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FOUNDATIONAL PUBLIC HEALTH SERVICES IN SUBURBAN, RURAL & FRONTIER NEVADA

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Foundational Public Health Services in Suburban, Rural, and Frontier Nevada

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The County Commissioners and County Health Officers serving Nevada's communities.

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Preface

Nevada Economic Assessment Project

Nevada Economic Assessment Project (NEAP) is a statewide program that develops a comprehensive data repository of county quantitative and qualitative baseline data to be used to assess local planning and economic development initiatives.

NEAP's mission is to develop and maintain an extensive data archive with timely, meaningful, and consistent characteristics and a set of analytical tools used to provide Nevada's communities with research and analysis of emerging issues through outreach and engagement.

NEAP is a program in Extension's Community and Economic Development department.

Extension is within the College of Agriculture, Biotechnology and Natural Resources and is the outreach unit of the University of Nevada, Reno, bringing the research of the University to Nevada's communities.

Nevada Association of Counties (NACO)

NACO was formed in Reno in 1924 under the name of Nevada County Commissioners' Association. NACO is comprised of representatives from all 17 of Nevada's counties, several statewide county associations, private industry representatives and government partners. They are the state association for county government officials and staff.

NACO's Vision is to encourage county government to adopt and maintain local, regional, state and national cooperation which will result in a positive influence on public policy and optimize the management of county resources; to provide valuable education and support services that will maximize efficiency and foster public trust in county government. County government, being closest to the people, has the best opportunity to make positive changes and lead our communities into the future. They work to provide our counties with the resources to achieve this end.

For more information on NACO, visit nvnaco.org.

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Executive Summary

Purpose

The purpose of this report is to provide Nevada's suburban, rural, and frontier county governments, community partners, and public health authorities with a baseline of public health services in their county and their regional counties utilizing a nationally recognized framework. The goal is to provide local infrastructure data that can be analyzed alongside local health indicators and community health needs assessments to support strategic decision-making for community health improvement.

The use of the national Foundational Public Health Services[1] model enables local and state public health agencies in Nevada to benchmark progress with other states, leverage data to secure federal funding for targeted improvement efforts, and more robustly consider Nevada's public health policy and infrastructure from a national perspective. Nevada's baseline public health services as defined in statute represent only a subsection of responsibilities outlined in the national model.

In addition to baseline data collection, the purpose of the assessment was to elevate the conversation on local public health. With stronger relationships and more open lines of communication between state and local partners serving the same communities, comes greater understanding, community utilization of services, and oversight of current programs and investments.

Through the assessment process, it was identified that improved communication and information sharing is critically needed between public health agencies, local governments, and the communities served. Towards this end, this report aims to improve knowledge of Nevada's public health system (see: Background and Critical Context) at the local level and to empower public health authorities and local governments to address communication and other gaps as resources allow in ways that align with each county's unique vision and need.

There are links to the health authority strategic plans, policies, dashboards, and websites, as well as resource directories for select services to allow this report to function as both a study and a guide to public health in Nevada's suburban, rural and frontier counties.

[1] The Foundational Public Health Services - Public Health Accreditation Board (phaboard.org)

Foundational Public Health Services

In 2013, the Public Health Leadership Forum, a project led by RESOLVE and funded by the Robert Wood Johnson Foundation (RWJF) convened a group of public health stakeholders to explore a recommendation from the Institute of Medicine (IOM) – **to define a minimum package of public health capabilities and programs that no jurisdictions can be without**. The result was the Foundational Public Health Services (FPHS), now housed at the Public Health National Center for Innovations (PHNCI) at the Public Health Accreditation Board (PHAB).

The FPHS model provides:

- A common language and national understanding of the vital role and unique responsibilities of governmental public health.
- The ability to assess gaps in capacity.
- Standardization to assure continuity across all states, but with the flexibility for communities to adapt to specific needs; and
- Alignment with national initiatives, such as public health accreditation.

The FPHS was designed as a framework for local and state public health departments to assess progress towards a minimum public health infrastructure. The Foundational Public Health Services are split into two categories: Foundational Areas and Foundational Capabilities.

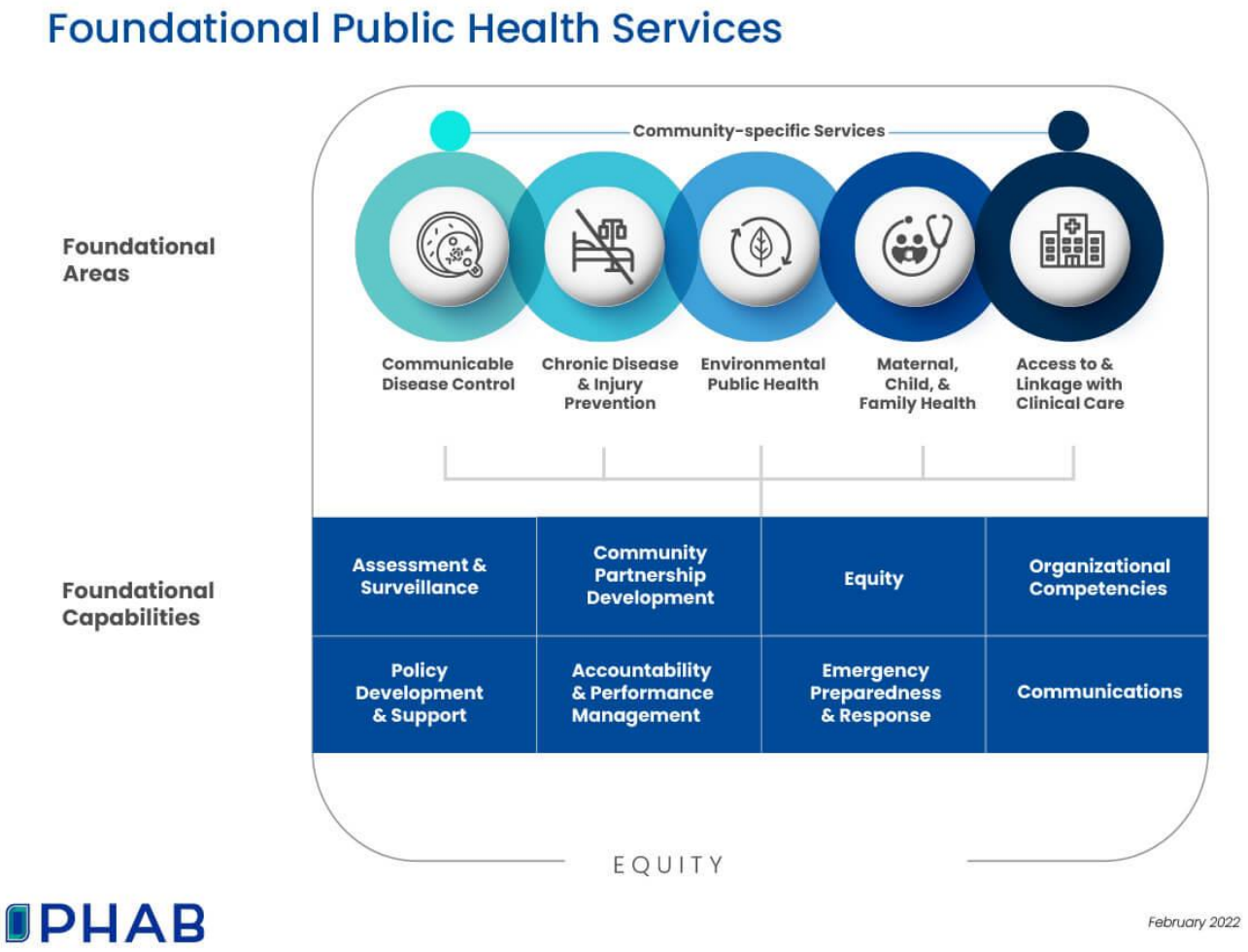
Foundational Areas

- Communicable Disease Control
- Chronic Disease & Injury Prevention
- Environmental Public Health
- Maternal, Child, & Family Health
- Access to & Linkage with Clinical Care

Foundational Capabilities

- Assessment and Surveillance
- Community Partnership Development
- Equity
- Organizational Competencies
- Policy Development and Support
- Accountability and Performance Management
- Emergency Preparedness and Response
- Communications

Figure 1. FPHS Graphic by the Public Health Accreditation Board



Behavioral Health is noticeably absent from the national FPHS model. This is due, in part, to the fact that public health departments in many states have not historically delivered behavioral health services or taken on prevention programs outside of notable exceptions such as tobacco use prevention. While there is increasing recognition that the population-based health promotion policies and strategies that support a strong public health system are also instrumental in improving the nation's behavioral health crisis, there remain differing opinions on the role of governmental public health in the delivery of behavioral health care.

The FPHS model includes recognition of "Community-Specific Services," which are the programs and activities specific to each jurisdiction based on the needs of the population served. Mental health improvement, especially for our youth, is a public health priority across Nevada, and therefore NACO and UNR Extension included the collection of local behavioral health infrastructure data.

Key Findings

Similar to states across the nation working to map Foundational Public Health Services in their communities, there was notable variation county-to-county in Capacity, Expertise, and Level of Implementation across all Program Areas and Capabilities, even where communities were served by the same governmental public health authority. There is no jurisdiction that rated any of the Program Areas or Capabilities as "Fully Implemented/Meets Demand," though there are certainly community-specific strengths.

The consolidated municipality of Carson City (served locally by Carson City Health & Human Services (CCHHS), Douglas County (served locally by CCHHS and Douglas County), and Churchill County (served locally by Central Nevada Health District) reported the highest overall ratings across the assessed counties. While many factors impact the ratings, a commonality across all three counties is the presence of locally-run, locally delivered, state-supported governmental public health services. Throughout the results discussion, there are numerous examples of where governmental public health authorities rely on strong local infrastructure, such as County Human Services teams, County Health Officers, and effective Community Action Agencies, to receive funds, develop and manage programs, communicate information, and partner with state agencies.

Notably, Expertise ratings overall fared better than Capacity ratings, which is not surprising due to workforce shortages and the historic underfunding of the public health system. Nye County, for example, rated the Expertise of DPBH as "Proficient" across nine of the thirteen Foundational Areas, but Capacity as "Minimal" or "Absent" across all but one area: Emergency Preparedness and Response. A significant factor in the ratings of "Absent" and "Minimal," not just for Nye County, but across the state, is geographic equity. For most of the counties surveyed, direct services (either delivered by the health authority or by a community agency that has been contracted to provide services) are frequently limited to a single population center within a county, though there are some notable exceptions (i.e. three full-time Lyon County Community Health Clinics; four NVHC locations within Elko County). The FPHS model holds that public health services must be accessible everywhere for public health to function everywhere.

SOME PROGRAMS ARE NOT MEANINGFULLY ACCESSIBLE TO ALL COUNTIES DUE TO LIMITED RESOURCES AND/OR HIGH-LEVEL INFRASTRUCTURE DEVELOPMENT DECISIONS. TRANSPARENT, FRANK COMMUNICATION ABOUT THIS WOULD GO A LONG WAY TOWARDS IMPROVING TRUST BETWEEN GOVERNMENTAL PUBLIC HEALTH AND LOCAL PARTNERS.

Emergency Preparedness and Response received the highest implementation ratings overall. This Capability Area is bolstered by regular Local Emergency Planning Committee (LEPC) meetings, support and regular communication from multiple state agencies, and a dedicated Public Health Preparedness Program supported at the state and local level. Central Nevada Health District's (CNHD) ratings for Emergency Preparedness and Response were relatively low, rated as "Minimal" across three of their four member counties. CNHD faced recruitment challenges for the Public Health Preparedness (PHP) Manager position during their first year of operations. As of August 2024, CNHD filled this position and is building a PHP program. Esmeralda County, despite having an active LEPC and some support from state agencies, reported infrastructure in this Capability as "Minimal" due to severely limited resources.

Accountability and Performance Management fared the worst across all the areas surveyed. The public health infrastructure at DPBH for this program area was largely unknown to participants. The experiences of participants, especially in the areas of communication, grants management, reimbursement processing, and technical assistance, drove the ratings. Notably, DPBH has undertaken significant Quality Improvement efforts in public health through the Public Health Infrastructure and Improvement Section (PHIIS)[2], including submitting for accreditation to the Public Health Accreditation Board, developing a statewide health improvement plan,

[2] https://dpbh.nv.gov/About/PHIS/

partnering on this FPHS assessment, and participating in the 21st Century Learning Community[3] for Public Health Transformation. Communications about these relatively new efforts are slowly trickling into communities. While these efforts will undoubtedly have long-term impacts on the state's public health system, the fruits of these labors are not yet shared across the state.

Throughout these pages readers will find examples of impactful partnerships and community successes. Readers will also find ample opportunities to further invest in and improve the public health system in Nevada. Notably, a theme that permeates the entire report is the need for improved, strategic, multi-channel communication.

Many local partners and officials from every jurisdiction reported that they do not receive timely updates on disease prevalence, health data, or program strategies from their governmental public health authority, despite the presence of new and robust public-facing data dashboards, improved websites, and governmental public health authorities' perceptions that they are regularly communicating. There is a significant and apparent communications gap (see: Communications).

Co-Author of this publication, NACO Public Health Coordinator Amy Hyne-Sutherland, was featured on the Public Health Accreditation Board (PHAB) '21C Learning Community Podcast,' speaking on this project.

Listen to the Podcast Here:

The labeling of programs as "statewide" or "district-wide" feels disingenuous and counter-productive to local partners where there is no local presence of a program, especially in cases where there is no funding to expand services, even if the local partners were ready to develop.

In some cases, programs are indeed open statewide, they are just not equitably distributed in practice for various reasons. Through improved two-way communications, understanding of the available resources can be reached and state or district programs could be brought to additional counties through partnership. An example of this is the J1-Visa Program (see: Access to & Linkage with Clinical Care), which supports 30 physicians from outside the U.S. to serve in designated shortage areas in Nevada. FPHS participants noted that this program is "absent" or "inactive" in their county. As of this writing, there are 29 physicians in the FY2024 program (5 in Carson City, 1 shared by Carson City/Elko, 1 in Elko, and the remaining 22 serving in Washoe and Clark Counties). There is a rigorous application process, but even so healthcare facilities in any county across Nevada can begin the process now for next year's cycle. While it is true that there are not currently physicians on this program serving in every county and not every healthcare facility has bandwidth to go through the process, it is not exactly the case that the program is "absent" or "inactive." It is also the case, though, that the program is limited. If every county assessed here chose to engage in this program next cycle, it is possible they would not all be successful, as the state has acute healthcare provider shortages in urban counties, as well.

There are other similarly limited programs (see: Maternal, Child, and Family Health) that rely completely on federal grant dollars. While this report demonstrates that counties with strong local infrastructure are better able to pull down state and federal dollars to develop programs, it is still the case that the pool of funds for public health programs is finite and unsustainable. With no additional investment, development of locally delivered, state-supported services in one jurisdiction just pulls dollars away from other locally delivered, state-supported services in another.

In this landscape, some programs are not meaningfully accessible to all counties due to limited resources and/or high-level infrastructure development decisions. Transparent, frank communication about this would go a long way towards improving trust between governmental public health and local partners. For example, Nevada Health Link (see: Access to & Linkage with Clinical Care), Nevada's ACA insurance marketplace, describes their

[3] https://phaboard.org/center-for-innovation/21st-century-learning-community/

Navigator/In-Person Assister service reach as "throughout the state." In practice, there are currently only physical In-Person Assiter sites in Washoe County and Clark County. The rest of the state is served via phone or Zoom. As almost every county in Nevada has significant connectivity issues for rural and frontier residents, the lack of In-Person Assisters poses a significant access problem.

On the major issue raised by this last point – that of health equity for rural and frontier communities – there is much more that can be written beyond what is found in these pages (see: Equity). There is a perception among some at the local level that governmental public health authorities are adequately staffed and funded to deliver programs, but do not equitably focus their efforts. In order to deliver to counties as accurate a baseline as possible, the project team followed up on numerous occasions with the governmental public health authorities to better understand the current infrastructure and test the veracity of that perception. The project team found that most programs have far less staff and funding than local partners assume, but this reality is obscured by robust public-facing program descriptions that claim equitable coverage, do not share current staffing levels or distribution of staff, and do not openly address gaps in service delivery, geographic or otherwise. All parties would benefit from more detailed, public-facing information, in a centralized place, that shows the statewide distribution of public health funding sources and staffing for all programs. This would help to manage expectations, identify true gaps in services and investment, and improve trust.

Additionally, until equitable delivery of a program across the service area is achieved, governmental public health authorities may consider limiting claims of "statewide" or "district-wide" or "county-wide." This erodes trust and signals to policy makers and residents alike that there is more infrastructure than there is. For some Program Areas, there are technological solutions that enable a county or statewide reach, such as telehealth options or remote service navigators. Clear delineation of what is available in-person versus electronically across all Program Areas and geographies will be helpful to both those planning infrastructure improvement initiatives and to community members trying to access services.

> Expertise ratings overall fared better than Capacity ratings, which is not surprising due to workforce shortages and the underfunding of the public health system…. Direct services are frequently limited to a single population center within a county.

Overall, the project team found that there are incredibly dedicated public servants at county governments, local health authorities, community organizations, and state agencies that are all working very hard to improve one or many of the FPHS Program Areas or Capabilities, but with very limited resources. There are opportunities to create more efficiency and maximize current investment through improved coordination and communication. Even so, the ubiquity of the gaps in services, paired with the unique challenges presented by Nevada's geography, demonstrate that current resources are not sufficient to meet the needs of Nevada's communities.

The following pages present the Expertise, Capacity, and Level of Implementation ratings for all counties assessed, organized by governmental public health authority. For the DPBH counties, the project team decided to list the counties next to their neighbors (rather than alphabetical order) so regional strengths and challenges could be more easily identified. The Results section of this report provides the following for each Foundational Program Area and Capability: Headline responsibilities as defined by the national FPHS model; Expertise, Capacity, and Level of Implementation ratings by county; Opportunities for Health Authorities, Counties, and Legislators; and Discussion, which includes numerous links and references to current infrastructure.

Additionally, county-level reports and listings of services to support strategic planning will be made available through the NACO website[4] with an anticipated completion date of December 2024.

[4] https://www.nvnaco.org/advocacy/public-health.php

Expertise

Below find the final expertise ratings for each county for the thirteen Foundational Public Health Services.

Table 1. Expertise of FPHS Across Nevada, 2024

Health Authority	Central Nevada Health District				CC HHS*	State of Nevada Department of Public and Behavioral Health									
County	**Churchill**	**Eureka**	**Mineral**	**Pershing**	**Carson City**	**Douglas**	**Lyon**	**Storey**	**Humboldt**	**Lander**	**Elko**	**White Pine**	**Lincoln**	**Nye**	**Esmeralda**
Communicable Disease Control															
Chronic Disease and Injury Prevention															
Environmental Public Health															
Maternal, Child, and Family Health															
Access to and Linkage with Clinical Care															
Assessment and Surveillance															
Community Partnership Development															
Equity															
Organizational Competencies															
Policy Development and Support															
Accountability and Performance Management															
Emergency Preparedness and Response															
Communications															

**Carson City Health and Human Services*

Table 2. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Capacity

Below find the final capacity ratings for each county for the thirteen Foundational Public Health Services.

Table 3. Capacity of FPHS Across Nevada, 2024

Health Authority	Central Nevada Health District				CC HHS*	State of Nevada Department of Public and Behavioral Health									
County	**Churchill**	**Eureka**	**Mineral**	**Pershing**	**Carson City**	**Douglas**	**Lyon**	**Storey**	**Humboldt**	**Lander**	**Elko**	**White Pine**	**Lincoln**	**Nye**	**Esmeralda**
Communicable Disease Control															
Chronic Disease and Injury Prevention															
Environmental Public Health															
Maternal, Child, and Family Health															
Access to and Linkage with Clinical Care															
Assessment and Surveillance															
Community Partnership Development															
Equity															
Organizational Competencies															
Policy Development and Support															
Accountability and Performance Management															
Emergency Preparedness and Response															
Communications															

**Carson City Health and Human Services*

Table 4. Color to Rating Scale Key for Capacity

Absent
Minimal
Moderate
Full

Implementation

Below find the final implementation ratings for each county for the thirteen Foundational Public Health Services.

Table 5. Implementation of FPHS Across Nevada, 2024

Health Authority	Central Nevada Health District				CC HHS*	State of Nevada Department of Public and Behavioral Health									
County	**Churchill**	**Eureka**	**Mineral**	**Pershing**	**Carson City**	**Douglas**	**Lyon**	**Storey**	**Humboldt**	**Lander**	**Elko**	**White Pine**	**Lincoln**	**Nye**	**Esmeralda**
Communicable Disease Control															
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Equity															
Organizational Competencies															
Policy Development and Support															
Accountability and Performance Management															
Emergency Preparedness and Response															
Communications															

**Carson City Health and Human Services*

Table 6. Color to Rating Scale Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Critical Context

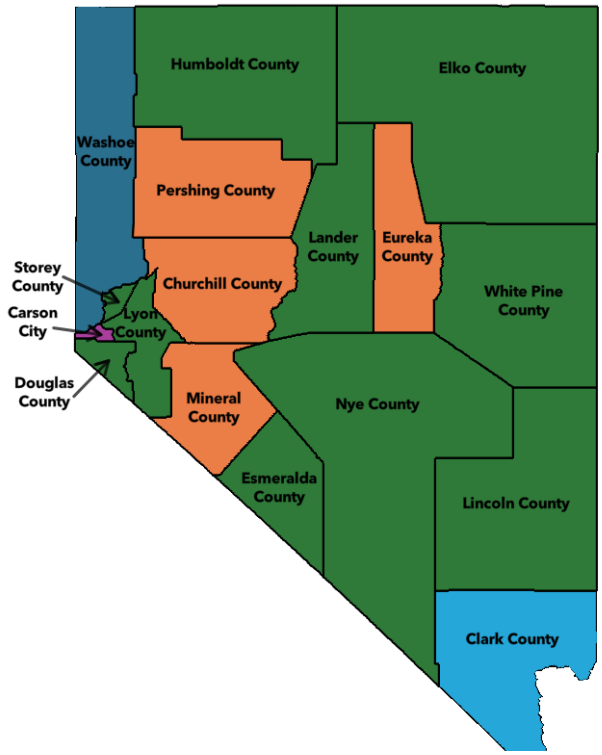
Public Health System in Nevada

Nevada's public health system is classified as a "largely decentralized" model. This means that over 75% of the State's population is served by local health authorities that are primarily led by employees of local governments and the local governments retain authority over most fiscal decisions[5]. In Nevada, there are three districts (Northern Nevada Public Health, Central Nevada Health District, and Southern Nevada Health District) serving six counties, and one local health department (Carson City Health & Human Services) that has been delegated public health authority by the State of Nevada.

Geographically speaking, Nevada's public health system has a large, centralized component. Ten of Nevada's counties (representing a majority of the geographic area) are served by the Division of Public and Behavioral Health (DPBH) as the health authority. Provision of public health service delivery, however, varies county by county. For example, Lander County and Douglas County provide and fund their own Community Health Nursing. Carson City Health & Human Services provides some public health services for Lyon, Storey, and Douglas Counties. Storey County and Elko County contract with local organizations for a variety of community public health services.

Most DPBH health authority counties pay an assessment for public health services provided by the State. A provision of that contract requires the county to hire administrative support and provide space for services. As a truly hybrid model, the efficiency and efficacy of the system depends heavily on both governments' ability to collaborate.

Figure 2. Health Authority by County



In comparison to most other states, Nevada's local public health infrastructure is minimal. Nevada's counties are geographically much larger than the national average, which makes county-government based delivery of public health services especially challenging. Nevada is the 7th largest state in the US by land area with just 17 counties. Nationally, the average number of counties per state is 63. The important thing to note here is that many states have fully decentralized models with local public health units dedicated to a geographically small county or group of counties. In some cases, this amounts to inefficiencies, and states situated in such a way are now focusing substantial effort on consolidation of services, encouraging shared staffing and resources across public health units. Nevada's services are so sparse that redundancy is very rare, if ever, a cause for concern. Rather, some redundancies may be welcomed in a landscape where turnover of even a single position can cause months of delay in the delivery of services. Nevada ranked 41st in the nation on the 2022 Scorecard on State Health System Performance produced by The Commonwealth Fund[6], and 47th in the country for state-level investment in public health[7].

[5] Microsoft PowerPoint - State Local Governance Classification Tree Final 6 12 2012.pptx (astho.org)
[6] Nevada | Commonwealth Fund: https://www.commonwealthfund.org/datacenter/nevada
[7] Explore Public Health Funding in Nevada | AHR (americashealthrankings.org)

Nevada Revised Statutes and Baseline Services

Nevada's baseline services as outlined in Nevada Revised Statutes (NRS) have some overlap with the FPHS Foundational Program Areas and Capabilities, but it is not a 1:1 correlation. In general, Nevada's public health statutes governing rural and frontier counties focus on communicable disease control and environmental health, which translates to services such as communicable disease investigations, surveillance, and treatment in the case of the former, and a host of permitting and inspection programs—of restaurants, cottage foods, cosmetics manufacturing, pools, mobile home parks, hotels, healthcare facilities, tattoo parlors, childcare facilities, and more—in the case of the latter. In some cases, the public health services delivered by governmental public health authorities in Nevada are more extensive, developed by either state or local health authorities in response to a community need, and/or because of Nevada receiving federal grant funding for a specific program or service line.

