire 6

Location	Item Description(s)	Amount
RIGHT SIDE		
Compartment 1		
Upper Shelf	Trauma Bags (see below for bag inventory)	14
Lower Shelf	Light Sticks: Red, Yellow, Green. Located in blue plastic bin	12 each
	Flare Alert light beacon/pucks kit. Contains: 5x White, 2x Red, 2x Yellow, 2x Green, w/ 3 conversion adaptors	1
Compartment 2		
Upper Shelf	Trauma Bags (see below for bag inventory)	21
Lower Shelf	Oxygen Bags (see below for bag inventory)	21
Compartment 3		
	Wool blankets	30
	Emergency Blankets: medium weight, yellow	44
	Emergency Blankets: light weight, orange	56
	Emergency Blankets: light weight, white	12
	Green, Yellow, Red, Black treatment area bags/totes	1 each
	Green, Yellow, Red, Black treatment area signs	1 each
	30 gallon biohazard barrels: red	2 each
	Biohazard bags/can liners	1 roll
Compartment 4		
	Backboards w/ straps (total count of walkthrough compartment)	109
	Cardboard headblocks/headhuggers	60
	Traffic Cones	10
	Awning	2
Oxygen Bag		
	"D" cylinder	1
	Nasal cannula, adult	1
	Non re-breather mask, adult	1
	Bag-valve-mask, adult	1
	Handle for O2 Cylinder	1

State EMS Medical Surge Trailers

State EMS Triage Trailers' Locations By County	City
Churchill	Fallon
Douglas	Zephyr Cove
Douglas	Minden
Elko	Duck Valley, Owyhee
Eureka	Eureka
Humboldt	Winnemucca
Humboldt	Fort McDermott/Pai-Sho Tribe
Lander	Battle Mountain
Lincoln	Caliente
Lyon	Yerington
Mineral	Hawthorne
Nye	Beatty
Nye	Tonopah
Nye	Pahrump
Pershing	Lovelock
Storey	Virginia City
Washoe	Gerlach
White Pine	Ely
White Pine	Shoshone Maintenance Yard, Ely
Elko	Elko
Storey	Dayton

Nevada Medical Surge Trailer Inventory

QTY PER TRAILER	Unit of Measurement	ITEM DESCRIPTION
1	each	Pace American Trailer, 20 ft. with interior racking system
50	each	Adult Dispos-A-Board, Four (4) Easy grip straps, auto cradle head immobilizer, 500lb. capacity
20	kits	Pediatric Dispos-A-Board System, integral head immobilizer, with head drop system
2	sets	Rapid Response Kit --four (4) 20' x 30' triage treatment tarps (12 positions per tarp)
2	each	Triage Flag Set--four (4) 8' telescoping flag pole, four (4) triage flags, carry bag
2	kits	5 Person O2 Manifold with 25' Hose
4	each	trauma patients or 40 walking wounded)
20	each	36" Padded cardboard splint
20	each	clear interior zippered layer, 800lb. Capacity
14	each	MCI mesh stretchers, 500lb. Capacity, two (2) integral Velcro patient straps
10	each	Rapid Rescue Strap, rated to 2400 lbs., Two (2) 10" easy grip handles, storage pouch
2	each	100' Heavy duty extension cord
2	each	UL Approved duel head light, 500 Watt Each, with Tripod
25	each	Orange 28" traffic cones
100	each	Infectious waste bags
50	each	Sterile burn sheet, 60" X 90" full body
50	each	Multi-trauma dressings, 10" X 30"
20	each	18" Disposable splints
50	each	Fluid shield mask with face shield
50	each	Adjustable cervical collar (Adult)
20	each	Adjustable cervical collar (Pediatric)
5	each	Nitrile, gloves, size Large (Box of 100)
5	each	Nitrile, gloves, size X-Large (Box of 100)
1	each	Non-rebreather masks (50/cs)
1	each	Adult nasal Cannulas (50/cs)
2	each	O2 Aluminum M Cylinder
1	each	Portable gas generator 6250 Peak
1	each	20 Watt megaphone with siren/whistle
1	each	12-Hour light stick, green (100/cs)
1	each	12-Hour light stick, yellow (100/cs)
1	each	12-Hour light stick, red (100/cs)

Nevada Medical Surge Trailer Inventory

QTY PER TRAILER	Unit of Measurement	ITEM DESCRIPTION
1	each	12-Hour light stick, orange (100/cs)
1	each	12-Hour light stick, blue (100/cs)
15	each	Adult blood pressure cuff
5	each	Pediatric blood pressure cuff
50	each	Tyvek coverall, size Large
50	each	Tyvek coverall, size X-Large
150	each	Disposable blanket
24	each	Orange vest with clear plastic ID holder on front and back, 1" wide Reflexite tape stripes
24	each	Ambu BVM (Adult)
12	each	Ambu BVM (Child)
1	each	Cardiac Science G3 Pro, AED, manual with 3 lead monitoring
1	each	Cardiac Science AED, Adult Pads
1	each	Cardiac Science AED, Ped Pads
1	each	Cardiac Science AED, 5 yr Battery
20	each	4" Kling (bag of 12)
6	each	EZ Up Shelter (6 Colors) 11'x16' twin peak with set of side curtains and carry bag (red, yellow, green, dark green, blue, black)
2	each	Pressure Reducer Regulators for O2 M cylinder
10	each	X-tra Spine Boards, adult, non-disposable, 72"L X 16"W, straps with integral hand loops
10	each	Disposable "S" strap
1	each	Antiseptic Hand Spray (2oz) 24/cs

APPENDIX F – MULTI-CASUALTY INCIDENT MANAGEMENT FORMS/FIELD FORM INSTRUCTIONS

The primary forms used to document the Medical Branch organization and the activities of treatment, staging and transportation are listed below with their designated form number. During an incident response, the DMS triage forms may also be utilized for patient tracking. The original forms in this appendix should be retained to make copies for use in the field. A copy of each form follows this introduction and instructions for completing the form are printed on the back.

- Incident Command Organizational Chart For A Medical Branch – Full Branch Response Level (MCM 401)
- Medical Branch Worksheet (MCM 402)
- Patient Transportation Summary Worksheet (MCM 403)
- Ambulance Staging Resource Status Log (MCM 404)
- ICS Unit Log 214

Multi-Casualty Incident Management Forms should be carried by all agencies providing medical first response to MCIs and who may fill Medical Branch ICS positions. The forms should be issued to personnel at the time they are assigned.

The Medical Branch Director/Group Supervisor must use the Medical Branch Worksheet (MCM 402) whenever he fills more than two positions under him.

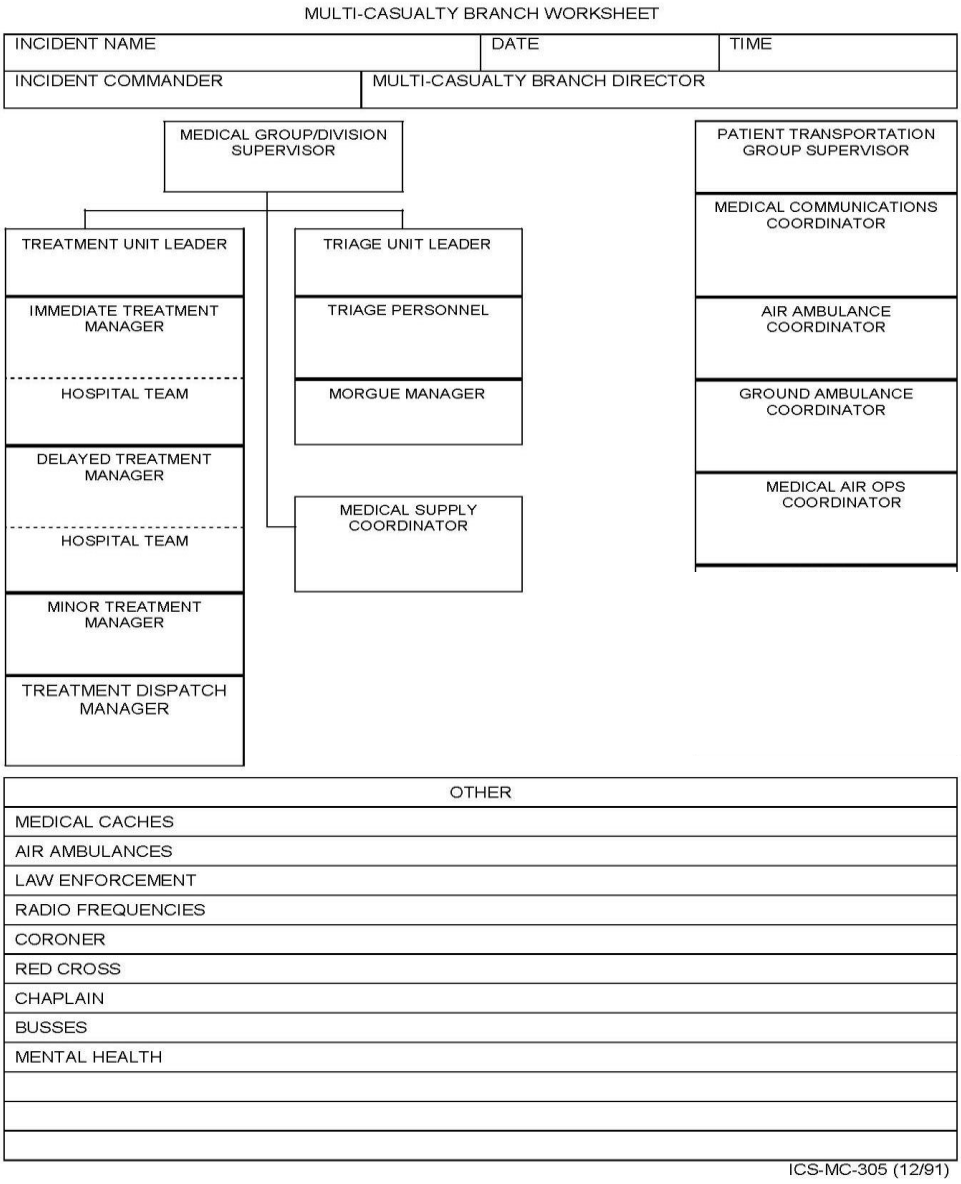
For those incidents of limited scope and duration, it might NOT be necessary to use all these forms. However, it is important that records be maintained on victim disposition so that immediate reference to their destination can be made available when requested.

Anytime the MCIP is activated, all medical personnel responsible for forms must complete them and forward them to the Medical Branch Director/Group Supervisor. He will in turn forward them to the Incident Commander. The Incident Commander will forward copies of all completed forms, including the medical forms, to the WCHD EMS Oversight Program within two working days after the incident. The Health District will coordinate debriefings on incidents involving 10 or more victims or of smaller incidents at the request of incident command personnel or medical agencies.

Incident Command Organizational Chart - Full Medical Branch Response Level

(MCM 401)

This form must be completed in a full branch response medical incident. It may also be used in smaller incidents to depict the specific medical branch positions that have been filled. This pictorial representation of the Medical Branch may be provided to additional incident personnel as they are assigned and to keep personnel updated as new positions are assigned.



Medical Branch Worksheet

(MCM 402)

The Medical Group Supervisor must use the Medical Branch Worksheet (MCM 402) whenever more than two components have been delegated to other individuals.

The form is an organizational aid and is an abbreviated flow chart that provides space for names of persons filling positions and a checklist of other resources to be considered.

PATIENT TRANSPORTATION SUMMARY WORKSHEET			1. Incident Name			2. Date Prepared		3. Time prepared	
PATIENT READY	PATIENT STATUS	INJURY TYPE (IE: HEAD)	MODE OF TRANSPORT	HOSPITAL DESTINATION	AMBULANCE CO. AND ID.	PATIENT NAME/TAG NUMBER	OFF SCENE TIME	ETA	DCF ADVISED
	I D M						___ :___		
	I D M						___ : ___		
	I D M						___ : ___		
	I D M						___ : ___		
	I D M						___ : ___		
	I D M						___ : ___		
	I D M						___ : ___		
	I D M						___ : ___		
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	I D M						___ : ___		
	I D M						___ : ___		
	I D M						___ : ___		
	I D M						___ : ___		
	I D M						:		
MCI ICS 2-91		4. PREPARED BY (PATIENT TRANSPORTATION GROUP SUPERVISOR/MEDICAL COMMUNICATIONS COORDINATOR)							

Patient Transportation Summary Worksheet

(MCM 403)

This form can be used to track all casualties from the treatment areas to the hospital destination. This requires close communication between the personnel in both the treatment and transport functions. The Patient Transportation Receipt Holder Worksheet (DMS 5767) may be used in lieu of the MCM 403 as the information is already captured on the transportation receipt.

Regardless of the form utilized, a photocopy or a picture of the worksheet will need to be obtained and forwarded to the Medical Unit at the EOC. This information would then be utilized for patient tracking purposes.

EXAMPLE OF MCM 403

PATIENT TRANSPORTATION SUMMARY WORKSHEET			1. Incident Name *Main St. Incident*			2. Date Prepared *2/1/04*		3. Time prepared *1300*	
PATIENT READY	PATIENT STATUS	INJURY TYPE (IE: HEAD)	MODE OF TRANSPORT	HOSPITAL DESTINATION	AMBULANCE CO. AND ID.	PATIENT NAME/TAG NUMBER	OFF SCENE TIME	ETA	DCF ADVISED
√	I D M	*Head*	*Air*	*Renown*	*Care Flt. 3*	*486624*	*13 : 12*	*12*	√
√	I D M	*Head*	*Ground*	*Renown*	*Medic 5*	*483290*	*13 : 15*	*18*	√
√	I D M	*Chest*	*Air*	*Saint. Mary's*	*Medic 2*	*436021*	*13 : 29*	*13*	√

Patient Transportation Receipt Holder Worksheet

(DMS – 5767)

This form is used by the PTGS and utilizes the transportation receipt from the DMS triage tag to track all casualties from the treatment areas or casualties coming directly from the initial triage to the hospital destination. This requires close communication between the personnel in both the treatment and transport functions as well as Medical Communications Coordinator (MCC).

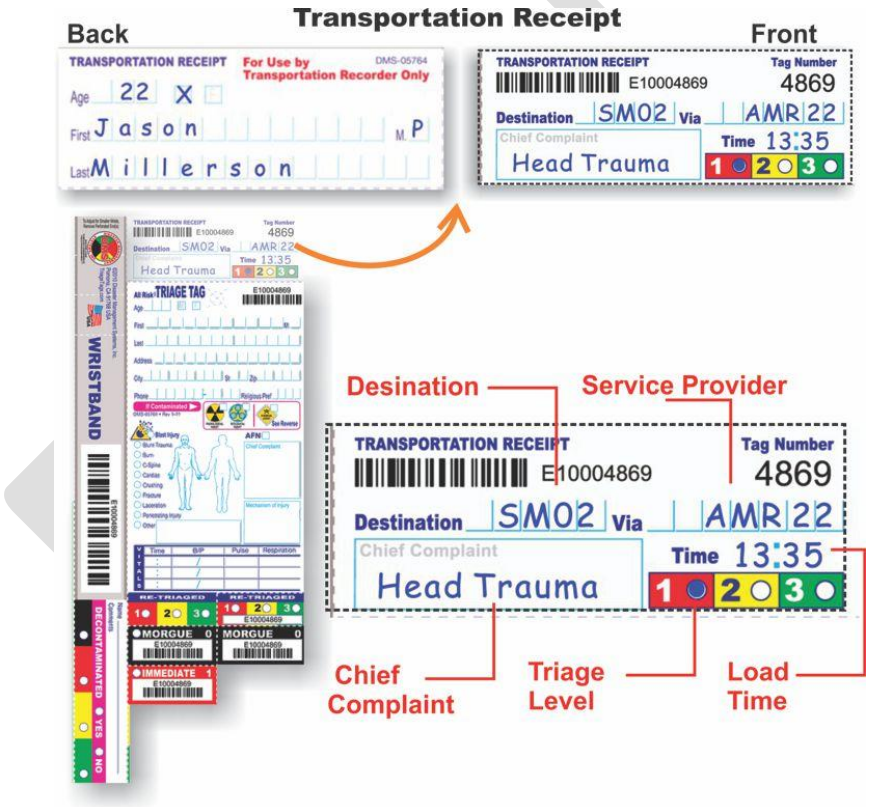
Utilize the triage tag receipt attached to patients coming from Treatment areas. In the event a patient arrives at the ambulance loading area without a triage tag, apply a triage tag to the patient prior to loading and remove the transportation receipt.

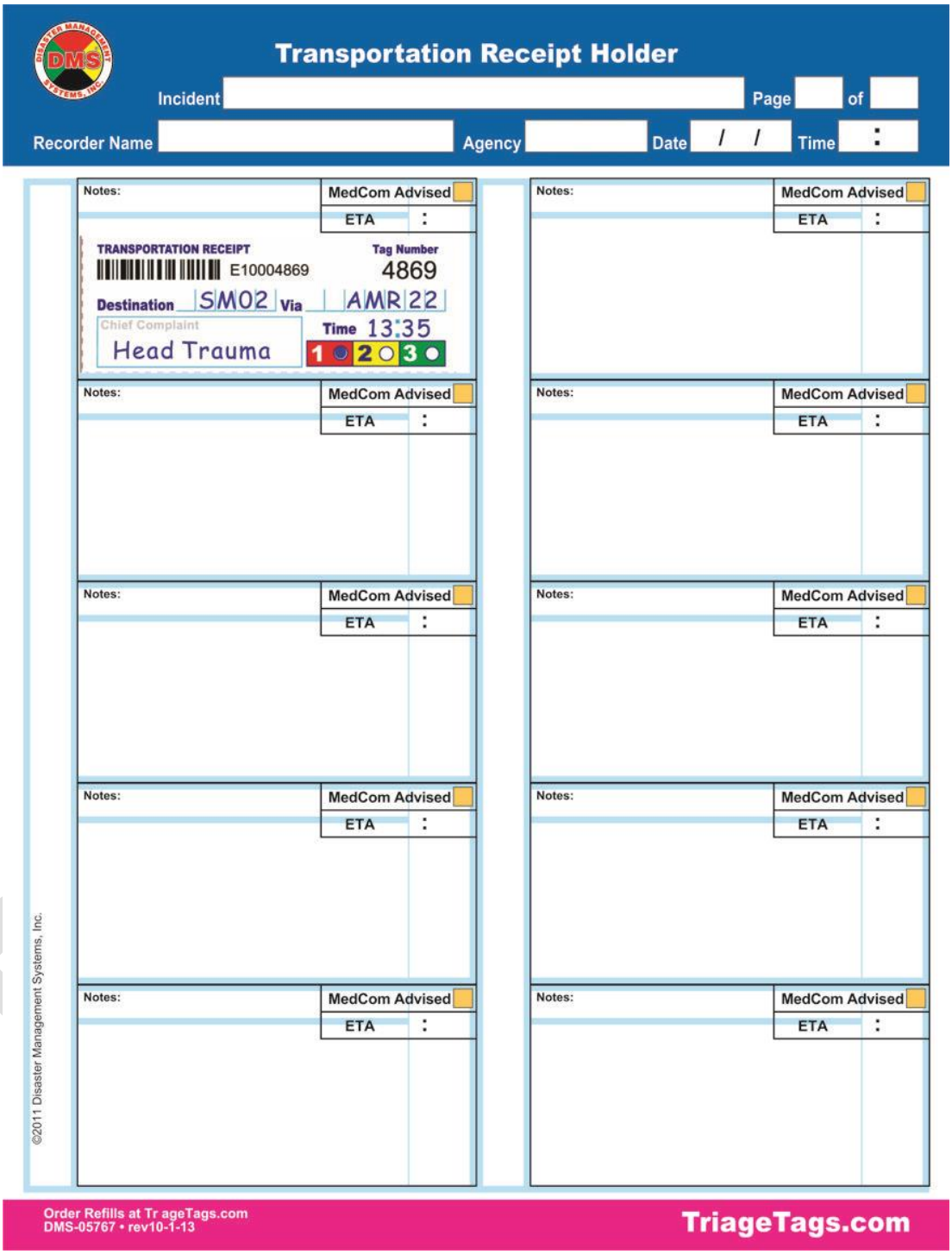
Use the Triage Tag Receipt and the Receipt Holder to record the following information:

Triage Tag Receipt:

Destination Hospital Code
Service Provider (Via)
Patient Load Time
Chief Complaint
Triage Level
Patient Name and Age (if available)

Receipt Holder:
Estimated Time of Arrival to Receiving Hospital
Any relative notes




Transportation Receipt Holder
Incident
Page
of
Recorder Name
Agency
Date / /
Time :
Notes:
MedCom Advised
ETA :
TRANSPORTATION RECEIPT
E10004869
Tag Number
4869
Destination SM02 Via AMR22
Chief Complaint
Head Trauma
Time 13:35
1 2 3
©2011 Disaster Management Systems, Inc.
Order Refills at Tr ageTags.com
DMS-05767 • rev10-1-13
TriageTags.com

Ambulance Staging Resource Status Log

(MCM 404)

This form should be maintained by the Ground Ambulance Staging Manager(s) to track ambulance availability and activities. Space is provided for the agency name and ambulance identification number, as well as their time in and out of staging. It can also be used to keep track of medical supplies and other personnel available at ambulance staging for use at the scene.

(MCM 404a)

This form should be maintained by the Air Ambulance Coordinator to track helicopter and fixed wing availability and activities. Space is provided for the tail number as well as their time in and out of staging. This form is also to be used to track patients transported by helicopter to a regional medical facility.

AMBULANCE STAGING RESOURCES STATUS	1. INCIDENT NAME			2. DATE PREPARED	3. TIME PREPARED
AGENCY	**UNIT NUMBER**			**TIME IN STAGING AREA**	**TIME OUT STAGING AREA**
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
			ALS		
			BLS	_____ : _____	_____ : _____
MCI ICS 2-91	4. PREPARED BY (GROUND/AIR AMBULANCE STAGING MANAGER)				

MCM 404a

AIR AMBULANCE COORDINATOR SPREADSHEET

GROUND CONTACT RADIO DESIGNATOR: **AIR to GROUND RADIO FREQUENCY:**	

INCIDENT: **DATE:**	**AIRPORT OR AIRSTRIP:**	**LAT:** **LONG :**

Radio #:	Tail #:	Radio #:	Tail #:
Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other	Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other
# Patients Can Take:	# Patients Transported:	# Patients Can Take:	# Patients Transported:
Destination:	Tag # (s):	Destination:	Tag # (s):

Radio #:	Tail #:	Radio #:	Tail #:
Landing time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other	Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other
# Patients Can Take:	# Patients Transported:	# Patients Can Take:	# Patients Transported:
Destination:	Tag # (s):	Destination:	Tag # (s):

Radio #:	Tail #:	Radio #:	Tail #:
Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other	Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other
# Patients Can Take:	# Patients Transported:	# Patients Can Take:	# Patients Transported:
Destination:	Tag # (s):	Destination:	Tag # (s):

Radio #:	Tail #:	Radio #:	Tail #:
Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other	Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other
# Patients Can Take:	# Patients Transported:	# Patients Can Take:	# Patients Transported:
Destination:	Tag # (s):	Destination:	Tag # (s):

Radio #:	Tail #:	Radio #:	Tail #:
Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other	Land time: Lift time:	ALS / Nurse/ Paramedic BLS/ EMT/ Other
# Patients Can Take:	# Patients Transported:	# Patients Can Take:	# Patients Transported:
Destination:	Tag # (s):	Destination:	Tag # (s):

MCM 404a PAGE _____OF_____

ICS Unit Log 214

The ICS Unit Log (#214) is a generic form used in a large incident to document and report the activities of incident personnel in charge of specific functions. In the Medical Branch the individual job descriptions will list which personnel may be required to complete such a form when appropriate. In general, they are the Medical Branch Director, Medical Group Supervisor, the Triage Unit Leader, Treatment Unit Leader, Patient Transportation Group Supervisor, and the Medical Supply Coordinator.

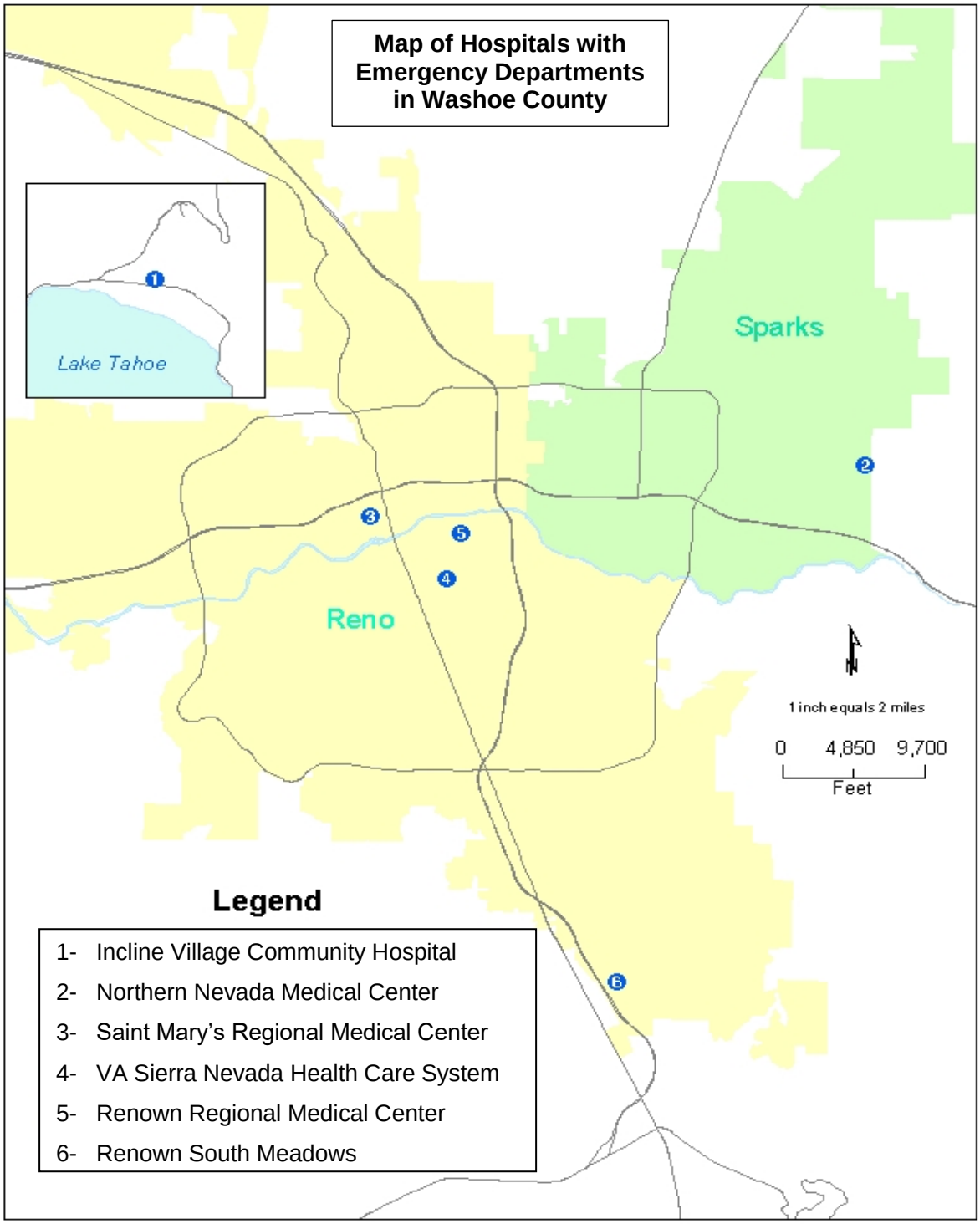
In a large or prolonged incident, additional personnel assigned specific functions may also find the form useful to track and document specific activities or personnel.