Discussions of public health infrastructure development at the county level in Nevada often focus first on a core set of mandated services that fall under the following three headings: (1) Community Health Nursing; (2) Epidemiology; and (3) Environmental Health Services. As a result of a 2011 legislative change to Chapter 439 of the Nevada Revised Statutes, counties pay assessments to the Division of Public and Behavioral Health (DPBH) for these services. Alternately, counties can choose to deliver these services directly or ensure delivery through an agreement or contract with another jurisdiction. When a county chooses this route, they must apply to the Office of the Governor and State Board of Health to have the assessments removed. The assessments charged to counties are based on the cost to deliver the programs minus any federal or state funding received to deliver the program. In almost all cases, the cost to counties is subsidized by federal grants or by State General Fund investment.

This publication includes an overview of these three service lines alongside maps by providing entity. The goal is to provide clarity for counties regarding their current infrastructure and investment. Additionally, it supports navigation to the correct health authority regarding questions within their jurisdiction. In the Results section of our study, we have also indicated where these service lines fit into the larger FPHS framework.

Community Health Nursing

Community Health Nurses (CHN) promote the public health of local residents, provide public health education and counseling services for individuals and the community related to infectious diseases, and work collaboratively with the county school district, Board of Health, and community partners to support public health. They support vaccination events, and provide family planning services, Tuberculosis screening and treatment, identification and treatment of Sexually Transmitted Infections (STIs), Human Immunodeficiency Virus (HIV) screening, and referral and navigation to primary and specialty care. Community Health Nurses in Nevada also support Public Health Emergency Preparedness efforts through participation in Local Emergency Planning Committees (LEPC).

Storey and Elko Counties do not have designated Community Health Nurses, but contract with Nevada Health Centers, a Federally Qualified Health Center (FQHC), for clinical services.

Figure 3. Community Health Nursing Providers by County

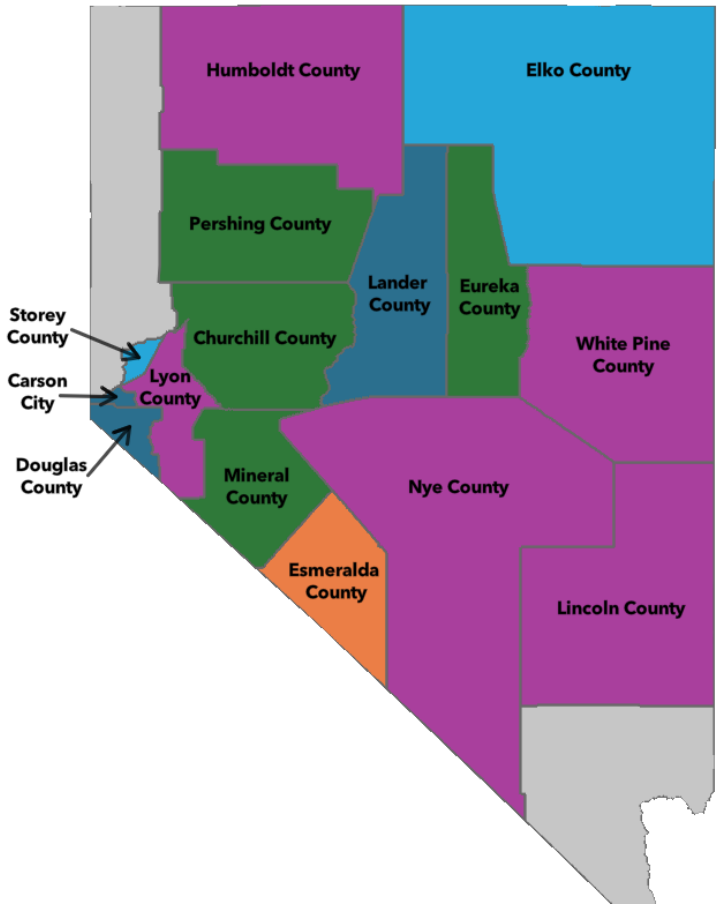


Table 7. Color Key for Community Health Nursing Providers

	=	Consolidated Municipality or County Employee(s)
	=	Central Nevada Health District Employee(s)
	=	County Contracts with Community Partner
	=	DPBH Nurse(s) and County Administrative Staff
	=	DPBH* Emergency/Event Back-up, No Regular CHN Presence

**Division of Public and Behavioral Health*

For more information on DPBH Community Health Nursing services, including contact listings and current clinic hours, please see section: Additional Infrastructure Mapping and Resources.

Epidemiology, Disease Investigations

Epidemiology, which can be considered a service under the larger umbrella of Public Health Preparedness, includes the management of infectious diseases through reporting and surveillance. Conducting disease investigations is a primary activity, which includes contact tracing, reporting, connecting patients to resources, and notification of facilities to prevent disease spread. The map to the right shows the health authority responsible for disease investigations in each county. In addition to the disease investigations mapped here, local and state public health authorities conduct additional disease surveillance and develop interventions to address disease prevalence.

Figure 4. Communicable Disease Investigations, Providers by County

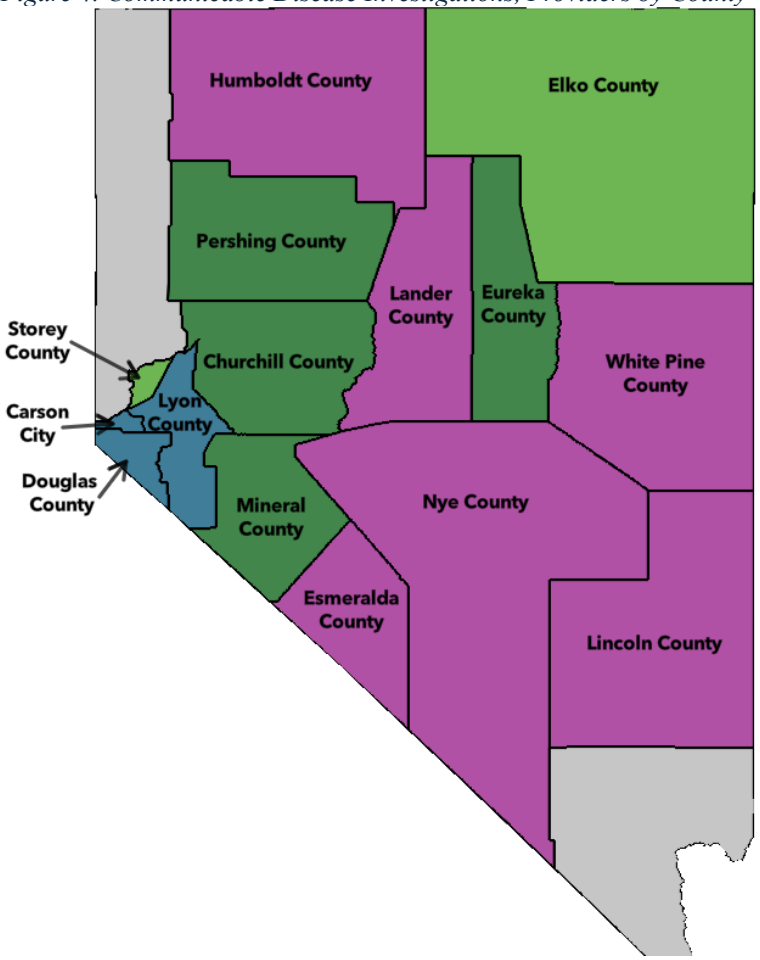


Table 8. Color Key for Epidemiology, Community Disease Investigations Providers

	=	CCHHS* Provides Service with grant from DPBH**
	=	Central Nevada Health District (CNHD)
	=	Local Partner for COVID; DPBH for all other morbidities***
	=	DPBH Nurse(s) and County Administrative Staff

**Carson City Health and Human Services*
***Division of Public and Behavioral Health*
****Storey COVID investigations via CCHHS; Elko COVID investigations via Great Basin College*

Relevant NRS: NRS 439 and 441A

Environmental Health Services – Facility Inspections

In Nevada, Environmental Health Services responsibilities are shared across jurisdictions, including the Department of Public and Behavioral Health, The Division of Environmental Projection (NDEP), the Bureau of Safe Drinking Water (within NDEP), county governments, local health authorities, and other entities such as Mosquito Abatement Districts. While the range of programming and services necessary to support a healthy environment is vast, the mandated public health services related to inspection of facilities is the service for which counties are assessed by DPBH, unless they provide the services independently or ensure provision through agreement with another health authority. The assessment charged to counties for DPBH environmental health inspections is subsidized by the collection of fees for services and, sometimes, other state or federal funding.

Environmental Health inspectors are responsible for completing inspections of restaurants, bars, schools, meat and poultry facilities, camping and RV parks, hotels, public pools, tattoo parlors, temporary mass gatherings, and manufacturers of food, drugs, and cosmetics. The following map provides a map of the health authority that staffs the environmental health inspectors for each county.

Figure 5. Environmental Health Services Inspections, Providers by County

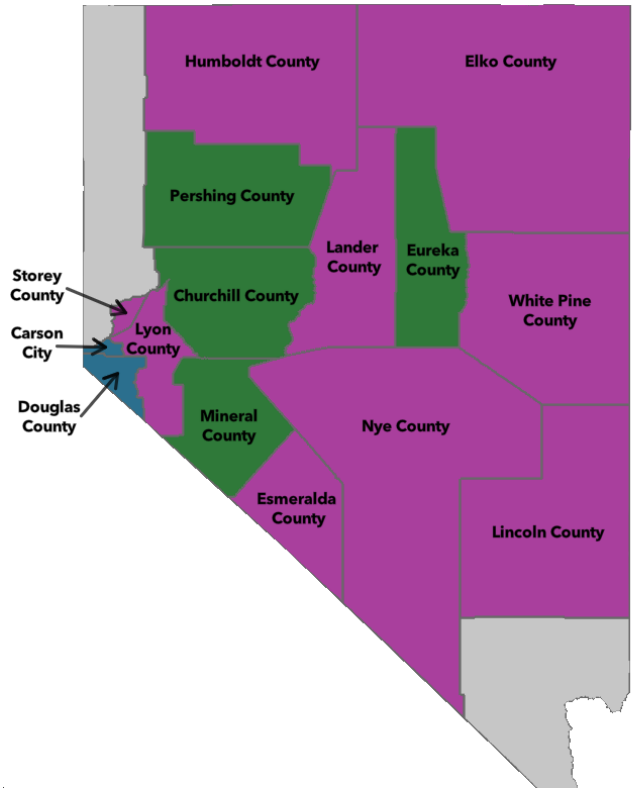


Table 9. Color Key for Environmental Health Services Inspections

	=	Carson City Health and Human Services (CCHHS)
	=	Central Nevada Health District (CNHD)
	=	Division of Public and Behavioral Health (DPBH)

A number of programs are regulated at the State of Nevada regardless of local health authority, and for permitting there are various exceptions where the State delivers a service that might otherwise be delivered by a health department (or vice-versa). The following guide developed by Environmental Health Services at DPBH is helpful with this navigation: How to choose your health department V1.pdf (nv.gov)[8]. Office locations, hours, and coverage areas for each DPBH Environmental Health Section office[9] are available through the state website, and the same is available for CNHD and CCHHS (see Results, Environmental Health Services).

[8] https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Reg/CLICS/Docs/How%20to%20choose%20your%20health%20department%20V1.pdf

[9] https://dpbh.nv.gov/Reg/Food/dta/Locations/Environmental_Health_ALL_Locations/

Nevada Revised Statutes and Current Infrastructure vis-à-vis the FPHS Framework

In contrast to the NRS public health baseline for counties, the FPHS model places substantially more focus on a public health agency's ability to complete local needs assessments, collect locally relevant data and share it, develop population-based community health improvement plans, implement population-based programs to improve health, and engage in multi-sector policy discussions to advance health. The core services of public health are still there, but the emphasis on community voice and partnership in all things, from strategic planning to program development and implementation, is highlighted. Communication is critical.

The contrast between Nevada's baseline and the FPHS model is a challenge shared with other states undergoing FPHS assessment and public health transformation efforts. Our nation's public health system has evolved over decades in response to new knowledge and new needs, but largely as a reactive enterprise. A review of NRS related to public health from a historical perspective makes this plain, as well-meaning mandates to deliver additional services and improve community health have been added over the years and in response to identified threats, but often without adequate funding to support the goals.

Considering the critical context above, the baseline results presented in this study provide a foundation for strategic planning and collaboration to improve the overall performance of the public health system in Nevada in ways that are now nationally recognized as emerging best practices. **It is not designed to rate the extent to which Nevada's governmental public health authorities are delivering on current NRS mandates.**

Foundational Public Health Services Modified for Nevada

The Foundational Public Health Services Capacity and Cost Assessment[10] tool was released by the Public Health Accreditation Board in April of 2023. The tool is designed to be completed by governmental public health department leadership. The tool includes headline responsibilities and core activities for each of the five Program Areas and eight Capabilities[11]. As designed, it collects data only on public health services provided by the health department completing the tool.

NACO modified the tool to reflect Nevada's unique infrastructure and to capture the data in a way that would make it most useful to county governments and their partners[12]. Due to Nevada's hybrid public health structure, public health services in Nevada are delivered by a variety of governmental and non-governmental partners. Thus, to get an accurate baseline, the project team collected information beyond just the services provided by governmental public health. The team adapted the methodology from that of the national tool to allow for this broader data collection. The national framework's Program Areas and Capabilities, operational definitions, and rating scales (Expertise & Capacity from the national tool, Level of Implementation from other states leading this work over the past decade) were all kept. Additional free-response survey fields and in-person verification and review meetings were added that allowed the project team to collect information on local infrastructure by providing entity across all Program Areas and Capabilities.

The national tool also includes a methodology for calculating the percentage of time all local health department employees dedicate to each activity with the goal of estimating the gap in workforce and cost to deliver FPHS services. As more states utilize the tool and provide data feedback, the comparative data becomes more accurate and actionable. For the purposes of this assessment, the project team did not utilize the staffing calculator feature of the tool, as this is best utilized by health department leadership with access to Full-Time Equivalent (FTE) allocations and staff workloads.

[10] https://phaboard.org/center-for-innovation/foundational-public-health-services-capacity-and-cost-assessment/
[11] https://phaboard.org/wp-content/uploads/FPHS-Operational-Definitions.pdf
[12] NACO and UNR Extension want to recognize Taylor Allison, NACO's previous Public Health Coordinator and current Lyon County Emergency Manager, who developed the modified tool. Taylor was instrumental in envisioning modifications to the national tool to suit Nevada's counties' needs, including the addition of behavioral health services infrastructure data.

Participating Jurisdictions

The following counties participated in this study: Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine.

Washoe County and Clark County were not assessed by the project team. Both counties have long-standing health districts that are better equipped to take on such assessments as needed. Washoe County's health district, Northern Nevada Public Health (NNPH), completed an early (and more extensive) version of this assessment in preparation for their Fiscal Year 2023 budget. Through their initial process, NNPH identified strengths and weaknesses of the assessment tool that further informed the development of the national model.

Central Nevada Health District (CNHD), which began operations in July of 2023, is the State's newest health district and first multi-county health district, serving Churchill, Eureka, Mineral and Pershing Counties, in addition to the City of Fallon. CNHD leadership participated in the process for each of their member counties in order to better understand the variation in local needs, as well as potential collective priorities for the district.

Carson City Health & Human Services (CCHHS), Nevada's first accredited health department, operates with delegated authority for public health services in the consolidated municipality of Carson City, and also provides some public health services to neighboring counties through interlocal agreements and delegation by DPBH. To support a robust baseline map for the state and the communities served by CCHHS, their leadership also chose to participate.

The remaining participating counties are served by Nevada's Division of Public and Behavioral Health (DPBH) as their health authority (see section: Public Health System in Nevada). This assessment was supported by DPBH in a variety of ways. The work was funded by a CDC Public Health Infrastructure Grant administered by the Division. DPBH leadership, in partnership with NACO, coordinated collection of state-level services by county across the Foundational Public Health Services Areas and Capabilities. This was a difficult task, as some services that fall within the FPHS are delivered by other Departments or Divisions within the state infrastructure (for example, the Nevada Department of Emergency Management, the Nevada Department of Transportation, and the Nevada Department of Environmental Protection). In many cases, state staff attended community-level verification meetings, most frequently from the Community Health Nursing section.

Limitations

Unlike a Community Health Needs Assessment, the public was not surveyed in this assessment. The project team developed lists of community experts in partnership with each county. Expert participants were instructed to fill out only the parts of the survey relevant to their expertise. In some instances, there were as few as two initial ratings for a given Program Area or Capability. The in-person review process enabled the large group of stakeholders to weigh in on the ratings and adjust as needed based on the additional information collected, and as such the initial ratings were taken as an initial basis for discussion. The ratings were frequently adjusted during the verification meetings in response to new knowledge shared.

It should be noted that the ratings of Expertise, Capacity, and Level of Implementation are based on both knowledge and perceptions of the governmental public health authority serving the county. While some criteria within each Foundational Program Area and Capability were able to be rated by local stakeholders with confidence (i.e. the extent of the governmental public health authority's partnership and communication with local communities), other criteria were more difficult for stakeholders to rate based as they were on internal procedures within the governmental public health authority, such as Human Resources or Information Technology practices. In most counties, staff from the governmental public health authority (CCHHS, CNHD, or DPBH) also completed the survey and participated in community verification meetings. Even so, direct knowledge of all back-end operations—highlighted especially in the Foundational Capabilities section—was not present in all cases.

Additionally, in a few instances, local leaders felt the local Capacity and Expertise of a particular Program Area or Capability was present separate from the governmental public health authority, and therefore would have assigned higher scores if rating all service providers and community partners collectively (not just the governmental public health authority, as the tool demands). This was especially common with respect to Foundational Capabilities such as Community Partnership, Organizational Competencies, and Communications. The process collected information on Programs and Capabilities at the local level across providing entities so these resources could be considered as assets in further assessing and developing the public health system.

Despite the limitations, the ratings represent a baseline understanding of Nevada's governmental public health authorities' ability to deliver on the Foundational Program Areas and Capabilities by those poised to work most closely with and in support of public health improvement in each county.

Methodology

Assessment Development

The FPHS pre-assessment process included developing initial stakeholder lists in partnership with each County Health Officer and other health-involved county staff. Local leaders from the following sectors were invited to participate; public health, public safety, emergency management, hospital leadership, social services, water quality, local government policy and planning, school-based health services, tribal health, veteran's services, community coalitions, local not-for-profits, and anyone else the state or county identified as supporting their local public health infrastructure.

Once the participant list was finalized, the project team scheduled a series of meetings for each county: Board of Health presentation, virtual survey participant kick-off call, and in-person community review and verification meeting. All in-person review meetings were scheduled in the county seat for each county unless otherwise requested by the county team. The assessment process began in August 2023 with Douglas County, the pilot, and finished with Lincoln County in July 2024. Each county process was completed over a period of 6 to 8 weeks.

NACO presented the assessment to each Board of Health and encouraged participation of a Commissioner Champion to participate in the virtual kick-off and community review and verification meeting. Invitations to the kick-off calls and the Board of Health meetings were sent to all identified participants. Virtual kick-off meetings were typically scheduled for 1-2 weeks after the Board of Health meeting to allow for identification of additional participants from the Board of Health. These virtual meetings introduced assessment participants to the FPHS model and survey tool, provided clarification on goals and process, and emphasized the importance of the in-person community verification meetings. The online survey and calendar invitations to the in-person meeting were distributed to all participants after the virtual call.

FPHS Timeline for Boards of Health

- Nominate/Volunteer Commissioner or Supervisor Champion at Board of Health (BOH)
- Virtual Kick-off Call / Q&A Session (BOH + 1-2 weeks)
- Survey Distributed after Kick-Off Call
- Survey Open for 3 weeks
- UNR Extension & NACO data compilation for in-person meeting (1-2 weeks)
- In-person 3hr Community Meeting to review and verify results (BOH + 6-8 week

After the virtual kickoff meeting, the online survey was sent to the list of identified participants for the county. This survey was built in Qualtrics and sent to participants through Qualtrics' built-in distribution methods. Participants were requested to review two documents prior to starting the survey: the PHNCI's FPHS Background Report[13] as well as the NACO FPHS Assessment Tool.

[13] https://phaboard.org/wp-content/uploads/FPHS-Background-Paper-2021.pdf

NACO FPHS Assessment Tool

The NACO FPHS Assessment Tool was created by the project team to be used as a basis of knowledge for the participant. The tool introduces the FPHS national background and provides instructions for the survey.

Participants are informed that they will be rating Expertise, Capacity, and Level of Implementation for each individual FPHS for their county. The tool gives definitions for each of the ratings (four ratings for Expertise and Capacity, five ratings for Level of Implementation).

The ratings scales are as follows:

Expertise

- **Absent** – None, or basic awareness of the expertise, but limited ability to apply it.
- **Basic –** Knowledge of the expertise and can apply it at a basic level.
- **Proficient**– Expertise is available and can be applied adeptly.
- **Expert** – Expertise is routinely applied and those with the expertise can build it within others.

Capacity

- **Absent** – Staff time and other resources are not present or are largely unavailable.
- **Minimal** – Some staff time and/or other resources are present to complete basic functions.
- **Moderate** – Most staff time and other resources are present to partially implement most functions.
- **Full** – Sufficient staff time and other resources are present to fully implement all functions.

Level of Program Implementation

- **Fully Implemented/ Meets Demand** – Services are fully implemented as well as meet the community's overall demand for public health services in this area.
- **Sufficient Services** – Services are mostly implemented as well as meet the community's overall demand for public health services in the area.
- **Some Services** – Some public health services are available. There is an overall demand for public health services in the community.
- **Minimal Services** – Minimal public health services are available. There is significant overall demand for public health services in the community.
- **Lacking/No Services** – There are no public health services available in this foundational area. There is significant overall demand for public health services in this community.

Next, the tool provides headline responsibilities for each FPHS as defined by the PHNCI.[14] These headline responsibilities can be found in the Results section.

Participants are provided examples of public health services for each FPHS by providing entity. Providing entities are separated into four categories: State, County, Regional Health Department/District, and Community Supported Services. The final category, Community Supported Services, is broad and captures programs implemented by school districts, tribal communities, local hospitals, non-profits, private industry, municipalities other than the county, and more. The rating scales and providing entity categories mirror what the participants will encounter in the online survey.

A copy of the NACO FPHS Assessment Tool can be found in the accompanying Appendix Handbook.[15]

[14] https://phaboard.org/wp-content/uploads/FPHS-Operational-Definitions.pdf
[15] All related publications for this project may be found online at both https://nvnaco.org/ and https://extension.unr.edu/neap/default.aspx

Online Survey

After the virtual kickoff meeting, the online survey was sent to the list of identified participants for the county. This survey was built in Qualtrics and sent to participants through Qualtrics' built-in distribution methods. Participants were requested to review two documents prior to starting the survey: the PHNCI's FPHS Background Report[16] as well as the NACO FPHS Assessment Tool.

Survey Methodology

The online survey tool was developed in Qualtrics, using a modified version of the FPHS tool created by the PHAB, as discussed earlier in this report. Overall, the survey asks participants for two things, to list programs that help implement FPHS and to rate FPHS in their county.

The survey starts with an intro page, giving the participant background information on FPHS and the goal of this project. Links were given to the PHNCI's FPHS Background Report as well as the NACO FPHS Assessment Tool. Participants were encouraged to review both documents prior to starting the survey, to ensure that they had a solid understanding of the scope and definitions of each individual FPHS.

The intro page of the online survey also asks for the participants' information including the organization they represent. While all responses were kept anonymous, this information was requested so that the program team could identify overall participation within the county and fields of expertise for the responses.

The online survey then has a page for each of the thirteen FPHS. As described in the Assessment Tool, the survey asks for two things, a list of programs implanting the FPHS, separated out by State, County, Health Authority, and Community-Supported, as well as rating the expertise, capacity, and implementation of the FPHS in the county. At the top of each of these pages, a link to the Assessment Tool was given, along with page numbers to guide the participant to information for that specific FPHS.

Programs were typed into one of four boxes, each representing the State, County, Health Authority, and Community Services, respectively. The ratings were asked in a series of drop-down boxes, one for each of Expertise, Capacity, and Implementation. Finally, a last text box was given for the participant to make any additional notes.

Participants were told that they should fill out only the information that they were comfortable with and could leave others blank. Some participants' responses were specialized in their field, such as water quality, emergency preparedness, etc. Due to this, the number of responses per FPHS may vary within each county.

A download of the full online survey can be found in the accompanying Appendix Handbook.

Participants were given a deadline of three to four weeks to complete the online survey. This date allowed the project team to analyze the data in preparation for the in-person session.

[16] https://phaboard.org/wp-content/uploads/FPHS-Background-Paper-2021.pdf

Data Analysis

A few days after the close of the survey for a county, to allow for late responses to be registered, the data was exported from Qualtrics to Excel for the project team to analyze. The project team created a template document to import the data into. Total number of responses varied county-to-county, from as little as 1 or 2 responses for a given FPHS up to 15 or more.

The data template assigned a numerical value to each rating. Expertise had values from 1 through 4, with Absent = 1 to Expert = 4. Capacity also had values from 1 through 4, with Absent = 1 to Full = 4. Implementation had values ranging from 1 through 5, with Lacking/No Services = 1 up to Fully Implemented/Meets Demand = 5.

In addition to numeric values, the data template also placed colors representing the ratings. For both Expertise and Capacity to color gradient was red (1), orange (2), yellow (3), and dark green (4). The implementation was similar with a five-color scale: red (1), orange (2), yellow (3), light green (4), and dark green (5).

The numeric values and color coding can be seen on the below two tables.

Table 10. Color Key for Environmental Health Services Inspections

Expertise Knowledge, skills, education, and experience related to the headline responsibility.		**Capacity** Staff and/or other resources, materials, and supplies to implement the headline responsibility.
Absent: No or basic awareness of the expertise, but limited ability to apply it.	**1**	**Absent**: Staff time and other resources and not present or are largely unavailable.
Basic: Knowledge of expertise and can apply it at a basic level.	**2**	**Minimal**: Some staff time and/or other resources are present to complete basic functions.
Proficient: Expertise is available and can be applied adeptly.	**3**	**Moderate**: Most staff time and other resources are present to partially implement most functions.
Expert: Expertise is routinely applied and those with the expertise can build it within others.	**4**	**Full**: Sufficient staff time and other resources are present to fully implement all functions.

Table 11. Implementation Definitions, Numeric Values, and Color Coding

Implementation Meeting the baseline recommendations for governmental public health for the headline responsibility.	
Fully Implemented/Meets Demand: Services are fully implemented as well as meet the community's overall demand for public health services in this area.	**5**
Sufficient Services: Services are mostly implemented as well as meet the community's overall demand for public health services in the area.	**4**
Some Services: Some public health services are available. There is an overall demand for public health services in the community.	**3**
Minimal Services: Minimal public health services are available. There is significant overall demand for public health services in the community.	**2**
Lacking/No Services: There are no public health services available in this foundational area. There is significant overall demand for public health services in this community.	**1**

After the numeric conversion, the data template averaged all the responses for each of Expertise, Capacity, and Implementation for each of the 13 FPHS. The averaged ratings were rounded to the nearest whole number and assigned the corresponding rating and color.

Handout Creation for Verification Workshops

For the in-person sessions scheduled, the project team developed handout documents for each participant. This handout contains averaged ratings and scores for each FPHS as well as a listing of programs implementing the FPHS in the county. A handout template was created to transfer the data template results into.

The Handout was separated into two main sections, one for the five (5) Foundational Program Areas, and one for the eight (8) Foundational Capabilities. The opening page for each section gives a brief overview of the overall rankings of the FPHS.

The individual pages for each FPHS contain the following:

- Headline Responsibilities
- Ratings from the online survey for each of Expertise, Capacity, and Implementation
    - This includes total number of responses, average value, rounded rating, and definition of that rounded rating
- Listing of programs implementing the FPHS (as gathered in the online survey)
- Any additional notes from the online survey

An example handout document is available in Appendix B.

Community Review and Verification Workshops

Community review and verification workshops were conducted in person in each of the 15 rural and frontier Nevada counties after their respective online FPHS survey was closed and data was compiled. The date, time, and location of each community workshop was scheduled in consultation with local stakeholders to find a suitable time for participants to attend. Although the online survey link was sent to a targeted audience, specifically county experts in public health and community champions, community workshop attendees included a broader audience of community health practitioners such as emergency response, sheriff offices, and local non-profits, in addition to experts and community champions. The number of attendees at the in-person community workshops usually exceeded the number of on-line surveyed responses for each county (see table to the right).

Table 12. Community Review and Verification Workshop, Dates and Number of Attendees by County

County	Workshop Date	Number of Attendees
Douglas	9/22/2023	14
Lyon	1/9/2024	24
Carson City	1/24/2024	21
Humboldt	3/7/2024	7
Elko	3/8/2024	12
Lander	3/13/2024	12
Storey	4/23/2024	14
Pershing	5/13/2024	11
Churchill	5/20/2024	14
Mineral	5/22/2024	12
Eureka	5/23/2024	7
Nye	6/5/2024	6
Esmeralda	7/17/2024	5
White Pine	7/18/2024	7
Lincoln	7/22/2024	10

The workshops were designed to meet three objectives:

1) **Educate** and share the survey collected data results with attendees for their county.
2) **Verify** or "ground truth" the summarized data from surveyed responses regarding Expertise, Capacity, and Implementation of the Foundational Programmatic Areas and Foundational Capabilities per the rating scale.
3) **Collaborate** among attendees to learn about potential opportunities in programming and services to meet county public health needs.

Workshop Process

Given the objectives of the community workshops, the group process for the workshops was designed to maximize community engagement. Each of the 15 county in-person workshops followed the same agenda, format and process (Appendix Handbook). Each workshop lasted three hours and began with brief introductions of presenters, facilitators, and workshop attendees followed by a quick review of the objectives of the community workshop. Results of the Foundational Programmatic Areas, (i.e., the baseline data) proceeded to be shared with attendees in a PowerPoint presentation. Attendees also were provided with paper copies of the baseline data for ease and convenience to review the full results. After Foundational Programmatic Areas were reviewed with the group (20 minutes), and questions asked, attendees were randomly divided into small groups. Depending on the size of attendance in the workshop, small group sizes were kept at four to six individuals, to maintain group discussion and engagement. The task for each small group was to review the baseline data presented regarding Foundational Programmatic Areas and verify if the summarized results are an accurate reflection of the county.

In addition to verification of results, each small group was asked to verify the list of services collected via the online survey, for each Foundational Programmatic Area. Each small group was provided with a total of three worksheets to assist in the verification process, as well as a color-coded rating scale was placed on each small group table for reference (Appendix Handbook). Small groups were allotted approximately 30 minutes to verify and discuss the Foundational Programmatic Areas. The 30 minutes included reviewing and discussing the ratings for the five programmatic areas regarding expertise, capacity and implementation. Verifying or changing any of the surveyed ratings in the small group was based on discussion and knowledge of the topic. If a change in rating among the group was agreed upon, the group needed to include the rationale of the altered rating or community service on the rating worksheets provided to each group. Each small group had to select a group recorder, and everything was written on the worksheets provided to each small group to ensure an accurate data record. The worksheets were collected by the project team after the session was completed. If more time was requested, additional minutes were allotted for discussion, but the facilitator was skilled in managing the meeting to ensure objectives were being met, and the workshop stayed on schedule and ended on time.

After the first round of verifying Foundational Programmatic Areas, a round-robin was conducted so each group could share their findings with the larger group. The round-robin allowed sharing, confirmation or questions to be asked by the larger group.

The second part of the workshop was focused on the Foundational Capabilities. The same process was applied. Results of the Foundational Capabilities, (i.e., the baseline data) were shared with attendees in a PowerPoint presentation. Again, attendees had a complete paper copy of the baseline report and were able to follow along with the presentation. Staying in the same small groups, participants were provided with a new set of worksheets (Appendix Handbook) to reflect the verification and discussion on the Foundational Capabilities. Attendees were allocated another 30 minutes to review and discuss the ratings for the eight capabilities areas regarding expertise, capacity and implementation, including verification of the Program Services listed for Capabilities. Although there were more categories to verify and discuss under Foundational Capabilities (i.e., eight) versus the Foundational Programmatic Areas (i.e., five) participants better understood the process and were usually able to complete the verification and discussion task within the allotted time. If more time was needed, a few minutes would be allocated. At the end of the small group verification process, another round robin was conducted to share verifications or alterations and discussion.

After the completion of the Foundational Capabilities, ten minutes of the workshop was dedicated to gathering input on Behavior Health Services in the county. This task involved each small group to add, question, remove or re-arrange services on the last page of the Programs Worksheet, Behavioral Health. Although typically the topic of behavioral health is not a component of Public Health infrastructure, the program team felt the importance of assessing and collecting services as a baseline on Behavioral Health, while experts and practitioners were in the room was important data to gather as a baseline. The last five minutes of the workshop was allocated to share "Next Steps" with participants. The program team shared what participants can expect from their participation, how participants can access the final report, and how participants input and can help their county and the work they do regarding public health in the community.

Results

The Foundational Public Health Services (FPHS) model is based on the idea that there are core services that must be available to everyone to work everywhere. Given this, participants were encouraged to consider the extent to which the Program Areas and Capabilities are delivered across the county and within their county's micro-communities (i.e. to veterans, older adults, residents outside of county seats or population centers, residents with a primary language other than English, etc.). Full Implementation is not possible unless all residents have access. In many cases, respondents reported some services in county seats (i.e. Winnemucca, Elko, Pahrump, Ely), but noted limited access and coverage in other parts of the county (i.e. Carlin, Tonopah, Gabbs).

Additionally, the project team invited representatives from Tribal Health Centers to participate in the mapping and rating of public health infrastructure in the counties adjacent to, or surrounding, tribal land. The ratings are not reflective of healthcare delivery at Tribal Health Centers, but the project team collected public health infrastructure information for tribes, where possible, to be considered in the development of further partnerships between public health authorities and sovereign tribal nations.

County-level detail of services by providing entity will be made available on the NACO website (Advocacy | Public Health | Nevada Association of Counties (nvnaco.org)[17]. The results reported here include the County-by-County Ratings and Summary Findings for each Program Area and Capability.

The results are divided into two sections: Foundational Program Areas and Foundational Capabilities.

Foundational Program Areas are specific areas of public health that directly address health issues within a community. Examples include communicable disease control, chronic disease prevention, environmental public health, and maternal and child health. Each program area focuses on a particular public health challenge and is supported by the foundational capabilities to ensure that services in these areas are consistently available and effective across all communities.

Foundational Capabilities are the essential, cross-cutting skills and capacities that every health department needs to support all public health services. They include things like having a skilled workforce, strong communication systems, robust data and surveillance systems, legal and policy support, and the ability to respond to emergencies. Essentially, these capabilities form the infrastructure that allows health departments to effectively carry out their work across all areas of public health.

In summary, Foundational Capabilities provide the necessary support structure that enables health departments to deliver services in the Foundational Program Areas. The capabilities ensure that the program areas function effectively and reach the populations that need them.

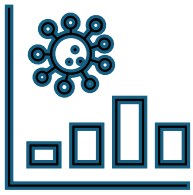
[17] https://www.nvnaco.org/advocacy/public-health.php

Foundational Program Areas

Foundational Program Areas are specific areas of public health that directly address health issues within a community. There are five Foundational Program Areas in the FPHS model. These are Communicable Disease Control, Chronic Disease and Injury Prevention; Environmental Public Health; Maternal, Child, and Family Health; and Access to & Linkage with Clinical Care. Each program area focuses on a particular public health challenge and is supported by the Foundational Capabilities to ensure that services in these areas are consistently available and effective across all communities.

The icons above are used below to indicate the following Foundational Program Areas (Clockwise from top left: Communicable Disease Control, Chronic Disease and Injury Prevention, Environmental Public Health, Access to & Linkage with Clinical Care, and Maternal, Child, and Family Health).

Communicable Disease Control



Communicable Disease Control in public health involves the prevention, detection, and management of infectious diseases–conditions like Influenza, Tuberculosis (TB), Hepatitis, COVID-19, Foodborne Illness, and Syphilis. The prevalence of over 50 communicable diseases are actively monitored by health authorities in Nevada. A strong Communicable Disease Control program includes monitoring outbreaks, implementing vaccination programs, promoting personal hygiene, and providing treatment and education to minimize the impact of these diseases.

The following headline responsibilities were the basis for the ratings:

- Develop a communicable disease prevention plan, as well as plans for the prevention and control of specific communicable diseases.
- Provide timely, scientifically accurate, and locally relevant information on communicable diseases and their control.
- Implement population-based communicable disease prevention and control programs and strategies.
- Inform, communicate, work cooperatively with, and influence others on policy, system, and programmatic changes for communicable disease prevention and control.
- Conduct disease investigations and respond to communicable disease outbreaks.
- Enforce public health laws to prevent and control communicable diseases.
- Maintain or participate in a statewide immunization program and assure the availability of immunizations

Opportunities for Health Authorities, Counties, and Legislators

- Consider improvements to communications infrastructure to ensure the work of the health authority, including plans and tools (prevention plans, data dashboards, educational programs, technical bulletins, etc.) are reaching local partners poised to act on or support the control and prevention of communicable diseases.
- Develop communicable disease prevention plans relevant to local disease threats in partnership with local partners who can support the work.
- Provide regular technical assistance and support to hospitals working to implement new communicable disease prevention and control strategies.
- Hire/Retain/Support County Health Officers who can provide locally relevant updates on communicable disease prevalence, plans, and programming in partnership with health authority staff.
- Legislators should consider sustainably funding public health infrastructure improvements made over the past five years with one-time funds that have either recently sunset or will in the next biennium.

Key Themes: Communication/Information Loop; Locally Relevant Planning + Programming

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Communicable Disease Control and provide more detailed discussion to support the opportunities listed above.

Figure 6. Expertise Ratings, Communicable Disease Control

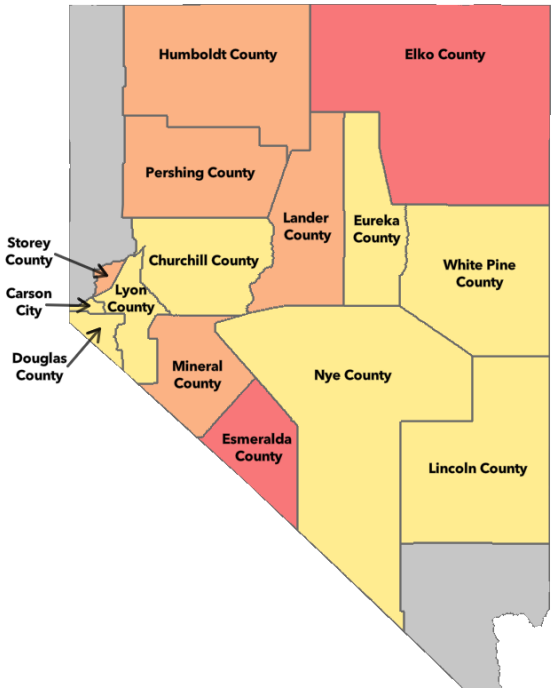


Figure 7. Capacity Ratings, Communicable Disease Control

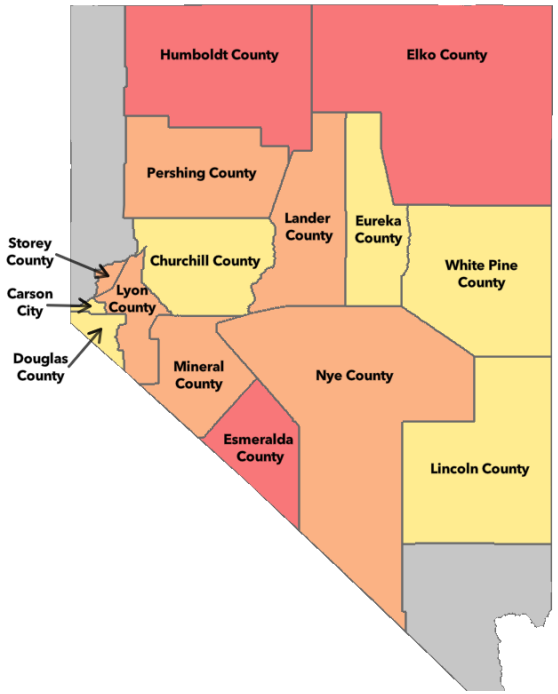


Figure 8. Implementation Ratings, Communicable Disease Control

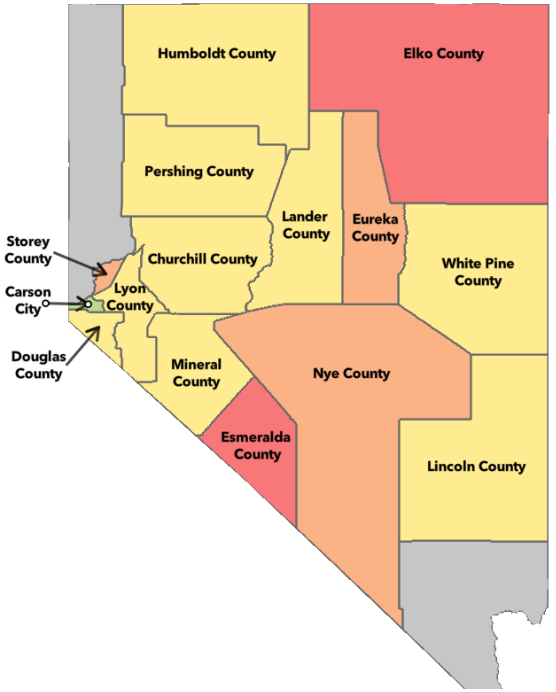


Table 13. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 14. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 15. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion – Communicable Disease Control

Through the FPHS process, the project team learned that there are epidemiology services being provided in every county, but the trends, implications, and potential community actions to reduce the prevalence of disease are not routinely communicated to local partners and leaders in the communities surveyed. As one FPHS participant group shared, "There is no communication from State Epidemiology to local partners (e.g. government or schools, or health clinics) about disease rise or outbreaks; no technical bulletins shared from the state." Such perceptions persist despite significant investment in website development at the Office of State Epidemiology[18] to provide technical bulletins, data and statistics, and community guidance to address public health threats. There is an opportunity to address the communications gap in this Program Area to better improve service and coordination.

Few participants outside of health authority staff were aware of how local disease prevalence gets collected or what is involved in a disease investigation. There is also limited knowledge of the many disease registries active in the state.

The accuracy of the disease prevalence data for rural and frontier counties was also questioned given the limited healthcare access points, the frequent travel for testing and/or care (including travel to Utah and California), and the inability of communities to verify – or at least gut check—their own data on the State of Nevada Office of Analytics[19] dashboards due to data suppression. Participants expressed a need for a feedback loop whereby organizations, either mandated or voluntarily providing data, receive summary reports or guidance on how to act on disease threats.

Hospital leadership across the surveyed counties noted their participation in mandatory reporting of certain conditions, which, in many cases, is the source for registry data. Summary reports or locally relevant action plans that could assist hospitals in managing the communicable diseases in their service area, or in implementing alternative procedures to mitigate issues, are desired but not currently present. Hospital leadership noted that there are abundant policies and compliance checks in place to keep patients safe but limited-to-no bandwidth for the health authority to support local implementation of the policies or changes to procedures.

> "MOST STATE PROGRAMS LISTED ARE NOT KNOWN TO US, BUT WE TALKED ABOUT HOW MOST SERVICES ARE NOT 'SEEN' IN THE COMMUNITY BECAUSE ILLNESS INVESTIGATION IS INDIVIDUALLY BASED. WE ALSO DID NOT KNOW MUCH ABOUT THE DASHBOARDS."
>
> Storey County Community Meeting Group Notes

Access to immunizations is a struggle statewide, though there are regions that fare far better than others. In community discussions of this FPHS Program Area, many participants discussed the barriers to getting kids immunized across all areas of their counties, including a complete lack of access without significant travel for some counties, such as Esmeralda. State funding for the Nevada State Immunization Program (NSIP) comes from both grants and the State General Fund. The State maintains the registry and reviews storage for all providers of vaccines. In some cases, local health authorities receive pass-through grant funds to support immunization delivery.

[18] https://nvose.org

[19] https://dhhs.nv.gov/Programs/Office_of_Analytics/OFFICE_OF_ANALYTICS_-_DATA___REPORTS/

Also of note, in this Program Area, is that in both Elko and Esmeralda counties, survey participants identified Expertise, Capacity, and Level of Implementation for Communicable Disease Control by their health authority as Absent, Absent, and Lacking/No Services, respectively. Although both are served by DPBH, neither county has a state Community Health Nurse. In counties with a state nursing presence there appears to be more two-way communication between state and local partners on other state supported services.

> "CNHD CAN TRACK AND REVIEW [CASES]. A BASIC LEVEL OF SERVICES IS OFFERED. INCREASED PUBLIC ENGAGEMENT AND DISSEMINATION OF BASIC EDUCATION IS NEEDED."
>
> Mineral County FPHS Community Meeting Group Notes

It is important to note here the divergence between Nevada's baseline services and the FPHS model. The State of Nevada has made investment in preventing communicable disease. The Bureau of Health Care Quality and Compliance (HCQC)[20], for example, provides for the licenses and certification of a wide range of healthcare facilities, and investigates complaints against healthcare facilities. These processes and interventions support the prevention of communicable diseases in healthcare settings where the risk of contracting disease can be high. Epidemiology teams at state and local health authorities conduct mandatory investigations and provide education to impacted individuals. DPBH provides sub-grants to local health authorities to support this work. Environmental Health Services efforts, which will be discussed separately, also support this Program Area.

What local leaders on the whole saw as only partially implemented, or sometimes absent, were the top FPHS headline responsibilities for this area. This includes having communicable disease prevention plans and implementing population-based communicable disease prevention and control programs and strategies. With respect to data, it includes collecting locally relevant, timely and accurate data, and ensuring that data gets communicated to the public and to partners. Finally, the ability to work cooperatively with, and influence others on, policy, system, and programmatic changes for communicable disease prevention was an area for further growth in all communities assessed.

[20] https://dpbh.nv.gov/Reg/HealthFacilities/HealthFacilities_-_Home/#:~:text=The%20Bureau%20of%20Health%20Care%20Quality%20and%20Compliance%20(HCQC)%20licenses

Chronic Disease and Injury Prevention

Chronic Disease and Injury Prevention in public health focuses on helping people stay healthy by reducing the risk of long-lasting illnesses like heart disease, diabetes, and cancer, as well as preventing injuries. This involves promoting healthy habits, like regular exercise and eating well, ensuring access to healthcare, and creating safer environments. The goal is to improve overall health and quality of life while lowering the chances of serious health problems and injuries that can affect individuals and communities over time.

The following headline responsibilities were the basis for the ratings:

- Develop a chronic disease and injury prevention plan, as well as plans for the prevention and control of specific chronic diseases or sources of injury.
- Provide timely, scientifically accurate, and locally relevant information on chronic diseases and injury prevention.
- Implement population-based strategies to address issues related to chronic disease and injury.
- Inform, communicate, work cooperatively with, and influence others on policy, system, and environmental changes that will prevent harm and improve health related to chronic disease and injury.

Opportunities for Health Authorities, Counties, and Legislators

- Health authorities, local governments, and community partners may consider developing (or re-evaluating) current public health communications pathways to ensure stronger partnership and understanding of strategic plans, as well as local data and impacts.
- Consider targeted efforts in Esmeralda, Nye, and White Pine counties where local partners reported "Lacking/No Services" for this Program Area.
- Establish adequate funding for the State Program for Wellness and the Prevention of Chronic Disease established in statute without designated, sustainable funding, either through legislative action or for consideration in state budget.
- Encourage participation in the Nevada Statewide Cardiovascular Learning Collaborative to build statewide coordination with currently available grant funding.
- Legislators may consider reinstating youth vaping prevention funding to ensure continued services.

Key Themes: Address gaps in geographically underserved areas; Increased partnership on current plans/programs; Locally Relevant Planning + Programming

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Chronic Disease and Injury Prevention and provide more detailed discussion to support the opportunities listed above.