UNIT LOG	1. INCIDENT NAME	2. DATE PREPARED	3. TIME PREPARED
4. UNIT NAME/DESIGNATORS	5. UNIT LEADER (NAME AND POSITION)	6. OPERATIONAL PERIOD	

7. PERSONNEL ROSTER ASSIGNED		
NAME	ICS POSITION	HOME BASE

8. ACTIVITY LOG **(CONTINUE ON REVERSE)**	
TIME	MAJOR EVENTS
214 ICS 5-80	9. PREPARED BY (NAME AND POSITION)

APPENDIX G - WASHOE COUNTY HOSPITAL MAP



APPENDIX H - INTEGRATION

Outside Agencies Responding into Washoe County
In the event of an MCI within Washoe County and an outside agency is requested or responds to said incident, the initial triage and setup of incident will be as follows:

- All agencies within Washoe County will use the ribbon triage system as outlined in this plan; all agencies outside of Washoe County will be permitted to use their designated system.
- When the victims of the MCI reach the treatment area, the initial triage tag will be removed and replaced with the appropriate DMS triage tag for accurate tracking and accounting of patients.
- The initial triage tag, whether it is a ribbon or some other sort of tag, will be removed and replaced at this time to ensure compliance with the Washoe County MCI plan.
    - The majority of initial MCI triage systems are somewhat similar in using color coding to designate the severity of the patient. It will be the responsibility of the treatment area leader to classify any outside triaging into the appropriate category following the guidelines set forth within the Washoe County MCI plan.

        - Immediate = Red
        - Delayed = Yellow
        - Minor = Green

- In the event of an outside agency being assigned to the treatment area, that agency will be given the appropriate tags to comply with the Washoe County MCI plan.

APPENDIX I – INDIVIDUAL RESILIENCE: FACTSHEET FOR RESPONDERS

Emergency responders know disasters and emergencies can cause great destruction to infrastructure and damage people's physical health. It can be challenging for responders to anticipate the behavioral health consequences of disasters for victims and for themselves. This is because the emotional effects of a disaster may not be seen in tangible ways. Effective coping with disaster has a lot to do with a responder's individual resilience.

What is individual resilience?

Individual resilience involves behaviors, thoughts, and actions that promote personal well-being and mental health. It refers to a person's ability to withstand, adapt to, and recover from adversity. People can learn coping skills to adapt to stress and maintain or return to a state of mental health well-being.

A disaster can impair resilience, even for experienced responders, due to stress, traumatic exposure, distressing psychological reactions, and disrupted social networks. Feelings of grief, sadness, and a range of other emotions are common after traumatic events. Resilient individuals, however, are able to work through the emotions and effects of stress and painful events and rebuild their lives.

Why is responder resilience so important?

When responders have the tools and support that they need to take care of themselves and manage stress, the team as a whole will be more effective. Resilient responders are better able to fulfill the requirements of the response.

Unaddressed responder stress can have a negative effect on others. Stress can lead to poor decisions and increase mistakes that might jeopardize the success of the task and the safety of others.

Resilient responders are better able to:

- Care for themselves and others.
- Access needed resources more efficiently and effectively.
- Be physically and mentally healthier and have overall lower recovery expenses and service needs.
- Miss fewer days of work.
- Get back to routines more quickly (which helps family members as well).
- Work through the strong emotions that come from being a responder, without relying on unhealthy coping strategies, such as drinking heavily or smoking.
- Return to their day-to-day role and have positive interactions with co-workers and family.
- Have greater job satisfaction and career longevity.

What contributes to individual resilience?

Resilience develops as individuals learn better strategies to manage stress and life's challenges. Building resilience involves tapping into personal strengths and the support of family, colleagues, and friends. Responders can foster individual resilience during pre-response, response, and post-response phases. Here are some examples:

Pre-response:

- Educate yourself and your colleagues about the behavioral health impacts of working in disaster environments.
- Plan for how you will cope with response & post-response stress.
- Talk with family & friends about how they can support you.
- Use healthy stress management strategies every day, not just when stress is at its highest.
- Engage in community activities for enjoyment and to build social connections.
- Exercise daily (running, stretching etc.).
- Develop and maintain healthy eating habits.
- Have a bedtime routine that you can maintain regularly.
- Identify people that are positive influences who can provide support during times of stress, even if you can only keep in touch online.
- Find what brings you positive feelings or enjoyment, such as a favorite book or movie. Keep it on hand for when you return from a response to help tap into positive emotions.

During response:

- Seek support or suggestions from staff assigned to provide responder behavioral health support.
- Take regular breaks and do your best not to work over expected shift lengths.
- Reach out to family, friends, or colleagues to get support.
- Maintain an exercise routine to help release stress.
- Eat healthy and make sure you get adequate sleep.
- Rotate job tasks before stress impacts performance.

Post response:

- Learn about potential challenges of returning from a disaster and share them with your family and friends.
- Get screened for stress or behavioral health needs.
- Use your employee assistance program or other resources, like the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Distress Helpline (1-800-985-5990 or text TalkWithUs to 66746) which provides free, confidential support to disaster survivors and responders.
- Use strategies that you identified before responding to the disaster.

Resources:

Employee Assistance Programs (EAPs)

Share the Load: A Support Program for Firefighters and EMTs

Share the Load National Fire/EMS Helpline: 1-888-731-3473

SAMHSA Disaster Distress Line

SAMHSA Disaster App

Psychological First Aid: A Guide for Emergency & Disaster Response Workers

A Guide to Managing Stress in Crisis Response Professions

Tips for Disaster Responders: Identifying Substance Misuse in the Responder Community

Tips for Disaster Responders: Preventing and Managing Stress

A Post-Deployment Guide for Families of Emergency & Disaster Response Workers

APPENDIX J - NEVADA GOOD SAMARITAN LAW

1. Except as otherwise provided in NRS 41.505, any person in this State who renders emergency care or assistance in an emergency, gratuitously and in good faith, except for a person who is performing community service as a result of disciplinary action pursuant to any provision in title 54 of NRS, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured person.

2. Any person in this State who acts as a driver of an ambulance or attendant on an ambulance operated by a volunteer service or as a volunteer driver or attendant on an ambulance operated by a political subdivision of this State, or owned by the Federal Government and operated by a contractor of the Federal Government, and who in good faith renders emergency care or assistance to any injured or ill person, whether at the scene of an emergency or while transporting an injured or ill person to or from any clinic, doctor's office or other medical facility, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance, or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured or ill person.

3. Any person who is an appointed member of a volunteer service operating an ambulance or an appointed volunteer serving on an ambulance operated by a political subdivision of this State, other than a driver or attendant of an ambulance, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person whenever the person is performing his or her duties in good faith.

4. Any person who is a member of a search and rescue organization in this State under the direct supervision of any county sheriff who in good faith renders care or assistance in an emergency to any injured or ill person, whether at the scene of an emergency or while transporting an injured or ill person to or from any clinic, doctor's office or other medical facility, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance, or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured or ill person.

5. Any person who is employed by or serves as a volunteer for a public fire-fighting agency and who is authorized pursuant to chapter 450B of NRS to render emergency medical care at the scene of an emergency is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering that care or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured or ill person.

6. Any person who:

(a) Has successfully completed a course in cardiopulmonary resuscitation according to the guidelines of the American National Red Cross or American Heart Association;

(b) Has successfully completed the training requirements of a course in basic emergency care of a person in cardiac arrest conducted in accordance with the standards of the American Heart Association; or

(c) Is directed by the instructions of a dispatcher for an ambulance, air ambulance or other agency that provides emergency medical services before its arrival at the scene of the emergency, and who in good faith renders cardiopulmonary resuscitation in accordance with the person's training or the direction, other than in the course of the person's regular employment or profession, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering that care.

7. For the purposes of subsection 6, a person who:

(a) Is required to be certified in the administration of cardiopulmonary resuscitation pursuant to NRS 391.092; and

(b) In good faith renders cardiopulmonary resuscitation on the property of a public school or in connection with a transportation of pupils to or from a public school or while on activities that are part of the program of a public school, shall be presumed to have acted other than in the course of the person's regular employment or profession.

8. Any person who gratuitously and in good faith renders emergency medical care involving the use of an automated external defibrillator is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering that care.

9. A business or organization that has placed an automated external defibrillator for use on its premises is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by the person rendering such care or for providing the automated external defibrillator to the person for the purpose of rendering such care if the business or organization:

(a) Complies with all current federal and state regulations governing the use and placement of an automated external defibrillator;

(b) Ensures that the automated external defibrillator is maintained and tested according to the operational guidelines established by the manufacturer; and

(c) Establishes requirements for the notification of emergency medical assistance and guidelines for the maintenance of the equipment.

10. As used in this section, "gratuitously" means that the person receiving care or assistance is not required or expected to pay any compensation or other remuneration for receiving the care or assistance.

APPENDIX K - ACRONYMS

ABC	Airway, Breathing, Circulation
ADA	Americans with Disabilities Act
AHJ	Authority Having Jurisdiction
ALS	Advanced Life Support
ARES	Amateur Radio Emergency Service
BIO	Biological
BLM	Bureau of Land Management
BLS	Basic Life Support
CCIU	Cardiac Intensive Care Unit
CCU	Cardiac Care Unit
CSU	Cardiac Surgery Unit
DBOH	District Board of Health
DEM	Nevada State Division of Emergency Management
DHO	District Health Officer
DPBH	Nevada Division of Public and Behavioral Health
ECF	Extended Care Facility
ED	Emergency Department
EM	Emergency Manager
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
ETA	Estimated Time of Arrival
FAC	Family Assistance Center
FCC	Federal Communication Commission
FEMA	Federal Emergency Management Agency
FSC	Family Service Center
HICS	Hospital Emergency Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
IAP	Incident Action Plan
IC	Incident Commander

ICS	Incident Command System
ICU	Intensive Care Unit
IHCC	Inter-Hospital Coordinating Council
I.V.	Intravenous
IVGID	Incline Village General Improvement District
IVCH	Incline Village Community Hospital
L&D/PP	Labor and Delivery/Postpartum
LZ	Landing Zone
MAA	Mutual Aid Agreement
MAEA	Mutual Aid Evacuation Annex
MCC	Medical Communications Coordinator
MCI	Multi-Casualty Incident
MCIP	Multi-Casualty Incident Plan
MED NET	Medical Network Radio Frequencies
MGR	Manager
MHz	Megahertz
MOU	Memorandum of Understanding
MUL	Medical Unit Leader
NAC	Nevada Administrative Code
NANG	Nevada Air National Guard
NAS	Naval Air Station - Fallon
Neo-ICU	Neonatal Intensive Care Unit
NLTFPD	North Lake Tahoe Fire Protection District
NNMC	Northern Nevada Medical Center
NRS	Nevada Revised Statutes
NWS	National Weather Service
OB/Gyn	Obstetrics/Gynecology
OR	Operating Room
PACU	Post Anesthesia Care Unit
Pediatric ICU	Pediatric Intensive Care Unit
PL Codes	Public License Codes

PSAP	Public Safety Answering Point
Pt	Patient
PTGS	Patient Transportation Group Supervisor
RACES	Radio Amateur Civil Emergency Services
REOC	Regional Emergency Operations Center
REOP	Regional Emergency Operations Plan
REMSA	Regional Emergency Medical Services Authority
RSCVA	Reno Sparks Convention and Visitors Authority
RTAA	Reno-Tahoe Airport Authority
RTC	Regional Transportation Commission
SMRMC	Saint Mary's Regional Medical Center
SNF	Skilled Nursing Facility
START	Simple Triage and Rapid Treatment
Telemetry SD	Telemetry/Step Down Unit
TFH	Tahoe Forest Hospital
TMFPD	Truckee Meadows Fire Protection District
TPHSM	Tahoe Pacific Hospital South Meadows
TPHW	Tahoe Pacific Hospital West
UHF	Ultra High Frequency
UNR	University of Nevada Reno
VA	VA Sierra Nevada Health Care System
WCHD	Washoe County Health District
WCMECO	Washoe County Medical Examiner/Coroner Office

APPENDIX L – GLOSSARY

Agency Representative
A person assigned by a primary, assisting or cooperating Federal, State, local, or tribal government agency or private entity that has been delegated authority to make decisions affecting that agency's or organization's participation in incident management activities following appropriate consultation with the leadership of that agency.

Assistant
Title for subordinates of principal Command Staff positions. The title indicates a level of technical capability, qualifications and responsibility subordinate to the primary positions. Assistants may also be assigned to unit leaders.

Authority Having Jurisdiction (AHJ)
The government agency, responsible for public safety or code enforcement within any given geographical area.

Branch
The organizational level having functional or geographical responsibility for major aspects of incident operations. A branch is organizationally situated between the section and the division or group in the Operations Section, and between the section and units in the Logistics Section. Branches are identified by the use of Roman numerals or by functional area.

Care Capacity
The number and types of patients a facility is able to accommodate based on a variety of internal factors as defined by the facility to include physician and nurse staffing, operating rooms available, Emergency Department capacity/staffing, and in-house capacity.

Chief
The ICS title for individuals responsible for management of functional sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established as a separate section).

Command Staff
In an incident management organization, the Command Staff consists of the Incident Commander and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed.

Deceased Patient
Mortally wounded or clinically dead.

Delayed Patient
Serious injury or illness; which may become life threatening; likely to survive if care is received within thirty (30) minutes to several hours.

Deputy
A fully qualified individual who, in the absence of a superior, can be delegated the authority to manage a functional operation or perform a specific task. In some cases, a deputy can act as relief for a superior and, therefore, must be fully qualified in the position. Deputies can be assigned to the Incident Commander, General Staff and Branch Directors.

Designated Overflow Area
Alternative care location identified by each facility where basic patient care can take place. Such locations may be auditoriums, cafeterias, hallways, or lobbies.

Division
The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A division is located within the ICS organization between the branch and resources in the Operations Section.

Emergency Management Plan
A plan maintained by a jurisdiction or agency, which describes activities to plan for, respond to, mitigate or recover from potential hazards that may result in loss of life or property during an emergency.

Emergency Operations Center (EOC)
The physical location at which the coordination of information and resources to support incident management activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., federal, state, regional, county, city, tribal), or some combination thereof.

Environment of Care
A term used to describe the building, equipment and people that provide services that allow patient care to take place in a medical facility.

Evacuation
Organized, phased and supervised withdrawal, dispersal, or removal of civilians from dangerous or potentially dangerous areas, and their reception and care in safe areas.

Field Command Post
The field location where primary tactical-level, on-scene incident command functions are performed.

Incident Commander (IC)
The person from the Authority Having Jurisdiction who responds to the emergency and who is responsible for all decisions relating to the incident and management of incident operations (e.g., fire or law enforcement).

Function
Function refers to the five major activities in ICS: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing the activity involved, e.g., the planning function. A sixth function, Intelligence, may be established, if required, to meet incident management needs.

General Staff
A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief.

Good Samaritan Law
A section of Nevada Revised Statutes, which describes the immunities under the law for those medical personnel who provide gratuitous medical services in an emergency.

Group
Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. Groups, when activated, are located between branches and resources in the Operations Section. (See *Division*).

HICS
An Incident Command System designed specifically for use in the medical environment.

Hospital Emergency Operations Center
A location where primary hospital command and coordination functions are carried out to manage a medical facility's emergency or catastrophic event.

Hospital Incident Commander
The individual responsible for decisions relating to the incident and management of all strategic and tactical operations within the hospital.

Immediate Patient
Critical, life-threatening injury or illness likely to survive if care is received within thirty (30) minutes.

Immediate Evacuation
Hospital evacuation due to life-threatening threats to the building's occupants, which require an immediate response.

Incident
An occurrence or event, natural or human-caused, that requires an emergency response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, wild land and urban fires, floods, hazardous material spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Incident Command System (ICS)
A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, and designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents; ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Initial Response
Resources initially committed to an incident.

Jurisdiction
A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., city, county, tribal, state or federal boundary lines) or functional (e.g., law enforcement, public health).

Liaison Officer
A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies.

Local Government
A county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a nonprofit corporation under state law), regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal organization, or in Alaska, a Native village or Alaska Regional Native Corporation; a rural community, unincorporated town or village, or other public entity. See Section 2(10), Homeland Security Act of 2002, Pub. L. 107-296, 116 Stat. 2135 (2202).

Logistics Section
The section responsible for providing facilities, services and material support for the incident.

Minor Patient
Not considered life threatening; care may be delayed hours or days; this group may be referred to as the walking wounded.

Multi-Casualty Incident Plan (MCIP)
Guidelines maintained by the Washoe County DBOH for the Reno, Sparks and Washoe County area to effectively, efficiently and safely organize multi-casualty incidents utilizing ICS as the management tool.

Political Subdivision
Under Nevada Revised Statutes 414.038, political subdivision means a city or a county.

Preparedness
The range of deliberate, critical tasks and activities necessary to build, sustain and improve the operational capability to prevent, protect against, respond to, and recover from domestic incidents. Preparedness is a continuous process. Preparedness involves efforts at all levels of government and between government and private sector and nongovernmental organizations to identify threats, determine vulnerabilities and identify required resources. Within the NIMS, preparedness is operationally focused on establishing guidelines, protocols and standards for planning, training and exercises, personnel qualification and certification, equipment certification and publication management.

Prevention
Actions to avoid an incident or to intervene to stop an incident form occurring. Prevention involves actions to protect lives and property. It involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and testing processes; immunizations, isolation or quarantine; and, as appropriate, specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice.

Public Information Officer
A member of the Command Staff responsible for interfacing with the public and media or with other agencies with incident-related information requirements.

Qualified Disaster
An unusual and unforeseen situation, which overtakes the operations (physical plant and staff) of a member facility resulting in a partial or full evacuation.

Recovery
The development, coordination and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private sector, nongovernmental and public assistance programs to provide housing and to promote

restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental and economic restoration; evaluation of the incident to identify lessons learned; post-incident reporting; and development of initiatives to mitigate the effects of future incidents.

Resources
Personnel and major items of equipment, supplies and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an EOC.

Response
Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. As indicated by the situation, response activities include applying intelligence and other information to lessen the effects or consequences of an incident; increased security operations; continuing investigations into nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation or quarantine; and specific law enforcement operations aimed at preempting, interdicting or disrupting illegal activities and apprehending actual perpetrators and bringing them to justice.

Safety Officer
A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring personnel safety.

Section
The organization level having responsibility for a major functional area of incident management (e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established). The section is organizationally situated between the branch and the Incident Command.

Skilled Nursing Facility (SNF)
An institution or facility that provides sub-acute nursing and/or rehabilitation services to patients with an illness or injury who are unable to care for themselves.

Special Care Patients
Those patients within a medical facility who require a higher level of patient care, equipment and staffing ratios than general medical or surgical patients.

Special Care Unit
A generalized term to include Intensive Care, Cardiac Care, Cardiac Surgery, Pediatric Intensive Care, Neonatal Intensive Care Units, patients currently undergoing surgical procedures, and patients that are in Post Anesthesia Recovery (PACU).

Staging Area
Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas.

START
A process of triaging patients in an MCI quickly and efficiently. It focuses on being simple to use, does not require any special skills, rapid, provides minimal stabilization, does not require specific diagnosis, and is easy to learn and teach. The START method utilizes four assessment tools to evaluate and categorize patients – ability to walk, ventilation, perfusion and mental status.

Strike Team
A set number of resources of the same kind and type that have an established minimum number of personnel. All resource elements within a Strike Team must have common communications and a designated leader.

Task Force
Any combination of resources assembled to support a specific mission or operational needs. All resource elements within a Task Force must have common communications and a designated leader.

Unified Command (UC)
An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross-political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single Incident Action Plan (IAP).

Urgent Evacuation
Hospital evacuation caused by factors that are non-life threatening which can be delayed for a period of hours to days.

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Alpha
Multi-Casualty Incident Plan

DRAFT

Table of Contents

Record of Changes

The Alpha Plan was established in 2018 to enhance the region's response to a large-scale or multi-location incident. Below is a record of changes made to the plan since its inception.

Record of Change	Date	Revisions	Agency
Original plan publication	10/01/2018		WCHD

Introduction

The Washoe County Health District (WCHD) maintains and updates the Multi-Casualty Incident Plan (MCIP). The MCIP was developed in the 1980s and has been activated on multiple occasions. While the MCIP has demonstrated effectiveness for small to moderate-sized incidents, it may not adequately prepare the region for major occurrences, such as wide-spread, multi-location incidents or sizable natural or man-made disasters. Therefore, the WCHD created the Alpha MCIP (Alpha Plan) to better prepare for large-scale and/or multi-location incidents. The Alpha Plan, and its components, should only be activated during large-scale events and/or incidents with multiple locations.

All disasters are considered local. It is local agencies that initially respond to a multi-casualty incident (MCI) and local agencies that initially manage the event. The WCHD encourages emergency medical services (EMS) response agencies and hospitals to stay involved in developing and enhancing local plans. The WCHD EMS Oversight Program also requests EMS response agencies and hospital staff, to include the emergency departments, stay current in the National Incident Management System (NIMS) training. The combination of these two efforts work to produce a better-prepared response system.

As stated in the MCIP, EMS efforts in a MCI will begin with the first arriving unit and expand to meet the needs of the incident. The first arriving unit should establish the Incident Command System (ICS). It is important for the first arriving units to be aware of the critical nature of the initial phase of an MCI response. The activities and effectiveness of all additional responding personnel will be affected by the initial responders' ability to effectively activate the appropriate disaster response plan(s).

The initial size-up requires special attention, as the successful operation of an MCI is dependent upon the accuracy of the reports provided by the first-in responders to the scene. The IC will establish an on-scene organization to manage the activities of responding emergency workers and to coordinate with off scene agencies. Those responding, regardless of agency or organization affiliation, should expect to participate as assigned within the established on-scene organization. For activation of the Alpha Plan, the IC will not be able to directly supervise operations; this responsibility must be delegated to an Operations Chief. The field operations will fall within the responsibility of the Operations section. It is important that medical personnel, treatment areas and medical management be easily identifiable.

The incident command structure will expand as necessary based on the size and complexity of the incident and to maintain the span of control. Only those functions/positions that are necessary will be filled and each element must have a person in charge.

This plan contains additional response components that would only be applicable during major incidents. A major incident is defined by the region as a large-scale event and/or incident with multiple locations.

Purpose

The Washoe County District Board of Health (DBOH) is committed to providing necessary emergency medical care to all patients involved in an MCI. The goal of the Alpha Plan is to provide a framework for an interoperable response by pre-hospital and healthcare agencies to effectively and safely manage large-scale events and/or incidents with multiple locations.

The MCIP establishes a mechanism to organize and mobilize emergency medical resources within Washoe County, while the Alpha Plan builds on the foundation of the MCIP and provides additional response options that would only be utilized in a major incident. Such actions would not be necessary for incidents where there are enough local resources to manage and mitigate the event.

Scope

The MCIP standardizes operations during MCIs. It is intended to be an "all hazards" plan to meet the needs of any MCI regardless of what caused the incident. If necessary, these procedures can be modified based on the number of patients, the severity of injuries, and special circumstances involved in the incident.

The Alpha Plan provides additional framework for organizing the pre-hospital and healthcare response systems to effectively respond to and assist in managing patients resulting from a major incident. For example, a community multi-casualty incident where there are greater than 100 individuals involved would stress our EMS and healthcare system and would warrant the activation of the Alpha Plan in order to use the provisions outlined for increasing bed availability in Washoe County facilities.

Activation

The Alpha Plan should only be activated when there is a large-scale event and/or incident with multiple locations. It is possible to activate the MCIP initially then transition to the Alpha Plan as situational awareness about the incident evolves. Command personnel (Battalion Chiefs/Supervisors/Sergeants) should be responsible for activating the Alpha Plan.

General Considerations and Assumptions

The following are considerations and assumptions made when the Alpha Plan is activated:

- All agencies will operate under NIMS and ICS.
- The Regional Emergency Operations Center (REOC) will activate.
- The resources needed to mitigate incidents are dependent on the size and complexity of the incident as well as the location.
- Expected mutual aid resources may not be available, or may be significantly delayed.
- Providers must be prepared to sustain their patients for longer periods of time.

- Non-traditional modes of transportation destinations will be used.
- Hospitals will activate their surge expansion plans.
    - Hospitals will need to consider using urgent care and other accessory facilities to accept "green" patients.
    - Hospitals may need to move lower acuity patients to skilled nursing/long-term care facilities in the region to increase bed capacity. It is understood that the VA of the Sierra Nevada Health Care System is not able to move patients like other private healthcare systems.
- Hospitals should anticipate victims transported by Good Samaritans and will need to use the DMS triage tags to track them as part of the incident. (See Appendix D for Nevada Good Samaritan Law, NRS 41.)

Regional Command Structure

NIMS will be used to manage MCI incidents in Washoe County. As defined in NIMS, ICS will be used for all incident types. The goal of ICS is to ensure central control, provide for inter-agency coordination and provide that no one individual or agency becomes overloaded with specific assignments or details. On simple incidents, the Incident Commander or any other position may well serve multiple roles; such will not be the case in the activation of the Alpha Plan.

The more ICS can be used on routine operations, the easier it will be to use on complex MCIs that would activate the Alpha Plan. The ICS is designed to allow even the smallest response cohort to "fill out" the command staff on a large incident through the use of mutual aid resources. All Fire and EMS agencies should follow NIMS for all responses, from a simple motor vehicle crash to major events.

As local, state, federal, and private party responders arrive on-scene of incidents, all responders should integrate into the ICS organization. All responders will operate within the incident command structure to provide for accountability, safety, and management of incidents. The first arriving unit on scene should identify and report the following to their own dispatch center. This information should then be relayed to all responding agencies' dispatch centers:

- If known, the type and cause of the incident
- The exact location of the incident
- An estimate of the number of casualties
- An estimate of the condition of casualties

The Incident Command structure will be initiated by the first qualified fire unit on scene. The first position to be assigned should be the Incident Commander and the subsequent assignments will be determined by the Incident Commander. At a minimum, the following information will need to be determined and relayed to all responding agencies dispatch centers:

- The establishment of command and name of the incident

- The identity of the IC
- The exact location of the Command Post
- Identify the radio frequency used for the incident
- An estimate of additional resources needed
- The appropriate routing to the incident
- The identification of special hazards, if any
- The exact location of the initial staging area

The second responsibility of the initial IC is to begin to delegate duties to all other on-scene responders, and to develop an incident action plan (IAP) that includes some of the following:

- Extrication/rescue
- Safety of personnel and scene safety
- Triage
- Treatment
- Transport
- Staging
- Security
- Communications
- Record keeping

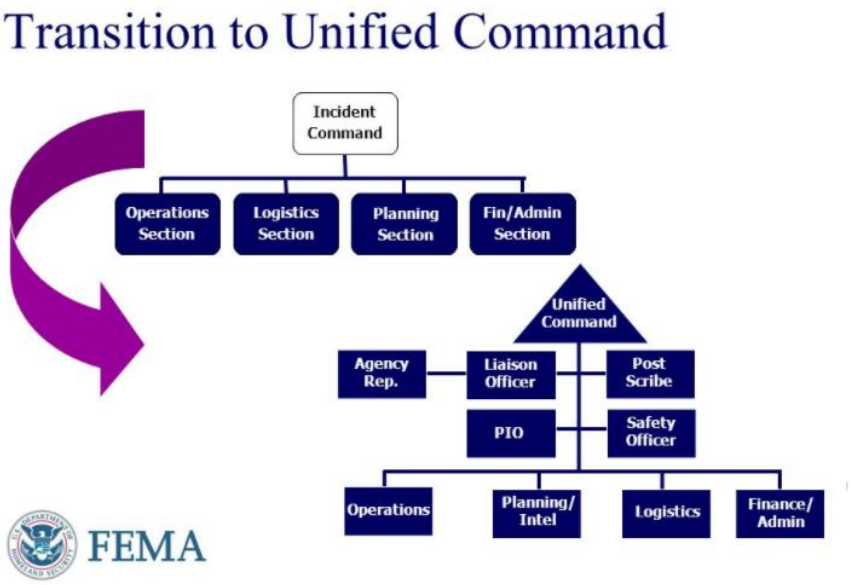
For any incident that may require the activation of the Alpha Plan, the Incident Commander should immediately consider expanding the Incident Command Structure to provide adequate span of control and provide for efficient management of the incident. Unified Command is recommended for multi-jurisdictional or multi-agency incident management. Agencies with jurisdictional authority may participate in the incident command structure as determined by the Incident Commander and jurisdictional representatives. Under the UC structure, the various jurisdictions and/or agency responders may blend together throughout the operation to create an integrated response team. Ultimately, the decision regarding the command structure is determined by the Incident Commander, through evaluation of the incident and resources needed.

The UC is responsible for overall management of the incident. The UC directs incident activities, including development and implementation of overall objectives and strategies, and approves ordering and releasing of resources. Members of the UC work together to develop a common set of incident objectives and strategies, share information, maximize the use of available resources, and enhance the efficiency of the individual response organizations. Actual UC structure for a specific incident will be determined on a case-by-case basis taking into account:

- The specifics of the incident;
- Determinations outlined in existing response plans; or
- Decisions reached during the initial meeting of the UC. The makeup of the UC may change as an incident progresses, in order to account for changes in the situation. The UC is a team effort, but to be effective, the number of

personnel should be kept as small as possible.

The figure below demonstrates how the initial response units can transition the ICS structure into UC.



Area Command

Area Command is an organization mechanism used to provide overall command and authority for two or more events or incidents. It works closely with the incident commanders (ICs) to establish overall objectives, priorities, management or critical resources, logistical concerns, and planning issues. When activated, Area Command eliminates confusion by providing the necessary oversight of the incidents/events being managed.

The members of the Area Command team should be qualified and trained in their respective functions. The minimum positions include:

- Area Commander
- Area Command Logistics Chief (which also may have a Critical Resource Unit)
- Area Command Planning Chief (which also may have a Situation Unit Leader),
- Liaison Officer
- Information Officer

In addition, there may be a need for a Technical Specialist or an Information/Intelligence Officer. Each of these positions will necessitate sufficient staff to assist the command staff in completing their duties. Just as in

the incident command system (ICS), command staff personnel may have assistants, and general staff positions may have deputies.

Area Command does not replace the incident command organization or functions. The incident will be managed using the ICS. Therefore, emergency incidents or events can be managed by a single IC, by an IC with deputy ICs, or through unified command. In addition, if incident command is unified, Area Command should also be unified.

The Area Command positions in the NIMS are established to enable ICs and their personnel to manage the incident, whereas Area Command assists the ICs in meeting their objectives through critical resource ordering and tracking, advance planning, and handling their logistical concerns. Area Command has six primary functions:

- To provide agency or jurisdictional authority for assigned incidents or events.
- To ensure a clear understanding of the agency's expectations, intentions, and constraints related to the incidents among the ICs.
- To establish critical resource use priorities among the various incidents based on need, agency policy, and direction.
- To ensure appropriate incident management team personnel assignments and organizations for the kind and complexity of the incidents involved.
- To maintain contact with officials in charge, assisting and cooperating with agencies and other interested groups.
- To coordinate the demobilization or reassignment of resources among assigned incidents.

Area Commanders should allow ICs as much latitude as possible in implementing their respective Incident Action Plans. This is usually done by ensuring that they have a complete and accurate understanding of the overall objectives and priorities not only of their incident but also the magnitude of the other ongoing incidents. Therefore, the Area Commander will need to have planning and operational meetings with the ICs.

Area Command is designed to be the last command element that deals directly with incident management personnel in the field. As mentioned above, Area Command must meet six primary functions to provide efficient and effective oversight. It is not an operational aspect of command and control. It coordinates and facilitates with agency administrators, multiagency coordination centers, and emergency operations centers to ensure that the IC's objectives and needs are communicated up through channels. In turn, Area Commanders also ensure that the ICs understand agency officials' needs and requirements.

Additional Response Components

The MCIP includes a detailed response structure and processes for triage, treatment and transport that should be used for any MCI, regardless of size. For all MCIs in Washoe County response agencies shall use the DMS triage system, which includes initial ribbon triage and triage tags.

When the Alpha Plan is activated, there are some additional response components to consider. These considerations include the possible use of police vehicles to transport victims, strategically placed medical supplies, and a coordinated healthcare response for creating more available beds in acute care facilities for victims of the incident. These response components should only be considered during major events.

Police Transports

Nevada Revised Statues (NRS) 450B.830 exempts the following from State EMS statues:

1. The occasional use of a vehicle or aircraft to transport injured or sick persons, which vehicle or aircraft is not ordinarily used in the business of transporting persons who are sick or injured.
2. A vehicle or aircraft rendering services as an ambulance or air ambulance in case of a major catastrophe or emergency if ambulance or air ambulance services with permits are insufficient to render the services required.
3. Persons rendering service as attendants in case of a major catastrophe or emergency if licensed attendants cannot be secured.
4. Ambulances based outside this State.
5. Air ambulances based outside this State which:
   (a) Deliver patients from a location outside this State to a location within this State; and
   (b) Do not receive any patients within this State.
6. Attendants based outside this State rendering service solely on ambulances which are exempt from the provisions of this chapter.
7. Attendants rendering service solely on air ambulances which are exempt from the provisions of this chapter.
8. Vehicles owned and operated by search and rescue organizations chartered by the State as corporations not for profit or otherwise existing as nonprofit associations which are not regularly used to transport injured or sick persons except as part of rescue operations.
9. Ambulances or air ambulances owned and operated by an agency of the United States Government.

Therefore during large scale MCIs, when there is likely no criminal element, responding officers may elect to transport highly critical patients to definitive care. The officers may conduct an assessment of the availability and/or proximity of EMS resources; this will provide situational awareness for the officers to determine whether police transport is necessary.

If law enforcement transport occurs in the initial incident response, officer(s) should take critical patients to Renown Regional Medical Center. If officer(s) vehicles are identified as a transport resource during later phases of the incident then the officer(s) must communicate with Medical Branch and/or the Patient Transportation Group Supervisor to receive direction on which hospital to transport the patient(s).

In instances where police or Good Samaritans transport, the patient will likely receive no on-scene triage or care. The receiving hospital will be responsible for tagging the patient with the DMS triage tag once the officer arrives to the hospital with the patient(s). Tagging the patient at the hospital is indispensable for patient tracking and family reunification during/after the incident.

MCI Medical Supplies

In instances where there may be the inability to travel throughout the region due to a natural or man-man disaster, the WCHD has strategically placed MCI medical supplies in the quadrants of the County for access by first responders.

The medical supplies may vary at each location, however the supplies are intended to provide basic support and care for victims of an MCI. The medical supplies may include items such as, personal protective equipment, bleeding control kits, airway management supplies and bandages.

In order to maintain the integrity of the medical supplies, those items that can be used by first responder agencies during daily operations will be exchanged prior to the expiration dates. The general locations of the medical supplies are on the map in Appendix A. The minimum medical supplies are included in Appendix B.[1]

Medical Dispatch Notification & Healthcare Response

The Medical Dispatch Center will immediately notify the healthcare facilities within the County of a MCIP or Alpha Plan activation. The Emergency Department Charge Nurse at Renown Regional Medical Center, Renown South Meadows, Northern Nevada Medical Center, Saint Mary's Regional Medical Center, and the Administrator on Duty at VA Sierra Nevada Health System will be notified. Depending on the location of the incident and the number of patients, the Medical Dispatch Center shall also notify Incline Village Community Hospital for a patient care capacity inventory.

All healthcare facilities in the County should activate their own Emergency Management Plan. It is recommended that each healthcare facility develop internal guidelines to identify how many patients and what type the facility can accept in a disaster or Alpha Plan activation.

[1] The medical supplies were agreed-upon and initially funded by the Inter-Hospital Coordinating Council (IHCC).

The MCIP baseline capacity numbers will be used initially, so that the Medical Dispatch Center can begin dispersing patients. It is the responsibility of the area facilities, through the IHCC, to periodically update baseline capacity numbers to ensure they remain current. During an activation of the Alpha Plan, healthcare facilities may need to move lower acuity patients to other facilities to increase acceptance numbers. If patients are being moved, the Evac1-2-3 patient tagging and tracking system of the Mutual Aid Evacuation Annex (MAEA) can be utilized. If it is determined that patients need to be moved in conjunction with the Alpha Plan activation, then non-ambulance transports (wheelchair vans, buses, etc.) can be requested to move patients from one facility to another.

The ambulance transport agency(s) will begin transporting patients from the scene(s) using the baseline capacity numbers as a guide. The ambulance transport agency(s) will update the healthcare facilities as additional information becomes available as to the number and types of patients the facilities may expect to receive. **Each facility is responsible for updating the Medical Dispatch Center if there is a change in capacity to receive patients in comparison to the baseline capacity numbers below:**

Hospital Baseline Capacity Numbers*

Hospital	Red	Yellows	Greens
Carson Tahoe Medical Center	3	8	15
Banner Churchill Community Hospital	2	4	15
Carson Valley Medical Center	2	4	15
South Lyon Medical Center	0	2	8
Renown Regional Medical Center	10	20	50
Renown South Meadows	3	4	10
Northern Nevada Medical Center	3	7	10
Saint Mary's Regional Medical Center	6	10	20
VA Sierra NV Health Care System	3	7	10
Incline Village Community Hospital	0	2	8
Tahoe Forest (Truckee, CA)[2]	0	2	8

Total baseline capacities numbers: 32 reds, 70 yellows and 169 greens.

Within the Truckee Meadows region of Washoe County, the first six most critical patients will be transported to the Trauma Center at Renown Regional Medical Center. Additional patients will be distributed to the healthcare facilities based on

[2] With the exception of Tahoe Forest, the baseline numbers were taken from the Statewide Medical Surge West Region Annex.

available patient care capacity. (State Trauma Destination Guidelines do not apply in these instances.) The Medical Branch Director, through the Medical Dispatch Center, will update the healthcare facilities as patient numbers are confirmed and notify the appropriate agencies when all patients have been transported.

There is the potential that green patients may impact the availability of critical resources that should be dedicated to the more critical red or urgent yellow patients. It is each facility's responsibility to notify the Medical Dispatch Center when they are considering the transfer of green patients to their affiliated urgent care and/or ancillary centers, whom the hospitals should pre-alert as part of the Alpha plan activation.

Currently there are no formal agreements in place for hospitals to utilize urgent care centers to receive walking wounded/green patients. However, the use of urgent care centers or community clinics can expand the capacity of the health care system to provide expedient care to non-critical green patients in an Alpha Plan activation.

Healthcare facilities further from the incident scene should prepare to provide manpower, equipment and supplies as requested through the ICS. These facilities may be activated under Mutual Aid Agreements (MAAs).

Due to safety and logistical issues, the landing of helicopters at hospital helipads during an MCI will be limited to those agencies that have pre-approved agreements with the medical facilities. All other helicopters will be directed by the Medical Dispatch Center to land at the Reno-Tahoe International Airport, and the Medical Dispatch Center will make arrangements for those patients to be transferred to area facilities.

The receiving hospital will be responsible for tagging any patient with the DMS triage tag that may get transported prior to receiving one on-scene. Tagging the patient at the hospital is indispensable for patient tracking and family reunification during/after the incident.

Plan References

Statewide Medical Surge Plan

The Nevada Statewide Medical Surge Plan is an all-hazards plan that works in conjunction with the Nevada Division of Emergency Management's State Comprehensive Emergency Management Plan (SCEMP) and serves as the document to assist with the deployment of requested resources in a time of need for the citizens, and visitors to the state of Nevada. The Statewide Medical Surge Plan includes regional annexes for response to various incidents like MCIs and healthcare evacuations. The West Region includes nine Northwestern Nevada counties: Carson City, Churchill County, Douglas County, Humboldt County,

Lyon County, Mineral County, Pershing County, Storey County and Washoe County.

The West Region is committed to providing necessary emergency medical care to all patients encountered in an MCI. The plan establishes a mechanism to organize and mobilize emergency medical resources within the West Region, should there be an MCI that warrants a West Region response and activation of this Annex.

Emergency medical personnel responding to an MCI must coordinate with a variety of agencies. Therefore, this plan also utilizes ICS to integrate these agencies. Emergency medical personnel should have formal training in the ICS to facilitate this plan.

The regional plans acknowledge that there are local variations in pre-healthcare facility medical management systems in the outlying areas of the West Region. This plan acknowledges existing mutual aid agreements between public and private agencies inside and outside the State of Nevada.

Nevada Intrastate Mutual Aid System

Initial response to emergencies is the responsibility of the appropriate local jurisdiction. The expectation is that the jurisdiction has exhausted their ability to respond to the incident before requesting aid from the next higher level of government. When the size or complexity of an emergency threatens to overwhelm local capabilities, mutual aid may be utilized to request assistance from other political subdivisions, special districts, state agencies, and tribal nations within the State of Nevada. The assistance provided may be through local mutual aid agreements or through the Nevada Intrastate Mutual Aid System (IMAS).

Mutual aid agreements are strongly encouraged by the federal government under the NIMS. The National Mutual Aid and Resource Management Initiative established under NIMS provides a comprehensive, integrated national mutual aid and resource management system. All mutual aid agreements must incorporate NIMS and the ICS. The responsibility of preparedness is tasked to the federal, state, local, and tribal agencies, also to include private, nongovernmental organizations and citizens. The IMAS is in accordance with the Presidential Policy Directive 8 to achieve all-hazards national preparedness.

NRS Chapter 414 authorizes the State and its political subdivisions to provide emergency aid and assistance in the event of an emergency or disaster. Chapter 414 authorizes the DEM to coordinate the provision of equipment, services or facilities owned or organized by the State or its political subdivisions, for use in the affected areas upon request of the duly constituted authority of the areas.

The IMAS was established by the 78th Session of the Nevada Legislature. Chapter 414A became effective July 1, 2015, and authorizes the Nevada Department of Public Safety, Division of Emergency Management, to administer

the System pursuant to the provisions of the chapter and shall coordinate the provision of mutual aid during the response to and recovery from an emergency or disaster (NRS 414A.100(2) (a)).

Initial response to emergencies is the responsibility of the appropriate local jurisdiction. The expectation is that the jurisdiction has exhausted their ability to respond to the incident before requesting aid from the next higher level of government. When the size or complexity of an emergency threatens to overwhelm local capabilities, mutual aid may be utilized to request assistance from other political subdivisions, special districts, state agencies, and tribal nations within the State of Nevada. The assistance provided may be through local mutual aid agreements or through the IMAS.

Communications

Communications is an integral component of MCI logistics. A largescale MCI will overwhelm the local agencies' ability to deploy adequate resources to manage injured victims. By virtue of the incident, local agencies will likely need to request out of jurisdiction resources to help manage the response; effective communication with the out of jurisdiction agencies is paramount. Therefore, the following communication strategies will aid in a more effective Alpha Plan response:

1. On scene radio communications should be kept to a minimum. When possible, use direct verbal contact, or runners.
2. Washoe County Emergency Management shall be responsible for posting the incident on WebEOC (if available), which should be used during the incident to for patient tracking and family reunification.
3. The IC assures a Communications Plan is developed for primary communications during the event.
4. The Transportation Group Supervisor/Unit Leader shall report to their supervisor when all patients have been transported from the scene. This is a benchmark to be communicated to the Medical Dispatch Center and posted to WebEOC.
5. Only in cases of imminent life threats, shall ambulances make enroute changes to hospital destination. Notification must be made to both the receiving facility and to the Medical Dispatch Center.
6. Clear language shall be used in all MCI responses per ICS standards.
7. Facilities that have 800 MHz radios available should utilize them as a redundant source of communications. A list of the available channels for healthcare facilities can be obtained from the Washoe County Health District.

It is incumbent upon the Medical Dispatch Center to have operational mastery of radio spectrum (VHF, UHF, 800 trunked) and local topographical issues within the respective jurisdictions and effectively mitigate these concerns. The Medical Dispatch Center must be intimately familiar with local, county, regional, and state communication channels/frequencies/talk groups (channels) available to meet communication needs during an Alpha Plan activation. Many of the agencies outside of Washoe County are on

UHF/VHF frequencies, which may make communications more of a challenge when MAA resources are entering Washoe County to assist with the MCI response.

The pre-developed ICS 205 form should be used for any MCI. It can be revised based on the nature and location of the incident.

The ICS 205 provides information on radio frequency or trunked radio system talkgroup assignments for each operational period. In most incidents communications is identified as a challenge for responding personnel. In an effort to overcome this barrier, regional Fire, EMS and Law Enforcement developed the following ICS 205 for pre-planned radio communication. It is understood that this is only a guideline for the beginning of an incident and the communications plan could expand or change, as appropriate.

INCIDENT RADIO COMMUNICATIONS PLAN			1. Incident Name	2. Date/Time Prepared	3. Operational Period Date/Time
4. Basic Radio Channel Utilization					
System/Cache	**Channel**	**Function**	**Frequency/Tone**	**Assignment**	**Remarks**
800 MHz	PS Fire 1	Command	WCRCS	PSAP Dispatch to Comm	Coordinated with PSAP
800 MHz	PS Fire 2	Tactical	WCRCS	Comm to Responders	Coordinated with PSAP
800 MHz	PS LE 1	Tactical	WCRCS	Comm to Responders	Coordinated with PSAP
800 MHz	PS LE 2	Command	WCRCS	PSAP Dispatch to Comm	Coordinated with PSAP
Med Radios	Mednet 3	EMS	UHF	Field to REMSA Dispatch	Subject to change depending on location
Med Radios	Mednet 8	EMS	UHF	REMSA Dispatch to hospitals	Subject to change depending on location
800 MHz	WC HDSUP	Command	WCRCS	Comm to WCHD	
VHF	NevCord 1	Air Resources	VHF	Air ambulance responders to ground crews	
800 MHz	PS Event 2	Tactical/Comm	WCRCS		
800 MHz	PS Event 3	Tactical/Comm	WCRCS	Optional – Comm to Responders	
5. Prepared by (Communications Unit)					

Demobilization

One of the more difficult tasks of an incident is deciding when and how to begin scaling down resources after an MCI response. When deciding how many units should remain on-scene, Unified Command should factor in resources to cover responder safety as well. During the incident and the demobilization phases, there should be adequate assets to deal with potential injuries or illnesses of responders as well.

The moment an asset is mobilized there should be plans for its demobilization. UC must remember that assets and resources are not just defined as personnel but also equipment. It is Unified Command's responsibility to gauge the support required for each resource. Unified Command must decide if the support is worth the advantages of maintaining the resource.

Regardless of incident type, demobilization should be well thought-out. Rapid demobilization may cause unintended hazards for responders and/or the community. Utilizing the NIMS model, Unified Command will develop a demobilization plan. Included within the demobilization plan is the notification to the Medical Unit Leader (MUL) that the incident is terminated and that operations may return to normal. The MUL will then make notifications to all receiving facilities through phone calls and/or WebEOC.

Training and Exercises

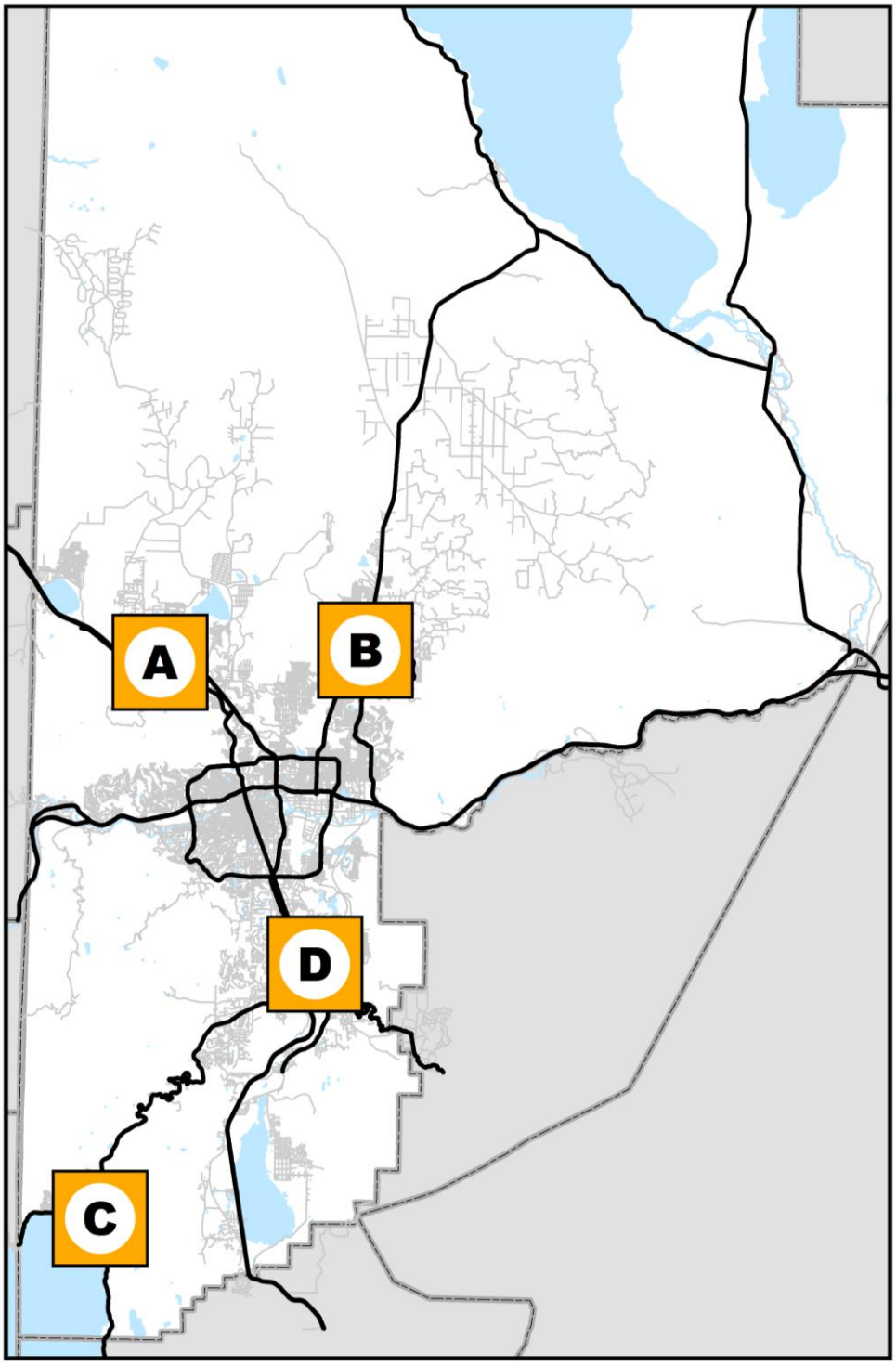
Training is an important part of the MCI process. Agencies need to recognize the significance of understanding the overall components of both the MCIP and Alpha Plan. Agencies should conduct regular training and exercise in accordance with The Homeland Security Exercise and Evaluation Program (HSEEP). Training exercise events should include scenarios involving diverse populations including pediatric patients or people with intellectual and/or developmental disabilities.

The nature of an MCI generally calls for the involvement of additional agencies and organizations other than Fire and the EMS/ambulance provider. These additional agencies are encouraged to participate in as much training relating to the response to a multi-casualty incident as possible. Healthcare and law enforcement agencies should be included in all Alpha Plan exercises and training, in addition to field triage and bleeding control courses.

Appendices

Appendix A: Map of Medical Supply Locations
Appendix B: Medical Supplies List
Appendix C: Agency Integration
Appendix D: Nevada Good Samaritan Law
Appendix E: Acronyms
Appendix F: Glossary

Appendix A: Map of Medical Supply Locations



Appendix B: Medical Supplies List

Category and Items	Quality per Kit
5x9 Abd Pads	50
10x30 Trauma Dressing	10
4x4 Sponges	100
Kling Gauze Roll	24
Israeli Bandages	10
Burn Sheets	10
Halo Chest Seals	10
Coban Wrap	8
2" Cloth Tape	6
SWAT-T Tourniquets	10
CAT Tourniquets	2
Liter Sterile Saline	2
.9% Sodium Chloride 500ml Bag	24
IV Administration Set	24
IV Catheters 16ga	25
IV Catheters 18ga	25
IV Catheters 20ga	10
IV Start Kits	25
Sharps Container	2
Ambu Bags - Adult	5
Ambu Bags - Child	2
OPA	10
NPA	10
Suction - Bulb (Adult)	2
King Airway Sets	5

Category and Items	Quality per Kit
Boxes of Gloves (M,L,XL)	6
Face Masks	1
Sani- Cloth Germicide Disposable Wipes	1
Mega Movers	10
SAM Splints (M/L)	10
Roll of Duct Tape	1
Hand Towels	10
Blood Pressure Kits	2
Stethoscopes	2
Yellow Disposable Emergency Blankets	20
Trauma Shears	4
BioBags	1
MCI Triage Tape (Red, Yellow, Green)	1
Cyalume Sticks (Red, Yellow, Green, and White)	10
LED Lighting System (magnetic)	10
Sets of Batteries (9-Volt, AA, AAA, AAAA, C, D)	10
Sharpies (Black)	10

Appendix C: Agency Integration

In the event of an MCI within Washoe County and outside agencies are requested or respond to said incident, the initial triage and setup of incident will be as follows:

- All agencies within Washoe County will use the ribbon triage system as outlined in the MCIP; all agencies outside of Washoe County will be permitted to use their designated system.
- When the victims of the MCI reach the treatment area, the initial triage tag will be removed and replaced with the appropriate DMS triage tag for accurate tracking and accounting of patients.
- The initial triage tag, whether it is a ribbon or some other sort of tag, will be removed and replaced at this time to ensure compliance with the Washoe County MCIP.
- The majority of initial MCI triage systems are somewhat similar in using color coding to designate the severity of the patient. It will be the responsibility of the treatment area leader to classify any outside triaging into the appropriate category following the guidelines set forth within the Washoe County MCIP.

  Immediate = Red
  Delayed = Yellow
  Minor = Green

- In the event of an outside agency being assigned to the treatment area, that agency will be given the appropriate tags to comply with the Washoe County MCIP.

Appendix D: Nevada Good Samaritan Law

1. Except as otherwise provided in NRS 41.505, any person in this State who renders emergency care or assistance in an emergency, gratuitously and in good faith, except for a person who is performing community service as a result of disciplinary action pursuant to any provision in title 54 of NRS, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured person.

2. Any person in this State who acts as a driver of an ambulance or attendant on an ambulance operated by a volunteer service or as a volunteer driver or attendant on an ambulance operated by a political subdivision of this State, or owned by the Federal Government and operated by a contractor of the Federal Government, and who in good faith renders emergency care or assistance to any injured or ill person, whether at the scene of an emergency or while transporting an injured or ill person to or from any clinic, doctor's office or other medical facility, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance, or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured or ill person.

3. Any person who is an appointed member of a volunteer service operating an ambulance or an appointed volunteer serving on an ambulance operated by a political subdivision of this State, other than a driver or attendant of an ambulance, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person whenever the person is performing his or her duties in good faith.