Figure 9. Expertise Ratings, Chronic Disease and Injury Prevention

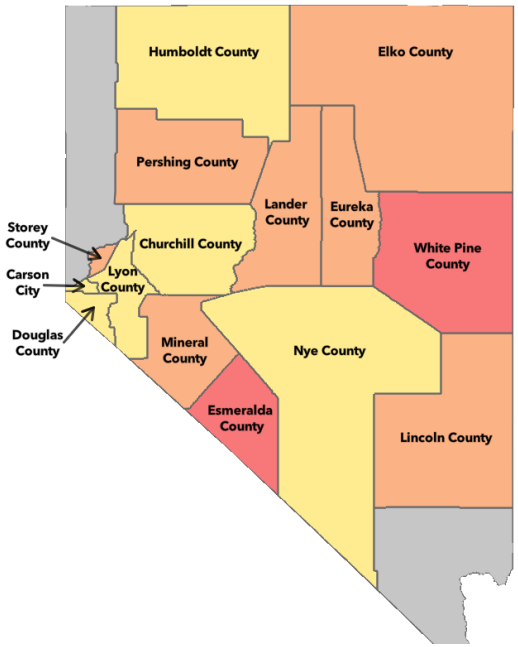


Figure 10. Capacity Ratings, Chronic Disease and Injury Prevention

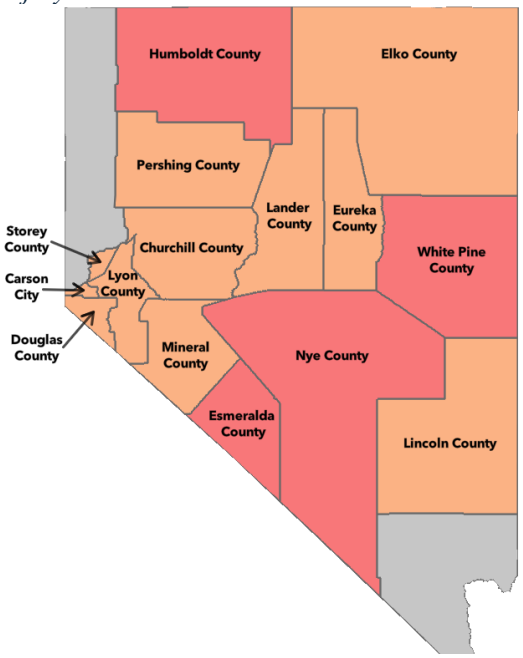


Figure 11. Implementation Ratings, Chronic Disease and Injury Prevention

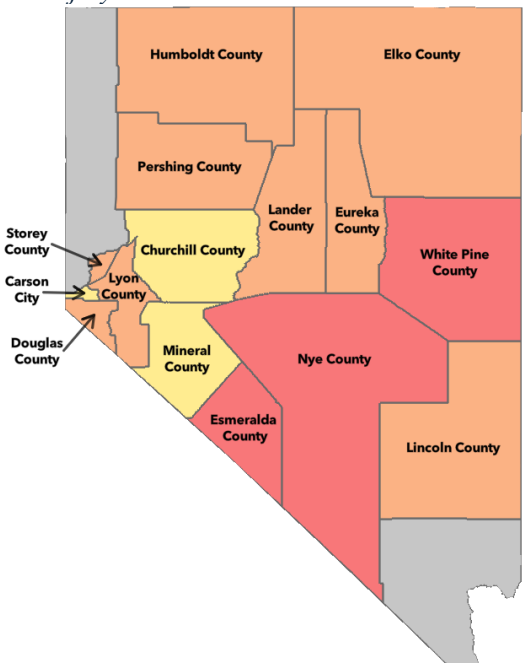


Table 16. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 17. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 18. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

Chronic Disease and Injury Prevention services have minimal implementation across most of the counties surveyed. For counties that are larger by area, many participants noted that available services are largely restricted to population centers. Six of the participating counties noted Expertise as "Proficient" for this Program Area, but the Capacity to deliver the services is "Minimal" or "Absent" due to either staff time or funding limitations. This is a Program Area with very few mandated services in NRS.

In many counties, programs were identified as delivered either by the county, for example through Senior Services and food pantries (sometimes with state or federal funding streams), or by a not-for-profit organization such as a hospital or coalition. Storey County, notably, reported that they would rate their local coordination and delivery of services (supported through the county, Nevada Health Centers, and Community Chest, Inc.) higher in this Program Area if rating their overall community capacity rather than solely the governmental public health authority.

The most extensive local implementation of Chronic Disease and Injury Prevention programming, though still limited, was reported in Carson City where Carson City Health & Human Services (CCHHS)[21] delivers tobacco prevention services, including outreach to providers regarding services such as the Nevada Tobacco Quitline[22], STI and HIV prevention, healthy living information for clients, and partnership with the school district to provide adolescent health education classes. Churchill County also rated implementation as "Some Services," as Central Nevada Health District[23] (CNHD) has community health education and healthy eating programs through their clinics. There is an opportunity to further communicate with all CNHD member counties about the availability of this programming.

Chronic Disease and Injury Prevention is a Program Area that could be greatly impacted by greater attention to the health impacts of community and economic development decisions.

Chronic Disease and Injury Prevention is one of the public health program areas that demands a Health in All Policies (HiaP)[24] approach. This is because the context in which people live has such a significant impact on both health outcomes and health behaviors. If someone lives in a food desert, maintaining a healthy diet can be very difficult. If there is little economic opportunity in one's community, funding for community features that promote healthy lifestyles, such as parks, community centers, and attainable housing, as well as sustainability of key services, such as pharmacies and primary and oral health care, is more difficult to achieve. This Program Area could be greatly impacted by attention to the health impacts of community development decisions. The Nevada Department of Transportation's policy on Complete Streets[25] and the federal Safe Streets and Roads for All (SS4A)[26] are examples of how intentional design in community development can have a positive impact on community health and safety.

[21] https://www.gethealthycarsoncity.org/divisions/chronic-disease-prevention-health-promotion
[22] https://dpbh.nv.gov/Programs/TPC/dta/Tobacco_Cessation/Tobacco_Cessation/
[23] https://www.centralnevadahd.org/clinical-health-services/
[24] https://www.cdc.gov/policy/hiap/index.html
[25] https://www.dot.nv.gov/home/showpublisheddocument/8594/636367663457970000
[26] https://www.transportation.gov/grants/SS4A

The State of Nevada has a robust statute establishing the State Program for Wellness and the Prevention of Chronic Disease (NRS 439.514-439.525)[27], but it is operationalized "within the limits of available money," so it is largely grant-dependent. The State established the Cardiovascular Health Program[28] in 2013, for example, with 100% of its funding through the CDC. There is also a new Nevada Statewide Cardiovascular Learning Collaborative[29], a grant-funded program that intends to build and manage a network of partners to address barriers and increase social support that affects heart health. DPBH also houses a CDC-funded Diabetes Prevention and Control Program[30]. There was limited knowledge of how these programs are operationalized in the DPBH health authority counties. The FPHS project team shared information on how to join the Nevada Statewide Cardiovascular Learning Collaborative during the meetings, but there remains an opportunity to better communicate the goals and resources of these programs to communities.

The State of Nevada also receives limited CDC funding for Tobacco Control and Prevention and sub-grants to health districts. The Fund for a Healthy Nevada previously funded youth vaping prevention programming, but this funding was not renewed in the 2023 legislative session.

Notably, the State has a current Chronic Disease Prevention and Health Promotion Strategic Plan[31], which outlines plans to increase local delivery of evidence-based chronic disease prevention programs and addresses the first headline responsibility in the FPHS model.

There is more opportunity to work with local partners on the other headline responsibilities including the (1) implementation of population-based strategies and (2) informing, communicating, and working cooperatively with others to influence the policy, system, and environmental changes needed to improve health. While the plan had statewide input during the development stages, local partners participating in the FPHS study were not aware of how to access the plan, what local data was being monitored to demonstrate progress, how it would impact their own community, or what progress had been made to achieve the outlined goals. CCHHS and CNHD do not have local Chronic Disease and Injury Prevention Plans.

> "I HAVE A LONG HISTORY SERVING RURAL COMMUNITIES. BUT THE FRONTIER, HERE AT THE CENTER OF THE STATE, HAS CRITICAL NEEDS UNLIKE ANYTHING I HAVE EVER EXPERIENCED BEFORE. I HAVE COMMUNITY PARTNERS THAT COMPARE SERVING MY COMMUNITIES TO SERVING THE ALASKAN BUSH… BY HOPPER PLANE. IT IS SO INCREDIBLY DIFFICULT TO GET PEOPLE OUT TO THE RESOURCES THEY NEED OR TO GET THE RESOURCES THEY NEED BROUGHT INTO THE COMMUNITY FROM URBAN CENTERS."
>
> Nye County FPHS Survey Participant

There is also much more opportunity to consider the reach of current efforts, as communities on the frontier report having minimal to no access.

Also of note, regarding Injury Prevention, is the Bureau of Behavioral Health, Wellness, and Prevention[32] at the State of Nevada, which has suicide prevention and overdose prevention programs. At the State level, these programs are primarily focused on grants management and sub-granting to local organizations to support the work. Please see the section on Behavioral Health for additional discussion of resources and services.

[27] https://www.leg.state.nv.us/nrs/nrs-439.html#NRS439Sec514
[28] https://dpbh.nv.gov/Programs/Heart/hdsp-home/
[29] Heart and Stroke Prevention and Control - Community
[30] https://dpbh.nv.gov/Programs/Diabetes/Diabetes_-_Home/
[31] https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/CDPHP-Strategic%20PlanvFINAL(1).pdf
[32] https://dpbh.nv.gov/Programs/BHWP/

Environmental Public Health

Environmental Public Health is about protecting people from harmful things in their surroundings that could affect their health. This includes making sure the air we breathe, the water we drink, and the food we eat are safe and free from pollution or contamination. It also involves controlling hazards like chemicals, waste, and other factors in our environment that could lead to illness or injury. The aim is to create healthier and safer communities by managing and reducing these environmental risks.

The following headline responsibilities were the basis for the ratings:

- Develop a plan to promote environmental health.
- Provide timely, scientifically accurate, and locally relevant information on the environment and environmental threats and their control.
- Implement population-based environmental health programs and strategies.
- Inform, communicate, work cooperatively with, and influence others whose work impacts environmental health.
- Diagnose, investigate, and respond to environmental threats to the public's health.
- Conduct mandated environmental public health inspections and oversight to protect the public from hazards in accordance with federal, state, and local laws and regulations.

Opportunities for Health Authorities, Counties, and Legislators

- Develop statewide and local strategic plans to promote environmental health that bring together experts from all agencies supporting this Program Area, including the Nevada Division of Environmental Protection, public health authorities, state and local planning departments, water and sewer authorities, air quality teams, and waste management.
- State agencies may consider hiring an Environmental Public Health Inter/Intra-governmental Liaison that engages regularly across State Divisions/Bureaus and with county governments, health districts, local Boards of Health, and local water authorities.
- Consider expanding and/or better communicating soil, water, and air quality sampling, especially in areas with higher incidence of chronic disease, to improve local knowledge of environmental risks and build case for support of remediation or mitigation efforts.
- Review local policies and programs for opportunities to close gaps where public health does not have jurisdiction, but where public health hazards remain (i.e., when rental properties have identified environmental health hazards such as bed bugs).
- Local Boards of Health may consider inviting regular presentations and data-sharing from Environmental Health Inspectors serving their jurisdiction to report out on activities and findings.

Key Themes: Inter- and Intra-agency Coordination; Communication/Information Loop; Strategic planning with analysis of local health indicators and environmental studies

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Environmental Public Health provide more detailed discussion to support the opportunities listed above.

Figure 12. Expertise Ratings, Environmental Public Health

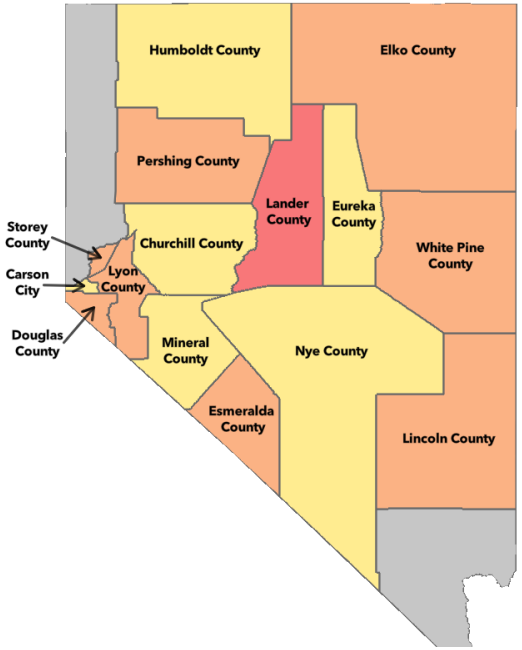


Figure 13. Capacity Ratings, Environmental Public Health

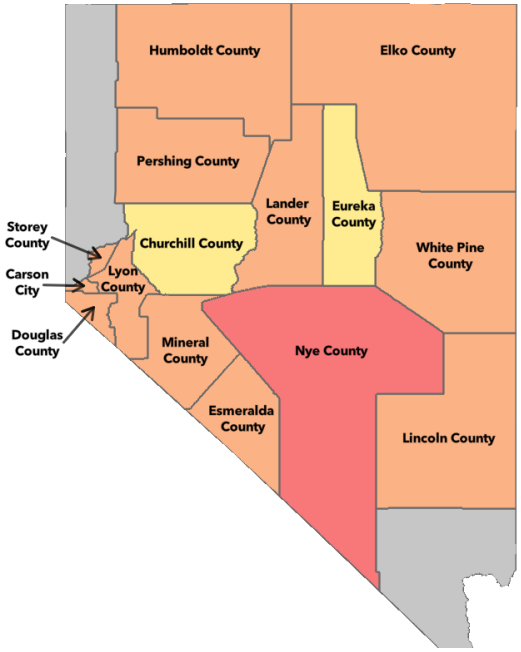


Figure 14. Implementation Ratings, Environmental Public Health

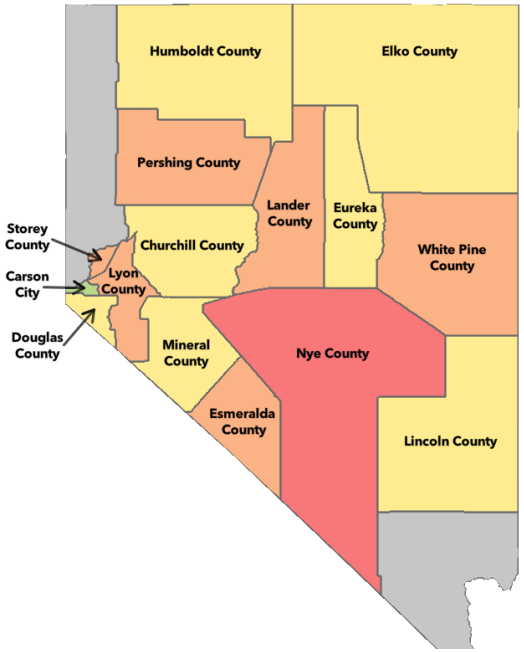


Table 19. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 20. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 21. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

The infrastructure for this Program Area is one of the most difficult to map due to the distribution of responsibility across so many agencies, districts, and municipalities. Local governments support and invest in this area in several ways. Some examples include public works departments, county codes and zoning regulations, water and utilities districts, animal control, emergency response support for spills, and dust abatement programs.

"I WOULD LIKE TO SEE THE HEALTH DISTRICT DO MORE TO ASSESS OUR ENVIRONMENT, OUR SOIL, AND OUR WATER. OUR CANCER RATES OUT HERE ARE SKYROCKETING AND WE NEED MORE DATA TO UNDERSTAND WHY."

Mineral County FPHS Survey Participant

The project team recognizes there is far more opportunity to map the Environmental Public Health system in Nevada beyond what was collected within this assessment. The focus for this report, driven by the governmental public health authority lens and local discussions, is Environmental Health Services typically provided through a governmental public health authority. Even so, it is important to note that more coordination is needed between the various public agencies that support this Program Area. There is limited statewide data analysis that brings together health outcomes data in comparison with data on local environmental health threats and hazards.

As mapped in the Background section of this report, both state and local public health authorities perform permitting, surveillance, and inspection of restaurants, bars, cottage food operations, schools, foods and cosmetics manufacturing, as well as public accommodations (hotels, lodging, motels), invasive body decoration (tattoos, piercings), and more. Permitting individual (but not commercial) sewage systems also falls within the purview of governmental public health in Nevada. For counties not within a health district, DPBH delivers this service. The Central Nevada Health District provides this service[33] across its member counties.

The Nevada Department of Environmental Protection[34] plays a significant role in protecting the land from contamination, ensuring safe drinking water and water pollution control, protecting air quality, prevention of chemical accidents in industrial facilities, and environmental clean-up. The Division of Welfare and Supportive Services[35] handles child-care licensing to ensure the health and safety of children in licensed facilities.

As with other FPHS Program Areas, establishing plans to promote environmental health are primary. Notably, the Silver State Health Improvement Plan[36] includes Air Quality as a priority action area.

The local discussions in this Program Area centered around mandated services, as well as opportunity areas. Local partners overall were not aware of the counts, frequency, or findings of EHS inspections in their counties, nor did they know whom to contact to get their local data. Local partners indicated that they would be interested in knowing which restaurants in their area, for example, had deficiencies, and additionally what steps are taken to help local business owners achieve compliance when there are findings.

[33] https://www.centralnevadahd.org/environmental-health-services/
[34] https://ndep.nv.gov/
[35] https://dwss.nv.gov/Care/CCL/ccl-licensing-home/
[36] https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/About/2023-28-SSHIP-23-28-Final2.pdf

In multiple counties, community health clinics received calls regarding environmental health complaints from the public, but staff did not know where to route the calls. The State of Nevada maintains an Environmental Health Complaints[37] landing page that includes a phone number, online portal, and navigation to appropriate local health authorities' complaints portals. There is an opportunity to increase outreach to local partners to spread awareness of the complaint and resolution process, as well as an opportunity for local partners to reach out to their health authority for more information.

Additionally, questions arose regarding powers and jurisdiction to respond to public health threats. Public health authorities, for example, cannot intervene when a public health threat, such as bed bugs, is reported in a rental property. Jurisdiction is limited to public accommodations. In some cases, there are city code enforcement procedures that can assist, but often the plan of action involves referring the residents to abatement companies or to social services if this situation is dire and children or seniors are involved. Greater clarity and communication regarding the scope of the local public health authority may assist in policy and program development to protect public health where these gaps exist.

> "CCHHS IS DEVELOPING A NEW LEAD TRAINING AND HOUSEHOLD TESTING PROGRAM FOR WHEN A CHILD TESTS FOR HIGH LEAD LEVELS. [THE PROGRAM HAS] SURVEILLANCE OF OTHER HEAVY METALS, ALSO.
>
> THE [ENVIRONMENTAL HEALTH] PROGRAM ALSO RESPONDS TO ENVIRONMENTAL HEALTH MATTERS IN THE COMMUNITY THROUGH PARTNERSHIPS WITH FIRE, PUBLIC WORKS, AND THE BUILDING DEPARTMENT."
>
> Carson City FPHS Community Meeting Group Notes

Notably, Carson City was the only jurisdiction surveyed where the Level of Implementation rating was "Sufficient Services." This local authority is relatively well-resourced with a dedicated Environmental Health Services Division[38]. This Division also serves Douglas County through a Memorandum of Understanding (MOU). Through the community discussion it was determined that Douglas County's population growth has led to a demand for services beyond the scope of the original agreement. For this reason, Douglas County's Level of Implementation rating was determined to be "Some Services."

CNHD has placed a focus on community education across all their programs. To support this effort, they hosted "Meet Your Health Inspector" events across their jurisdiction to increase community knowledge of services. Counties and local partners can support the health district by promoting these types of events and encouraging additional community conversation around Environmental Public Health.

[37] https://dpbh.nv.gov/Reg/EHS_Complaints/Complaints/
[38] https://www.gethealthycarsoncity.org/divisions/environmental-health

Maternal, Child, and Family Health

Maternal, Child, and Family Health, in public health, focuses on the well-being of mothers, babies, children, and families. This area of public health works to ensure that pregnant women receive the care they need for a healthy pregnancy, and that children grow up healthy and strong. It includes services like prenatal care, immunizations, and nutrition support. The goal is to support families at every stage, from pregnancy through childhood, to improve health outcomes and ensure everyone has the opportunity to lead a healthy life.

The following headline responsibilities were the basis for the ratings:

- Develop a maternal and child health plan, as well as plans for addressing specific maternal, child, and family health issues.
- Provide timely, scientifically accurate, and locally relevant information on maternal, child, and family health.
- Implement population-based strategies to address issues related to maternal, child, and family health.
- Inform, communicate, work cooperatively with, and influence others on policy, system, and environmental changes that will prevent harm and improve maternal, child, and family health.
- Assure provision of mandated newborn screenings and follow-ups according to state or federal mandates.

Opportunities for Health Authorities, Counties, and Legislators

- Consider investing in local Human Services infrastructure, as a strong local department can provide targeted resource navigation and effectively pull in and manage state and federal dollars.
- DPBH may consider providing current, regularly updated information on which local organizations and entities receive Maternal, Child, and Family Health-related federal pass-through dollars, and assist counties that are minimally served by these programs in developing capacity to apply for funds.
- Local Boards of Health may consider requesting organizations and/or county staff delivering services to report on local implementation of Maternal, Child, and Family Health-related programs to build greater understanding of local needs and resources.
- Consider increased targeted efforts in Nye and Mineral Counties, which have been identified as high risk for poor Maternal and Child Health outcomes (see Discussion), as well as initiating new efforts in Esmeralda County where there is no access to services.
- Legislators may consider identifying adequate funding sources for programs before mandating them in statute.

Key themes: Program Management vs. Direct Services; Funding Transparency; Local Infrastructure; Geographic Equity

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Maternal, Child, and Family Health provide more detailed discussion to support the opportunities listed above.

Figure 15. Expertise Ratings, Maternal, Child, and Family Health

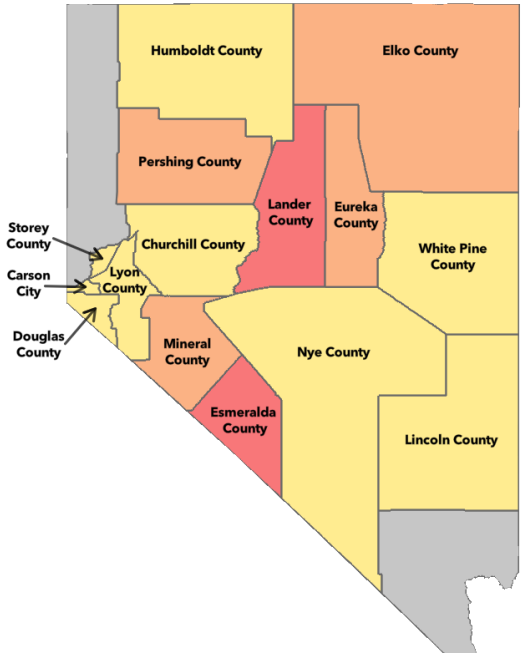


Figure 16. Capacity Ratings, Maternal, Child, and Family Health

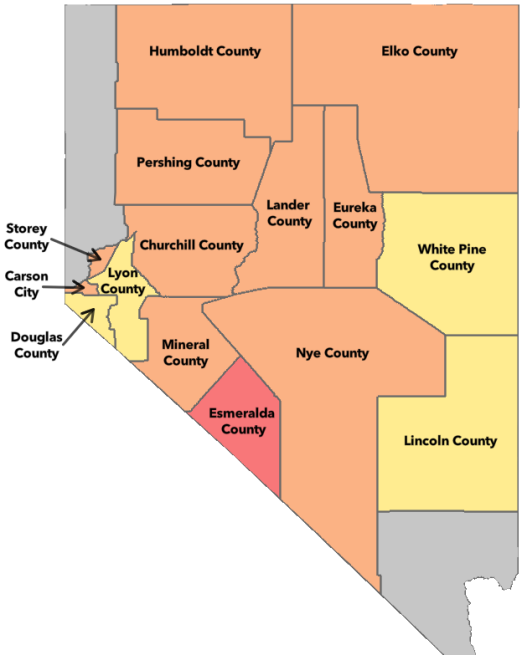


Figure 17. Implementation Ratings, Maternal, Child, and Family Health

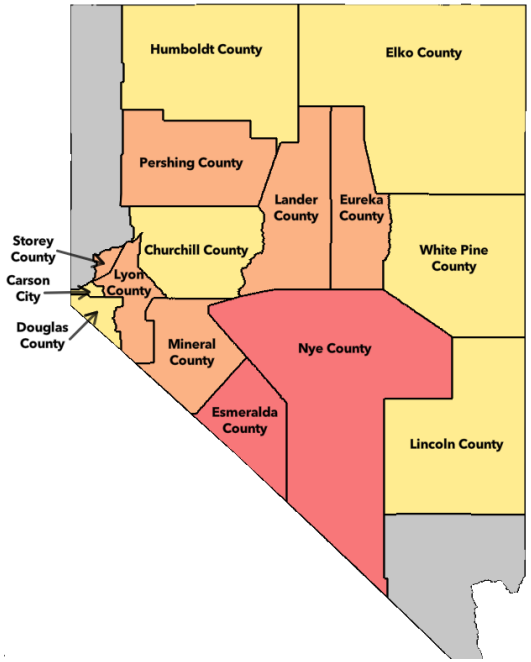


Table 22. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 23. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 24. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

Ratings in the Maternal, Child, and Family Health Program Area largely fell between "Some Services" and "Minimal." No local plans specific to Maternal, Child, and Family Health were identified through the FPHS process. The project team located the 2020: Nevada's Maternal and Child Health Needs Assessment[39] during follow-up research, but there was no local knowledge of this assessment or planning attached to it among participating partners. Notably, Nye and Mineral Counties were identified as being at high risk for poor MCH outcomes in that assessment (p. 36). Both counties rated Level of Implementation of this Program Area as "Lacking/No Services" and "Minimal Services," respectively, during the FPHS assessment process.

DPBH activities in this Program Area include management of registries and monitoring systems (i.e. Pregnancy Risk Monitoring System or PRAMS[40]), and development and maintenance of a Maternal and Child Health Dashboard[41] with data on births, teen pregnancy, fetal deaths, maternal mortality, and more. Beyond this critical data management function, much of the state scope is program oversight and grants management with limited state-delivered direct services. This creates confusion for local partners who see information about programs on the State website, but do not see State implementation locally. In some cases, local participants expressed resentment or frustration that programs are listed as statewide, but local access points in rural and frontier counties are either non-existent or not widely known. On the flipside, state participants noted that local communities often misunderstand the state's role in the programs. There is ample opportunity to clarify the limitations on program development, as well as clarify which programs follow the state-funded, locally delivered model, so expectations can be appropriately managed and progress made to fill true gaps.