4. Any person who is a member of a search and rescue organization in this State under the direct supervision of any county sheriff who in good faith renders care or assistance in an emergency to any injured or ill person, whether at the scene of an emergency or while transporting an injured or ill person to or from any clinic, doctor's office or other medical facility, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance, or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured or ill person.

5. Any person who is employed by or serves as a volunteer for a public fire-fighting agency and who is authorized pursuant to chapter 450B of NRS to render emergency medical care at the scene of an emergency is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering that care or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured or ill person.

6. Any person who:

(a) Has successfully completed a course in cardiopulmonary resuscitation according to the guidelines of the American National Red Cross or American Heart Association;

(b) Has successfully completed the training requirements of a course in basic emergency care of a person in cardiac arrest conducted in accordance with the standards of the American Heart Association; or

(c) Is directed by the instructions of a dispatcher for an ambulance, air ambulance or other agency that provides emergency medical services before its arrival at the scene of the emergency, and who in good faith renders cardiopulmonary resuscitation in accordance with the person's training or the direction, other than in the course of the person's regular employment or profession, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering that care.

7. For the purposes of subsection 6, a person who:

(a) Is required to be certified in the administration of cardiopulmonary resuscitation pursuant to NRS 391.092; and

(b) In good faith renders cardiopulmonary resuscitation on the property of a public school or in connection with a transportation of pupils to or from a public school or while on activities that are part of the program of a public school, shall be presumed to have acted other than in the course of the person's regular employment or profession.

8. Any person who gratuitously and in good faith renders emergency medical care involving the use of an automated external defibrillator is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering that care.

9. A business or organization that has placed an automated external defibrillator for use on its premises is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by the person rendering such care or for providing the automated external defibrillator to the person for the purpose of rendering such care if the business or organization:

(a) Complies with all current federal and state regulations governing the use and placement of an automated external defibrillator;

(b) Ensures that the automated external defibrillator is maintained and tested according to the operational guidelines established by the manufacturer; and

(c) Establishes requirements for the notification of emergency medical assistance and guidelines for the maintenance of the equipment.

10. As used in this section, "gratuitously" means that the person receiving care or assistance is not required or expected to pay any compensation or other remuneration for receiving the care or assistance.

Appendix E: Acronyms

ABC	Airway, Breathing, Circulation
ADA	Americans with Disabilities Act
AHJ	Authority Having Jurisdiction
ALS	Advanced Life Support
BIO	Biological
BLS	Basic Life Support
DBOH	District Board of Health
DEM	Nevada State Division of Emergency Management
DHO	District Health Officer
DPBH	Nevada Division of Public and Behavioral Health
ED	Emergency Department
EM	Emergency Manager
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
ETA	Estimated Time of Arrival
FAC	Family Assistance Center
FCC	Federal Communication Commission
FEMA	Federal Emergency Management Agency
FSC	Family Service Center
HICS	Hospital Emergency Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
HSEEP	Homeland Security Exercise and Evaluation Program
IAP	Incident Action Plan
IC	Incident Commander
ICS	Incident Command System
IHCC	Inter-Hospital Coordinating Council
IMAS	Nevada Intrastate Mutual Aid System
IVCH	Incline Village Community Hospital
LZ	Landing Zone
MAA	Mutual Aid Agreement
MAEA	Mutual Aid Evacuation Annex
MCC	Medical Communications Coordinator
MCI	Multi-Casualty Incident
MCIP	Multi-Casualty Incident Plan
MHz	Megahertz
MOU	Memorandum of Understanding
MUL	Medical Unit Leader
NAC	Nevada Administrative Code
NLTFPD	North Lake Tahoe Fire Protection District
NNMC	Northern Nevada Medical Center
NRS	Nevada Revised Statutes
NWS	National Weather Service
OR	Operating Room

PSAP	Public Safety Answering Point
Pt	Patient
PTGS	Patient Transportation Group Supervisor
REOC	Regional Emergency Operations Center
REOP	Regional Emergency Operations Plan
REMSA	Regional Emergency Medical Services Authority
RRMC	Renown Regional Medical Center
RSMMC	Renown South Meadow Medical Center
RTAA	Reno-Tahoe Airport Authority
RTC	Regional Transportation Commission
SCEMP	State Comprehensive Emergency Management Plan
SMRMC	Saint Mary's Regional Medical Center
SNF	Skilled Nursing Facility
START	Simple Triage and Rapid Treatment
TFH	Tahoe Forest Hospital
TMFPD	Truckee Meadows Fire Protection District
TPHSM	Tahoe Pacific Hospital South Meadows
TPH	Tahoe Pacific Hospital
UC	Unified Command
UHF	Ultra High Frequency
UNR	University of Nevada Reno
VA	VA Sierra Nevada Health Care System
VHF	Very High Frequency
WCHD	Washoe County Health District
WCMECO	Washoe County Medical Examiner/Coroner Office

Appendix F: Glossary

Agency Representative
A person assigned by a primary, assisting or cooperating Federal, State, local, or tribal government agency or private entity that has been delegated authority to make decisions affecting that agency's or organization's participation in incident management activities following appropriate consultation with the leadership of that agency.

Assistant
Title for subordinates of principal Command Staff positions. The title indicates a level of technical capability, qualifications and responsibility subordinate to the primary positions. Assistants may also be assigned to unit leaders.

Authority Having Jurisdiction
The government agency, responsible for public safety or code enforcement within any given geographical area.

Branch
The organizational level having functional or geographical responsibility for major aspects of incident operations. A branch is organizationally situated between the section and the division or group in the Operations Section, and between the section and units in the Logistics Section. Branches are identified by the use of Roman numerals or by functional area.

Care Capacity
The number and types of patients a facility is able to accommodate based on a variety of internal factors as defined by the facility to include physician and nurse staffing, operating rooms available, Emergency Department capacity/staffing, and in-house capacity.

Chief
The ICS title for individuals responsible for management of functional sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established as a separate section).

Command Staff
In an incident management organization, the Command Staff consists of the Incident Commander and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed.

Deceased Patient
Mortally wounded or clinically dead.

Delayed Patient
Serious injury or illness; which may become life threatening; likely to survive if care is received within thirty (30) minutes to several hours.

Deputy
A fully qualified individual who, in the absence of a superior, can be delegated the authority to manage a functional operation or perform a specific task. In some cases, a deputy can act as relief for a superior and, therefore, must be fully qualified in the position. Deputies can be assigned to the Incident Commander, General Staff and Branch Directors.

Designated Overflow Area
Alternative care location identified by each facility where basic patient care can take place. Such locations may be auditoriums, cafeterias, hallways, or lobbies.

Division
The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A division is located within the ICS organization between the branch and resources in the Operations Section.

Emergency Management Plan
A plan maintained by a jurisdiction or agency, which describes activities to plan for, respond to, mitigate or recover from potential hazards that may result in loss of life or property during an emergency.

Emergency Operations Center
The physical location at which the coordination of information and resources to support incident management activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., federal, state, regional, county, city, tribal), or some combination thereof.

Field Command Post
The field location where primary tactical-level, on-scene incident command functions are performed.

Incident Commander
The person from the Authority Having Jurisdiction who responds to the emergency and who is responsible for all decisions relating to the incident and management of incident operations (e.g., fire or law enforcement).

Function
Function refers to the five major activities in ICS: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing

the activity involved, e.g., the planning function. A sixth function, Intelligence, may be established, if required, to meet incident management needs.

General Staff
A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief.

Good Samaritan Law
A section of Nevada Revised Statutes, which describes the immunities under the law for those medical personnel who provide gratuitous medical services in an emergency.

Group
Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. Groups, when activated, are located between branches and resources in the Operations Section. (See Division).

HICS
An Incident Command System designed specifically for use in the medical environment.

Hospital Emergency Operations Center
A location where primary hospital command and coordination functions are carried out to manage a medical facility's emergency or catastrophic event.

Hospital Incident Commander
The individual responsible for decisions relating to the incident and management of all strategic and tactical operations within the hospital.

Immediate Patient
Critical, life-threatening injury or illness likely to survive if care is received within thirty (30) minutes.

Incident
An occurrence or event, natural or human-caused, that requires an emergency response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, wild land and urban fires, floods, hazardous material spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Incident Command System
A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by

jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, and designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents; ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Initial Response
Resources initially committed to an incident.

JumpSTART
The pediatric triage method to help meet the needs of children and responders in an MCI. JumpSTART was developed because the physiologic parameters used in START are not suitable for children (i.e. walking, respiratory rates, mental status assessment, etc.).

Jurisdiction
A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., city, county, tribal, state or federal boundary lines) or functional (e.g., law enforcement, public health).

Liaison Officer
A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies.

Local Government
A county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a nonprofit corporation under state law), regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal organization, or in Alaska, a Native village or Alaska Regional Native Corporation; a rural community, unincorporated town or village, or other public entity. See Section 2(10), Homeland Security Act of 2002, Pub. L. 107-296, 116 Stat. 2135 (2202).

Logistics Section
The section responsible for providing facilities, services and material support for the incident.

Minor Patient
Not considered life threatening; care may be delayed hours or days; this group may be referred to as the walking wounded.

Multi-Casualty Incident Plan (MCIP)
Guidelines maintained by the Washoe County DBOH for the Reno, Sparks and Washoe County area to effectively, efficiently and safely organize multi-casualty incidents utilizing ICS as the management tool.

Political Subdivision
Under Nevada Revised Statutes 414.038, political subdivision means a city or a county.

Preparedness
The range of deliberate, critical tasks and activities necessary to build, sustain and improve the operational capability to prevent, protect against, respond to, and recover from domestic incidents. Preparedness is a continuous process. Preparedness involves efforts at all levels of government and between government and private sector and nongovernmental organizations to identify threats, determine vulnerabilities and identify required resources. Within the NIMS, preparedness is operationally focused on establishing guidelines, protocols and standards for planning, training and exercises, personnel qualification and certification, equipment certification and publication management.

Prevention
Actions to avoid an incident or to intervene to stop an incident form occurring. Prevention involves actions to protect lives and property. It involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and testing processes; immunizations, isolation or quarantine; and, as appropriate, specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice.

Recovery
The development, coordination and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private sector, nongovernmental and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental and economic restoration; evaluation of the incident to identify lessons learned; post-incident reporting; and development of initiatives to mitigate the effects of future incidents.

Resources
Personnel and major items of equipment, supplies and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an EOC.

Response
Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. As indicated by the situation, response activities include applying intelligence and other information to lessen the effects or consequences of an incident; increased security operations; continuing investigations into nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation or quarantine; and specific law enforcement operations aimed at preempting, interdicting or disrupting illegal activities and apprehending actual perpetrators and bringing them to justice.

Safety Officer
A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring personnel safety.

Section
The organization level having responsibility for a major functional area of incident management (e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established). The section is organizationally situated between the branch and the Incident Command.

Skilled Nursing Facility
An institution or facility that provides sub-acute nursing and/or rehabilitation services to patients with an illness or injury who are unable to care for themselves.

Staging Area
Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas.

START
A process of triaging patients in an MCI quickly and efficiently. It focuses on being simple to use, does not require any special skills, rapid, provides minimal stabilization, does not require specific diagnosis, and is easy to learn and teach. The START method utilizes four assessment tools to evaluate and categorize patients – ability to walk, ventilation, perfusion and mental status.

Strike Team
A set number of resources of the same kind and type that have an established minimum number of personnel. All resource elements within a Strike Team must have common communications and a designated leader.

Task Force
Any combination of resources assembled to support a specific mission or operational needs. All resource elements within a Task Force must have common communications and a designated leader.

Unified Command (UC)
An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross-political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single Incident Action Plan (IAP).

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 12

DD__CW__
DHO_____ KD

Staff Report
Board Meeting Date: June 28, 2018

TO: District Board of Health

FROM: Chad Westom, EHS Division Director
775-328-2644, cwestom@washoecounty.us

SUBJECT: Presentation, discussion and possible direction regarding request for augmentation of budget and plans for FY19 mosquito abatement activities

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SUMMARY

This report provides approximate mosquito larvicide treatment recommendations for fiscal year 2019 for flood impacted areas in Washoe County. Estimated costs for products are based on vendor contract pricing and recommended application rates by Washoe County Health District staff. The application rates listed below are on the lower range but within the rates listed for each product labels. Helicopter application costs and application rates are based on contract services through Alpine Helicopter Services, Lodi, California. Table 1 provides pricing for preferred application products and estimated costs per acre for each product. To avoid building larvicide resistance in the local mosquito population, it is recommended to rotate/alternate products for each application. For effective mosquito abatement, it is recommended that the time period between treatments be scheduled for no longer than the manufacturer's maximum residual control period given on each product label.

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

On May 20, 2003, the Board of County Commissioners (BCC) approved the Fiscal Year 2003-2004 budget which included a property tax in the amount of $0.005 per $100 assessed valuation to be dedicated for use by the Health District for the Vector Borne Diseases Program. On May 25, 2004, the BCC approved a resolution to place an advisory question on the November 2, 2004 ballot, seeking the advice of the voters as to their desire to continue the $0.005 property tax. The voters *approved* the advisory question to continue the imposition of a property tax dedicated for use for the Vector Program. Due to the dramatic erosion of the County's revenue base beginning in 2008, along with the forecasted lower future revenue growth, on May 11, 2010 the BCC approved a resolution removing the restrictions on the use of the property tax in the amount of $0.005 per $100 assessed valuation that was dedicated for use by the Health District for the Vector Borne Diseases Program. Additional funding beyond the base for Vector was no longer available after Fiscal Year 2009-2010. Further direction was given on June 23, 2009 by the BCC

that, due to the impacts of the 2009 Legislative Session, the accumulated savings of approximately $2.5 million for the Vector Program was to be redirected to help off-set the revenue loss in the County General Fund.

On February 22, 2018 the District Board of Health adopted a Fiscal Year 2018-2019 Budget that included an above base request to increase the General Fund transfer from Washoe County by $192,750 for chemical and helicopter costs to increase the mosquito abatement activities in the Environmental Health Division. This increase in the transfer was not included in the County Manager's budget approved by the Board of County Commissioners on May 22, 2018.

BACKGROUND

Currently, with Washoe County Geographic Information Services map data and our April 25-26, 2018 treatment of 2000 acres, a reasonable estimate of 1225 acres per treatment is predicted for FY2019 given projected precipitation levels. The estimated product costs per application are therefore $68,845 (1225 acres @ $56.20 per acre) for Vectolex FG and $84,525 (1225 acres @ $69.00 per acre) for Altosid P35. Helicopter contract rates are $750.00 for arrival to treatment site (setup) and $1,550 per hour of run time. The helicopter can treat roughly 150 acres per hour resulting in approximately $13,408 per application ((1225 acres @ 150 acres per hour and $1,550 per hour) + $750.00). Tables 1, 2, and 3 show the estimated treatment costs per acre, per application, and cost per day respectively. Table 4 lists all estimated product costs per region. Table 5 suggests recommended treatment dates for FY2019. Given the current budget for FY2019 for product costs of $231,500 and contract services (helicopter) of $45,000, the program would require budget augmentations of $160,000 and $20,000 for products and helicopter services, respectively (See table 6).

Table 1. Estimated product costs by unit and acres treated.

Product	Max Treatment Period (days)	Rate (#/acre)	($/unit)	(#/unit)	($/#)	($/acre)
Vectolex FG (EPA Reg No. 73049-20)	21	10	$224.80	40	$5.62	$56.2
Altosid P35 (EPA Reg No. 89459-95)	35	4	$690.00	40	$17.25	$69.00

Table 2. Estimated total treatment costs per application for Vectolex FG and Altosid P35.

Product	($/acre)	$ Total Product	Helicopter Arrival	Helicopter Per Hour	Total Hours	Total Helicopter	Total Treatment
Vectolex	$56.20	$68,845	$750	$1550	8.17	$13,413	$82,258
Altosid P35	$69.00	$84,525	$750	$1550	8.17	$13,413	$97,938

Table 3. Estimated treatment cost per residual days of application period.

Product	Treatment Rates #/acre	Max Treatment Period (days)	Total Treatment Cost	Cost per day
Vectolex	10	21	$81,845	$3,897
Altosid P35	4	35	$97,525	$2,786

Table 4. Estimated treatment acres and product costs by region per application.

Area Name	Estimated Acreage	Costs, Vectolex FG	Costs, Altosid P35	Helicopter (time only)
Stead	267	$15,005.40	$18,423	$2,759
Spanish Springs	106	$5,957.20	$7,314	$1,096
Rosewood Lakes	162	$9,104.40	$11,178	$1,674
Damonte Ranch	265	$14,893	$18,285	$2,737
Washoe Valley	425	$23,885	$29,325	$4,390
Totals	**1225**	**$68,845**	**$84,525**	**$12,656**

Table 5. Proposed treatment schedule for FY2019 (approximate product plus helicopter costs)

Date	Product	Control period	Acres	Costs
July 11, 2018	Altosid P35	35	1225	$97,525
August 15, 2018	Vectolex FG	21	1225	$81,962
September 5, 2018	Altosid P35	35	1225	$97,525
May 15, 2019	Altosid P35	35	1225	$97,642
June 19, 2019	Vectolex FG	21	1225	$81,845
			Totals	**$456,500**

Table 6. Proposed budget augmentations for FY2019.

Line Item	Estimated Cost	Current Allocation	Proposed Augmentation
Products	$391,500	$231,500	$160,000
Contract Services	$65,000	$45,000	$20,000
Totals	**$456,500**	**$276,500**	**$180,000**

FISCAL IMPACT

Should the Board approve this item and funding becomes available, there would be an additional $180,000 required to fund mosquito abatement efforts, above the $276,500 amount included in the FY19 adopted budget for chemical and helicopter costs.

RECOMMENDATION

Staff recommends that the Washoe County Board of Health requests that Washoe County augment the Health District budget for mosquito control in the amount of $180,000 for pesticide purchase and helicopter costs, to apply larvicide to flooded areas and other water bodies in the region.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to approve the request that Washoe County augment the Health District FY 2018-2019 budget for mosquito control in the amount of $180,000 for pesticide purchase and helicopter costs, to apply larvicide to flooded areas and other water bodies in the region."

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 13

DHO_KD___
DDA _____
Risk _____

STAFF REPORT
BOARD MEETING DATE: June 28, 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 Improvement Plan

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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 CHIP (2016-2018) was presented to the board and accepted on January 28, 2016.
- The 2016 and 2017 CHIP annual reports have been presented to the board and accepted.
- The 2018-2020 CHNA was present to the board and accepted on January 25, 2018.

BACKGROUND

The 2018-2020 CHIP provides a framework for community partners to improve the health and well-being of residents in Washoe County by taking into account our community's unique circumstances and needs. Strategies and tactics identified within the CHIP are addressed through partnerships with a diverse array of community based organizations, with the Health District taking on a supportive role. The Public Health Accreditation Board defines a CHIP as "a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources".

The CHIP action plans outline the next steps taken over the coming three years to address the community health needs identified and rely heavily on a collaborative approach to make a collective, broad impact on the health of our community.

FISCAL IMPACT

- *Should the Board approve the CHIP, there will be no fiscal impact to the adopted FY18 budget.*

RECOMMENDATION

Staff recommends the DBOH approve the 2018-2020 Community Health Improvement Plan as presented.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be "Move to approve the 2018-2020 Community Health Improvement Plan as presented."

Summary of Goals and Objectives

Focus Area One: Housing			
Goals		**Objectives**	
1	To stabilize and improve housing security for people spending more than 30% of their income on housing.	1.1	By June 15, 2018 complete Phase I of the Enterprise Affordable Housing Regional Strategy.
		1.2	By September 1, 2018 complete Phase II of the Enterprise Affordable Housing Regional Strategy.
		1.3	By December 31, 2018 complete Phase III of the Enterprise Affordable Housing Regional Strategy.
		1.4	By July 1, 2020 implement Enterprise Affordable Housing Regional Strategy as indicated in plan implementation schedule.
2	To stabilize and improve housing security for people spending more than 50% of their income on housing.	2.1	By September 1, 2018 identify and support alternative funding models for housing severely mentally ill (SMI).
		2.2	By September 1, 2018 identify best practices for incorporating community case management for people receiving housing assistance.
Focus Area Two: Behavioral Health			
Goals		**Objectives**	
1	To stabilize and improve housing security for the severely mentally ill (SMI).	1.1	By September 1, 2018 identify and support alternative funding models for housing SMI.
		1.2	By September 1, 2018 identify best practices for incorporating community case management for SMI receiving housing assistance.

2	Assess and address current status and need for Behavioral Health services in Washoe County	2.1	By October 1, 2018 develop a strategy to collect and disseminate information related to the annual statistics on Behavioral Health providers in Washoe County.
		2.2	By December 31, 2018 identify gaps in service and access for those needing behavioral health services in Washoe County.
		2.3	By September 1, 2018 develop strategies and advocate for policies to address gaps and needs identified.
3	Reduce depression and suicidal behaviors in adolescents	3.1	By September 1, 2018 increase mental health screening of 7th grade students in Washoe County using a standardized screening tool and provide appropriate referral to care.
Focus Area Three: Nutrition and Physical Activity			
Goals		**Objectives**	
1	To increase physical activity and improve nutrition among adults and youth using the 5210 Let's Go framework.	1.1	By July 2019, increase the number of community organizations implementing aspects of the 5210 program from 1 to 12.
		1.2	By July 2019, improve the nutrition environment in the community by improving the nutritional offerings in vending machines and concession stands in schools, workplaces, and community settings.
		1.3	By July 2019, improve access and availability of nutrition and physical activity opportunities by implementing three Family Health Festivals in zip codes with high Community Needs Index (CNI) scores.
		1.4	By July 2019, improve the nutrition environment in targeted parks by increasing the number of environmental cues related to healthy food and beverage consumption by at least 3.

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

2018-2020
Community Health Improvement Plan

June 2018

Public Health
Prevent. Promote. Protect.

Record of Changes To Plan:

Date of Review	Reviewed By	Pages Where Changes Were Made	Summary of Changes

Table of Contents

Community Health Improvement Plan Authors

Lead Author
Catrina Peters – Director of Programs and Projects, WCHD

Supporting Author
Rayona Dixon – Health Educator II, WCHD

Editing and Support
Falisa Hilliard – Office Support Specialist, WCHD
Laura Rogers – Administrative Secretary, WCHD

Community Health Improvement Plan Committees

Once focus areas were selected as described in the introduction, the following committees were developed to determine the items to be included in the action plan for each focus area. The Community Health Improvement Plan (CHIP) Committees met several times between February and May of 2018 to help guide the development of the focus area action plans. The CHIP focus area Committee leaders include:

Housing
JD Klippenstein - ACTIONN

Behavioral Health
Catrina Peters - Washoe County Health District

Nutrition and Physical Activity
Kelli Goatley-Seals - Washoe County Health District
Rayona Dixon- Washoe County Health District

Community Members

The Washoe County Health District would like to thank the community for their involvement and participation in the community health improvement process. Your time and effort is greatly appreciated as we move forward to improve the health and well-being of Washoe County residents. We especially appreciate the work of the Truckee Meadows Healthy Communities Steering Committee for their work to deliberate and consider the weighty volume of information to ultimately determine the focus areas to include in the CHIP.

Community Partners

The Washoe County Health District would like to thank the following organizations for their participation in the CHIP committee meetings, action plan development and for serving as subject matter experts to shape the development of the Community Health Improvement Plan and the priorities outlined within.

Boys and Girls Club of Truckee Meadows
Charles Schwab Bank
Children's Cabinet
City of Reno
City of Sparks
Communities in Schools, Western Nevada
Community Foundation of Northern Nevada
Community Health Alliance
Community Services Agency
Food Bank of Northern Nevada
Health Plan of Nevada
High Sierra AHEC
Immunize Nevada
JTNN
Nevada Division of Public and Behavioral Health, Chronic Disease Prevention & Health Promotion
Nevada Division of Public and Behavioral Health, Community Services
Nevada Division of Public and Behavioral Health, Office of Suicide Prevention
Nevada Division of Public and Behavioral Health, Primary Care Office
Northern Nevada HOPES
NVEnergy
Praxis
Reno Area Alliance for the Homeless
Reno Housing Authority
Reno + Sparks Chamber of Commerce
Renown Health
San Francisco Federal Reserve Bank
Silver Summit Health Plan
Social Entrepreneurs, Inc.
The Eddy House
Truckee Meadows Healthy Communities
Truckee Meadows Regional Planning Authority
United Health Care
University of Nevada, Reno School of Community Health Sciences
Washoe County Chronic Disease Coalition
Washoe County Health District
Washoe County Human Services Agency
Washoe County School District
Wells Fargo

Letter from the Board of Health Chair

Dear Colleagues,

The 2018-2020 Community Health Improvement Plan (CHIP) is a true reflection of the collaboration and partnership seen across the Truckee Meadows in pursuit of better health. It provides an excellent foundation to align the efforts of the many community partners working together collectively to improve the health of our community. Development of the 2018-2020 CHIP is a critical step towards tackling some of our most pressing public health issues.

I'm especially proud to see housing and behavioral health included as focus areas as we know those are both critical issues in our community. Our recent economic growth has brought many benefits to the community but has also resulted in high costs and limited availability of housing. We know there is a strong relationship between housing and health outcomes and addressing our housing crisis is essential for improving the health of all in the community, especially those who are most vulnerable. We also know that housing is an important first step on the road to recovery for those struggling with mental illness or substance abuse and the strong overlap of these issues is reflected in both the housing and behavioral health focus areas of the CHIP.

Please join me in supporting the work this plan outlines as we look towards the future and improve the health of our community. The strategies laid out are a robust body of work and will only be possible with community partners working together. While this will undoubtedly be a challenging endeavor, it will ultimately lead to a better and healthier Truckee Meadows for all of us.

Sincerely,

Kitty Jung
Washoe County Commissioner
Chair, Washoe County District Board of Health

Letter from the District Health Officer

Dear Friends and Colleagues,

As we recently wrapped up our first ever Community Health Improvement Plan (CHIP), celebrated the progress made and reflected on the lessons learned, I'm excited to share with you our second Community Health Improvement Plan. The 2018-2020 CHIP was developed in response to the 2018-2020 Community Health Needs Assessment (CHNA) and is the result of six months of planning, evaluating and engaging the community to gain a better understanding of what the community sees as the top priorities for us to focus our work on.

While we know there are many health needs in our community, our current housing crisis is the focus area that has been selected as the first priority. Using the Regional Comprehensive Strategy for Affordable Housing, developed through Truckee Meadows Healthy Communities, Truckee Meadows Regional Planning Agency, and Enterprise Community Partners, it seeks both short and long term solutions to address the high cost and limited availability of housing in Washoe County. Our second focus area, Behavioral Health, is of utmost urgency to address the current public health crisis we are experiencing due to limited capacity to prevent, diagnose, and treat mental illness and substance use. Our third focus area, Nutrition and Physical Activity, is at the core of preventing chronic disease and helping our residents live healthy lives.

As you review the 2018-2020 Community Health Improvement Plan, you'll find that we've included specific goals, objectives and strategies to not only align the efforts of many community partners, but also enable measurement and evaluation of our accomplishments. Community-wide collaboration is essential to the success of every CHIP and this document reflects a high level of cooperation and partnership across the Truckee Meadows. My thanks to all our community partners who made this plan possible.

Sincerely,

Kevin Dick
Washoe County District Health Officer

Introduction

Background

In 2017, the Washoe County Health District and Renown Health sponsored the development of the 2018-2020 Washoe County Community Health Needs Assessment (CHNA). The CHNA is a comprehensive health overview that informs the development of two action plans; the Community Health Improvement Plan (CHIP) and Renown Health's Community Benefit Plan.

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 in January of 2015. The second collaborative assessment utilized validated and reliable secondary data sources, results from an online community survey, feedback from subject matter experts, and input from participants through a Community Workshop. A community health index and information on community strengths and challenges gathered from the online survey are also identified in the CHNA in sections two and three. 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.

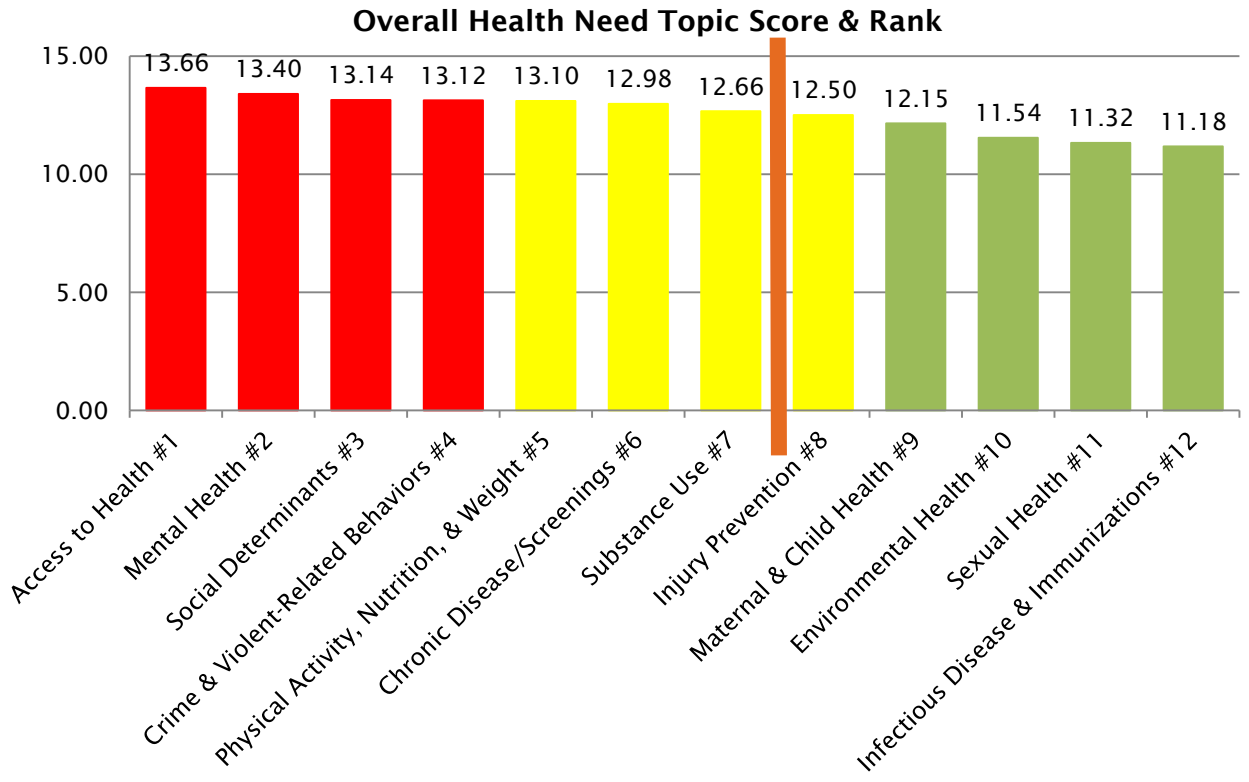
In addition to extensive amounts of data, the CHNA contains a prioritization of health needs to better understand and organize the large amount of secondary data (county, state and national level statistics/numbers) and primary data (online community survey) contained within the assessment. The selected five criteria; magnitude, severity, trend, benchmark, and community perception, were utilized to objectively score and rank health topics. The detailed methodology for prioritization, scoring, and ranking is included within the CHNA and can be accessed from the Washoe County Health District website.

From this ranking of areas of health need, in combination with the results of the Community Workshop, a broad list of potential focus areas were presented to the Truckee Meadows Healthy Communities (TMHC) Steering Committee. The primary and secondary data and resulting prioritization and ranking provides a data-driven starting point for consideration of which health topics to focus on. The Community Workshop provided insights into the specific topics the community viewed as most critical to be addressed. Both elements, in addition to conversations on the existing capacity within community based organizations to work on these issues, were utilized in determining which focus areas to include in the CHIP.

The TMHC Steering Committee was presented with this information contained within the CHNA and was asked to use this information and their knowledge of the community to recommend focus areas to include in the CHIP. TMHC is a cross-sectorial coalition representing the Truckee Meadows community including local governments, non-profits, education, healthcare, business and supporting partners. The Steering Committee was requested to select no more than three focus areas from the broader list of focus areas presented in order to keep the efforts of the CHIP focused and achievable. Due to the CHIP cycle being 3 years in length, limiting the number of focus areas is key to success as is looking at existing, successful programs and how they can be expanded or further supported. Limiting the number of focus areas allows for a concentration of resources and thus increases the likelihood of impactful collaboration to improve the health of our community.

While all the health need topics are worthy of the community's attention, concentrated efforts on a smaller number of focus areas is more likely to result in impactful change. Extensive discussion was engaged in by the TMHC Steering Committee members on areas of the highest need, the community's capacity to take on work in each focus area and how efforts could be measured. Two meetings were needed to fully discuss these topics due to the complexity of the issues and the extensive amount of data to consider.

The top 12 health focus areas from the CHNA were shared with the Steering Committee as shown below:



While there was some variability between the top 12 items when looking at the primary and secondary data, several focus areas were consistently ranked higher. The initial broad list for consideration included:

1. Housing
2. Healthcare workforce
3. Diagnosable mental illness
4. Educational Attainment
5. Preventative care services
6. Depression
7. Prescription drug use

Among the top seven focus areas, some common themes developed. Housing remained a top priority, while the remaining topics outside of educational attainment were condensed under a general Behavioral Health focus area. After condensing the focus areas down to Housing and Behavioral Health, other areas were considered including chronic disease, nutrition, physical activity and general wellness.

After careful consideration and deliberation, the Steering Committee determined the following focus areas to be the highest areas of need and the areas where there was community capacity to initiate work:

1. Housing
2. Behavioral Health
3. Nutrition/Physical Activity

Housing was selected as it plays a critical role in laying a foundation for success for all health improvement efforts. Without adequate housing other efforts to provide adequate treatment and improve health are unlikely to succeed. Increasing the community's capacity to provide adequate and affordable housing was seen as a critical element in improving the health of the community.

Behavioral health was also seen as a top concern cited by the community, and is one that greatly suffers from lack of adequate resources and available workforce. It also ties in closely to the Housing focus area as many chronically homeless individuals suffer from mental illness and substance use disorder, and adequate housing is seen as a critical foundation to providing successful treatment.

When looking at chronic disease and general wellness, nutrition and physical activity was selected as a focus area as it plays a critical role in preventing a wide array of chronic diseases. While diabetes, heart disease and stroke are diseases of concern, they are all diseases that can be decreased by improving nutrition and physical activity.

Once focus areas were determined, committees were formed to undertake the work of determining goals and objectives of each focus area. After goals and SMART objectives were drafted, corresponding strategies and tactics were created to further detail the

steps that need to be taken to accomplish the objective. The results of the committee's work and efforts to engage a broad array of stakeholders in each focus area are reflected in the final action plans.

What is a Community Health Improvement Plan?

The 2018-2020 CHIP provides a framework for community partners to improve the health and well-being of residents in Washoe County by taking into account our community's unique circumstances and needs. Put simply, the CHIP is a plan of action to address local conditions that are contributing to or causing poor health in Washoe County. Strategies and tactics identified within the CHIP are addressed through partnerships with a diverse array of community based organizations, with the Health District taking on a supportive role.

The Public Health Accreditation Board defines a CHIP as "a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources". Furthermore, specific guidance on the development of the CHIP states that the plan must include "the desired measurable outcomes or indicators of the health improvement effort and priorities for action, from the perspective of community members. The plan must include community health priorities, measurable objectives, improvement strategies and activities with time-framed targets that were determined in the community planning process".

The CHIP action plans outline the next steps taken over the coming three years to address the community health needs identified and rely heavily on a collaborative approach to make a collective, broad impact on the health of our community.

Management of the Community Health Improvement Plan

The CHIP is managed by community workgroups, with the Health District acting in a supportive role. On an annual basis, the Health District will provide a community report as it relates to the status of all goals, objectives and strategies included within the CHIP. The community report will consider the feasibility and effectiveness of the strategies, as well as community resources and assets. After measuring the performance of CHIP action plan implementation, revisions may be made to the strategies, time-frames, targets, or the ownership of specific objectives. These annual reports will be made available on the Washoe County Health District website.

In summary, the CHIP provides an initial direction with revisions expected in the future as Washoe County organizations and community members work in greater partnership to improve upon the health and well-being of Washoe County residents.

Summary of Goals and Objectives

Focus Area One: Housing			
Goals		**Objectives**	
1	To stabilize and improve housing security for people spending more than 30% of their income on housing.	1.1	By June 15, 2018 complete Phase I of the Enterprise Affordable Housing Regional Strategy.
		1.2	By September 1, 2018 complete Phase II of the Enterprise Affordable Housing Regional Strategy.
		1.3	By December 31, 2018 complete Phase III of the Enterprise Affordable Housing Regional Strategy.
		1.4	By July 1, 2020 implement Enterprise Affordable Housing Regional Strategy as indicated in plan implementation schedule.
2	To stabilize and improve housing security for people spending more than 50% of their income on housing.	2.1	By September 1, 2018 identify and support alternative funding models for housing severely mentally ill (SMI).
		2.2	By September 1, 2018 identify best practices for incorporating community case management for people receiving housing assistance.
Focus Area Two: Behavioral Health			
Goals		**Objectives**	
1	To stabilize and improve housing security for the severely mentally ill (SMI).	1.1	By September 1, 2018 identify and support alternative funding models for housing SMI.
		1.2	By September 1, 2018 identify best practices for incorporating community case management for SMI receiving housing assistance.

2	Assess and address current status and need for Behavioral Health services in Washoe County	2.1	By October 1, 2018 develop a strategy to collect and disseminate information related to the annual statistics on Behavioral Health providers in Washoe County.
		2.2	By December 31, 2018 identify gaps in service and access for those needing behavioral health services in Washoe County.
		2.3	By September 1, 2018 develop strategies and advocate for policies to address gaps and needs identified.
3	Reduce depression and suicidal behaviors in adolescents	3.1	By September 1, 2018 increase mental health screening of 7th grade students in Washoe County using a standardized screening tool and provide appropriate referral to care.
Focus Area Three: Nutrition and Physical Activity			
Goals		**Objectives**	
1	To increase physical activity and improve nutrition among adults and youth using the 5210 Let's Go framework.	1.1	By July 2019, increase the number of community organizations implementing aspects of the 5210 program from 1 to 12.
		1.2	By July 2019, improve the nutrition environment in the community by improving the nutritional offerings in vending machines and concession stands in schools, workplaces, and community settings.
		1.3	By July 2019, improve access and availability of nutrition and physical activity opportunities by implementing three Family Health Festivals in zip codes with high Community Needs Index (CNI) scores.
		1.4	By July 2019, improve the nutrition environment in targeted parks by increasing the number of environmental cues related to healthy food and beverage consumption by at least 3.

Focus Area 1—Housing

After a period of economic recession, Washoe County has experienced growth for the past seven years and has experienced significant economic development within the last two years. There has been an influx of people relocating to Washoe County primarily driven by large corporations such as Tesla/Panasonic, Apple, Switch and Google establishing factories and data centers in and outside of Reno. While this influx of business relocation/expansion and economic growth has resulted in an increase in jobs available across multiple sectors, it has substantially increased demand for housing. As a result of increased demand, there has been a corresponding increase in housing costs and an increase in the homeless population.

Housing costs have been rising since the bottom of the recession in 2009, when average rental prices and home sale prices were at a 10 year low. Median home prices have increased from $192,000 in May of 2013 to $352,000 in May of 2018, an 83% increase[1]. When comparing the same timeframe, there has been a 34% increase in the average rental price from $829 to $1,111[2] and vacancy rates remain very low. Some of the lowest cost housing, the weekly motels, has had a reduction in available units as aging properties in the urban core are being redeveloped. And while housing costs have risen dramatically, wages have remained relatively stagnant. Currently, the average hourly wage in Reno remains 8% lower than the national average[3]. As a result, households are often forced to pay a larger percentage of their income on housing.

With these changes, the most vulnerable populations often experience the most adverse outcomes. For lower income households this may mean having to choose between paying rent and buying food or medicine, or facing an eviction. Residents living on a fixed income have also been adversely affected as social security or other types of fixed income have not increased to meet the rising cost of housing. According to Enterprise Community Partners, 39% of Washoe County residents are low income and paying more than 50% of their income on housing costs. For those paying more than 50% of their income on housing, rising rents may result in homelessness.

[1] Zillow. United States Home Prices & Values. Accessed https://www.zillow.com/home-values/
[2] Nevada Housing Division. (2017). "Taking Stock" Nevada's 2017 Affordable Housing Apartment Survey. Accessed https://housing.nv.gov/uploadedFiles/housingnvgov/content/programs/LIHD/2017Taking%20Stock20180306.pdf
[3]Bureau of Labor Statistics. Western Information Office. Accessed https://www.bls.gov/regions/west/news-release/occupationalemploymentandwages_reno.htm

The strain of housing costs have already been reflected in increased numbers of homeless individuals. The number of homeless individuals living in a shelter or transitional housing has increased 43%, from 705 in January of 2012 to 1,008 in January of 2018. The largest percentage increase in the homeless population is in the number of homeless senior citizens identified, from 13 in 2014 to 35 in 2018. The number of children identified by the Washoe County School District is also remains high, with 3,359 children being identified as homeless in the 2016-2017 school year.

Loss of adequate, secure housing has been shown to have an array of unfavorable health outcomes, the largest of which is the negative impacts on one's health[4]. Rates of mental health crisis, substance abuse[5], food insecurity rates[6] and emergency department utilization have all been shown to increase when homelessness is experienced. In an effort to reverse that trend, many believe that secure housing must be established first before any resources put towards improving health will be fruitful. For those who are struggling with behavioral health issues, adequate housing is critical to getting consistent and effective treatment. This is commonly referred to as the "housing first" model and serves as the basis from which housing was selected as the first priority for the 2018-2020 Community Health Improvement Plan.

After discussions with many community stakeholders on which strategies to focus on to improve the housing challenges of the Truckee Meadows, the following key themes were identified:

- Develop and implement a Regional Housing Strategy
- Explore models to provide funding for the severely mentally ill
- Support community case management to increase the success rate of those placed in housing assistance programs

These key themes were further developed into strategies and tactics to accomplish the objectives that were outlined. Both long and short term efforts were considered and the items reflected in the table below are the results of careful consideration of the most pressing needs and resources available to address such needs.

[4] Sarah C. Oppenheimer, Paula S. Nurius, and Sara Green (*2016*) Homelessness History Impacts on Health Outcomes and Economic and Risk Behavior Intermediaries: New Insights From Population Data. Families in Society: The Journal of Contemporary Social Services: 2016, Vol. 97, No. 3, pp. 230-242.
[5]American Psychiatric Association Publishing. Accessed https://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.162.2.370
[6]Wiley Online Library. Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans. Accessed https://onlinelibrary.wiley.com/doi/full/10.1111/j.1525-1497.2005.00278.x

Community Health Improvement Plan

Housing Action Plan

Focus Area: Housing

Goal 1: To stabilize and improve housing security for people spending more than 30% of their income on housing.

Objective (SMART Format):

1. By June 15, 2018 complete Phase I of the Regional Strategy for Housing Affordability.
2. By September 1, 2018 complete Phase II of the Regional Strategy for Housing Affordability.
3. By December 31, 2018 complete Phase III of the Regional Strategy for Housing Affordability.
4. By July 1, 2020 implement Regional Strategy for Housing Affordability as indicated in plan implementation schedule.

Outcome Indicator (From CHNA):

Indicator	Trend	Most Recent Year	Outcome Indicator Change Desired
Number of housing units		191,390 (2016)	Increase
Number of housing units per capita	Decreasing	43,026 houses per 100,000 population (2016)	Increase
Unaffordable rent (paying more than 30% income on rent)	STABLE	48.7% (2016)	Decrease
Children in Transition (CIT-homeless youth)	Increasing	3,359 grades K-12 (2016-2017)	Decrease
Vacancy rate for low income rental units**	Decreasing	2.6%	Increase

**Vacancy rate for Reno rental units at properties that are participating in the low income housing tax credit program.
Source: "Taking Stock" Nevada Housing Division, 2017

Robert Wood Johnson County Health Ranking Indicator Impacted: Severe housing problems

Objective 1	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By May 1, 2018 complete Phase I of the Regional Strategy for Housing Affordability.	Facilitate local leadership meetings for Enterprise and provide any requested information	Conduct meetings needed and requested, Enterprise to develop roadmap	Phase I of roadmap complete	June 1, 2018	Owner: Project Director, Truckee Meadows Healthy Communities, TMRPA

Objective 2	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 complete Phase II of the Regional Strategy for Housing Affordability.	Facilitate local leadership meetings for Enterprise and provide any requested information	Conduct meetings needed and requested, Enterprise to develop roadmap	Phase II of roadmap complete	September 30, 2018	Owner: Project Director, Truckee Meadows Healthy Communities, TMRPA

Objective 3	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By December 31, 2018 complete Phase III of the Regional Strategy for Housing Affordability.	Facilitate local leadership meetings for Enterprise and provide any requested information	Conduct meetings needed and requested, Enterprise to develop roadmap	Phase III of roadmap complete	Nov 31, 2018	Owner: Project Director, Truckee Meadows Healthy Communities, TMRPA

Objective 4	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By July 1, 2020 implement Regional Strategy for Housing Affordability as indicated in plan implementation schedule.	Advocate for and work to identify or establish an organization or coalition that can accomplish the implementation plan and advocacy mission of phase IV of the Regional Strategy for Housing Affordability	Identify or establish organization to lead implementation	Organization identified/established	June 1, 2018 – June 30, 2019	Owner: Truckee Meadows Healthy Communities
		Organization identified in strategy one to complete implementation plan	Activities and strategies outlined in implementation plan completed	To be determined	Owner: To be determined

Community Health Improvement Plan

Housing Action Plan

Focus Area: Housing/Homeless

Goal 2: To stabilize and improve housing security for people spending more than 50% of their income on housing.

Objective (SMART Format):

1. By September 1, 2018 identify and support alternative funding models for housing severely mentally ill (SMI).
2. By September 1, 2018 identify best practices for incorporating community case management** for people receiving housing assistance.

**Case management as defined by HUD, i.e. serves as a central point of contact for service providers and addresses the biological, psychological and socials needs of the person and helps him/her to maintain housing.

Outcome Indicator (From CHNA):

Indicator	Trend	Most Recent Year	Outcome Indicator Change Desired
Number of homeless persons	Increasing	989 persons (2016)	Decrease
Children in Transition (CIT-homeless youth)	Increasing	3,359 grades K-12 (2016-2017)	Decrease
Housing units per capita	Decreasing	43,026 per 100,00 population	Increase
Unaffordable rent (paying more than 30% income on rent)	STABLE	48.7% (2016)	Decrease
Vacancy rate for low income rental units**	Decreasing	2.6%	Increase

**Vacancy rate for Reno rental units at properties that are participating in the low income housing tax credit program.
Source: "Taking Stock" Nevada Housing Division, 2017

Robert Wood Johnson County Health Ranking Indicator Impacted: Severe housing problems

Objective 1	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 identify and support alternative funding models for housing severely mentally ill (SMI).	Identify alternative funding models for housing SMI	Map out options for utilizing Medicaid waivers or state plan revisions for cost savings to fund housing for homeless individuals with SMI	Document that lists options for utilizing Medicaid waivers or cost savings to fund housing	June 15, 2018	Owner: Washoe County Human Services, RAAH, ACTIONN
		Document steps needed to pursue Medicaid state plan revisions for cost savings to fund housing for SMI	Document that outlines steps needed to implement funding models identified (i.e., State Medicaid Administrator approval/letter of support, legislative action needed, etc.)	July 15, 2018	
		Determine if non-federal match funds are required for funding options identified and if so, initiate communication to determine if state or local funding could be utilized to meet matching requirement	Meetings conducted to explore possible sources of matching funds A memorandum of understanding to provide match funds needed	August 15, 2018	
	Support alternative funding models identified	Coordinate advocacy efforts needed to support funding models identified	Central point of contact identified for disseminating information	August 15, 2018-June 30, 2020	
	Work with State Medicaid agency to revise state plan to include expansion of 1915(i) subpopulations to include homeless people who are severely mentally ill.	Document steps needed to revise state plan to expand 1915(i) subpopulations.	Document that outlines steps needed to revise state plan.	June 1, 2018	Owner: Nevada Interagency Council on Homelessness
		Identify steps for implementation of revised state plan.	Action plan for implementation activities.	July 31, 2018	Owner: Nevada Interagency Council on Homelessness

Objective 2	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 identify best practices for incorporating community case management for those receiving rental assistance.	Survey and identify all existing case managers in the community across non-profit and government agencies and the general scope of the case management provided.	Each agency will list their case managers, and identify their duties and responsibilities	Completed list of case managers and the scope of the case management and the resources the case manager has available to contribute	July 15, 2018	Owner: Washoe County Human Services Division, Housing Specialist Supporter: WCHD MPH Intern, RHA
		Convene a case management specific meeting(s) to facilitate collaboration of case management and sharing of best practices	Meetings convened, best practices shared	August 15, 2018	
Objective 2	**Strategy 2**	**Tactic**	**Performance Indicator**	**Target Date**	**Owner**
By September 1, 2018 identify best practices for incorporating community case management for those receiving rental assistance.	Document experiences and results from Washoe County's Community Case Managers.	Work with Shelia Leslie and Community Case Managers to document experiences and results to date.	Completion of report on Washoe County Community Case Management experiences and results.	July 30, 2018	Owner: Washoe County Human Services Supporter: UNR MPH Intern
	Compile and share best practices examples from other communities.	Conduct internet research.	Creation of a report presenting options used successfully in other communities.	August 1, 2018	Owner: Anne Cory Supporter: UNR MPH Intern
		Develop a timeline for implementation of best practices identified for incorporating collaborative case management for those receiving rental assistance.	Completed document reflecting a timeline and implementation steps for best practices identified, may be combined with report on experiences and best practices identified.	August 15, 2018	Owner: UNR MPH Intern

Objective 2	Strategy 3	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 identify best practices for incorporating collaborative case management for those receiving rental assistance.	Create diversion case managers at the Community Assistance Center (CAC). Working directly with the individuals and families at the CAC that are NOT in the shelters and are on the waiting list. Provide supportive services and crisis management prior to entering the shelter.	Identify a case manager who can be solely dedicated to working with families on the waiting list for the family shelter to identify housing opportunities to prevent them from needing to be housed at the family shelter.	Document reflecting roles and responsibilities of existing case managers at the CAC. No families on the wait list at the CAC.	Sept 1, 2018	Owner: Washoe County Human Services Division, Housing Specialist Supporter: City of Reno, Volunteers of America

Objective 2	Strategy 4	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 identify best practices for incorporating collaborative case management for those receiving rental assistance.	Support implementation of objectives/strategies outlined in the HUD Youth Demonstration grant.	Identify a timeline to implement grant objectives	Document reflecting implementation timeline	July 1, 2018	Owner: Eddy House, RAAH Youth Subcommittee
		Gather key stakeholders to determine lead agencies on grant objective implementation. Establish process for training, agency communication and service delivery that include best practices for homeless youth.	Meetings conducted to determine lead agencies that specifically serve homeless youth.	Sept 1, 2018	Owner: Eddy House, RAAH Youth Subcommittee
		Explore best practices and establish a process for training, agency communication and service delivery for entities that encounter homeless youth.	Document reflecting training best practices and the process identified for providing training for entities encountering homeless youth	Dec 1, 2018	Owner: Eddy House, RAAH Youth Subcommittee

Focus Area 2—Behavioral Health

Behavioral Health is a broad term that includes both mental health and substance abuse; two issues that continue to increase across the nation. Often they occur in tandem, with higher rates of substance abuse being seen in those experiencing mental illness which can further exacerbate a condition. These are two health problems that can also vary in severity; mental illness can range from mild to substantially interfering with day-to-day activities,[7] and substance use disorders can also range from mild to severe with varying degrees of impact on health and the ability to perform daily functions.

Across the nation a growing number of Americans are struggling with a mental illness. The CDC reports about 25% of all U.S. adults currently have a mental illness and nearly twice that number will develop at least one mental illness in their lifetime.[8] While Nevada has the fifth highest suicide rate in the country, Washoe County currently leads the state in suicide prevalence with 23.6 suicide deaths per 100,000 people. This rate is substantially higher than the national average of 13.3 suicide deaths per 100,000 people. Substance use disorders also continue to be a challenge for our community and an increasing number of Washoe County residence report needing but not receiving treatment for both alcohol and illicit drug use. Adding to past and current challenges in Northern Nevada with high rates of alcohol and methamphetamine abuse, the nation's opioid crisis has also hit Nevada with increases in opioid use and subsequent increases in overdose deaths.

Historically, Nevada has struggled to identify adequate resources and community based solutions to appropriately respond to our behavioral health needs due to a variety of factors. Lack of funding has often been cited as a top limitation to providing adequate services to our most vulnerable populations, with the per capita funding of mental health services averaging $89.41, far short of the national average of $131 per capita[9]. The available workforce has also presented limitations to providing services; nearly the entire state of Nevada has been in a mental health provider shortage area as defined by the US Department of Health and Human Services. Entities that have the resources to hire additional providers are limited by the ability to recruit appropriate providers given the shortage of available workforce in the area. Those who accept referrals for behavioral health from community based partners are often limited by lack

[7] National Institute of Mental Health. Health Information. Accessed https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
[8] Center for Disease Control and Prevention. CDC Mental Illness Surveillance. Accessed https://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html
[9] NRI Analytics Improving Behavioral Health. Accessed http://www.nri-inc.org/

of capacity to meet the overwhelming need or are faced with long wait times to provide care to those who need it.

Adding to limited ability to hire from the current workforce, challenges are also seen in the amount of time needed for a behavioral health board to approve licensure for a provider coming from out of state once they are hired. In order to address these challenges, an action plan was developed to increase information dissemination of behavioral health workforce statistics. This objective is intended to draw attention to the need and to identify potential opportunities to expedite licensure for behavioral health providers once they are hired.

In Northern Nevada, the housing crisis has further exacerbated the challenges of meeting the needs for substance use and mental health treatment. Patients who have completed in-patient treatment and are ready for a more independent living situation struggle to find available housing, further limiting available treatment for those needing it. As a result of the strong overlap between the challenges of limited affordable housing and accessing appropriate substance use and mental health treatment, the action plans for the Behavioral Health focus area includes strategies for supportive housing. These action plans mirror the items included in the housing action plan focused on decreasing homelessness.

The third strategy included in this section of the CHIP focuses on reducing depression and suicide in adolescents. While this is a complex problem to tackle and requires a collaborative approach that includes parents, schools and mental health providers, strategies are outlined to address some components of this substantial issue. Given the limited resources available to tackle this challenge, the strategies included in the action plan focus on supporting an existing education and screening program, Signs of Suicide. This program provides suicide education to all students and a screening for high risk behaviors when parents provide a signed consent form. Finally, the plan includes a strategy to expand efforts to allow mental health providers to see students in schools, thereby decreasing the logistical and transportation challenges to access that type of care.