> *"The only way the State is able to provide these programs is through nonprofits in the area; If the nonprofits didn't implement the programs, we would not have the services provided by the State; If the nonprofits went away these ratings would all have to drop to 1 [indicating Absent/No Services]."*
>
> Elko County Community Meeting Group Notes

Direct services in this area are most often delivered by local partners or government departments that have demonstrated capacity to receive funds to deliver services and comply with federal grant requirements. Lyon County is a notable example where Lyon County Human Services[42] houses the Women, Infants and Children (WIC)[43] clinic, family planning, and housing support, as well as the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV),[44] and parenting classes. The Healthy Communities Coalition[45] also provides a large array of services in this region. Successful implementation of this Program Area requires local expertise and infrastructure beyond the governmental public health authority.

[39] https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/TitleV/2020%20Nevada's%20Maternal%20and%20Child%20Health%20Needs%20Assessment.pdf
[40] https://dpbh.nv.gov/Programs/PRAMS/PRAMS/
[41] https://app.powerbigov.us/view?r=eyJrIjoiNzgxNGI2MjItMWZkNC00Y2Y4LTgzYjItZWU1Y2Y1OGI2NjgxIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9
[42] https://www.lyon-county.org/175/Human-Services
[43] https://nevadawic.org/
[44] https://dpbh.nv.gov/Programs/MIECHV/Nevada_Home_Visiting_(MIECHV)_-_Home/
[45] https://healthycomm.org/

During the FPHS process it was frequently noted that local partners did not know whether any agencies within their county were receiving funding or direct services for this Program Area, especially regarding the Title V Maternal and Child Health Block Grant Program[46] and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)[47]. In the case of the latter (MIECHV), the State website notes that this program is available through agencies in four counties (Clark, Washoe, Lyon, and Storey) and through the Yerington Paiute Tribe. In some cases, the local agency receiving funds also delivers home-visiting services to neighboring counties. Community Chest, Inc., for example, provides home visiting services in Storey, Mineral, Carson City, Douglas, Churchill, and Northern Nye County (Tonopah). There is opportunity to keep the state website updated to ensure communities know what services are available locally. The statewide partners for the Account for Family Planning[48] are also available on the DPBH website.

> "HEALTHY COMMUNITIES COALITION PROVIDES DIABETES PREVENTION EDUCATION THROUGH THE FOOD BANK, DENTAL OUTREACH, SUBSTANCE USE/ABUSE PREVENTION, TOBACCO USE PREVENTION, SIGNS OF SUICIDE PROGRAM, AND ALSO DOES PRESCRIPTION FOOD SUPPORT, WHICH SUPPORTS CARDIAC HEALTH AND CARDIOVASCULAR WELLNESS."
>
> Lyon County Community Meeting Group Notes

Participation in the Early Hearing Detection and Intervention Program[49] was noted by all hospitals serving the area. The lack of access to prenatal care, however, was frequently mentioned given the shortages of OB/GYNs in the counties served. There are only 5 birthing hospitals in rural and frontier Nevada and none in the southern half of the state outside of Clark County.

Finally, while assurance of immunization availability is a part of the FPHS model's Communicable Disease Control Program Area, disparities in the availability of childhood vaccinations and discussions regarding the eligibility criteria for the Vaccines for Children Program was also a priority focus in this Program Area, too. The Vaccines for Children Program [50]does not cover children who are privately insured, and private vaccines are cost-prohibitive for the Nevada State Immunization Program (NSIP). With access to medical providers limited across rural and frontier areas, it is very difficult for parents to access vaccinations for their children, even when their insurance covers the cost.

Immunization pop-ups in advance of the school year help increase access, but these are infrequent. Additionally, many have the same insurance restrictions, and are often hosted in population centers, which may still require significant travel for many residents depending on where they live in the county. Pharmacies can help increase access in remote areas, but in at least one reported instance (Tonopah, Nye County), the only local pharmacy will not provide vaccinations to children under 10.

[46] https://dpbh.nv.gov/Programs/TitleV/TitleV-Home/
[47] https://dpbh.nv.gov/Programs/MIECHV/Nevada_Home_Visiting_(MIECHV)_-_Home/
[48] https://dpbh.nv.gov/Programs/AFP/AFP/
[49] https://dpbh.nv.gov/Programs/EHDI/dta/Providers/Early_Hearing_Dectection_and_Intervention(EHDI)_-_Providers/
[50] https://dpbh.nv.gov/Programs/VFC/VFC_-_Home/

Access to and Linkage with Clinical Care

Access to and Linkage with Clinical Care, in public health, is about making sure people can easily get the medical services they need to stay healthy. This means helping individuals find and use healthcare, whether it's visiting a doctor, getting medication, or receiving important health screenings. It also involves connecting people with the right resources and services, especially those who might face barriers like cost or transportation. The goal is to ensure everyone can receive the care they need to maintain good health and prevent illness.

The following headline responsibilities were the basis for the ratings:

- Develop a plan to address gaps and barriers and assure access to clinical care services.
- Provide timely, scientifically accurate, and locally relevant information on the importance, impact, and accessibility of healthcare systems, including barriers to care.
- Implement population-based strategies to improve barriers to accessing clinical care.
- Inform, communicate, work cooperatively with, and influence others on policy, system, and programmatic changes to facilitate access to health services.
- Examine and monitor the quality, effectiveness, and cost-efficiency of clinical care.
- Ensure licensed health care facilities and providers comply with laws and rules as appropriate.

Opportunities for Health Authorities, Counties, and Legislators

- Public health authorities may consider providing current, centralized information on all medical transportation services within their jurisdiction with detailed information such as hours, populations served, enrollment processes, and explicit mention of remaining gaps in service to ensure new efforts address the greatest needs.
- District and County Boards of Health, as public bodies tasked with overseeing health in the counties served, can request presentations and data sharing from local providers of healthcare to encourage open discussion and problem solving.
- Provide additional support to the current workforce development efforts and investment in Community Health Workers. CHWs can help navigate individuals to care, identify transportation opportunities and resources to minimize skipped appointments, provide health promotion education, and coordinate care between healthcare providers, the public health department/authority, and community partners.
- Public health leaders and county elected officials may consider formalized agreements and strategic planning with large employers and economic development stakeholders to identify impacts to local healthcare infrastructure because of economic development. Develop infrastructure that supports sustainability of the larger local health ecosystem.

Key themes: Coordination and shared planning; Role of business and industry; data sharing and communication; transportation; cost monitoring.

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Access to and Linkage with Clinical Care provide more detailed discussion to support the opportunities listed above

Figure 18. Expertise Ratings, Access to and Linkage with Clinical Care

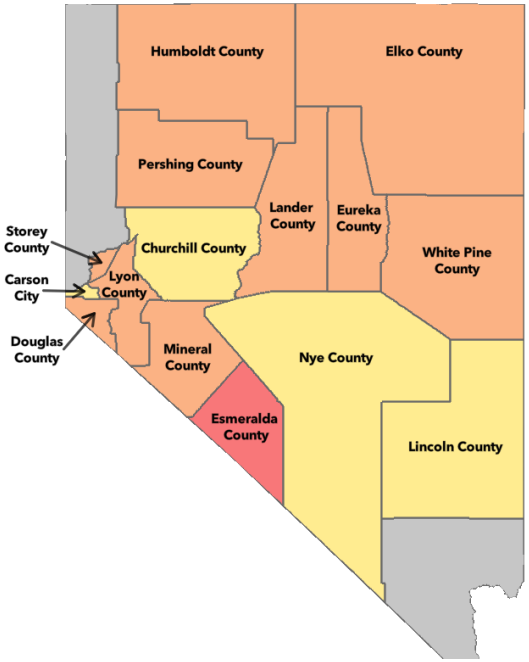


Figure 19. Capacity Ratings, Access to and Linkage with Clinical Care

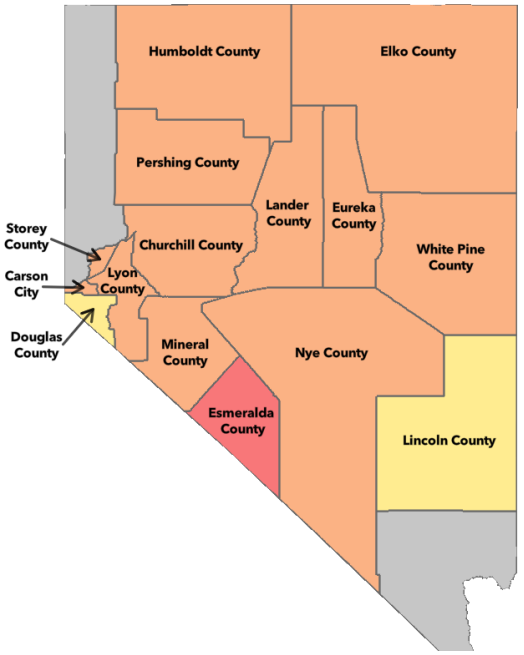


Figure 20. Implementation Ratings, Access to and Linkage with Clinical Care

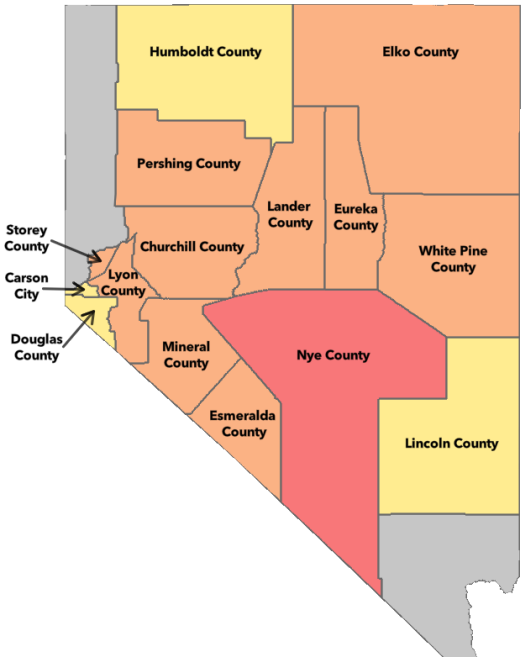


Table 25. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 26. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 27. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

The role of governmental public health for this FPHS Program Area includes the same four headline responsibilities as outlined in the previous areas, namely: planning, data sharing, implementation of population-based strategies, and communication and cooperation to improve access. Level of Implementation was largely deemed "Minimal," as counties continue to note access to healthcare as a significant challenge that appears to be worsening. Additionally, there was varied recognition of how governmental public health authorities on the whole have been drivers of access. More often, participants pointed to local efforts through Case Management in Social Services / Human Services departments, Federally Qualified Health Centers (FQHCs), Prevention Coalitions, not-for-profits, and formal and informal networks such as the Rural Nevada Health Network, a long-standing working group that supports rural healthcare advocacy, education, and resource sharing.

> DOUGLAS COUNTY COMMUNITY CLINIC PROVIDES REFERRALS AND LINKAGE TO COMMUNITY HEALTHCARE PROVIDERS, BUT THERE IS NO CASE MANAGEMENT FOR MEDICAL CARE…THE PUBLIC STRUGGLES TO SEE A PROVIDER, THERE ARE HIGH WAIT TIMES AND INSURANCE ISSUES, AND OUR AGING POPULATION REQUIRES DIFFERENT SERVICES."
>
> Douglas County FPHS Community Meeting Group Notes

There is ample opportunity for greater communication between all partners to better understand the current role of governmental public health in driving access to care across Nevada. Similar to the Maternal, Child, and Family Health Program Area, effective delivery of services requires both local and state infrastructure to maximize resources and efficiency.

Statewide programs that support this program area include the J1 Visa Program[51] (sponsors 30 physicians from outside the U.S. to serve in designated shortage areas in Nevada; under this program, currently 5 physicians serve in Carson City, one in Elko, and one in both Carson City and Elko), MTM[52] (non-emergency medical transport), Ryan White HIV/AIDS Program[53] (connection to care for individuals living with HIV/AIDS), and various services and supports through the Department of Health and Human Services Division of Healthcare Financing and Policy[54] (DHCFP), the Division of Welfare and Supportive Services[55], and the Division of Aging and Disability Services[56].

While services are technically available statewide, challenges to access and utilization varied by county. Overall, counties with health departments or strong Social Services/Human Services infrastructure had more local knowledge of how these services operate at the local level. For example, some counties noted they work with "Medicaid Navigators" (a loose term, as there are various staff positions at various agencies that perform a navigating function) to support access to care, but other county participants noted that they did not believe this was a service any longer. Nevada Medicaid leadership clarified that they currently staff 16 Health Care Coordinators across four District Offices[57] to support connection to care for the Fee-For-Service population.

[51] https://dpbh.nv.gov/Programs/Conrad30/Conrad30-Home/
[52] https://www.mtm-inc.net/nevada/
[53] https://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/
[54] https://dhcfp.nv.gov/
[55] https://dwss.nv.gov/Care/CCL/ccl-licensing-home/
[56] https://adsd.nv.gov/
[57] https://dhcfp.nv.gov/Contact/Contact_Home/

Nevada Health Link (NVHL) contracts with agencies to staff Navigators/In-Person Assisters that assist Nevadans in finding the right health insurance plan based on their medical and budgetary needs. They do not receive commissions, provide unbiased education on plans available through the Silver State Health Insurance Exchange, and are licensed through the Division of Insurance. There are no physical locations in rural counties to access the In-Person Assisters. However, the service is available at no-cost virtually and telephonically. There is an opportunity to analyze rural utilization of this service and consider targeted efforts to increase access and/or consider the development of rural in-person access points.

Transportation was frequently noted as a significant barrier. Services such as RSVP[58], a volunteer-based program that provides transportation for seniors across rural Nevada, and MTM[59], Nevada's non-emergency medical transport, help to fill the gap. Scheduling in advance is needed and geographic barriers remain. Participants shared that MTM is "broken" and, in multiple counties, participants indicated that MTM is "not active here" or simply, "No access." Every county in Nevada is an ambulance desert[60], a significant gap in the state's public health infrastructure.

> "There is nowhere in the county where you can pop-in to consult with a physician, and there are no docs you can call. You never know whether something is just a small issue or a larger one, and we really struggle with whether to call in an ambulance because we have so few, it's expensive, the trip to a hospital is so long. A few years ago, we had three different kids with a ruptured appendix. They had super long hospital stays as a result. That shouldn't be happening. Kids in Dyer have to travel to Bishop, CA, just for a sports physical. That's an hour and a half away and a full-day off work for their parents."
>
> Esmeralda County FPHS Participant

The Community Health Worker (CHW) model was discussed as an effective, cost-efficient, and underutilized model for increasing access, especially for rural and frontier communities where cultural competence and local trust play such an important role in connecting community members to care. CHWs are healthcare workers who support the health of individuals by providing education, connection to resources, emotional support and patient advocacy, and conducting outreach to special populations. In Nevada, CHWs are employed across the network of agencies that support public health, including county governments, health departments, coalitions and not-for-profit organizations. The barriers to success of CHW programs include the lack of physicians or clinics to link someone to locally, the lack of transportation to healthcare appointments (both local and outside of the community), and the low reimbursement rates for CHW positions. This last point significantly impacts the growth and sustainability of this vital workforce and local organizations' ability to recruit and retain quality staff. The Nevada Community Health Worker Association[61] was cited as a critical partner for this work.

Community Health Nurses (CHNs) were identified as an important part of the public health infrastructure for this Program Area, as well, though it was noted that community members do not always understand the scope of CHNs and expect to be able to access Primary Care through these clinics, which is not within the scope.

[58] https://www.nevadaruralrsvp.org/
[59] https://www.mtm-inc.net/nevada/
[60] https://digitalcommons.usm.maine.edu/ems/16/
[61] https://nvchwa.org/#:~:text=nvchwa.org%20%E2%80%93%20Nevada%20Community%20Health%20Worker%20Association.%20Team%20Based%20Care.

The Federally Qualified Health Centers that serve the communities assessed create additional access and care navigation opportunities for community members. For example, Nevada Health Centers supports school-based vaccination pop-ups in Storey County. They also provide nursing education and care coordination in Lockwood on a weekly basis. Even so, limitations remain. Community partners reported that the clinic in Virginia City, for example, lacks sufficient services for youth 13 years and under. Nevada Health Centers' Mammovan[62] regularly visits rural communities across the state and has increased its rural and frontier mobile clinic[63] capabilities in 2024.

Business and Industry also plays a complex role in access to clinical care. Participants noted, for example, that the clinics that serve mining employees and their families create greater access for that micro-community. At the same time, one participant shared that these clinics could have a destabilizing effect on the local healthcare landscape for retirees from the industry, as well as the rest of the community, due to the well-insured community members (the current mining employees and their families) not contributing to the payor mix of local physicians. There is an opportunity for further collaboration and co-development of the healthcare landscape to ensure a stable community health infrastructure for all.

Regarding data, many participants pointed to the Rural and Frontier Health Data Book published by the UNR Office of Statewide Initiatives, which provides abundant data on health and healthcare for the counties assessed, including information about provider shortages by specialty. In addition to data, this Office has a long history of providing education, research, and support across rural Nevada through workforce development efforts, the Nevada State Office of Rural Health, and Project ECHO.

> "THE MINES IMPACT THE SUSTAINABILITY OF LOCAL HEALTHCARE. THEIR EMPLOYEES AND THEIR FAMILIES ARE INSURED, BUT ONLY USE THE MINE'S HEALTH CENTERS. WHEN THEY [MINING EMPLOYEES] RETIRE ON MEDICARE, THEY COME BACK TO US [LOCAL PHYSICIANS]. IT'S HARD FOR US TO STAY IN PRACTICE WITH THIS PAYOR MIX."
>
> Humboldt County Community Stakeholder

The final two headline responsibilities for this Program Area focus on licensing, compliance, and monitoring the quality, effectiveness, and cost-efficiency of clinical care. Regardless of which agency serves as the local health authority in a county, the Bureau of Health Care Quality and Compliance (HCQC)[64] licenses health facilities in Nevada and investigates complaints. Participants in FPHS meetings, especially hospital administrators, noted that these licensing processes are in place, and that investigations and compliance checks are routinely conducted.

Monitoring the cost-efficiency of clinical care is an opportunity area as participants did not know of resources or sources of knowledge for this headline responsibility within the state. Providers noted the well-documented barriers to healthcare access in rural areas[65], including increased costs. An executive order establishing the Nevada Health Care Cost Growth Benchmark[66] was signed in 2019 by former Governor Steve Sisolak, but impacts and progress made as a result of this effort are unknown to survey participants. Upon further investigation by the project team, it was found that this is a largely dormant effort and perceptions on the potential efficacy of this measure in creating cost-efficiencies are mixed.

[62] https://www.nevadahealthcenters.org/pdf-mammovan-calendars/
[63] https://www.nevadahealthcenters.org/
[64] https://dpbh.nv.gov/Reg/HealthFacilities/HealthFacilities_-_Home/#:~:text=The%20Bureau%20of%20Health%20Care%20Quality%20and%20Compliance%20(HCQC)%20licenses
[65] https://www.ruralhealthinfo.org/topics/healthcare-access
[66] https://gov.nv.gov/layouts/full_page.aspx?id=347117

Foundational Capabilities

Foundational Capabilities are the essential, cross-cutting skills and capacities that every health department needs to support all public health services. They include things like having a skilled workforce, strong communication systems, robust data and surveillance systems, legal and policy support, and the ability to respond to emergencies. Essentially, these capabilities form the infrastructure that allows health departments to effectively carry out their work across all areas of public health.

The Foundational Capabilities in many ways address the business capabilities and internal processes of the health authority. For the counties with local public health authorities (Carson City – CCHHS; Churchill, Eureka, Mineral, and Pershing – CNHD), health department leadership participated in the survey process and community meetings and could speak directly to internal operations and capabilities. For counties served by DPBH, the health authority participants in the community meetings were Community Health Nurses that could speak to some internal processes, but not all. As a result, in some cases, participants felt unable to verify the ratings collected in the survey process. They did not have enough information.

In service to the goal of enabling progress and public health infrastructure development as a result of this study, the project team has included the results from the survey and community meetings process here with a focus on providing qualitative insights from local partners and documentation of known infrastructure. The project team recommends that public health authorities consider the results listed here against their own understanding of their agencies internal capabilities, work collaboratively with local stakeholders to share strengths and challenges, and develop plans for system improvement.

The icons above are used below to indicate the following Foundational Capabilities (Left to right, from top left: Assessment & Surveillance; Community Partnership Development; Equity; Organizational Competencies; Policy Development & Support; Accountability & Performance Management; Emergency Preparedness & Response; Communications).

Assessment and Surveillance

Assessment and surveillance in public health involves gathering and analyzing data to understand community health and identify public health priorities. The process includes building and maintaining systems for data collection, working with community partners to identify health disparities, and ensuring that vital records and public health laboratory infrastructures are secure and effective. Activities include developing systems for surveillance, conducting health assessments, and supporting laboratory testing to detect and respond to health risks and threats. The goal is to use data to guide public health decisions and improve the overall well-being of communities.

The following headline responsibilities were the basis for the ratings:

- Develop and maintain an assessment and analysis infrastructure.
- Use collaborative processes to assess community health and identify health priorities.
- Develop and maintain a surveillance and epidemiology infrastructure.
- Develop and maintain a vital records infrastructure.
- Develop and maintain a public health laboratory infrastructure.

Opportunities for Health Authorities, Counties, and Legislators

- Develop mechanisms to ensure two-way communication between state and local governments around formal assessments and plans that impact community health (not limited to health authorities, but other agencies with impactful work in this area such as the Nevada Division of Environmental Protection, the Nevada Division of Emergency Management, and the Nevada Department of Transportation).
- Develop a public-facing inventory of state assessments and plans that touch public health, including Behavioral and Environmental Health.
- Consider increased state oversight or service review of the Nevada State Public Health Laboratory to ensure efficient delivery of services across the state.
- County Boards of Health may consider developing Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIP) in partnership with local stakeholders and state teams able to support. Where there are assessments, but no county-wide Community Health Improvement Plans (CHIPs), consider utilizing existing assessments to develop county-wide plans including specific, feasible goals and metrics for success.

Key themes: Infrastructure Development; Collaboration and Synthesis; Need for Data to Action framework.

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Assessment and Surveillance and provide more detailed discussion to support the opportunities listed above.

Figure 21. Expertise Ratings, Assessment and Surveillance

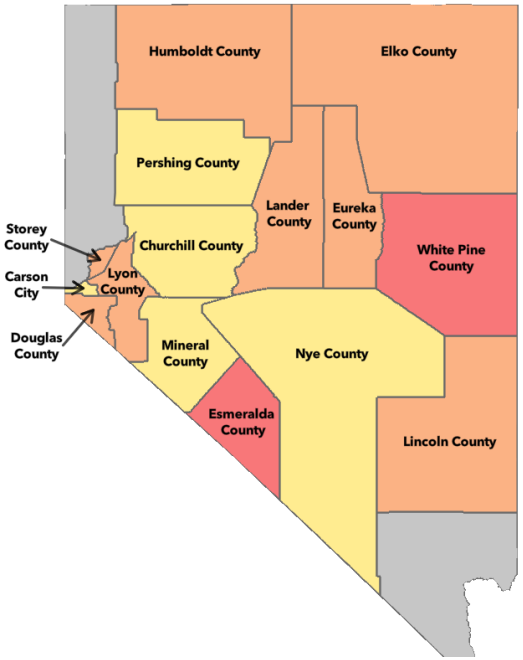


Figure 22. Capacity Ratings, Assessment and Surveillance

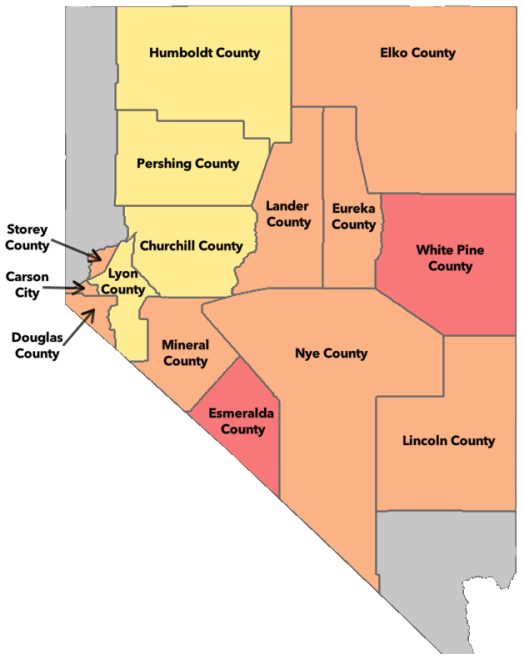


Figure 23. Implementation Ratings, Assessment and Surveillance

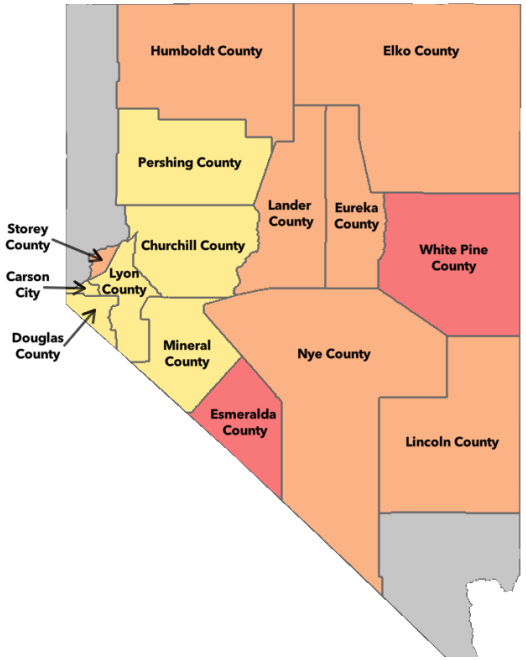


Table 28. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 29. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 30. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

Community Health Needs Assessments and Improvement Plans[67] were the focus of discussion for this Capability. Ongoing assessment and planning activities are critical to ensure existing resources are maximized and new resources are strategically developed, supported, and measured to ensure positive outcomes.