Community Health Improvement Plan

Behavioral Health Action Plan

Focus Area: Behavioral Health

Goal 1: To stabilize and improve housing security for the severely mentally ill (SMI).

Objective (SMART Format):

1. By September 1, 2018 identify and support alternative funding models for housing SMI.
2. By September 1, 2018 identify best practices for incorporating community case management** for SMI receiving housing assistance.

**Case management as defined by HUD, i.e. serves as a central point of contact for service providers and addresses the biological, psychological and socials needs of the person and helps him/her to maintain housing.

Outcome Indicator (From CHNA):

Indicator	Trend	Most Recent Year	Outcome Indicator Change Desired
Number of homeless persons	Increasing	989 persons (2016)	Decrease
Children in Transition (CIT-homeless youth)	Increasing	3,359 grades K-12 (2016-2017)	Decrease

Robert Wood Johnson County Health Ranking Indicator Impacted: Severe housing problems, poor mental health days, premature death

Objective 1	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 identify and support alternative funding models for housing severely mentally ill (SMI).	Identify alternative funding models for housing SMI	Map out options for utilizing Medicaid waivers or state plan revisions for cost savings to fund housing for homeless individuals with SMI	Document that lists options for utilizing Medicaid waivers or cost savings to fund housing	June 15, 2018	<u>Owner:</u> Washoe County Human Services, RAAH, ACTIONN
		Document steps needed to pursue Medicaid state plan revisions for cost savings to fund housing for SMI	Document that outlines steps needed to implement funding models identified (ie, State Medicaid Administrator approval/letter of support, legislative action needed, etc)	July 15, 2018	
		Determine if non-federal match funds are required for funding options identified and if so, initiate communication to determine if state or local funding could be utilized to meet matching requirement	Meetings conducted to explore possible sources of matching funds A memorandum of understanding to provide match funds needed	August 15, 2018	
	Strategy 2	**Tactic**	**Performance Indicator**	**Target Date**	**Owner**
	Support alternative funding models identified	Coordinate advocacy efforts needed to support funding models identified	Central point of contact identified for disseminating information	August 2018-June 2020	

	Strategy 3	Tactic	Performance Indicator	Target Date	Owner
	Work with State Medicaid agency to revise state plan to include expansion of 1915(i) subpopulations to include homeless people who are severely mentally ill.	Document steps needed to revise state plan to expand 1915(i) subpopulations.	Document that outlines steps needed to revise state plan.	June 1, 2018	Owner: Nevada Interagency Council on Homelessness
		Identify steps for implementation of revised state plan.	Action plan for implementation activities.	July 31, 2018	Owner: Nevada Interagency Council on Homelessness

Objective 2	Strategy 2	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 identify best practices for incorporating community case management for those receiving rental assistance.	Document experiences and results from Washoe County's Community Case Managers.	Work with Shelia Leslie and Community Case Managers to document experiences and results to date.	Completion of report on Washoe County Community Case Management experiences and results.	July 30, 2018	Owner: Washoe County Human Services Supporter: UNR MPH Intern
	Compile and share best practices examples from other communities.	Conduct internet research.	Creation of a report presenting options used successfully in other communities.	August 1, 2018	Owner: Anne Cory Supporter: UNR MPH Intern

		Develop a timeline for implementation of best practices identified for incorporating collaborative case management for those receiving rental assistance.	Completed document reflecting a timeline and implementation steps for best practices identified, may be combined with report on experiences and best practices identified.	August 15, 2018	Owner: UNR MPH Intern

Objective 2	Strategy 3	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 identify best practices for incorporating collaborative case management for those receiving rental assistance.	Create diversion case managers at the Community Assistance Center (CAC). Working directly with the individuals and families at the CAC that are NOT in the shelters and are on the waiting list. Provide supportive services and crisis management prior to entering the shelter.	Identify a case manager who can be solely dedicated to working with families on the waiting list for the family shelter to identify housing opportunities to prevent them from needing to be housed at the family shelter.	Document reflecting roles and responsibilities existing case managers at the CAC. No families on the wait list at the CAC.	Sept 1, 2018	Owner: Washoe County Human Services Division, Housing Specialist Supporter: City of Reno, Volunteers of America

Community Health Improvement Plan

Behavioral Health Action Plan

Focus Area: Behavioral Health

Goal 2: Assess and address current status and need for Behavioral Health services in Washoe County

Objective (SMART Format):

1. By October 1, 2018 develop a strategy to collect and disseminate information related to the annual statistics on Behavioral Health providers in Washoe County.
2. By December 31, 2018 identify gaps in service and access for those needing behavioral health services in Washoe County.
3. By September 1, 2018 develop strategies and advocate for policies to address gaps and needs identified.

Outcome Indicator (From CHNA):

Indicator	Trend	Most Recent Year	Outcome Indicator Change Desired
Percent of population living in HRSA primary care provider shortage area	Increasing	35.4% (2016)	Decrease
Percent of population living in HRSA mental health provider shortage area	STABLE	100.0% (2016)	Decrease
Ratio of providers to population (mental care)	~	390:1 (Mental Health-2014)	Increase

Robert Wood Johnson County Health Ranking Indicator Impacted: Premature death, poor mental health days, mental health providers

Objective 1	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By October 1, 2018 develop a strategy to collect and disseminate information related to the annual statistics on Behavioral Health providers in Washoe County.	Collect and disseminate information related to the annual statistics on the number of Psychiatrist in Washoe County, FTEs, sliding fee scale utilization and Medicaid acceptance in Washoe County.	Collect existing information from NV DHHS Primary Care Office	Needed information is collected	August 1, 2018	Owner: Washoe County Health District, Nevada DHHS Primary Care Office, NV Primary Care Association
		Determine optimal format of information sharing, ie, one page handout,	Informational materials are developed	Sept 1, 2018	
		Distribute information amongst state and local elected officials, board, etc	Information distributed to appropriate contacts	October 1, 2018	

Objective 2	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By December 31st, 2018 identify gaps in service and access for those needing behavioral health services in Washoe County.	Publish report outlining gaps in service and access for those needing behavioral health in Washoe County	Collect needed information and oversee UNR MPH intern in the development of the report.	Needed data collected and evaluated	August 15, 2018	Owner: Shelia Leslie, Washoe County Regional Health Board Supporter: WCHD MPH Intern
		Complete draft of report and distribute to Regional Behavioral Health Board for review and feedback.	Report completed	December 31, 2018	Owner: Shelia Leslie, Washoe County Regional Health Board Supporter: WCHD MPH Intern

Objective 3	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 develop strategies and advocate for policies to address gaps and needs identified.	Explore opportunities to increase efficiency of Behavioral Health Licensure boards in order to expedite licensure	Identify means of modernization of licensure boards and resources needed for modernization	Document reflecting opportunities for modernization corresponding resources needed	Sept 1st, 2018	Owner: NV Primary Care Association, Washoe County Health District
		Identify potential opportunities to revise policies that would allow for expedited licensure	Document outlining policies and potential revisions		

Community Health Improvement Plan

Behavioral Health Action Plan

Focus Area: Behavioral Health

Goal 3: Reduce depression and suicidal behaviors in adolescents

Objective (SMART Format):

1. By September 1, 2018 increase mental health screening of 7th grade students in Washoe County using a standardized screening tool and provide appropriate referral to care.

Outcome Indicator (From CHNA):

Indicator	Trend	Most Recent Year	Outcome Indicator Change Desired
Adolescents that felt sad or hopeless	~	33.5% (2015)	Decrease
Adolescents that seriously considered suicide	~	18.8% (2015)	Decrease
Number of intentional self-harm deaths (age 15-24)	~	5 (2015)	Decrease

Robert Wood Johnson County Health Ranking Indicator Impacted: Premature death, injury deaths

Objective 1	Strategy 1	Tactic	Performance Indicator	Target Date	Owner
By September 1, 2018 increase mental health screening of 7th grade students in Washoe County using a standardized screening tool and provide appropriate referral to care.	Implement Signs of Suicide education and screening program for all 7th grade students in Washoe County	Approval of District administrative regulation for implementation of Signs of Suicide education and screening for all 7th grade students	Approved Administrative regulation	Sept 1, 2019	Owners: Washoe County School District, Children's Cabinet
		Identify stable funding sources for Signs of Suicide education and screening program	Funding sources secured for 3 years of programming	Sept 1, 2018	
		Identify strategies to build support for consent for screening	Document reflecting strategies that could be employed to build support for consent for screening	March 1, 2019	
	Strategy 2	**Tactic**	**Performance Indicator**	**Target Date**	**Owner**
	Identify a means for the school district to provide space and allow outside behavioral health providers on school site to provide care to students.	Meet with Washoe County School District administration to determine what the barriers are to facilitating space sharing Work with stakeholders to identify ways to overcome barriers	Pilot behavioral health provider workspace at 2 elementary, middle and high schools in the district	March 1, 2019	Owners: Washoe County School District Supporter: Communities in Schools, Northern Nevada HOPES, Children's Cabinet

Focus Area 3—Nutrition and Physical Activity

Obesity is a chronic problem of individual and public health affecting a large number of people all over the nation. According to the 2018-2020 Washoe County Community Health Needs Assessment, the percentage of adults, seventh graders, and tenth graders in Washoe County classified as overweight or obese is steadily increasing. Overweight and obesity is a health condition that occurs when a person's Body Mass Index (BMI) is over 25.0. A BMI above 25.0 is a concern because it is strongly correlated with adverse health outcomes and reduced quality of life.[10] Overweight and obesity in children are among the most important risks to children's long and short-term health. Children and adolescents who are overweight have a greater risk of developing Type 2 diabetes and asthma and they are more likely to have increased blood pressure and high cholesterol levels. In addition, the majority of children and adolescents who are overweight are likely to remain overweight throughout adulthood.[11]

There is strong scientific evidence that supports the benefits of eating a healthful diet, participating in regular physical activity and maintaining a healthy body weight to decrease a person's risk of developing serious health conditions. The U.S. Department of Health and Human Services has physical activity guidelines for children, adolescents, adults, and older adults that recommend the quantity and type of physical activity ideal for each population subgroup.[12] Similar to physical activity, dietary guidelines have been established. Though we know that these behaviors combined can lead to positive health outcomes, a large segment of Washoe County residents struggle to achieve recommended daily amount of physical activity and consume recommended amounts of fruits and vegetables. Adults and children are regularly faced with unhealthy food and beverage options in their daily lives.

Residents and service agencies within Washoe County identified increasing physical activity and optimal nutrition for all as a key priority because of the current state of these concerns in our community. The 5210 Framework will guide the Physical Activity and Nutrition Committee's work to combat chronic conditions and improve health behaviors related to physical activity and nutrition for youth and adults. The educational campaign adapted from Maine's LetsGo! 5210 program aims to help kids and families recognize healthy choices.

[10] Center for Disease Control and Prevention. Healthy Weight. Accessed https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html
[11] Center for Disease Control and Prevention. Childhood Obesity Causes & Consequences. Accessed https://www.cdc.gov/obesity/childhood/causes.html
[12] U.S. Department of Health and Human Services and U.S. Department of Agriculture. 2015–2020 Dietary Guidelines for Americans. Accessed http://health.gov/dietaryguidelines/2015/

By promoting physical activity and nutrition across sectors, partners will increase awareness of their role in fostering positive health outcomes and increase their active participation in this role. Health and wellness (behaviors) are shaped by the places where community members live, work, learn and play. The community environment, including homes, schools, worksites, parks, and streets can be transformed to make healthy choices easy and accessible for all.

The importance of a consistent message about healthy habits will increase our community's knowledge on how to make healthier decisions. Policy and environmental changes implemented in locations such as worksites, health care providers and locations frequented by youth can likely influence desired behavior change related to nutrition and physical activity. The PA/N CHIP Committee will also advocate for organizational changes in regards to the types of food offered to our residents whether it be in a school vending machine, a park's concession stand, or during workplace events.

Community Health Improvement Plan

Physical Activity and Nutrition Action Plan

Focus Area: Physical Activity and Nutrition

Goal 1: To increase physical activity and improve nutrition among adults and youth using the 5210 Let's Go framework.

Objective (SMART Format):

1. By July 2019, increase the number of community organizations implementing aspects of the 5210 program from 1 to 11.
2. By July 2019, improve the nutrition environment in the community by improving the nutritional offerings in vending machines and concession stands in schools, workplaces, and community settings.
3. By July 2019, improve access and availability of nutrition and physical activity opportunities by implementing three Family Health Festivals in zip codes with high Community Needs Index (CNI) scores.
4. By July 2019, improve the nutrition environment in targeted parks by increasing the number of environmental cues related to healthy food and beverage consumption by at least 3.

Outcome Indicator (From CHNA):

Indicator	Most Recent Year	Outcome Indicator Change Desired
Physical Activity among adolescents	27.0% (2015) 7+ days/week	Increase
Adults that met aerobic and strength guidelines	28.5% met both (2015)	Increase
Adults that met aerobic guidelines	32.5% (2015)	Increase
Adults that met strength guidelines	7.9% (2015)	Increase
Fruit consumption among adolescents	32.2% 2+ times/day (2015)	Increase
Vegetable consumption among adolescents	27.2% 2+ times/day (2015)	Increase
Fruit consumption among adults	80.8% 1+ servings/day (2015)	Increase
Vegetable consumption among adults	80.8% 1+ servings/day (2015)	Increase

Robert Wood Johnson County Health Ranking Indicator Impacted:
Percent of adults that report a BMI ≥ 30, Percent of adults aged 20 and over reporting no leisure-time

Objective 1	Strategy	Tactic	Performance Indicator	Target Date	Owner
By July 2019, increase the number of community organizations implementing aspects of the 5210 program from 1 to 11.	1. Develop 5210 Let's Go! infrastructure to support program implementation	Organize a 5210 Let's Go! Advisory Board	Advisory Board established	August 31, 2018	Owner: Community Health Alliance Supporter: PA/N CHIP Committee
		Determine branding of local 5210 efforts	Local brand approved by advisory board	September 30, 2018	Owner: Community Health Alliance (CHA) Supporters: WCHD, Advisory Board
		Identify a minimum of three ways to market and educate the public on the 5210 program efforts	# of marketing strategies identified	October 31, 2018	
		Identify and develop appropriate and consistent evaluation measures for use by organizations that implement 5210	Evaluation measures/ toolkit developed	September 30, 2018	
	2. Educate community organizations and health care providers about Let's Go 5210 program and how to implement it.	Coordinate with Let's Go 5210 staff in Maine to plan a learning opportunity	# of learning opportunities planned	September 30, 2018	Owner: Community Health Alliance (CHA) Supporter: WCHD, Advisory Board
		Offer at least one Let's Go 5210 learning opportunity for the community to increase knowledge and understanding of the Let's Go 5210 program	# of 5210 learning opportunities offered # of organizations/health care practices educated	December 31, 2018	
	3. Build a financial support system for 5210 efforts by securing at least two financial supporters in year one.	Identify funding sources to support 5210 program efforts	Two funding sources identified	June 30, 2019	Owner: Community Health Alliance (CHA) Supporter: WCHD, Advisory Board

Objective	Strategy	Tactic	Performance Indicator	Target Date	Owner
By July 2019, increase the number of community organizations implementing aspects of the 5210 program from 1 to 11.	Increase the number of businesses, community organizations, and health care providers that are implementing the 5210 program in Reno/Sparks.	Recruit a minimum of 5 youth organizations to implement 5210! program	# of organizations implementing 5210 # of youth impacted by 5210	June 30, 2019	Owners: Community Health Alliance (CHA) Supporters: WCHD, Advisory Board
		Recruit 1 health care provider to implement 5210 program	# of health care providers implementing 5210 # of families impacted by 5210	June 30, 2019	Owners: Community Health Alliance (CHA) Supporters: WCHD, Advisory Board
		Coordinate with Reno/Sparks Chamber of Commerce (Chamber) to reach 100% of their member organizations (~1500) with information about Let's Go 5210	# of organizations reached	September 30, 2018	Owners: Community Health Alliance (CHA) Supporters: Reno/Sparks Chamber of Commerce, WCHD, Advisory Board
		Recruit a minimum of 5 organizations from the Chamber to participate in the implementation of Let's Go 5210 with their employees.	# of organizations implementing 5210 # of employees impacted by 5210	June 30, 2019	
		Educate and provide technical assistance (TA) to organizations about 5210 and how to implement	# of organizations reached with education and TA about 5210 components	Through June 2019	

Objective 2	Strategy 2	Tactic	Performance Indicator	Target Date	Owner
By July 2019, improve the nutrition environment in the community by improving the nutritional offerings in vending machines and concession stands in schools, workplaces, and community settings.	Develop a toolkit for implementing healthy vending and concessions in Washoe County.	Work with the Business Enterprises of Nevada (BEN) Program to implement healthy vending per the BEN Nutrition Standards Policy	# of BEN locations successfully implementing the Nutrition Standards Policy	March 31, 2019	Owner: WCHD Supporter: Renown Health
		Communicate with vendors and identify those in the community that have the capacity and willingness to work with businesses on healthy vending	List of vendors available for healthy vending and concessions	March 31, 2019	
		Work with businesses to provide healthy food options at concessions located in Washoe County	List of healthy concession sites		Owner: Renown Health Supporter: WCHD
		Compile key information on process of healthy vending and concession implementation into a comprehensive toolkit	# of toolkits and informational documents developed	April 30, 2019	Owners: WCHD and Renown Health
	Identify strategies to increase healthy vending and concessions in Washoe County.	Form a healthy vending and concessions committee to lead implementation of healthy vending and concessions initiative	Healthy vending and concessions committee formed	May 30, 2019	Owners: Renown Health and WCHD Supporter: Reno/Sparks Chamber of Commerce
		Develop a plan to increase the number of healthy vending and concession locations in Washoe County and evaluate impacts	# of plans Evaluation assessment	June 30, 2019	Owners: Renown Health and WCHD Supporters: Reno/Sparks Chamber of Commerce, Healthy Vending committee

Objective 3	Strategy	Tactic	Performance Indicator	Target Date	Owner
By July 2019, improve access and availability of nutrition and physical activity opportunities by implementing three Family Health Festivals in zip codes with high Community Needs Index (CNI) scores.	Implement three Family Health Festivals (FHFs) located in zip codes with high Community Needs Index (CNI) scores.	Secure/apply for monies to support FHF efforts	Funds secured	By September 28, 2018	Owner: FHF sub-committee Supporters: FBNN, WCHD, Renown Health, Community Health Alliance, High Sierra AHEC
		Coordinate three FHFs/year with at least 100 attendees at each event	# of FHFs # of attendees participating	By June 30, 2019	Owner: FHF sub-committee Supporters: WCHD, FBNN, Renown Health

Objective 4	Strategy	Tactic	Performance Indicator	Target Date	Owner
By July 2019, improve the nutrition environment in targeted parks by increasing the number of environmental cues related to healthy food and beverage consumption by at least 3.	Increase knowledge of healthy behaviors among populations at greatest risk.	2.1 Complete a series of pre/post assessments to measure one's knowledge and skills to engage in physical activity	# of assessments completed	By June 30, 2019	Owners: FHF sub-committee Supporters: FBNN, WCHD, Renown Health * WCHD can lead efforts, but will need help with assessments from 2-4 additional agencies
		Complete a series of pre/post assessments to measure one's knowledge and skills to prepare nutritious foods.	# of assessments completed	By June 30, 2019	

Appendices

The following appendices are included within the CHIP:

Appendix One: Acronyms

Appendix Two: Community Assets and Resources

Appendix One: Acronyms

ACA	Affordable Care Act
ADA	Americans with Disabilities Act
BRFSS	Behavior Risk Factor Surveillance System
CDC	Centers for Disease Control
CHA	Community Health Alliance
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHP	Community Health Program
CSA	Community Services Agency
ED	Emergency Department
FBNN	Food Bank of Northern Nevada
NN HOPES	Northern Nevada HOPES
SMI	Serious Mental Illness
SNAP	Supplemental Nutrition Assistance Program
SOS	Signs of Suicide
UNR	University of Nevada Reno
WCHD	Washoe County Health District
WCSD	Washoe County School District
YRBS	Youth Risk Behavior Survey

Appendix Two: Community Assets and Resources

The following community assets and resources were taken from the Community Health Needs Assessment for the focus areas identified in the CHIP.

Organization	Community Health Improvement Plan Focus Area: Housing
Reno Housing Authority	Affordable Housing
ActioNN	Housing Support Services
Children in Transition (WCSD)	Housing Support Services
Committee to Aid Abused Women (CAAW)	Housing Support Services
Community Assistance Center	Housing Support Services
Footprints Counseling Service	Housing Support Services
Healthcare for Homeless Veterans	Housing Support Services
Inter-Tribal Council of Nevada (ITCN)	Housing Support Services
Northern Nevada HOPES	Housing Support Services
Reno-Sparks Indian Colony Housing Department	Housing Support Services
Sierra Regional Center	Housing Support Services
St. Vincent's Resource Network (CCNN)	Housing Support Services
Veterans Center	Housing Support Services
Washoe Legal Services	Housing Support Services
Project ReStart, Inc.	Housing Support Services/ Supportive Housing

Community Services Agency	Housing Support Services/Affordable Housing
Reno-Sparks Indian Colony Housing Department	Housing Support Services/Affordable Housing
Northern Nevada Community Housing Resource Board	Housing Support Services/Affordable Housing/Supportive Housing
Crossroads (CCNN & WCSS)	Supportive Housing
The Park House (CCNN & WCSS)	Supportive Housing
WCSS	Supportive Housing
A Safe Embrace	Transitional Housing
Casa de Vida	Transitional Housing
Nevada Youth Empowerment Project	Transitional Housing
North Star Treatment & Recovery Center	Transitional Housing
Quest House	Transitional Housing

Organization	Community Health Improvement Plan Focus Area: Behavioral Health
Children's Cabinet	Behavioral Health
Victims of Crime Treatment Center	Behavioral Health
ACCEPT	Behavioral Health
Behavioral Health at Renown	Behavioral Health
Big Brothers Big Sisters	Behavioral Health
Bristlecone Family Resources	Behavioral Health
Bristlecone Family Resources	Behavioral Health
Community Health Alliance	Behavioral Health
Family Resource Centers	Behavioral Health

Human Behavior Institute	Behavioral Health
Nevada Division of Public & Behavioral Health, OPHIE	Behavioral Health
Northern Nevada HOPES	Behavioral Health
Project ReStart, Inc.	Behavioral Health
Quest Counseling	Behavioral Health
Safe Embrace	Behavioral Health
Sequel Alliance Family Serives	Behavioral Health

Organization	Community Health Improvement Plan Focus Area: Physical Activity and Nutrition
ACCEPT	General Health and Wellness
Access to Healthcare Network (AHN)	General Health and Wellness
Casa de Vida	General Health and Wellness
Crisis Pregnancy Center	General Health and Wellness
Family Counseling Service	General Health and Wellness
Girls on the Run-Sierras	General Health and Wellness
Immunize Nevada	General Health and Wellness
Nevada Urban Indians, Inc.	General Health and Wellness
Northern Nevada HOPES	General Health and Wellness
Northern Nevada Outreach Team	General Health and Wellness
Regional Emergency Medical Services Authority	General Health and Wellness
Reno + Sparks Chamber of Commerce	General Health and Wellness
Reno-Sparks Indian Tribal Health Center	General Health and Wellness

Sanford Center Geriatric Clinic	General Health and Wellness
St. Mary's Low Cost Clinic	General Health and Wellness
Teen Health Mall (WCHD)	General Health and Wellness
The Healthcare Center	General Health and Wellness
Washoe County School District Safe and Healthy Schools Commission	General Health and Wellness
Catholic Charities of Northern Nevada	Nutrition
Food Bank of Northern Nevada	Nutrition
Urban Roots	Nutrition
Washoe County Human Services	Nutrition
Education Alliance	Physical Activity
Boys and Girls Club	Physical Activity
High Sierra AHEC	Physical Activity
Regional Transportation Commission	Physical Activity
Children's Cabinet	Physical Activity and Nutrition
Community Health Alliance	Physical Activity and Nutrition
Nevada Department of Health and Human Services	Physical Activity and Nutrition
Renown Health	Physical Activity and Nutrition
Washoe County Health District- CCHS	Physical Activity and Nutrition
Washoe County School District- Wellness Advisory Committee	Physical Activity and Nutrition

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

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AIR QUALITY MANAGEMENT
DIVISION DIRECTOR STAFF REPORT
BOARD MEETING DATE: June 28, 2018

DATE: June 8, 2018

TO: District Board of Health

FROM: Charlene Albee, Director
775-784-7211, calbee@washoecounty.us

SUBJECT: Program Update, Divisional Update, Program Reports

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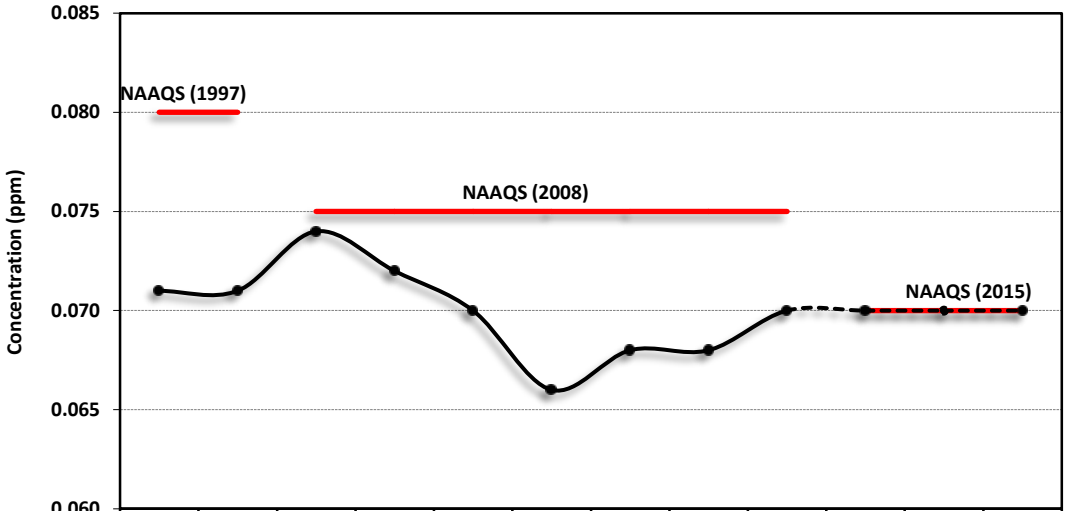
1. Program Update

a. Air Quality Trends Report (2008 - 2017) Illustrates the Significance of Ozone Advance Initiatives

The Air Quality Trends Report (2008 - 2017) summarizes the monitoring data collected in 2017 and provides the 10-year trend for each pollutant. The following graph provides a summary of the past 12-year trend of ozone design values for Washoe County:



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015*	2016*	2017*
NAAQS	0.08	0.08	0.075	0.075	0.075	0.075	0.075	0.075	0.075	0.070	0.070	0.070
Design Value	0.071	0.071	0.074	0.072	0.070	0.066	0.068	0.068	0.070	0.070	0.070	0.070

Note: 2015* - 2017* indicates years with exceptional events demonstrations affecting the 3-year average design values.

The graph clearly identifies a reduction in ozone during the economic recession the region suffered between 2008 and 2011. The recession also slowed pollution generating activities such as construction, manufacturing, and vehicle miles traveled. Starting in 2012, the region began to experience a cautiously optimistic economic recovery. By 2017, the rate of economic recovery is approaching record setting levels with comparisons to the growth experience in the early 1980's. Existing businesses are thriving with expansions and new businesses are moving to the area every month.