Central Nevada Health District (Churchill, Eureka, Mineral, Pershing) is developing their first district-wide Community Health Needs Assessment with an anticipated completion date in 2025. Carson City Health & Human Services completes both a Community Health Needs Assessment[68] and Community Health Improvement Plan on a regular cycle as part of their accreditation and strategic planning processes. Additionally, DPBH recently completed the Silver State Health Improvement Plan, 2023-2028[69] informed by the 2022 State Health Needs Assessment as part of their accreditation efforts.

Critical access hospitals in Lander, Lincoln, and Humboldt counties completed Community Health Needs Assessments in 2023 in partnership with the UNR Office of Statewide Initiatives. These assessments include community surveys as well as health and health access indicators from the County Health Rankings initiative.

"THERE IS A DISCONNECT BETWEEN DATA [COLLECTION] AND PROACTIVE SERVICES DEVELOPED AROUND DATA; OUTLYING AREAS HAVE NO LOCAL ASSESSMENT OR SURVEILLANCE."

Humboldt County Community Stakeholder

Some counties have assessments completed through their Human/Social Services (Churchill County, Lyon County) or Community Services (Douglas County) Departments, or by community partners (Storey County), which inform community health programs as well as social determinants of health such as access to housing, childcare, recreational activities, food security and social services. Eureka County completed a county-wide survey in 2024 and a needs assessment based on that data is in development. White Pine and Esmeralda do not have local community health assessments, and Elko's most recent assessment was completed in 2017.

Prevention coalitions across the state also conduct needs assessments and community prevention plans, which are specific to the behavioral health scopes of the coalitions. Additionally, 11 of the assessed counties have completed Opioid Needs Assessments and Plans specific to opioid abatement. Lander County is completing a county-wide health assessment specific to Vitamin D deficiency.

In completing follow-up research for this assessment, the project team found there are many assessments and plans at either the state or community level that touch on public health in some way. Many of these have been highlighted in previous sections of this report. It should be noted that the Department of Health and Human Services and other state agencies have numerous legislative mandates to complete assessments and plans but are not always adequately funded to implement plans. Additionally, the project team noted that it is not clear if strategic planning occurs between agencies serving public health goals (i.e. DPBH and NDEP). A public-facing synthesis of the various assessments and action plans for individual state units may help to break down silos and increase cooperation both between state agencies and between county and state governments.

With respect to public health laboratory infrastructure, which is also a headline responsibility for this Capability, the Nevada State Public Health Lab (NSPHL), established in NRS 439.240, is run by the University of Nevada, School of Medicine separately from the Department of Health & Human Services. County participant perspectives on this lab were mixed, with some noting delays in results reporting and access issues. The new Churchill County Public Health Laboratory will be administered at the county level.

[67] https://www.cdc.gov/public-health-gateway/php/public-health-strategy/public-health-strategies-for-community-health-assessment-health-improvement-planning.html
[68] https://www.gethealthycarsoncity.org/home/showpublisheddocument/84563/638140451233170000
[69] https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/About/2023-28-SSHIP-23-28-Final2.pdf

Community Partnership Development

Community Partnership Development in public health involves creating and nurturing relationships with a wide range of partners, including government agencies, non-governmental organizations, and communities, to improve public health outcomes. It includes training and supporting staff to engage with partners, developing policies for meaningful collaboration, and maintaining systems for regular communication. Strategic partnerships are formed to coordinate efforts across different sectors as trust and strong relationships are built within communities. Collaborative efforts focus on developing health improvement plans that address community priorities and monitoring the progress of these plans to ensure positive health outcomes.

The following headline responsibilities were the basis for the ratings:

- Develop and maintain capabilities to cultivate relationships and convene partners.
- Develop and maintain strategic partnerships with governmental and non-governmental partners.
- Develop and maintain trusted relationships with communities.
- Use collaborative processes to develop health improvement plans to address identified priorities.

Opportunities for Health Authorities, Counties, and Legislators

- The state may consider developing a Community Engagement Hub where partners can learn about the many statewide meetings and workgroups. Consider the same for local health authorities. There is an established Nevada Public Notice Website[70] with information on public meetings across the state that includes filters for various levels of government, special districts, libraries, and Higher Education. Consider adding a filter for Public Health that pulls in all public meetings related to health, including the Environmental Health meetings such as water authority meetings.
- Utilize existing County Board of Health infrastructure to support coordination between state and local partners and develop CHNAs and CHIPs.
- Create Staff Community Liaison positions and/or integrate travel budget and designated time for participation in collaborative meetings into current staff roles.
- Implement local CHNAs and CHIPs with all key stakeholders (including county planning, utilities, Community Development, NDEP, etc.) to ensure strategic community health improvement.

Key themes: Limited staff time for relationship building; Need for coordination; Need for Community Health Improvement Plans

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Community Partnership Development and provide more detailed discussion to support the opportunities listed above.

[70] https://notice.nv.gov/

Figure 24. Expertise Ratings, Community Partnership Development

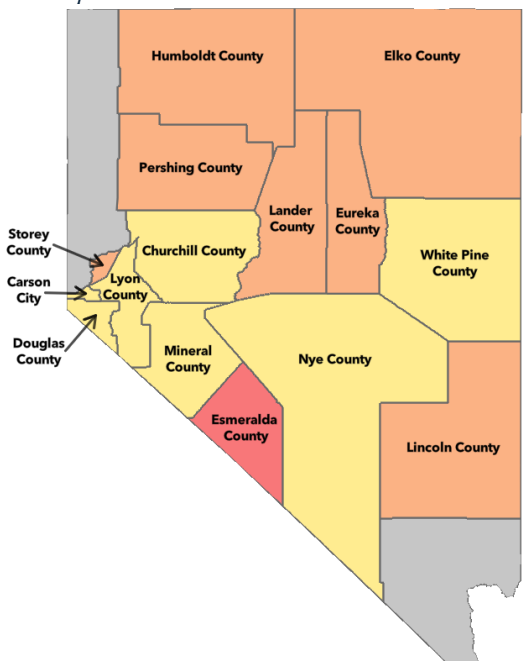


Figure 25. Capacity Ratings, Community Partnership Development

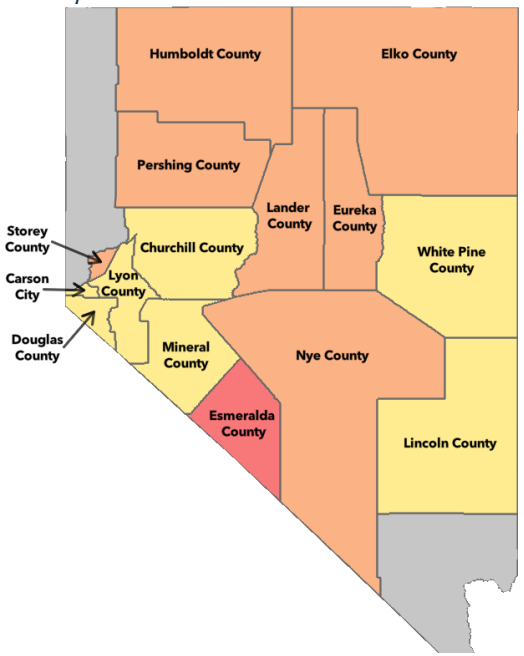


Figure 26. Implementation Ratings, Community Partnership Development

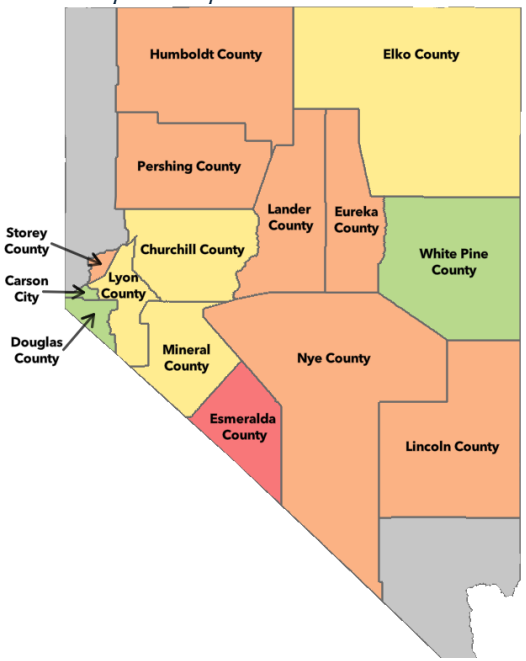


Table 31. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 32. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 33. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

Community Partnership was recognized as a relative strength with Carson City, Douglas County, and White Pine all indicating "Sufficient Services." However, Community Partnership between the local partners and their public health authority has room for improvement. Community Health Improvement Plans (CHIPs) are the critical next step after the Community Health Needs Assessments, discussed already under the Assessment and Surveillance Capability. Collaboration on CHIPs is one of the primary ways that public health authorities stay engaged and in coordination with local partners and stakeholders to improve health outcomes. Carson City (via CCHHS) is the only county surveyed with a formalized local Community Health Improvement Plan process, which by nature of their service area also, to some extent, includes Douglas, Lyon, and Storey Counties.

There are various statewide meetings that support public health community partnership such as the Nevada Advisory Committee on Traffic Safety (NVACTS[71]), the Maternal, Child and Family Health Advisory Board (MCHAB[72]), and the Nevada State Emergency Response Commission (SERC[73]). Knowledge of these meetings is present among stakeholders, but not consistently across the counties surveyed. Staff time to engage in collaborative task forces and workgroup meetings – or to take collective action in response to issues or opportunities identified at partner meetings – was identified as a barrier at both the state and local level. Additionally, some counties reported that collaboration and partnership is focused in population centers, so outlying areas may not benefit from the collaboration to the same extent.

> "WILLIAM BEE RIRIE HOSPITAL DOES A LOT OF EDUCATION FOR THE COMMUNITY AND THE SCHOOL DISTRICT IS ACTIVELY DEVELOPING COMMUNITY PARTNERSHIPS FOR MENTAL HEALTH. OUR STATE HEALTH NURSE IS LOCAL AND PARTICIPATES IN LOCAL EFFORTS."
>
> White Pine County FPHS Community Meeting Group Notes

[71] https://zerofatalitiesnv.com/safety-plan-what-is-the-shsp/nvacts/
[72] https://dpbh.nv.gov/Boards/MCAB/Maternal_and_Child_Health_Advisory_Board_home/
[73] https://serc.nv.gov/

Equity

Equity in public health involves ensuring that all individuals have fair access to the resources and opportunities they need to achieve optimal health. This includes fostering a shared understanding of what equity means and integrating it into the organization's culture, policies, and practices. The goal is to support staff in promoting equity across all programs and services. Additionally, it involves collaborating with partners to address the needs of populations at greater risk for poor health, ensuring their representation in decision-making, and advocating for public policies that prioritize equity-focused interventions.

The following headline responsibilities were the basis for the ratings:

- Develop and demonstrate agency commitment to equity.
- Inform and influence public and external organizational policies to advance equity.

Opportunities for Health Authorities, Counties, and Legislators

- Consider formally recognizing rural and frontier residents as a minority group or target population for Nevada Office of Minority Health and Equity effort with the goal of increasing visibility, data collection, advocacy, and strategic planning to support rural health improvement efforts.
- Local governments, local public health authorities, and local community partners can utilize the Health Equity Action Plan (HEAP[74]) to assess their current state and opportunities for improvement.
- In conducting CHNAs and CHIPs, consider local demographics and barriers to care/services for minority groups in the county.
- Invite participation of leaders from minority groups and leaders from organizations serving minority groups into assessment and improvement plan processes and commit to meaningfully integrating their expertise and leadership in strategic planning.
- Local Boards of Health can improve visibility of health equity concerns in the county by inviting presentations from organizations serving minority communities to share successes, challenges, and opportunities for support and collaboration.

Key themes: Rurality as a Social Determinant of Health (SDOH); Local data needs; Culturally Informed training and services; CLAS standards.

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Equity and provide more detailed discussion to support the opportunities listed above.

74 https://dhhs.nv.gov/uploadedFiles/dhhs.nv.gov/content/Programs/CHA/MH/Health%20Equity%20Action%20Plan%202(1).pdf

Figure 27. Expertise Ratings, Equity

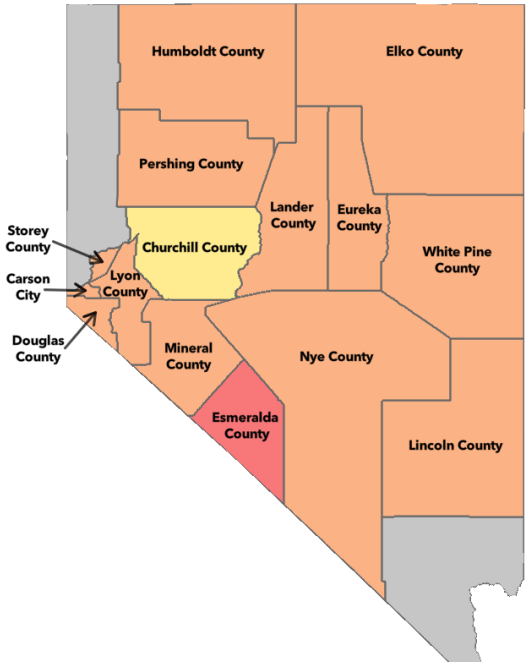


Figure 28. Capacity Ratings, Equity

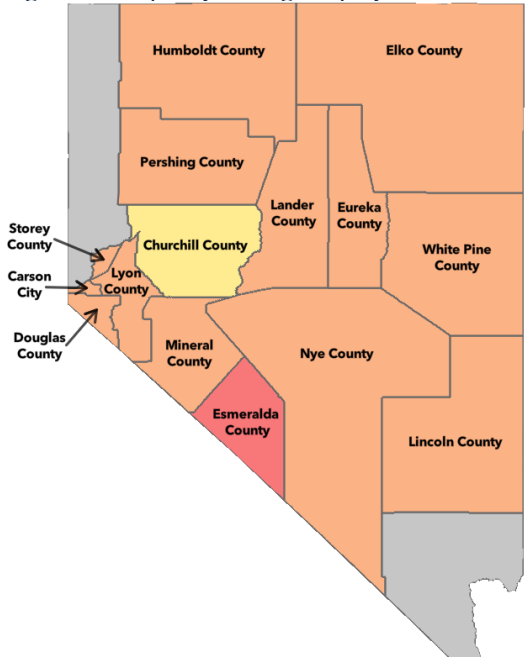


Figure 29. Implementation Ratings, Equity

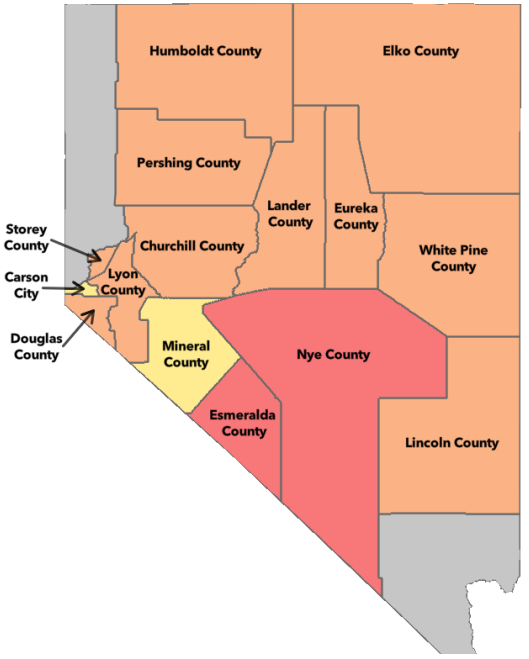


Table 34. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 35. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

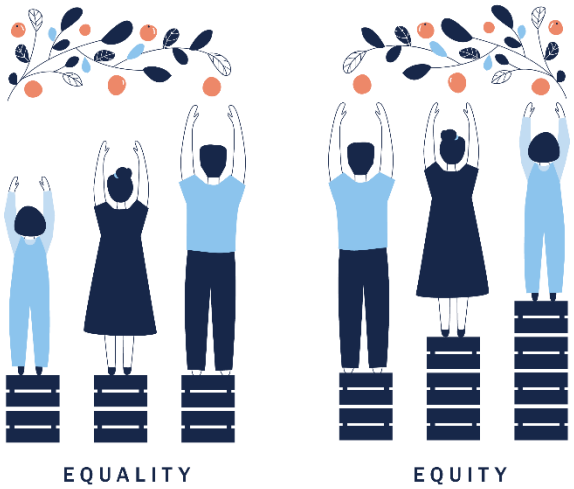
Table 36. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

The governmental public health infrastructure to support this Capability across the counties surveyed is largely "Minimal," with a perception of "No Services" in Esmeralda County and Nye County. "Our doors are open to everyone," or similar messages were commonly shared in the community meetings, but consistent and wide-spread agency commitment to equity as demonstrated through specific programs to reach target populations with increased health risk or less access is not widely operationalized.

Figure 30: Illustration of Equality versus Equity



Lack of widespread agency commitment to equity is a resource issue, both in terms of budgets, expertise, and—sometimes, but not always—due to the politicization of conversations around equity.

The politicization of equity frequently stems from a misunderstanding about what equity means in the practice of health care and in health and human services settings. An image similar to the one at left (Figure 33) was utilized in FPHS discussions to ensure participant understanding of this concept. If all three individuals, regardless of height, are given the same box to reach the fruit on the tree, only the tallest individual can actually access the fruit in this instance. There is *equality* in terms of the resource provided (i.e. the box), but the end result is not equal access to the fruit. If each individual has a box sized appropriate to their need, they can all access the fruit. This is *equity* – designing programs and initiatives to meet people where they are at and improve access to services for everyone. The Meals on Wheels Program, which delivers food to seniors at their homes, is an illustrative example. Many seniors are home-bound and cannot safely travel to pick up food. If a program offers free food for seniors, but it requires them to travel to pick it up, homebound seniors do not have meaningful access to that service. Transportation of food bridges the gap.

Some participants noted that Equity is politicized to such a degree that discussions of how to increase access for specific populations are more successful when the word is omitted entirely. Other participants noted that "dancing around" Equity perpetuates the issue, and that examples of programs that advance Health Equity, such as mobile vans for rural populations or transportation for seniors or Spanish-language support groups (all of which are active in one or more of the counties assessed), should be highlighted to help community leaders and community members better understand what advancing equity actually looks like in their own communities.

> "LINCOLN COUNTY STRIVES TO PROVIDE EQUITY TO EVERYONE BUT DOES NOT HAVE THE RESOURCES TO PROVIDE THE SERVICES. SOME AGENCIES AND ORGANIZATIONS ARE STARTING TO TRAIN ON THE CLAS [CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES] STANDARDS."
>
> Lincoln County FPHS Community Meeting Group Notes

Lincoln County participants noted, for example, that agencies in their community are beginning to train on the Culturally and Linguistically Appropriate Services (CLAS) Standards,[75] which help guide healthcare professionals to better serve their diverse populations.

On the whole, the project team found that community health leaders who participated in the FPHS studies were knowledgeable about their community demographics and gaps in services for specific populations, and CLAS standards were mentioned in a handful of instances. The ability to develop targeted efforts beyond a set of core services, however, was constrained by both resource availability and knowledge of best practices.

The Nevada Office of Minority Health and Equity (NOMHE)[76] was established in statute in 2005 to provide statewide support for this Capability. It is an important piece of the public health infrastructure and demonstrates an agency commitment to equity. NOMHE provides Cultural Competency Training, some resource navigation for minority communities, and developed the Health Equity Action Plan (HEAP[77]). Additionally, DPBH received a Health Disparity Grant[78] for a two-year period 2021-2023, through which a wide variety of equity initiatives were advanced across the state, including in rural and frontier counties.

> "I have found that the agencies charged with serving us lack an understanding of our need and/or a willingness to travel to reliably serve us with services such as a public health nurse or Child Protective Services. We have absolutely zero licensed childcare. Emergency medical service is 4 hours away. We haven't had any development since the 80s and can't get contractors out here to improve the existing supply of houses from the mining camp days! These communities are destabilized and struggling. It is a hardship living out here, serving the mineral / extraction/ energy/ agricultural demands of the state and nation."
>
> Northern Nye County FPHS Participant

Notably, NRS 232.472, which defines the purpose of NOMHE, does not identify rural and frontier communities as a minority group. Yet, it is well-established that rurality is a Social Determinant of Health[79]. The consequence of rurality not explicitly being included in the NOMHE scope is a lack of visibility for the unique challenges that rural and frontier organizations face in developing health equity efforts, and the unique challenges that rural and frontier community members, including those from minority groups, face in trying to access services.

Rural and frontier counties sometimes feel like the perpetual "other," as data collection efforts that focus statewide equity strategy and priority identification (for example, the Minority Health Report[80]) lump all 15 non-urban counties into the "Balance of State" category. In some cases, this is a necessity to protect individual privacy, but some county populations are large enough that their data could be shared. While the "Balance of State" strategy is helpful for identifying alarming rural and frontier trends, it is not helpful for individual counties looking to develop strategies based on their community's most pressing needs. In a context where state efforts sometimes focus on population centers as a strategy to reach the largest audience, it is even more imperative that local public health authorities, local governments, and community partners have their own community-specific data with which to work.

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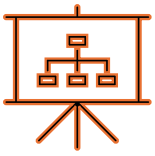
[75] Culturally and Linguistically Appropriate Services - Think Cultural Health
[76] https://dhhs.nv.gov/Programs/CHA/MH/Office_of_Minority_Health/
[77] https://dhhs.nv.gov/uploadedFiles/dhhs.nv.gov/content/Programs/CHA/MH/Health%20Equity%20Action%20Plan%202(1).pdf
[78] https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/2023-Health-Disparity-Report.pdf
[79] https://www.ruralhealthinfo.org/topics/social-determinants-of-health
[80] https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Minority%20Health%20Report%202023(1).pdf

Organizational Competencies



Organizational competencies in public health involve establishing and maintaining the essential structures and systems that enable public health agencies to operate effectively and achieve their goals. This includes creating a strong governance structure, developing strategic plans, and setting up systems to monitor progress. Agencies must also ensure robust information technology, privacy, and security systems are in place, support workforce development, and manage financial resources efficiently. Additionally, it involves maintaining legal services to navigate statutes and regulations that impact public health. Together, these competencies ensure that public health organizations are well-equipped to lead, manage, and support public health initiatives and services.

The following headline responsibilities were the basis for the ratings:

- Maintain a governance structure and establish the strategic direction for public health.
- Provide or access services for information technology, privacy, and security.
- Provide or access human resources services and develop and maintain a competent workforce.
- Provide or access financial management services and facilitate contracting, procurement, and maintenance of facilities and operations.
- Access public health legal services and analysis.

Opportunities for Health Authorities, Counties, and Legislators

- Health authorities may consider more extensive self-assessment utilizing the full FPHS toolkit to identify areas for improvement.
- CNHD member counties and CNHD may consider further discussions to partner on infrastructure development utilizing the respective strengths of the member municipalities.
- Counties may assess the strength of their internal infrastructure to support improvement of the Public Health Organizational Competencies and consider taking on additional infrastructure to improve services, either independently or together with neighboring counties. The Churchill County Public Health Lab is an example of this.
- Legislators can support local public health workforce development efforts that encourage uptraining of community members interested in public health, as well as recruitment funding that incentivizes experts to serve in rural and frontier Nevada.

Key themes: Health Authority + County partnership; self-assessment; communication.

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Organizational Competencies and provide more detailed discussion to support the opportunities listed above.

Figure 31. Expertise Ratings, Organizational Competencies

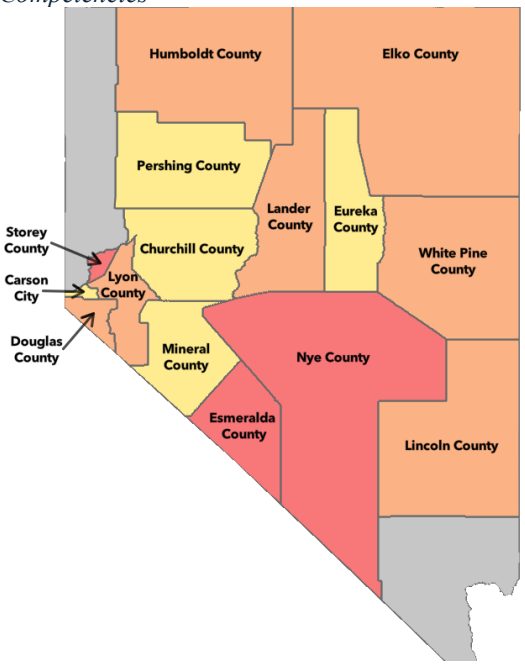


Figure 32. Capacity Ratings, Organizational Competencies

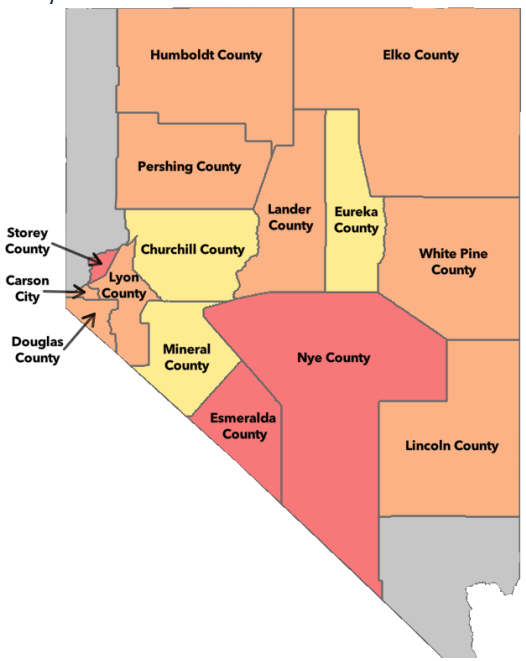


Figure 33. Implementation Ratings, Organizational Competencies

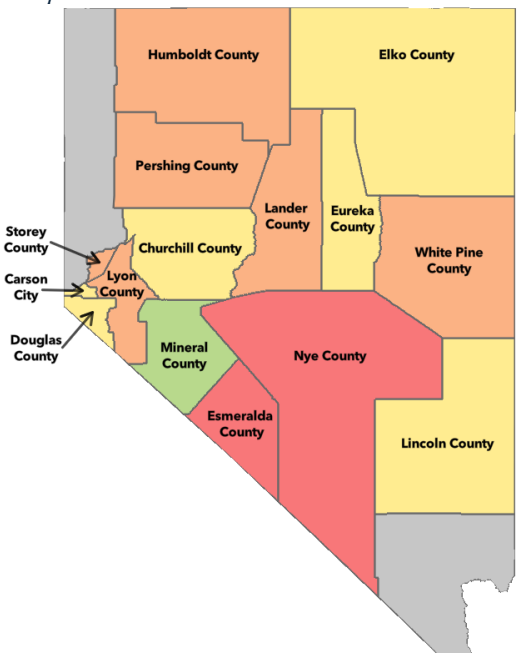


Table 37. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 38. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 39. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

Organizational Competencies is a Capability that warrants further assessment by individual public health authorities. The full FPHS toolkit includes extensive activities under each headline responsibility that support such a self-assessment.

It is notable that the infrastructure supporting multi-county health authorities (CNHD and DPBH) received different ratings across their service areas. To summarize, perceptions of Organizational Competencies varied, though presumably the same staffing and structures are providing the IT, HR, fiscal and other services. There is opportunity for better two-way communication between health authority and local public health leaders to clarify resources.

The ability to maintain a competent workforce was frequently discussed, with examples of recruitment delays for CNHD, the Churchill County Public Health Lab, and vacancies in DPBH's Community Health Nursing clinics and Rural Mental Health Clinics cited as examples.

For CNHD, Expertise in this area was deemed "Proficient" across the service area. Currently, Churchill County infrastructure is utilized to support a number of Organizational Competencies. This is similar to Northern Nevada Public Health, which is supported in part by Washoe County's infrastructure. It was noted in community meetings that CNHD's Board of Health is interested in transitioning CNHD to a fully independent model. A cost-benefit analysis may be helpful in determining the level of investment needed to maintain the same level of proficiency for the district.

> "RECRUITMENT AND RETENTION OF PUBLIC HEALTH WORKERS IN THE COMMUNITY IS NEEDED; [THERE IS A] NEED TO PROVIDE SERVICES & SUPPORT FOR PUBLIC HEALTH WORKERS."
>
> Elko County FPHS Meeting Group Notes

Policy Development and Support

Policy Development and Support in public health involves working to create and improve public health policies in collaboration with partners, policymakers, and community members. The process starts with analyzing existing policies and identifying needs for new or updated ones. It includes engaging with stakeholders to develop evidence-based policies that reflect the experiences of those affected. Once policies are developed, support is organized to present them to decision-makers for enactment. After policies are in place, they are evaluated for effectiveness and impacts. Additionally, public health authorities participate in broader policy discussions that affect health, support the implementation of policies through education and training, and enforce compliance to ensure policies are followed.

The following headline responsibilities were the basis for the ratings:

- Develop, amend, and enact public health policies in collaboration with partners, policymakers, and community members.
- Participate in policy development initiatives being considered by partners that affect the public's health.
- Implement and support enacted public health policies.

Opportunities for Health Authorities, Counties, and Legislators

- Policy makers may consider more collaborative approaches to policy development including opportunities for partner input and feedback, and a willingness to adjust policy in light of new data.
- Health authorities may consider hiring Government Affairs / Policy staff to support collaborative policy making, and/or integrate a public health focus into current county lobbyist portfolios.
- Partners may consider regional opportunities to collaborate and hire staff that can support rural hospitals with new policy implementation, including a liaison role with state units developing new policy.
- Legislators may consider the additional staffing and resources needed to improve core business practices and develop sustainable funding for these responsibilities.

Key themes: Collaboration; Technical Assistance and Implementation Support.

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Policy Development and Support and provide more detailed discussion to support the opportunities listed above.

Figure 34. Expertise Ratings, Policy Development and Support

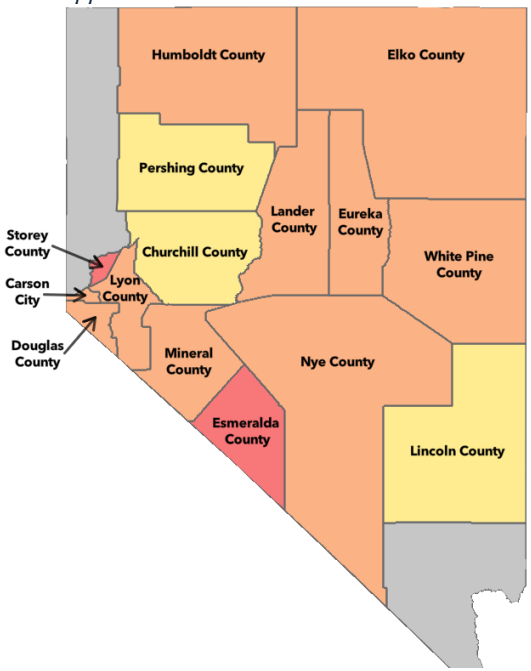


Figure 35. Capacity Ratings, Policy Development and Support

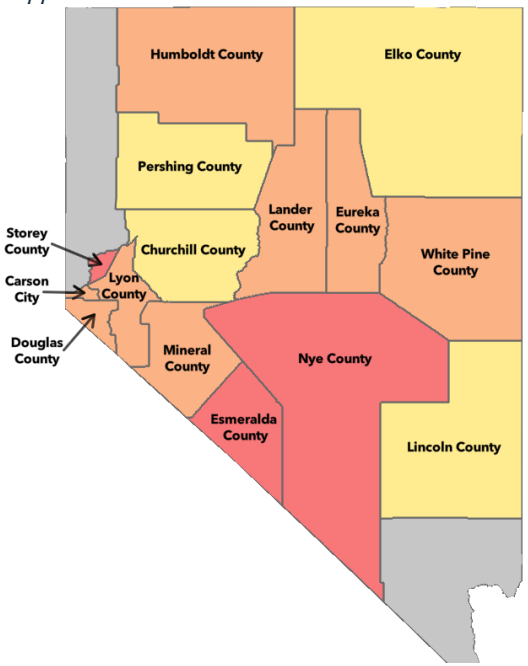


Figure 36. Implementation Ratings, Policy Development and Support

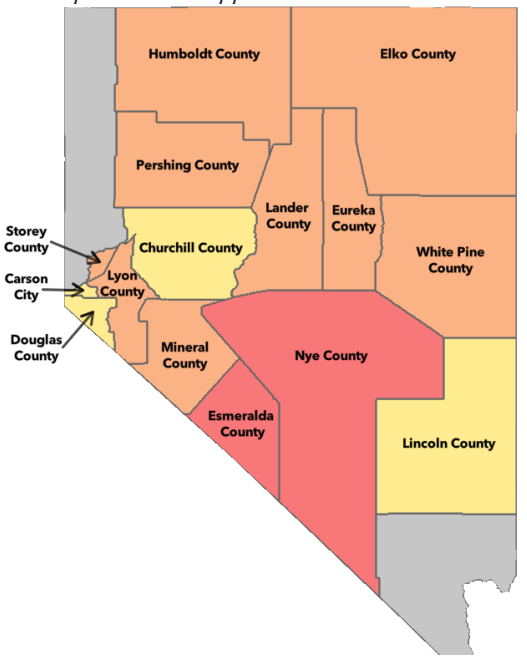


Table 40. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 41. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 42. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

The FPHS community discussions surrounding this Capability focused on the criteria that policy development be enacted in collaboration with partners, policymakers, and community members. While participants recognized health authority expertise or capacity to develop appropriate policy, they noted that policies are often developed without community input or without all relevant stakeholders engaged. This leads to gaps in the feasibility and applicability of new policies. This was noted for all public health authorities serving the counties surveyed (CCHHS, CNHD, DPBH).

> "ENGAGEMENT NEEDS EVERYONE AT THE TABLE."
>
> Pershing County FPHS Meeting Group Notes

The headline responsibility to "Participate in policy development initiatives being considered by partners that affect the public's health" was also noted as a gap area. Given the significant resource constraints on public health authorities, there is limited time to engage in policy considerations strictly within public health. This doesn't include areas that affect health but are more tangential to the core work of health departments. There are no dedicated public health lobbyists for the rural and frontier counties, though there are agencies that play a supportive role including NACO, the Nevada Public Health Association (NPHA), the Rural Nevada Healthcare Network, the Nevada Emergency Preparedness Association (NEPA), and POOL/PACT. The UNR Office of Statewide Initiatives published a Rural Local Health District Toolkit to support infrastructure development. While the latter is not strictly a policy document, it helps counties and county partners understand the process and relevant NRS related to forming new public health districts in the state.

Community Health Nurses and Hospital Leadership noted receiving policy updates from the State, and perceived that the expertise was present at the state level to develop sound policy. However, participants noted that the unique challenges to implementation for specific entities–and this was especially the case for hospital leadership–is often not considered in policy development. Additionally, technical assistance and other types of support with implementation is minimal or absent.

On the behavioral health side, the Regional Behavioral Health Policy Boards were noted as drivers of policy change and collaboration, though knowledge of these Boards, their role, and their accomplishments is not consistent across the state. There is limited administrative infrastructure to support the Boards and Board Members all serve in a volunteer capacity. As a result, FPHS participants noted that these Boards' abilities to be effective agents for policy development rely heavily on the Regional Behavioral Health Coordinator's capacity to support with advocacy efforts. The Regional Behavioral Health Coordinator roles are grant-funded through DPBH, housed within two separate not-for-profit organizations for the region assessed, and operate with varied and expansive scopes of work tailored to the needs of their regions, the programmatic needs of DPBH, and the needs of their host organizations. In sum, participants recognized the need for the Boards and the Coordinators to support rural behavioral health policy development while also noting the opportunities to improve alignment and sustainability of this infrastructure.

Notably, again with respect to the Behavioral Health Policy Boards, Nye County participants noted their frustration with Nye County's split into two regions and the impact this has on their policy development. Northern Nye County (including the county seat of Tonopah) is served by the Southern Region Behavioral Health Policy Board and Southern Nye County (including Nye's most populous city, Pahrump) is served by the Clark Behavioral Health Policy Board. The logic of this split at the state level had to do with care-seeking patterns, but from a county government perspective it makes it difficult to move forward with strategic behavioral health efforts at the local level. In behavioral health data reporting, Nye County's data is split. Additionally, the Southern Region Behavioral Health Coordinator is not responsible for Southern Nye, and the Clark Region Behavioral Health Coordinator position had been vacant for over a year at the time of writing.

Accountability and Performance Management

Accountability & Performance Management in public health involves setting up systems to ensure public health activities meet established standards and policies. It includes tracking actions, maintaining accountability, and adhering to business practices and accreditation. Performance management focuses on measuring performance, improving processes, and building staff evaluation skills. A key element is implementing a quality improvement plan to enhance public health services and outcomes.

The following headline responsibilities were the basis for the ratings:

- Maintain accountability according to accepted business practices, applicable policies, and public health accreditations.
- Maintain a performance management structure and establish appropriate quality improvement initiatives.

Opportunities for Health Authorities, Counties, and Legislators

- Health authorities may consider more extensive self-assessment utilizing the full FPHS toolkit to identify areas for improvement.
- Increase training and technical assistance for Quality Improvement initiatives.
- Legislators may consider the additional staffing and resources needed to improve core business practices and develop sustainable funding for these responsibilities.

Key themes: Consistency of QI initiatives; Need for more study/assessment

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Accountability and Performance Management and provide more detailed discussion to support the opportunities listed above.

Figure 37. Expertise Ratings, Accountability and Performance Management

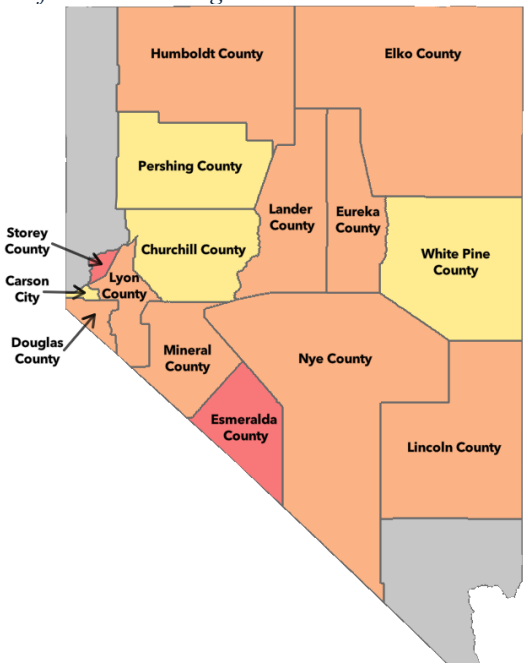


Figure 38. Capacity Ratings, Accountability and Performance Management

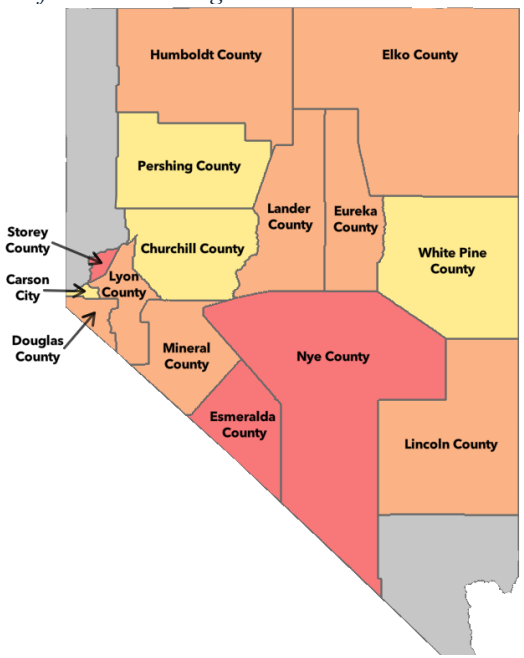


Figure 39. Implementation Ratings, Accountability and Performance Management

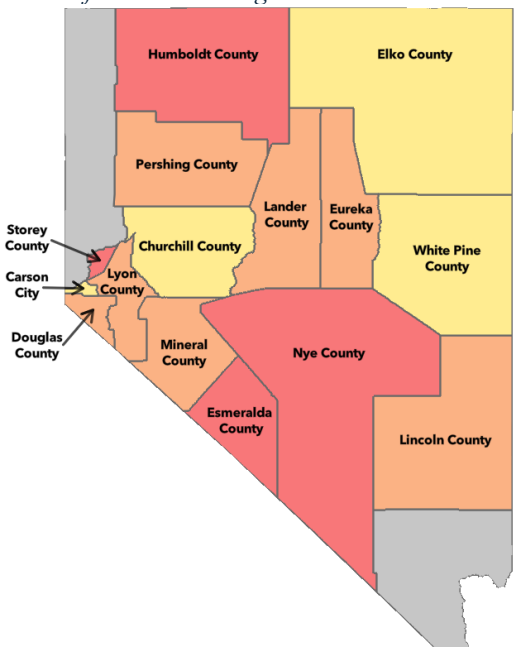


Table 43. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 44. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 45. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

Similar to Organizational Capacities, this is a Foundational Capability that is difficult to assess from the outside looking in. Leadership from CCHHS and CNHD were present for their jurisdictions. DPBH staff (typically, Community Health Nurses) were present for some counties and could speak to the accountability and performance management within their own teams, but a systemic picture was not available. Results must be considered with this in mind.

Some participants noted they did not have enough information or experience to be able to reliably rate this area. Other participants had direct experience with the health authorities through receipt of grants or other partnerships, and provided insights based on that experience. For example, one FPHS community meeting group noted that programmatic reporting and robust evaluation is present for some funding streams managed by the state, but not all.

Carson City, Churchill, and White Pine Counties all noted "Proficient" Expertise, "Moderate" Capacity, and "Some Services" for Level of Implementation. The project team recommends that individual health authorities consider a self-assessment utilizing the more extensive national tool, and also an analysis of the disparate perceptions across their service areas to look for opportunities to improve communications and workflows.

> "[THE STATE DOES] A GOOD AT MAINTAINING ACCOUNTABILITY BUT [DOES] A POOR JOB AT SUPPORTING US TO MEET THE REQUIREMENTS – [THEY] DON'T FUND US OR SUPPORT US FINANCIALLY TO MEET COMPLIANCE STANDARDS."
>
> White Pine FPHS Meeting Group Notes

Notably, the state of Nevada has made strides in this area through the Public Health Infrastructure and Improvement section at DPBH. Efforts include working with UNR's Center for Public Health Excellence within the School of Public Health to earn accreditation through the Public Health Accreditation Board, expanding academic health departments within the state to drive workforce development, working with NACO to fund and support this FPHS study and improve coordination with local governments, and a variety of Quality Improvement efforts being undertaken in partnership with a new Agency Manager and Public Health Improvement team at DPBH. There is an opportunity for increased communication about these efforts.

Emergency Preparedness

This capability ensures public health agencies are ready to respond to emergencies effectively. It involves establishing roles, creating information-sharing systems, and leading emergency health operations. Agencies develop and maintain preparedness plans, train staff, and ensure continuity of essential public health services during crises. They also coordinate with partners to respond to incidents, assess needs, and activate response personnel and systems. After incidents, agencies focus on recovery efforts, evaluating responses, and improving future preparedness.

The following headline responsibilities were the basis for the ratings:

- Establish governmental public health's role in preparedness and response to incidents.
- Develop, exercise, and maintain preparedness and response plans.
- Assure public health continuity of operations.
- Respond to incidents.
- Recover from incidents.

Opportunities for Health Authorities, Counties, and Legislators

- Health authorities and counties may utilize the strong LEPC infrastructure to develop plans, tabletop exercises, and collaborations specific to public health threats.
- County Boards of Health may request updates from their Emergency Managers and/or Health Authority on Public Health Preparedness efforts in their jurisdiction to identify ways to improve infrastructure and communications.
- Health Authorities may consider disparities in Public Health Preparedness infrastructure in their jurisdiction and develop targeted efforts to ensure equitable services.
- Health Authorities and Counties may consider evaluating their COVID-19 response to assess gaps and develop critical infrastructure to improve future response and recovery.
- As a relative strength, all partners should consider how the processes and infrastructure developed in Emergency Preparedness may be preserved and leveraged to support development and improved communication for other Foundational Program Areas and Capabilities.

Key themes: Strong local infrastructure; strong partnerships.

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Emergency Preparedness and provide more detailed discussion to support the opportunities listed above.

Figure 40. Expertise Ratings, Emergency Preparedness

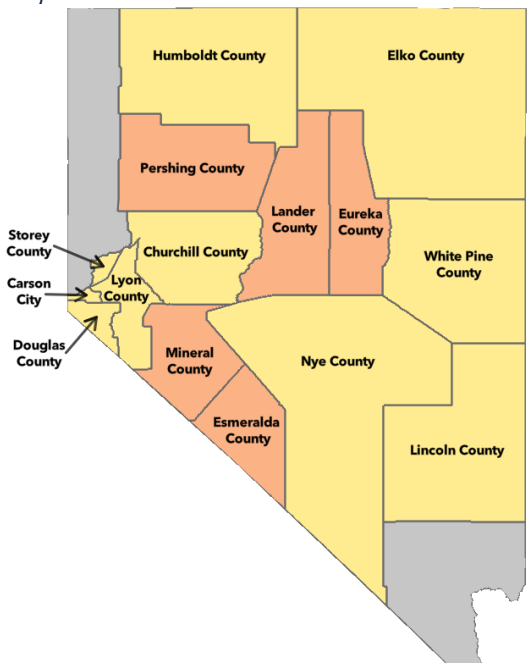


Figure 41. Capacity Ratings, Emergency Preparedness

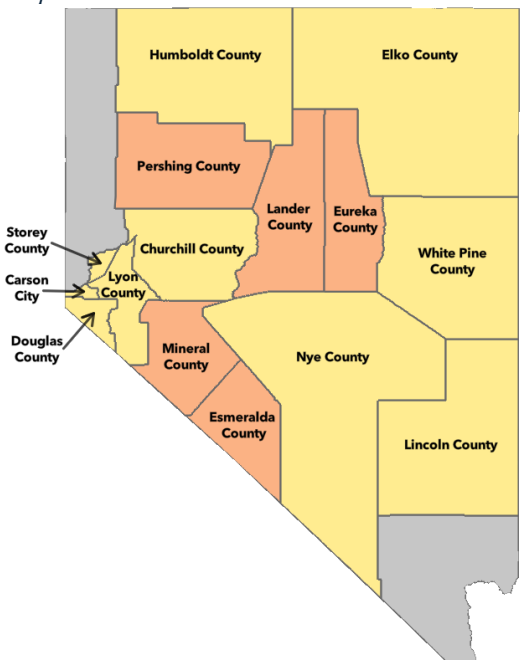


Figure 42. Implementation Ratings, Emergency Preparedness

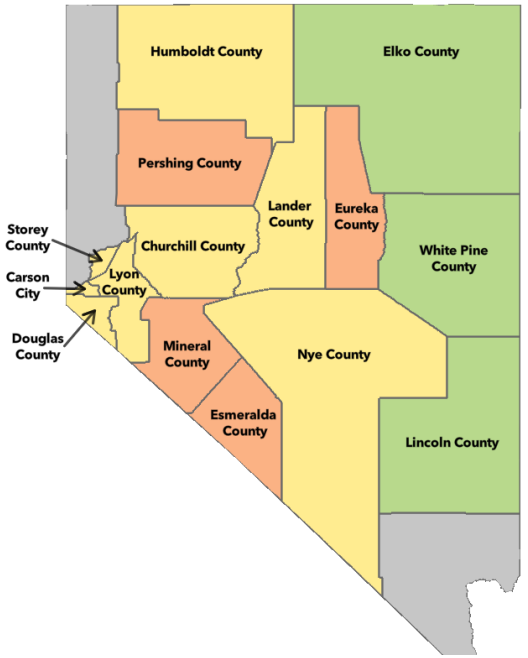


Table 46. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 47. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 48. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

This Capability received the strongest ratings across all the Foundational Program and Capability areas with "Proficient" Expertise, "Moderate" Capacity, and "Some Services" or "Sufficient Services" for Level of Implementation across the majority of counties. The format of the in-person meetings allowed groups to take notes next to the services that survey participants input during the data collection phase. There are frequent notations of "works well with hospital," "works well with LEPC (Local Emergency Planning Committee[81])," "works closely with local EMS," and the like.

> "WE NEED TO BETTER UNDERSTAND THE RESPONSE SYSTEM WITHIN THE DISTRICT."
>
> Eureka County FPHS Meeting Group Notes

DPBH hosts a Public Health Preparedness Unit[82], which supports statewide efforts and manages grants to local health authorities and partners to improve public health infrastructure. The Division of Emergency Management/Homeland Security[83] was also frequently cited as an active partner in local Emergency Preparedness efforts. With respect to these two lead state agencies, the headline responsibility to "Establish governmental public health's role in preparedness and response to incidents" was an area that could use further clarification and education at the local level, as local partners recognized state-level expertise and support for this area, but were not clear on how the teams at the Division of Emergency Management work together with the Public Health Preparedness team at DPBH to support response and recovery.