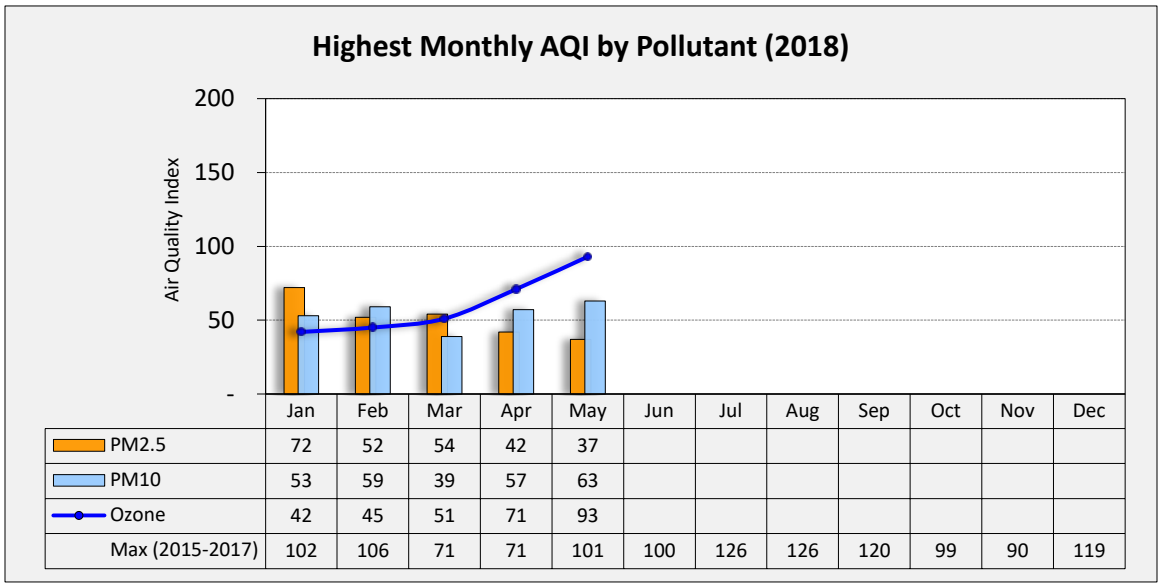
Since 2014, the ozone design values for Washoe County have reached the 2015 Ozone National Ambient Air Quality Standard (NAAQS) which translates into our area barely qualifying for an attainment designation. With economic forecasts estimating up to 189,000 people moving to the area in the near future, the challenge to continue to meet the ozone NAAQS is clearly the greatest challenge for the AQMD.

Knowing the scenario we are facing, AQMD staff continues to communicate the significance of implementing the Ozone Advance Program initiatives whenever possible. These voluntary control strategies and initiatives are only effective in reducing indirect sources of emissions if they are actually implemented. In order to achieve emission reductions, staff will continue to provide comments on development projects, both commercial and residential. Community development investments in strategies such as ENERGY STAR buildings to reduce fuel consumption; providing safe routes to school and work to reduce vehicle miles traveled; and reducing heat island effects are short term solutions with long term results. The value of financial commitments made today will be returned to the citizens for generations to come by protecting the personal and economic health of the community.

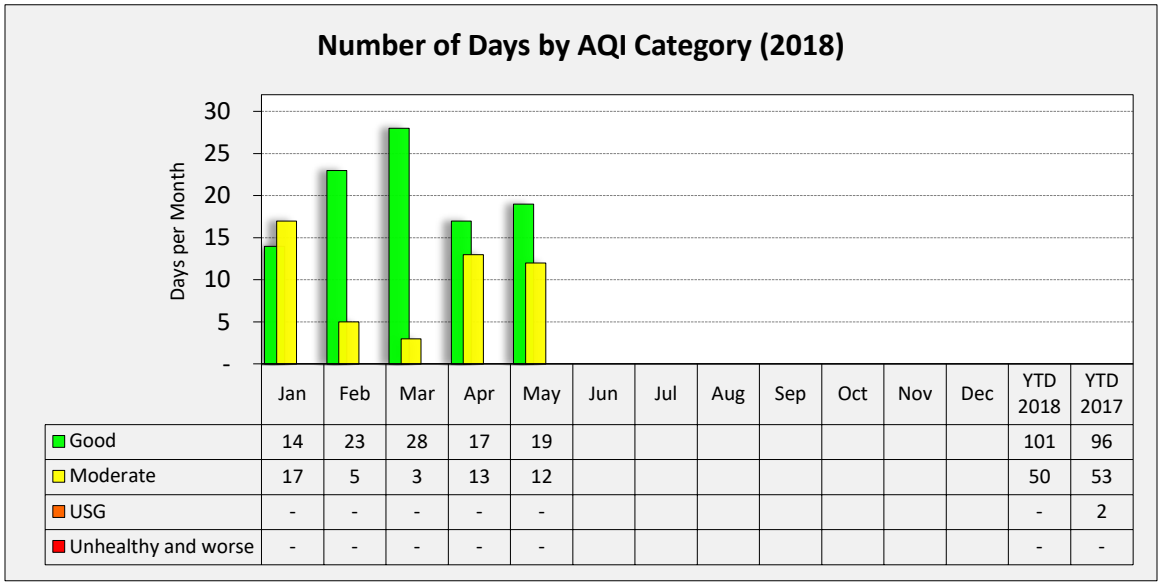
Charlene Albee, Director
Air Quality Management Division

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.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
PM2.5	72	52	54	42	37							
PM10	53	59	39	57	63							
Ozone	42	45	51	71	93							
Max (2015-2017)	102	106	71	71	101	100	126	126	120	99	90	119



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD 2018	YTD 2017
Good	14	23	28	17	19								101	96
Moderate	17	5	3	13	12								50	53
USG	-	-	-	-	-								-	2
Unhealthy and worse	-	-	-	-	-								-	-

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, visit OurCleanAir.com.

3. Program Reports

a. Monitoring and Planning

May Air Quality: There were no exceedances of any National Ambient Air Quality Standard (NAAQS) during the month of May.

Spanish Springs Monitoring Station: The newest monitoring station in the network is located at Lazy 5 Park in Spanish Springs. It has been collecting ozone and particulate matter data since January 1, 2017. In May 2018, installation of a telescoping 10-meter meteorological tower was completed. The delay was primarily due to the additional engineering necessary to ensure the tower met wind loading code requirements. Collection of wind speed, wind direction, and ambient temperature data will begin in Summer 2018. Data from the AQM monitoring network are updated hourly and available at AirNow. EPA provided one-time funding through the Section 103 grant program to construct this monitoring station.


Spanish Springs Air Monitoring Station
Lazy 5 Regional Park

Annual Network Plan: The DRAFT "2017 Ambient Air Monitoring Network Plan" is available for public inspection at OurCleanAir.com. The Network Plan summarizes monitoring network operations for 2017 and includes proposed modifications for 2018-2019. This plan is a federal requirement and will be submitted to EPA by July 1, 2018.

RTC Transportation Alternatives (TA) Set-Aside Projects for FFY 19 and 20: The RTC anticipates receiving approximately $390,000 for each federal fiscal year to provide funding for projects that improve non-motorized mobility. The RTC Technical Advisory Committee, which AQM is a member of, recommended several projects for each FFY for approval by the RTC Board. These projects include: 1) Improvement of a regional trail in the Kiley Ranch area of Sparks, 2) support of the Reno Bike Project's Major Taylor program, 3) sidewalk improvements near Hunter Lake Elementary School in Reno, 4) support of the regional bikeshare program, and 5) support of WCSD's Safe Routes to School program. These programs improve air quality by providing additional active transportation options. The RTC Board approved funding of these TA Set-Aside projects at their May 21, 2018 meeting.

Daniel K. Inouye
Chief, Monitoring and Planning

b. Permitting and Enforcement

Staff reviewed forty (40) sets of plans submitted to the Reno, Sparks or Washoe County Building Departments to assure the activities complied with Air Quality requirements.

- Enforcement staff has been working with the local planning divisions, the organizers of Charreadas (Traditional Mexican Rodeos), and those of local horse racing events in an effort to address dust issues generated by these events prior to it becoming a problem. Every year several organizers will stage a couple dozen of these type events throughout the summer. Each event may have an attendance of 200 to 400 people which could equate to 100 to 200 vehicles at each event. Without careful attention to dust control at these events, there is a high potential for all of these activities to generate a lot of blowing dust which can impact local air quality.

Staff conducted thirty five (35) stationary source inspections, nineteen (19) gasoline stations and six (6) initial compliance inspections in May 2018. Staff was also assigned fourteen (14) new asbestos related projects and ten (10) new demolition projects to oversee. There were also nineteen (19) new construction/dust projects to monitor; additionally fifty nine (59) construction site inspections were documented. Each asbestos, demolition and construction notification project is monitored regularly until each project is complete and the permit is closed. During the month enforcement staff also responded to fourteen (14) complaints.

Type of Permit	2018		2017	
	May	YTD	May	Annual Total
Renewal of Existing Air Permits	129	493	132	1055
New Authorities to Construct	4	26	10	60
Dust Control Permits	17 (143 acres)	83 (1294 acres)	15 (70 acres)	173 (2653 acres)
Wood Stove (WS) Certificates	45	174	73	474
WS Dealers Affidavit of Sale	0 (0 replacements)	44 (29 replacements)	0 (0 replacements)	54 (40 replacements)
WS Notice of Exemptions	801 (15 stoves removed)	3433 (46 stoves removed)	1048 (12 stoves removed)	9722 (88 stoves removed)
Asbestos Assessments	111	490	43	1029
Asbestos Demo and Removal (NESHAP)	25	118	30	241

COMPLAINTS	2018		2017	
	May	YTD	May	Annual Total
Asbestos	0	4	1	13
Burning	0	1	0	10
Construction Dust	5	18	6	42
Dust Control Permit	0	0	1	2
General Dust	2	16	11	54
Diesel Idling	1	6	0	0
Odor	2	15	0	15
Spray Painting	3	4	3	11
Permit to Operate	1	4	0	3
Woodstove	0	3	0	7
TOTAL	**14**	**71**	**22**	**157**
NOV's	**May**	**YTD**	**May**	**Annual Total**
Warnings	6	10	1	10
Citations	1	1	1	7
TOTAL	**7**	**11**	**2**	**17**

*Discrepancies in totals between monthly reports can occur due to data entry delays.

Mike Wolf
Chief, Permitting and Enforcement

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 14B

DD__SK_
DHO____KD_

Community and Clinical Health Services
Director Staff Report
Board Meeting Date: June 28, 2018

DATE: June 15, 2018

TO: District Board of Health

FROM: Steve Kutz, RN, MPH
775-328-6159; skutz@washoecounty.us

SUBJECT: Divisional Update – New Third Party Payer; Data & Metrics; Program Reports

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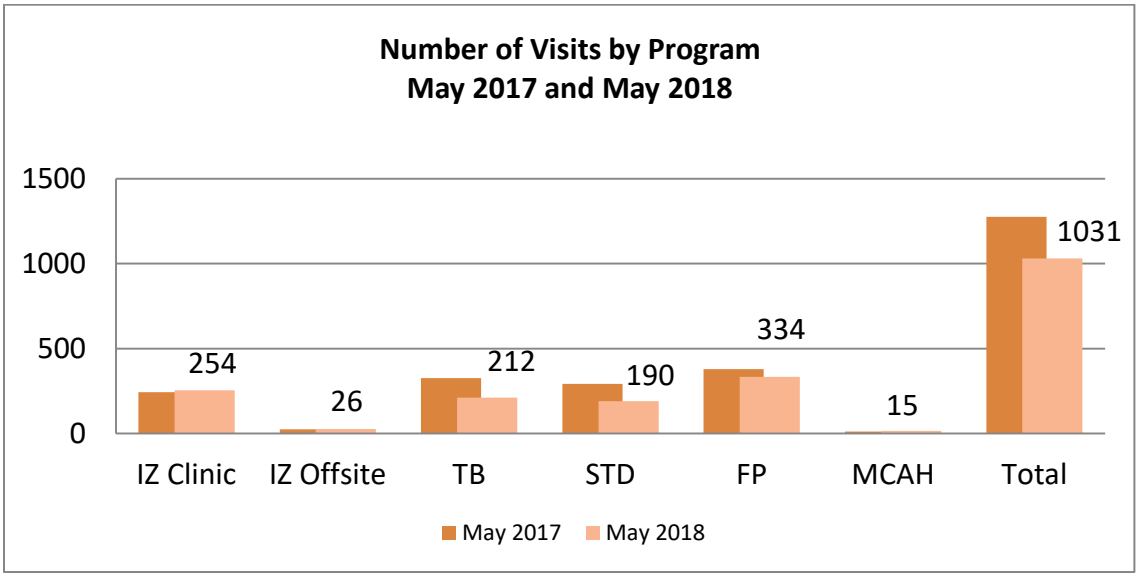
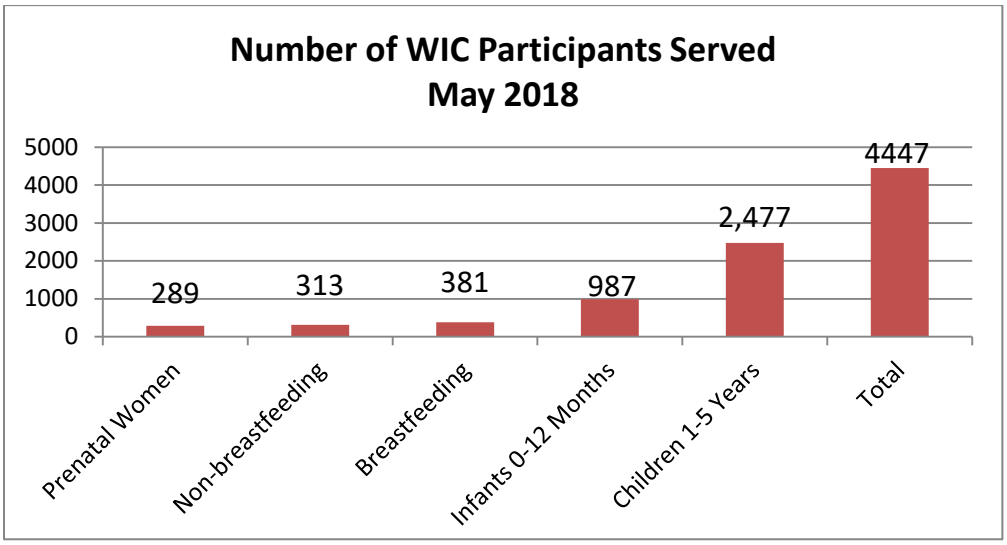
1. Divisional Update

a. **New Third Party Payer –** our agreement with Prominence Health Plan has finally been approved by Prominence. This agreement also includes their HealthFirst HMO, and Universal Health Network, a PPO. CCHS now has eight third party payer agreements. We are still awaiting final contracts from United Health Care and SilverSummit.

b. **Data/Metrics**





Changes in data can be attributed to a number of factors – fluctuations in community demand, changes in staffing and changes in scope of work/grant deliverables, all which may affect the availability of services.

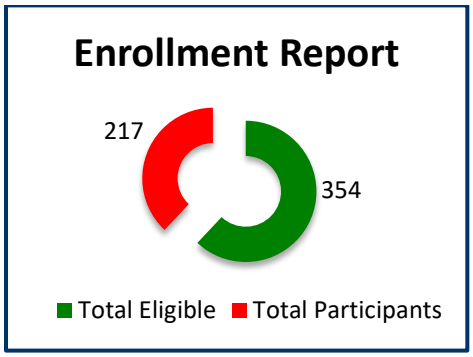
2. Program Reports – Outcomes and Activities

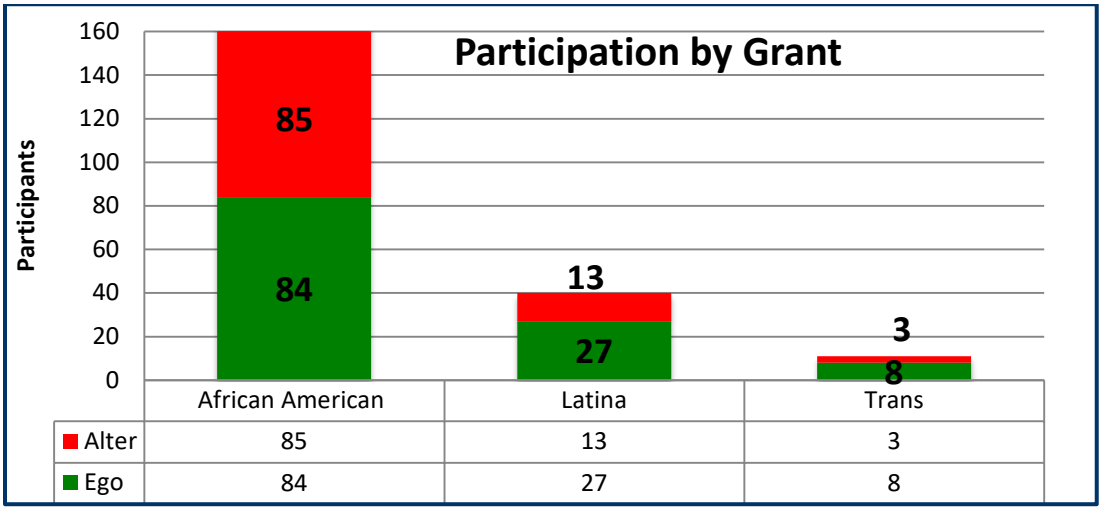
a. **Sexual Health** – Cory Sobrio, PHN, Disease Intervention Specialist, is leaving the Sexual Health Program July 9, 2018, and joining the Tuberculosis Program. Staff wishes him good luck in his new assignment. Staff welcomes Nathan Militante who joined the Sexual Health Program June 11, 2018, as an intermittent hourly Health Educator. assigned to HIV's Ryan White Part B program.

Kelly Verling, PHN, Disease Intervention Specialist, attended Sexually Transmitted Disease training at the San Francisco City Clinic on June 1, 2018.

The Sexual Health Program received a Certificate of Appreciation for support of phase one of the Connect the DOTs social network study conducted by Karla Wagner, PhD in UNR's School of Community Health Sciences. This study, funded by the National Institutes of Health aims to learn about how social networks, social norms, and cultural beliefs affect health, specifically related to barriers to HIV testing and health services. African American, Latina and transgender women were recruited, along with their social networks to participate in interviews around how health information is shared within their social networks. Enrollment goals were surpassed. HIV testing was offered to participants throughout recruitment and interviews. WCHD contributed to the study by participating on the community advisory panel, offering technical assistance, and providing data to inform recruitment efforts.

Focus groups and additional interviews with the participants comprise the next phase of the study. Information from the study will inform programs and interventions on better reaching females of color and transgender women when delivering health education and program services.





*Egos are the primary participant. Alters are social network participants referred by the primary participants.

b. **Immunizations** – Staff administered 43 doses of vaccine to 12 children at the Health Plan of Nevada Summer Kickoff Event at Little Flower Church on Saturday, June 2, 2018 in partnership with Immunize Nevada. Planning is underway for additional Summer Back to School offsite immunization clinics this summer.

c. **Tuberculosis Prevention and Control Program** – TB program is bidding a fond farewell to Diane Freedman as she retires after just shy of 13 years as TB program Coordinator. The program also welcomes Cory Sobrio, who will step into the coordinator position July 9, 2018. Diane has been working to orient Cory to the TB program since May.

For 2018, there have been four people diagnosed with active TB and who are currently receiving treatment. Three have Extra-pulmonary TB: pleura, lymph node and spine. One has Pulmonary TB. Staff are also busy evaluating and treating multiple new clients for Latent TB Infection

(LTBI). These include several newly arrived immigrants and community referrals for treatment of LTBI in persons with an increased risk of progression to TB disease. Additionally, the clinic has received 28 reports of non-tuberculosis mycobacterium (NTM) in the community, many of which start out being suspect MTB cases, requiring monitoring while waiting for final culture results. As mentioned in the April report, nationally NTM infection is steadily rising at a rate of 6-8%/100,000 each year.

d. **Family Planning/Teen Health Mall** – Staff welcomes Miriam Cervantes, Intermittent Hourly Health Educator. Miriam will focus on Information and Education (I and E), a Title X requirement. She will also concentrate on outreach activities. On June 22, 2018, staff will say farewell to Ruth Soto-Castillo, Community Health Aide, and Christina Sheppard, Advanced Practice Registered Nurse. Sheila Juskiw, Advanced Practice Registered Nurse, will transition to the Family Planning Program from the Sexual Health Program. Sheila attended Long Acting Reversible Contraceptive (LARC) training on June 1, 2018, at the National Clinical Training Center in San Francisco.

   Staff continue to work with the Washoe County Sheriff's Office to implement a program for female inmates which provides reproductive health counseling, birth control methods, and referrals. Staff will film an educational segment to be shown to the females. The females will then have the opportunity to sign up for additional counseling and a birth control method. Family Planning Program staff will be onsite to provide these services one to two times per month, and services will start June 20, 2018.

e. **Chronic Disease Prevention Program (CDPP)** – Staff presented at an invite-only community meeting to begin conversations about smoke free workplaces in Nevada. The meeting was hosted by the American Heart Association and attendees included leadership from the WCHD, UNR's School of Community Health Sciences, Division of Public & Behavioral Health and representatives from Renown, American Cancer Society, Nevada Cancer Coalition, and local business, among others. A next step involves planning a follow up meeting to continue and expand the conversation.

   The tobacco media campaign that began running in April continues to run on TV, radio and social media and has ads in both English and Spanish. The report for April indicated that there were 2,757,128 total impressions from the various media platforms.

   Staff completed a Modified STARS (Standardized Tobacco Assessment for Retail Settings). The summary of key findings is attached at the end of this report.

   CDPP staff organized and participated in a "Jane's Walk" which is an international festival of walking conversations inspired by Jane Jacobs. The WCHD Jane's Walk was planned from Echo

Loder Elementary School to Yori Park in the 89502 area and the topic was staying healthy and how parks can help people stay healthy. Community Health Alliance partnered with the WCHD to offer blood pressure screening. Ten adults and 17 youth participated. Information was provided in both English and Spanish.

f. **Maternal, Child and Adolescent Health (MCAH)** – Staff participated in a webinar on the new National FIMR case reporting system that may be implemented in FY 2019. Staff also participated in the Pregnancy and Infant Loss Support Organization of the Sierras annual fundraising garage sale on June 2, 2018.

g. **Women, Infants and Children (WIC)** – Staff provided information and resources at the Veterans Baby Shower. It was hosted by the Women Veteran's Program as a resource for pregnant veterans. Staff also provided outreach and information at another Community baby shower at the Meadowood Mall.

The program will continue its lease at the 601 W. Moana. It is an ideal location in an area lacking other services. The WIC program has offered services in this neighborhood for over ten years.

Washoe County Health District
Chronic Disease Prevention Program

MODIFIED STARS

Summary Report of Key Findings

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Tobacco advertising, promotion and sponsorship foster positive attitudes towards tobacco use among youth, which effectively motivates youth to smoke.

- Campaign for Tobacco Free Kids

STANDARDIZED TOBACCO ASSESSMENT FOR RETAIL SETTINGS (STARS) MODIFIED

What is Modified STARS?

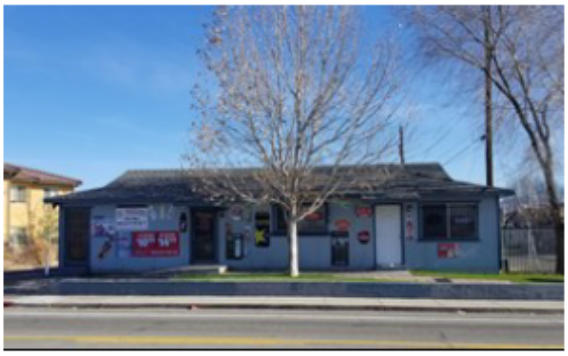
Modified STARS is a survey tool used to assess tobacco point of sale tactics at tobacco retail stores.

What point of sale tactics does the survey assess?

It assesses types of tobacco products sold, advertisements, store qualities (e.g. pharmacy, whether alcohol is sold), store type, product placement, prices, and price promotions.

What types of stores were surveyed?

Twenty-five (25) stores in the 89502 zip code were surveyed. Tobacco retail stores including: convenience stores (48%), gas stations (24%), pharmacies (4%), grocery stores (4%), mass merchandisers (4%), smoke shops, (8%) and vape shops (8%).



El Paisano Mini Market-Across from a local Boys and Girls Club

Who surveyed the stores?

College-aged youth surveyed the stores after being trained by Washoe County Health District (WCHD) program staff.

How many questions were on the modified STARS survey?

The survey consists of 22 questions.

Why was the STARS survey modified?

The WCHD and the Southern Nevada Health District (SNHD) collaborated on survey development. The changes were based on SNHD's prior experience (and barriers) with STARS. The goal was to make it more feasible for youth surveyors to complete.

KEY FINDINGS

- 64% of surveyed stores were located within walking distance (.25mi/3 blocks) from a school, park, or youth venue.
- The majority of surveyed stores sold flavored cigarettes (100%), vapor products (64%), chew/snuff/dip/snus (92%), and cigars/cigarillos (96%).
- Cigarettes, vapor products, chew/snuff/dip/snus were not placed within 12 inches of toys, candy, gum, slushy/soda machines, or ice cream. Cigarillos/cigars (16%) were sometimes placed near these items.

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

KEY FINDINGS (CONTINUED)

- Tobacco product ads were often placed within three feet of the floor (targeting children); Cigarettes (48%), vapor products (20%), chew/snuff/dip/snus (36%), cigarillos/cigars (4%).
- Cigarillos/cigars were available via a self-service display in the store (40%) more often than other tobacco products [Cigarettes (1%), vapor products (4%), chew/snuff, dip, snus (0%)].
- Price promotions for tobacco products were common at the stores; Cigarettes (68%), vapor products (44%), chew/snuff, dip, snus (60%), cigarillos/cigars (44%).
- Cigarillos/cigars were the only tobacco products assessed that were sometimes advertised for less than a dollar (12%).
- 44% of surveyed stores had a menu/display promoting e-liquids/juices that are sold.
- Tobacco and vapor products were generally not advertised more than other products, such as, snacks, alcohol, and drinks.
- 12% of the stores surveyed had at least 25% of the visible store front covered by ads/signs (not tobacco specific).
- All of the stores surveyed had signs/posters inside or outside of the store than warn customers of age requirements to purchase tobacco products.

For complete survey findings contact: GetHealthy@washoecounty.us

"For this project, it worked well to survey the stores without necessarily asking for permission. If the store clerk or manager saw us and was wondering what we were doing we were happy to provide an explanation. We did not have any issues accessing stores other than one store having limited parking."

-Lona Bogale, MPH

Recommendations
⇒ Allow time for training of youth and assist with trial surveys.
⇒ Remind youth surveyors that safety is a priority. Establish a regular check in system, and buddy system when appropriate.
⇒ Educate youth surveyors on key tobacco products and clarify definitions in advance, including flavored cigarettes (does not include menthol), and whether or not a small can of chew will be considered a "single".
⇒ Keep examples of decisions and sticky situations as training opportunities for future youth surveyors.

GetHealthyWashoe.Com

Chronic Disease Prevention Program
Visit us: GetHealthyWashoe.com Contact us: GetHealthy@washoecounty.us

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 14C

DD__CW__
DHO_____ KD

Environmental Health Services
Division Director Staff Report
Board Meeting Date: June 28, 2018

DATE: June 15, 2018

TO: District Board of Health

FROM: Chad Warren Westom, Director
775-328-2644; cwestom@washoecounty.us

SUBJECT: Environmental Health Services (EHS) Division and Program Updates –Training Program, Epidemiology Program, Community Development, Food, Special Events, Hotel/Motel, Land Development, Safe Drinking Water, Schools, Vector-Borne Diseases, Inspections

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Division Updates

- **Environmental Health Services Training Program** – Two REHS trainee positions were filled in May 2018. Training is underway.
- **Environmental Health Services Epidemiology Program** – In May, Environmental Health Services (EHS) Epidemiology program staff worked with Communicable Disease (CD) program on several outbreaks of Hand, Foot and Mouth Disease (HFMD) at five local child care facilities. Investigations were conducted at two facilities by EHS staff and recommendations were made at one of the locations to discontinue the use of sensory bins. As the month came to an end, four of the outbreaks were still open. Staff from EHS continues to discuss outreach efforts for HFMD to childcares in the coming months.

Program Updates

Community Development

- Community Development is working with Health District administration on a quality improvement project to improve plan review turnaround times and modify the plan review system. Several meetings have been held and the existing flows identified, along with areas for potential improvement. Weekly tracking of 30-day turnaround times are being monitored. So far, the team is already operating well below the set goal of 14 calendar day average turnaround times with an average of 8.3 calendar days.
- Training of new staff is efficiently moving forward. Training is being split between all team members.

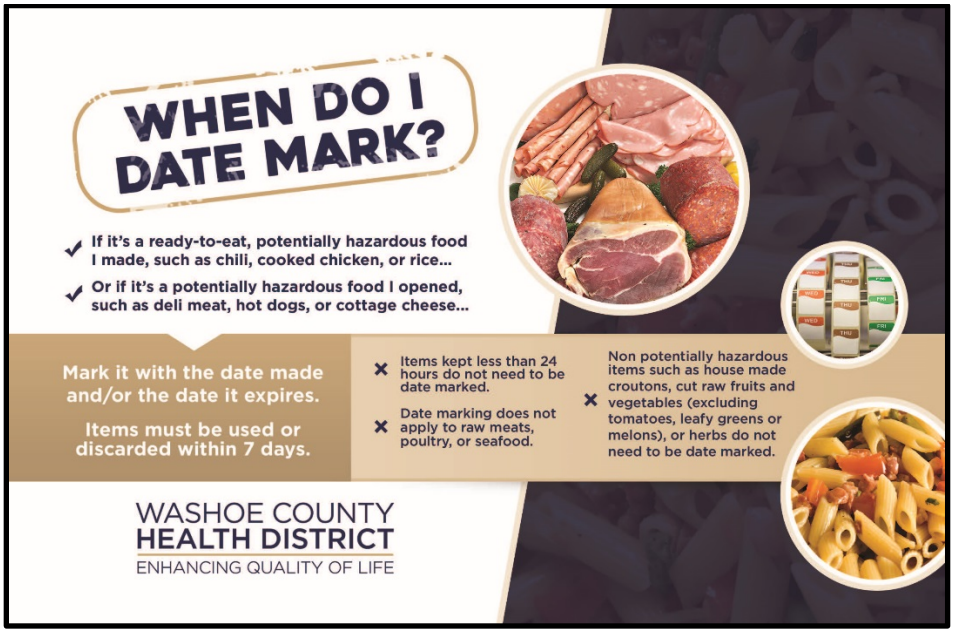
- Water project review times are at 14 calendar days and a total of 3,375 lots/units have been approved to be constructed thus far, which is 81.9% of last year. Community Development is expecting to meet the last year total and exceed that within 2 months.
- Please see the table below for the specific number of plans per program, inspections and the number of lots or units that were approved for construction within Washoe County:

Community Development	JAN 2018	FEB 2018	MAR 2018	APR 2018	MAY 2018	YTD 2018	2017 TOTAL
Development Reviews	44	49	44	41	43	221	426
Commercial Plans Received	76	78	87	91	141	473	780
Commercial Plan Inspections	23	16	26	23	25	113	407
Water Projects Received	27	26	24	20	23	120	287
Lots/Units Approved for Construction	975	970	582	445	403	3,375	4,117

Food

- Staff held an internal EHS contest to develop outreach material related to the food preparation activities and behaviors identified in the 2017 Foodborne Illness Risk Factor Study as needing improvement. The winning designs were sent to a local graphic design company to develop the outreach materials. See the magnet and informational brochure below aimed at educating food establishment operators on requirement to date mark certain foods. Funding for the project was provided by an FDA Voluntary National Retail Food Regulatory Program Standards grant. Implementation of a targeted intervention strategy designed to address the occurrence of risk factors identified in the Risk Factory Study meets the criteria of Standard 9 - Program Assessment.

MAGNET:



- **Special Events –** The Cinco de Mayo and the Reno River Festival took place during the month of May. June is historically one of the busiest months of the year in the Special Events Program with Street Vibrations Spring Rally, BBQ Brews & Blues Festival, and the Reno Rodeo being the largest events on the schedule.

Hotel/Motel

- Alex Woodley, Reno Code Enforcement Services Manager, will present to the Reno City Council (Council) on June 13 the proposed recommendations for the Motel Inspection Program. The Council will not be voting on the proposed ordinance. Alex's presentation was given to the District Board of Health on February 22. The ordinance recommendations are as follows: inspection of every unit and the exterior; crime prevention through environmental design review from the motel inspection team; owners and property managers to attend crime free training; weekly clean linens; on-site manger available 24 hours; $50.00 license fee per unit; citations not issued for initial failure of inspections; and allow hybrid rentals (nightly and extended stay).

Land Development

- Land Development is working with Health District administration on a quality improvement project to improve plan review turnaround times. Several meetings have been held and the existing flows identified, along with areas for potential improvement. Weekly tracking of 30 day turnaround times are being monitored. So far, the team is already operating within or just above the set goal of 14 day average turnaround times. It is only in the late summer months when inspection activities can get very time intensive that review times exceeded 30 days in the past.
- Training of the new staff member is efficiently moving forward. Training is being split between all team members and the trainee is getting a lot of exposure. Being exclusively assigned to

Land Development during training, it has been easier to get the amount of exposure necessary to see the broad scope of the program. They are learning quickly; a good fit within the team.

Land Development	JAN 2018	FEB 2018	MAR 2018	APR 2018	MAY 2018	YTD 2018	2017 TOTAL
Plans Received (Residential/Septic)	75	52	68	74	67	336	816
Residential Septic/Well Inspections	65	57	69	105	96	392	1,056
Well Permits	7	7	4	9	7	34	146

Safe Drinking Water

- The State finalized and completed its new enforcement process. Fortunately, it was very similar to the process that the Safe Drinking Water team developed over the last year. The group will only have to make minor adjustments to internal processes.
- The team is currently resolving deficiencies from last year's sanitary surveys and beginning to schedule this year's surveys. Consumer Confidence Reports are due in the coming month so the team is busy reviewing these for community water systems and ensuring they are accurate so customers will have accurate information on the quality of their water.

Schools

- EHS staff completed all but one Washoe County school inspection by the end of May for the spring 2018 semester (total of 128). The remaining inspection is scheduled for early June. EHS staff attended the site safety officer meeting on May 17, with the Washoe County School District (District) to review findings of the spring inspections with regard to chemical safety. The District has been responsive to inspections and greatly improved their chemical storage overall.

Vector-Borne Diseases

- The stationery New Jersey light traps are collecting small numbers of Culex tarsalis, the primary vector of mosquito-borne viruses, and higher numbers of Culiseta inornanta that also transmit mosquito viruses. The Culex tarsalis collections in the New Jersey light traps are highest in Spanish Springs, Damonte Ranch and Washoe Valley. The current average daily temperatures are supporting mosquito disease virus transmission.
- The 650 acres larvacided via helicopter on June 6 included Lemmon Valley, Wingfield Springs, Butler Ranch, Rosewood Lakes, South Meadows and Damonte Ranch. Staff inspections detected culiseta and culex larvae in these areas. Washoe Valley will be larvacided with ground equipment including fogging in the early morning hours. Fogging adults requires more staff time in reacting to mosquitoes than larvaciding.
- An unusually high number of tick service requests (13) for this time of year were identified by staff as Dermacentor variablis, the American dog tick or wood tick. This tick is known to transmit bacteria responsible for Rocky Mountain spotted fever. Rashes occur within a 2-5 day period on the wrists and ankles followed a week later by fever, vomiting, headaches, muscle pain, lack of appetite and liver issues. This tick can also transmit Tularemia, a bacterium from a tick or deer fly bite. Skin ulcers appear where the bacteria enters the body followed by swelling of the lymph glands in the arm pit or groin.

- Staff responded to a leak in Lake Ditch that affected six properties on Clough Road, south of Mayberry. Leaks in this ditch have been an ongoing issue. Staff contacted water master Dave Waltham and ditch tender Steve Benna to reduce water flows in the ditch until repaired.
- Drew Hunter from Clarke Mosquito will be providing a presentation June 20 on Integrated Mosquito Management for the public health interns and new Vector staff.
- Vector Responses to Public Requests:

Vector Responses	JAN 2018	FEB 2018	MAR 2018	APR 2018	MAY 2018	YTD 2018	2017 TOTAL
Mosquito	0	0	3	20	20	43	289
Mosquito Fish – Gambusia	0	0	0	5	23	28	124
Gambusia Delivered	0	0	0	0	0	0	807
Hantavirus	7	0	6	9	11	33	126
Plague	0	0	0	0	4	4	17
Rabies	3	4	1	4	2	14	104
Planning Calls	8	14	9	15	16	62	163
Lyme Disease/Ticks	1	0	1	4	13	19	26
Media	0	0	2	2	2	6	47
Outreach / Education / Misc.	9	11	13	28	23	84	442
Cockroach / Bedbug	3	7	9	9	15	43	227
West Nile Virus	0	0	0	0	0	0	55
Zika	0	0	0	0	0	0	12
TOTAL	**31**	**36**	**44**	**96**	**129**	**336**	**2,439**
Planning Projects Reviewed by Vector	**6**	**15**	**13**	**16**	**12**	**62**	**149**

EHS 2018 Inspections

	JAN 2018	FEB 2018	MAR 2018	APR 2018	MAY 2018	YTD 2018	2017 TOTAL
Child Care	11	11	4	6	15	47	115
Complaints	70	57	53	68	52	300	883
Food	650	724	709	625	471	3,179	4,997
General*	120	100	71	116	476	883	2,032
Temporary Foods/Special Events	17	19	25	59	105	225	1,686
Temporary IBD Events	2	0	1	85	0	88	96
Waste Management	6	29	14	16	5	70	286
TOTAL	**876**	**940**	**877**	**975**	**1,124**	**4,792**	**10,095**

* **General Inspections Include:** Invasive Body Decorations; Mobile Homes/RVs; Public Accommodations; Pools; Spas; RV Dump Stations; and Sewage/Wastewater Pumping.

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 14D

DD RT
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Risk

EPIDEMIOLOGY AND PUBLIC HEALTH PREPAREDNESS
DIVISON DIRECTOR STAFF REPORT
BOARD MEETING DATE: JUNE 28, 2018

DATE: June 14, 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

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Communicable Disease (CD)

Outbreaks – Since the last District Board of Health meeting in May, the Communicable Disease Program has opened seven outbreak investigations. Of these, five were Hand Foot and Mouth Disease (HFMD). One was viral gastroenteritis. And, one was Influenza-like Illness (ILI). All of these were in childcare facilities. As of June 14, four of these outbreak investigations were still open.

Extraordinary occurrence of illness – On June 6, the Communicable Disease Program was notified of a New Delhi Metallo-beta-lactamase Carbapenem-resistant Enterobacteriaceae (NDM CRE) in a hospitalized patient with *Klebsiella pneumoniae*. The patient is a new immigrant from an Asian country and had surgery in that country. The patient was not initially placed under contact precautions during his stay in the hospital. The CD Program is working with the hospital to perform contact tracing. As of June 13, three of the four contacts require a screening test. One of the four contacts is a California resident and California State has been notified. The CD Program is coordinating with CCHS for specimen collection.

Presentations at CSTE Annual Conference – Two epidemiologists' abstracts were accepted by the Council of State and Territorial Epidemiologists (CSTE) committee to make presentations at the 2018 Annual CSTE conference on June 13. Kerry Chalkley, MPH, made an oral presentation entitled "Two Cases of Hantavirus Pulmonary Syndrome in Washoe County, Nevada, 2017". Heather Holmstadt, RN, made a poster presentation entitled "Viral Meningitis Outbreak in Washoe County, Nevada, 2017". The CSTE's review process is very strict and conducted by subject matter experts. This is the first time for the intermediate level of epidemiologists in WCHD to submit abstracts and get accepted.

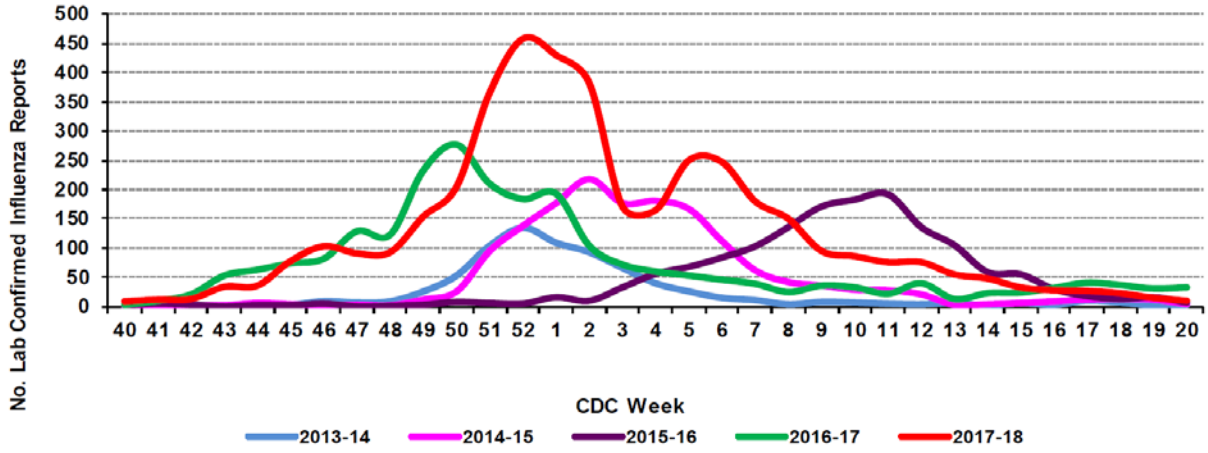
Seasonal Influenza Surveillance – May 19, 2018 was the last day for the 2017-2018 Seasonal Influenza Surveillance. For the week ending May 19, 2018 (CDC Week 20), 11 participating sentinel providers reported a total of 64 patients with influenza-like-illness (ILI). The percentage of persons seen with ILI by the 11 providers was 1.0% (64/6168) which is below the regional baseline of 2.4%. During the previous week (CDC Week 19), the percentage of visits to U.S. sentinel providers due to

ILI was 1.2%. This percentage is below the national baseline of 2.2%. On a regional level, the percentage of outpatient visits for ILI ranged from 0.5% to 2.1%.

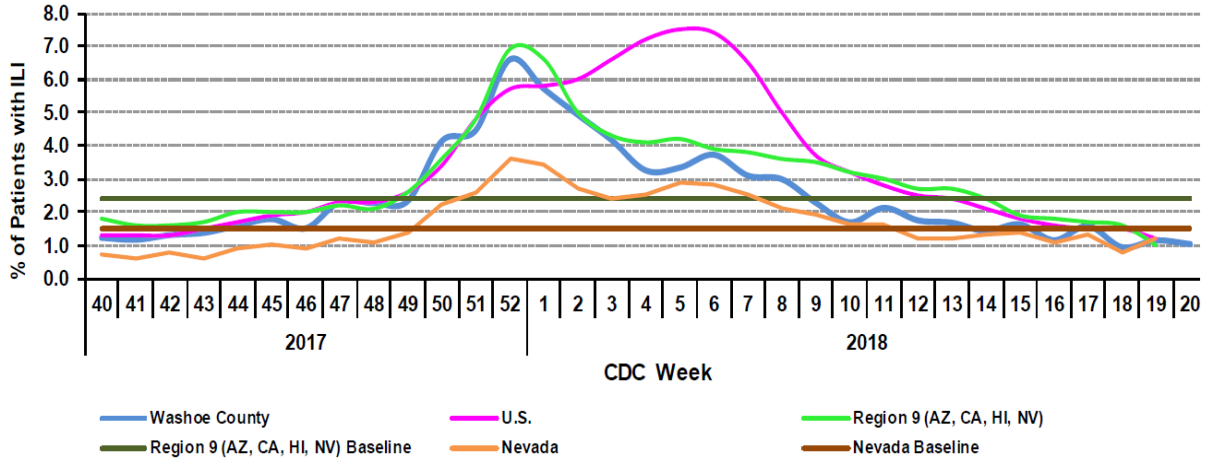
One death certificates was received for week 20 listing pneumonia (P) or influenza (I) as a factor contributing to the cause of death. The total number of deaths submitted for week 20 was 74. This reflects a P&I ratio of 1.4%. The total P&I deaths registered to date in Washoe County for the 2017-2018 influenza surveillance season is 256. This reflects an overall P&I ratio of 7.9% (256/3249).

For laboratory-confirmed influenza cases this season there were a total of 5,521 of which 542 (9.8%) were hospitalized. Of the hospitalized cases, 221(40.8%) had been vaccinated. Of the total cases, 88 (1.6%) were admitted to an Intensive Care Unit (ICU). Of the total cases, 26 (0.5%) died.

Laboratory Confirmed Influenza Reports, 2013-2018 Seasons:



Proportion of Patients Seen with ILI by Sentinel Physicians, Washoe County Influenza Surveillance, 2017-2018:



Data source for U.S., Region 9, and Nevada ILI activity and baselines: CDC Flu View Weekly Influenza Surveillance Report, https://www.cdc.gov/flu/weekly/index.htm.

This is the final report for seasonal influenza surveillance for the 2017-2018 season. The 2018-2019 season will begin on September 30, 2018 and end on May 18, 2019.

Public Health Preparedness (PHP)

On June 13 PHEP staff provided the POD Command Training to the Reno-Sparks Indian Colony in preparation for the fall flu POD exercises. This course was developed to provide command level training to ICS trained staff in running Point of Dispensing sites.

On June 21 the PHEP program will be conducting a radiological exercise in conjunction with the City of Reno Preparedness Expo. The exercise is setting up a community reception center (CRC) for population monitoring following a radiological exposure incident. This exercise involves multiple agencies and organizations in our community.

Emergency Medical Services (EMS)

On May 4 there was a car accident on I-80 at the exit ramp to I-580 and northbound US-395 that prompted first responders to activate the multi-casualty incident plan (MCIP). It took several hours to clean up the scene and 9 people were transported to area hospitals. The EMS Program Manager held the after action review meetings on May 21 and May 30. A draft of the After Action Report/Improvement Plan (AAR/IP) is being written and will be distributed to responding agencies for review by the end of the month.

The Regional Protocols task force convened on May 31 to review all the changes made during the April meeting. The group also discussed implementation and items they would like to watch for possible future revisions. All changes to the protocols will be implemented with the start of the fiscal year, July 1. The group will meet quarterly to report on the items being reviewed.

Through grant funds from the Nevada Governors Council on Developmental Disabilities (NGCDD) the EMS Program coordinated with the JUSTin HOPE Foundation to bring three days of training to law enforcement, EMS/fire and healthcare personnel about responding to and interacting with individuals with autism. The trainings were held June 4-6 and more than 70 people attended the various sessions.

The EMS Program Manager and EMS Coordinator held a low acuity/P3 calls committee meeting on June 5. The group continued the discussion of the alpha level calls and reviewed 5 more determinants for alternative response. The group also discussed the implementation process for the changes for response to Card 33 facilities. (Card 33 facilities have medical professionals on-staff during all hours of operation and have access to an AED or crash cart.)

The Prehospital Medical Advisory Committee (PMAC) held its regularly scheduled meeting on June 13 where the members discussed two EMS strategic plan items in goal #5: Regional Protocols and Continuous Quality Improvement. PMAC members had quality input on the Continuous Quality Improvement guidelines. EMS staff will continue to work on the project and bring a revised version to PMAC in September. The PMAC members also reviewed the protocol updates/revisions made by the task force and suggested two small revisions that will be incorporated into the Regional EMS Protocols update for July 1.

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%
January 2018	93%	94%	96%	100%	95%	93%
February 2018	92%	96%	97%	100%	96%	92%
March 2018	91%	90%	97%	100%	93%	91%
April 2018	93%	98%	91%	100%	96%	93%
May 2018	91%	90%	97%	100%	92%	92%
YTD	**92%**	**93%**	**95%**	**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*
January 2018	8:31	14:51	16:02	N/A*
February 2018	8:39	14:37	15:28	N/A*
March 2018	8:50	15:15	19:29	N/A*
April 2018	8:28	13:01	19:41	N/A*
May 2018	8:38	15:45	16:25	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.

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

DBOH AGENDA ITEM NO. 14E

DHO__ KD ___

Office of the District Health Officer
District Health Officer Staff Report
Board Meeting Date: June 28, 2018

DATE: June 28, 2018

TO: District Board of Health

FROM: Kevin Dick, District Health Officer
775-328-2416; kdick@washoecounty.us

SUBJECT: District Health Officer Report – Public Health Accreditation, Quality Improvement, Workforce Development, Community Health Improvement Plan, Truckee Meadows Healthy Communities, Washoe Behavioral Health Policy Board, Plan Reviews, Other Events and Activities and Health District Media Contacts.

Public Health Accreditation

The Accreditation team continues to make progress gathering the needed documents. One-on-one meetings have been conducted with every team member to determine progress and estimated date of submission of any remaining documents. We now have about 139 of the required documents gathered, and 84 documents uploaded into the online submission system out of the required 213 documents.

Quality Improvement

The QI team continues to meet every other month to support implementation of Quality Improvement Projects. A rapid QI form has been developed and the QI plan has been updated to reflect the new form which is intended to capture the success of small QI projects. A revised QI survey is being developed by the QI team to gather more actionable data on QI knowledge and barriers to success across the Health District. A QI newsletter was developed and distributed across the Health District to increase QI knowledge and celebrate recent QI successes.

Workforce Development

Two training sessions were conducted by Dr. Mel Minarik as described in the previous update with considerable positive feedback from Health District staff and with support from County HR. Health District staff participated and the training was also made available to County staff outside the Health District. A follow-up training will be held in August to further develop the concepts and skills shared in the initial training.

Community Health Improvement Plan

The 2018-2020 CHIP has been completed and submitted for DBOH approval. Once approved, implementation of the plan will begin. The draft plan was presented to the TMHC Steering Committee during their June 13 meeting.

Truckee Meadows Healthy Communities

Enterprise Community Partners continues to work on the Comprehensive Regional Strategy for Affordable Housing. They have completed Phase I and initiated Phase II of the work. They visited the region the week of June 11 and held meetings of the Executive Leadership Team and the Regional Staff and Community working groups. They provided updates and discussed the project with the TMHC Steering Committee and the Truckee Meadows Regional Planning Agency Governing Board.

As part of the CHIP, TMHC is organizing a Family Health Festival that will be held at Miguel Ribera Park on July 25, 2018.

Washoe Behavioral Health Policy Board

The regional Behavioral Health Policy Board met at the Reno Behavioral Healthcare Hospital on June 18 and toured the new facility. The Board heard presentations which included substance abuse and treatment, the Interim Legislative Committee to Study Issues Regarding Affordable Housing, the transfer of Enliven/Raise Up Nevada program from Children's Cabinet to NNAMHS, an update on the Triage Center planning and update on the State Legal 2000 workgroup. The Board will discuss potential BDR focus areas during the July 16, 2018 meeting. Topics for consideration include Crisis Stabilization Units, prevention initiatives and additional caseworker/care manager resources for high mentally ill utilizers of public safety and emergency medical programs.

Plan Reviews

On June 8 NDEP held a workshop on the proposed revisions to NAC445A regarding Water Projects. The proposed revisions will be presented to the State Environmental Commission for possible approval on June 27, 2018.

NDEP, TMWA and the Health District met on May 30, 2018 to further discuss alternative oversight of TMWA plan review of water projects.

Chad Westom and I met with representatives from NAIOP and BANN on June 7 to discuss experiences with Health District plan reviews.

Other Events and Activities

5/25/18	REMSA Board Meeting
5/25/18	EHS – DHO/DD/Board Member Meeting
5/30/18	Renown Behavioral Health Institute Announcement
5/30/18	NDEP/WCHD/TMWA meeting re: alternative oversight approach
5/30/18	AHS – DHO/DD/Board Member Meeting

5/31/18	TMHC Board of Directors Meeting
5/31/18	CCHS – DHO/DD/Board Member Meeting
6/1/18	Monthly Meeting with Assistant Co. Manager Solaro
6/5/18	Nevada Oral Health Program Meeting
6/5/18	Accela Regional Project Management Oversight Group Quarterly Meeting
6/7/18	2018 Washoe County Chronic Disease Coalition Annual Meeting Welcome
6/7/18	Meeting with NAIOP and BANN Meeting regarding plan reviews
6/8/18	State Board of Health Meeting
6/13/18	Department Heads Meeting
6/13/18	TMHC Steering Committee Meeting
6/14/18	NV Health Authorities Conference Call
6/14/18	Enterprise Housing Strategy Presentation to TMRPA Governing Board Meeting
6/15/18	NPHA Advocacy Call
6/15/18	Learning Organizations Training
6/18/18	Behavioral Health Policy Board
6/18/18	New Employee Introduction to the Health District Orientation
6/20/18	Monthly Meeting with DBOH Chair
6/20-21/18	Black Rain Radiological Event Exercise
6/22/18	REMSA Board Meeting
6/25/18	Funding for Health Programs – DHHS
6/26/18	Isolation and Quarantine Tabletop Exercise
6/26/18	NALHO
6/28/18	EPHP – DHO/DD/Board Member Meeting

Health District Media Contacts: May 2018

DATE	MEDIA	REPORTER	STORY
5/23/2018	Reno Gazette-Journal	Ben Spillman	CAFÉ Standards-Albee
5/21/2018	Reno Gazette-Journal	Siobhan McAndrew	LARCs/Contraceptives-Ulibarri
5/21/2018	Reno Gazette-Journal	Siobhan McAndrew	Measles-Ulibarri
5/21/2018	Reno Gazette-Journal	Johnathan Wright	Home Kitchen & Food Safety-Messinger-Patton/Ulibarri
5/17/2018	Reno Gazette-Journal	Siobhan McAndrew	Measles-Ulibarri
5/17/2018	KTVN CH2 - CBS Reno	Jaimie Hays	Hantavirus-Ulibarri
5/17/2018	This Is Reno	Bob Conrad	Environmental Health Services-Ulibarri
5/14/2018	Reno Gazette-Journal	Johnathan Wright	Consumer Dining Guidance-A. English
5/7/2018	KRNV CH4 - NBC Reno	Melissa Metheney	Flu-Ulibarri
5/3/2018	KTVN CH2 - CBS Reno	Liz Olveda	Ticks-Shaffer
5/2/2018	KRNV CH4 - NBC Reno	Carson Buschjost	Mosquitos & Ticks-Shaffer
5/2/2018	KTVN CH2 - CBS Reno	Kristen Remington	Congenital Syphilis-Howell

Press Releases/Media Advisories/Editorials/Talking Points

5/10/2018	May is Teen Pregnancy Month	Ulibarri

Social Media Postings

Facebook	AQMD/CCHS/ODHO EHS	131 (CCHS 23 EHS 12 ODHO 1 AQM 95)
Twitter	AQMD/CCHS	71 (AQM 70 CCHS 1)