> "THE AVAILABILITY OF LOCAL RESPONSE TEAMS INCREASES UPPER [STATE] GOVERNMENT SUPPORT."
>
> Lander County FPHS Meeting Groups

CCHHS has a dedicated Public Health Preparedness Unit[84] that serves Carson City, Douglas, Lyon, and Storey Counties. CNHD experienced some delays in developing a program due to workforce issues, but as of August 2024, the CNHD Public Health Preparedness Program[85] is staffed with a Public Health Preparedness Manager to lead the work. Notably, this position was hired after the completion of data collection and community meetings for this FPHS assessment. County Emergency Managers and staff within the CNHD jurisdiction have an opportunity to collaborate with the health district to support operations of this new program.

[81] https://serc.nv.gov/LEPCs/LEPC/
[82] https://dpbh.nv.gov/Programs/PHP/PHP_-_Home/
[83] https://dem.nv.gov/
[84] https://www.gethealthycarsoncity.org/divisions/public-health-preparedness
[85] https://www.centralnevadahd.org/public-health-preparedness/

"Nye County handled the COVID response by a unified command structure. [We had] good community response and collaboration among organizations to respond to the pandemic. [We] cross-trained EMS for injections, medical organizations offered medical staff for PODs; Key stakeholders in bi-monthly meetings. The State needed County assistance to handle COVID response."

Nye County FPHS Community Meeting Group Notes

Some support services reported through the survey at the state level were known to Emergency Managers, but unknown to other FPHS participants who can support the work. One example of this is the Access and Functional Needs Unit[86] at the Nevada Department of Emergency Management. As rural and frontier communities may face compounding challenges in serving the needs of individuals with disabilities or a condition that requires additional assistance, participants noted an interest in additional support from this unit/staff person in Public Health Preparedness efforts. Local Emergency Managers can act as a liaison to this team, and further advocate for local needs. Realistically, however, participants also noted challenges in having a single position support this work across the state. As with other Program Areas and Capabilities that struggle with Capacity levels, it is not feasible to expect more from current staff who already manage full workloads, on either the state or local side. More support is needed.

The counties that noted "Basic" Expertise and "Minimal" Capacity are Esmeralda, Eureka, Lander, Mineral, and Pershing County. There is an opportunity for health authorities serving these counties to improve Public Health Preparedness and Emergency Response communications and planning to these areas. Across the board it was noted that Emergency Preparedness requires strong partnerships between local governments, health authorities, and community partners.

[86] https://dem.nv.gov/preparedness/Access___Functional_Needs/

Communications

The Communications capability in public health involves creating and maintaining systems that allow for effective, bi-directional communication with the public and partners. This includes developing communication plans, ensuring messages are accessible and reach their intended audience in a clear and understandable way, and building relationships with media outlets including so-called "non-traditional" outlets. Agencies work with communities to co-create communication strategies, utilize social media, and address misinformation. Additionally, they focus on health education and risk communication, ensuring that information during public health crises is accurate, consistent, and accessible to all audiences.

The following headline responsibilities were the basis for the ratings:

- Develop and maintain a public communications infrastructure.
- Develop and maintain public health education and risk communication capabilities.

Opportunities for Health Authorities, Counties, and Legislators

- Legislators may consider flexible public health funding for public health authorities to support the development of improved communications and coordination, which are both vital activities that are not often funded with programmatic-focused federal grants.
- Health authorities may consider engaging communications professionals in developing public health communications infrastructure in partnership with the communities served and via local communications infrastructure (including tribal infrastructure, schools, community centers, etc.) to ensure reach.
- Health authorities may consider website traffic analysis to assess the extent to which investments in web communications infrastructure is achieving the desired reach; targeted outreach efforts may be developed for specific communities that currently do not access new pages and resources.
- Health authorities may consider regular participation in active community leadership meetings in their jurisdiction that either directly or tangentially impact health.
- Counties may consider improvements to Board of Health meetings and CHO infrastructure to build local communications pathways, and (where applicable) lending county PIO support to public health efforts.
- Counties and Health Authorities may consider targeted efforts to improve communications in a single critical area based on need (i.e. specific community health indicators) as a starting point.
- Health authorities may consider evaluating their own programmatic reach and refrain from communicating that a service is available across the district/health authority when in practice there is no capacity to support all counties or parts of each county.
- Counties and Health Authorities may explore Artificial Intelligence (A.I.) applications, such as chatbots and enhancements to translation services, to improve communications.

Key themes: Ineffective/minimal communications; leverage local infrastructure; need for local public health infrastructure to support communications; funding limitations; staff bandwidth/capacity limitations.

The following pages show the statewide ratings for Expertise, Capacity, and Level of Implementation for Communications and provide more detailed discussion to support the opportunities listed above.

Figure 43. Expertise Ratings, Communications

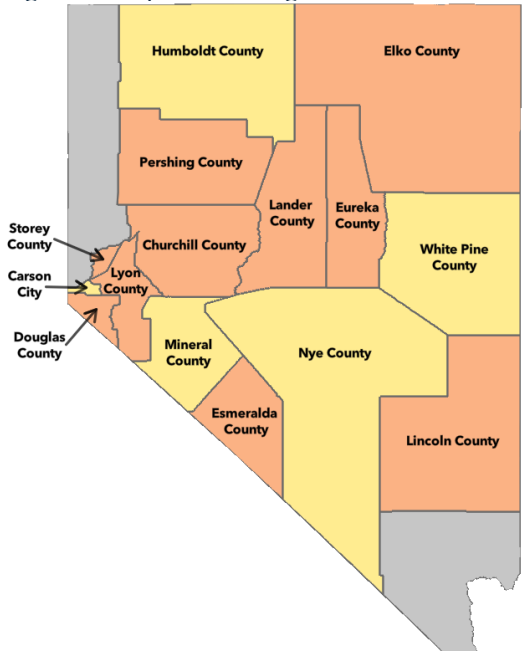


Figure 44. Capacity Ratings, Communications

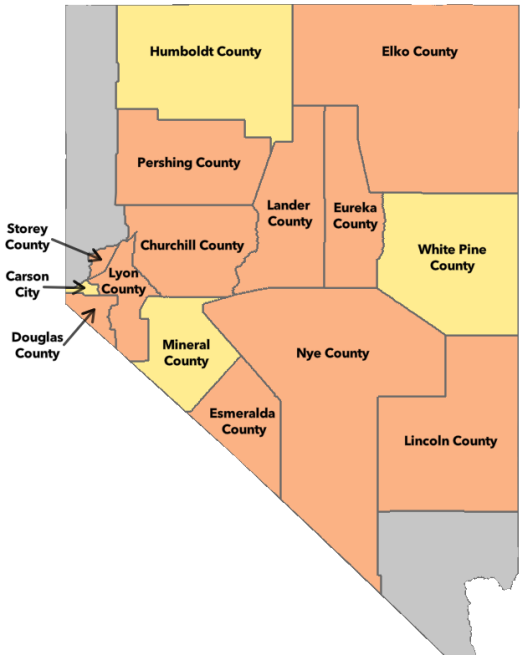


Figure 45. Implementation Ratings, Communications

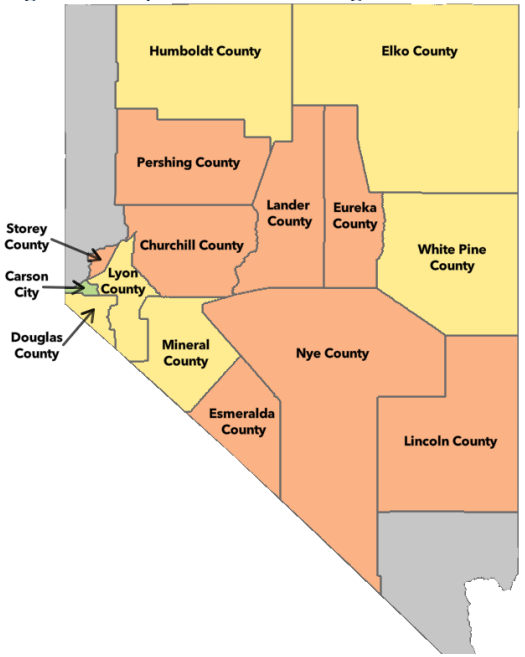


Table 49. Color to Rating Scale Key for Expertise

Absent
Basic
Proficient
Expert

Table 50. Color to Rating Key for Capacity

Absent
Minimal
Moderate
Full

Table 51. Color to Rating Key for Implementation

Lacking/No Services
Minimal Services
Some Services
Sufficient Services
Fully Implemented/Meets Demand

Discussion

From the perspective of the project team, further development of the Communications Capability is the single most important next step that could come out of this FPHS Assessment effort.

The headline responsibility to "Develop and maintain a public communications infrastructure" appears to be fragmented and ineffective across most of the counties assessed. While there is an abundance of information on health authority websites, it should be noted that this is not a reliable method for delivering communications equitably across the state considering significant connectivity issues, as well as population-specific preferences for accessing information. For a significant portion of Lincoln County, there is limited internet access. Other counties face similar connectivity challenges. In at least three counties, FPHS participants noted that they do not receive any bulletins or special reports on public health threats from their health authorities, though all health authorities operating in the counties surveyed do produce or distribute (to varying degrees based on capacity) public health bulletins and publish them to their websites. The communications pathways are underdeveloped or broken.

> NEED TO VET INFORMATION PROVIDED; WE WOULDN'T KNOW IF THIS INFO IS ACCURATE; WE DO KNOW ABOUT THE SAFE VOICE PLATFORM, BUT NOT THE OTHERS."
>
> Humboldt County FPHS Meeting Group Notes on the list of public health authority communications infrastructure at DHHS

Public health professionals are not necessarily communications professionals, and yet strong communication is one of the most essential functions of public health, especially in places like Nevada where staffing, infrastructure, and access points are so limited. The project team found that tensions between public health authorities, community leadership, and the communities served were quite often due, in part, to mismanaged expectations. There is an assumption of more knowledge, resources, and capacity than is actually available at both the local and state level. Better communications pathways would help with expectation setting and the development of communications pathways to address true gaps. It would also help to build trust. Local partners reviewing lists of health authority services across the Program Areas and Capabilities expressed skepticism about whether the services applied to their counties, as they did not know of them. This could be improved with more relationship building between health authories and local partners.

In conducting follow-up research for this FPHS assessment, the project team found a number of statewide public health resources with county-level data that could help leaders at the local level develop strategies and targets for health improvement, for example the State of Nevada's Network for Care[87] resource. There is an opportunity to increase knowledge and utilization of these resources.

In some cases, communications and cooperation between health authorities is strong, but communications out of the health authority to community partners and to the communities at large is limited. Carson City Health and Human Services (CCHHS) is an exception, as participants in that FPHS process rated Level of Implementation for Communications as "Sufficient Services."

[87] https://publichealth.networkofcare.org/state-nv

There are structures in place that can be leveraged to improve this Capability, though additional investment is likely needed. In-person health authority engagement in active community workgroups such as LEPC, Public and Behavioral Health Task Forces, Boards of Health, and Prevention Coalition meetings was identified as an opportunity in most communities. Health authority capacity to send staff to regular meetings, however, is not widely available. There is opportunity to budget travel funds and time for staff to engage in these types of meetings, especially in rural and frontier counties where it is often the case that key leadership across health, public safety, and human services sectors are present.

> Further development and support for the County Health Officer role is a major opportunity area for Nevada's counties.

Additionally, through the FPHS process, the project team collected local modes of communications in each county, including radio stations, local publications, county-based social media and email infrastructure, and popular community forums. These will be made available with the rest of the county-specific infrastructure lists on the web through NACO's public health page. Developing a public health communications infrastructure in partnership with high-traffic local communications pathways is an opportunity area.

Further development and support for the County Health Officer (CHO) role in every county not within a health district is critical for improvement in this area. The CHO role is also critical for health districts, too, though a core difference is that health districts have Administrators and staff that can support basic communications functions. In counties outside of districts or without local departments, the CHO is the primary public health contact. The CHO can build trust between public health partners. The CHO can receive and interpret information from state agencies, health authorities, and community partners, and then convey this information back to counties through Board of Health meetings, LEPCs and other workgroups. CHO compensation and capacity, however, need to be revisited for this to be feasible. In most counties, CHOs have full-time jobs beyond the CHO role and are not compensated to a level that would merit the kind of engagement that communities need. In counties with an engaged and knowledgeable CHO, such as Elko County, many of the responsibilities that would typically be handled by a CHO in partnership with a local health department in other states, are managed by a single individual in Nevada. This is not a sustainable infrastructure.

Figure 46. DPBH Network of Care Resource, https://publichealth.networkofcare.org/state-nv

In counties without an engaged and knowledgeable CHO, the project team found more gaps in communications at the local level and more gaps in communications between local partners and health authorities. NACO hosted a County Board of Health workshop[88] in 2024, which provides additional context and guidance for this area. Additionally, SB118, passed by the Nevada Legislature in 2023, provided a $15M investment in public health improvement funds to local health authorities and counties. These funds can be used to hire and retain CHOs.

Lyon County's Public and Behavioral Health Task Force recognized the need for public health communications as a top priority for their county. The County Board of Health has invested SB118 funding into a public health marketing campaign to address the communications gaps described above. Services are available and community partners are ready to support, but the public does not always know what is available or where to access. Strong Communications infrastructure can be utilized to address a community's unique challenges and needs. In the case of Lyon County, transportation safety and risky driving is a top public health concern. In addition to other top priorities, the public health marketing workgroup is developing messaging and tools with the goal of behavior change at the community level to reduce traffic deaths.

Finally, Artificial Intelligence applications are increasingly utilized by governments across the country to improve communications. The Guinn Center published a policy brief[89] in 2024 outlining risks and opportunities with this emerging technology, including how some states are using AI to support enhancements to translation services.

[88] https://www.nvnaco.org/resources/education-workshops.php
[89] https://www.guinncenter.org/research/ai-government

Behavioral Health

***NOTE**: Much of this behavioral health infrastructure discussion and inventory was originally written and compiled by NACO's Public Health Coordinator for the "Local Health District Toolkit: A Two-Year Operational Guide for Developing Local Health Districts in Rural Nevada" published by the University of Nevada School of Medicine Office of Statewide Initiatives in 2023. It is reproduced here in a modified format with additional insight provided by FPHS assessment participants across the state and with additional infrastructure information that reflects state and local developments over the past year.*

The Foundational Public Health Services model does not include Behavioral Health as a Foundational Program Area. This is likely due, in part, to the historical siloing of public health and behavioral health fields, as well as the now-dated notion that behavioral health services are more in line with the 1:1 treatment model that is found in traditional health care, not the more population-based approaches of public health. Increasingly, however, the population health strategies that are deployed in the field of public health are increasingly being deployed within behavioral health fields. For example, the Social Determinants of Health (SDoH)[90]—the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks—are being studied for their impacts on mental health outcomes. Addressing the Social Determinants of Health as a shared strategy between public and behavioral health partners can lead to improved outcomes for all.

Figure 47. Social Determinants of Health (SDOH) graphic from cdc.gov

Effective community health campaigns can address both public and behavioral health challenges while developing community cohesion and resilience, as is demonstrated by the Native Connections' Culture is Prevention[91] program and Nevada's Resilient 8 (now Formidable 14), a coalition of rural Nevada counties that came together to combat the opioid crisis and also encouraged the integration of Community Health Workers into the rural Nevada health workforce.

Building an infrastructure from the outset where public and behavioral health professionals communicate, collaborate, and create a shared vision and plan will help drive positive health outcomes and will contribute to the efficient use of scarce resources. Local and regional partners working within the field of behavioral health can share their knowledge of current infrastructure and available data, including the prevalence of specific risk and protective health factors in the region, health promotion and substance use prevention strategies that have been effective, information about school-based health programming and partnership, as well as other community-specific assets and gaps.

[90] https://www.cdc.gov/publichealthgateway/sdoh/index.html
[91] https://www.samhsa.gov/sites/default/files/nc-oy1-task-3-culture-is-prevention-final-2018-05-31.pdf

Through the FPHS assessment process, the project team found that where there are *county government-based* behavioral health services in the assessed counties, these are most often through Sheriff's offices and/or Social/Human Services teams in partnership with local coalitions or community organizations. For example, many counties have (either developed or in development) a version of a Mobile Outreach Safety Team (MOST)[92], a co-responder model that ensures that people in behavioral health crisis receive the right care at the right time and do not end up unnecessarily incarcerated. Though each is in different stages of development and sustainability, and the model looks a little different in each jurisdiction, MOST is in the following counties: Carson City, Douglas, Lyon, Mineral, Nye, Lincoln and Storey County, with Esmeralda and possibly Elko in development pending funding. Churchill County Social Services utilizes a Resource Liaison model to support crisis response and connection to behavioral health care, and this County has also recently partnered with the school district and community to develop a county-wide Behavioral Health and Suicide Prevention Plan. Carson City Sheriff's Office has a new Family Services Unit and is also developing peer support resources for first responders. Lyon County has a Behavioral Health Services Unit[93] that includes MOST, a Resilient Families Program, and Trauma Focused Cognitive Behavioral Therapy (CBT). Another impactful county-based model is the Forensic Assessment Services Triage Team (FASTT),[94] which supports people who are involved with the criminal justice system, or are at risk of involvement, in getting connected to the behavioral health resources they need. There are FASTT teams in the following counties: Carson City, Churchill, Douglas, Lyon, and Nye.

NAMI Western Nevada[95] is a key player across many of the counties surveyed with a Teen Text Line and Chat, Nevada Warmline, developing Freedom Bridges Program (connects incarcerated individuals to services and recovery supports in advance of release back into the community), and the Avell Program, which provides law enforcement officers on-the-scene connection to mental health providers through iPads.

Opioid epidemic abatement and the prevention, treatment, and recovery landscape for opioids and other substances is another significant area of focus for counties in the behavioral health space. As a result of the One Nevada Agreement[96], all of Nevada's counties are receiving Opioid Abatement Funds to support their local needs. Ten of the counties surveyed in the FPHS have completed Opioid Needs Assessments and Plans[97], and some have received further funding through the Fund for a Resilient Nevada[98].

Governor Joe Lombardo and the Division of Health Care Financing and Policy (Nevada Medicaid) at the Department of Health and Human Services are working on a complete transformation of Children's Behavioral Health Services[99] supported with a $200M investment[100] over the 2023-2025 biennium. Nevada Medicaid is engaging counties and local partners across the state to inform that process.

In addition to the resources listed below, the locally available behavioral health services collected for each county during the FPHS process will be made available via the NACO website[101] in October/November 2024.

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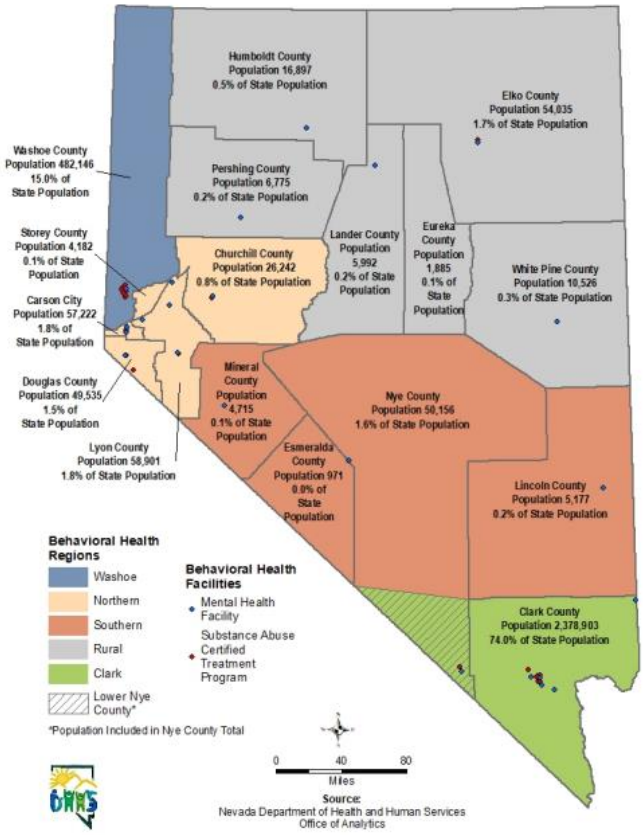
[92] https://nvbh.org/most/
[93] https://www.lyon-county.org/1101/Behavioral-Health-Services
[94] https://nvbh.org/f-a-s-t-t/
[95] https://namiwesternnevada.org/
[96] https://ag.nv.gov/uploadedFiles/agnvgov/Content/News/PR/PR_Docs/2021/One%20Nevada%20Agreement%20on%20Opioid%20Recoveries%20-%20Approved.pdf
[97] https://www.nvnaco.org/advocacy/public-health.php
[98] https://dhhs.nv.gov/Programs/FRN/Home/
[99] https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/CBHT%20Informational%20Flyer%20(Fall%202024)%20ADA_FINAL.pdf
[100] https://gov.nv.gov/Newsroom/PRs/2024/2024-03-22_behavioral_health_care/
[101] https://www.nvnaco.org/advocacy/public-health.php

Regional Behavioral Health Infrastructure in Nevada

- Nevada Regional Behavioral Health Policy Boards + Regional Coordinators[102]

NRS 433.429 established five regional behavioral health policy boards tasked with coordinating, monitoring, assessing, and advising the State of Nevada on the behavioral health needs of their region, as well as promoting and advancing needed policy change at the local, regional, and state level to improve the behavioral health outcomes in the region.

- **Washoe Region** (Washoe County)
- **Rural Region** (Humboldt, Pershing, Lander, Eureka, White Pine, and Elko Counties)
- **Northern Region** (Carson City, Douglas, Lyon, Storey, and Churchill Counties)
- **Southern Region** (Mineral, Esmeralda, Northern Nye, Lincoln Counties)
- **Clark Region** (Southern tip of Nye County, Clark County)

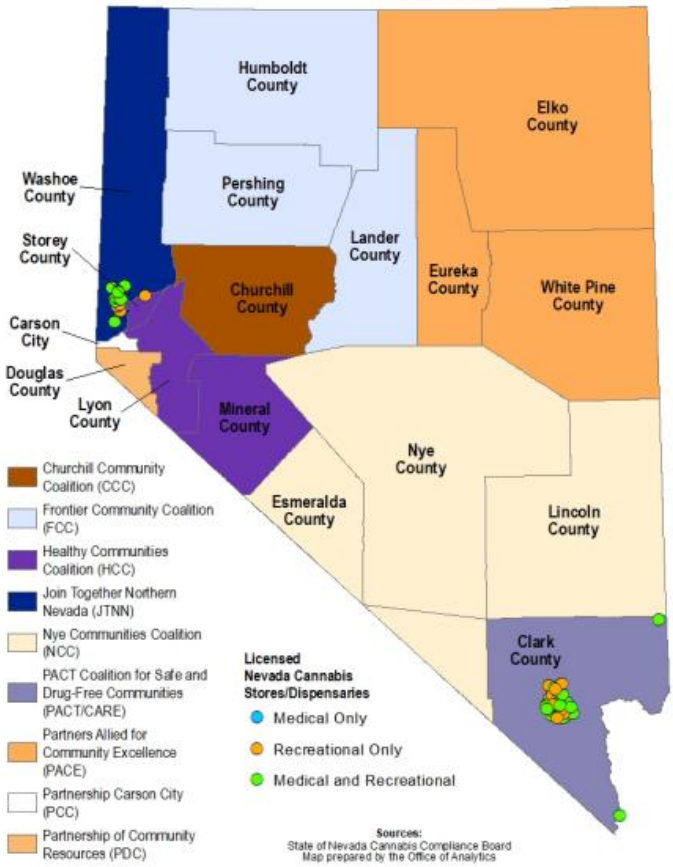


[102] https://nvbh.org/

- Statewide Nevada Coalition Partnership[103]

Every community in Nevada is served by a prevention coalition working to reduce the number of overdose deaths through family and prescriber education. Depending on the region, the coalitions have expanded into an array of other health promotion, community-building, and resilience-building activities.

- CARE Coalition[104] (Clark County)
- Churchill Community Coalition[105] (Churchill County)
- Frontier Community Coalition[106] (Humboldt, Lander, and Pershing Counties)
- Healthy Communities Coalition ([107]Lyon, Storey, and Mineral Counties)
- Join Together Northern Nevada[108] (Washoe County)
- Lincoln County Coalition[109] (Lincoln County, newly developed and working in partnership with NyE Communities Coalition)
- NyE Communities Coalition[110] (Nye, Lincoln, and Esmeralda Counties)
- PACE Coalition[111] (Elko, Eureka, and White Pine Counties)
- PACT Coalition[112] (Clark County)
- Partnership Carson City[113] (Carson City)
- Partnership Douglas County[114] (Douglas County)



[103] https://healthiernv.org/
[104] https://www.carecoalitionnv.org/
[105] http://www.churchillcoalition.com/
[106] http://www.frontiercommunity.net/
[107] https://healthycomm.org/
[108] https://jtnn.org/
[109] https://www.facebook.com/lccoalition/
[110] https://nyecc.org/
[111] https://www.pacecoalition.org/
[112] https://drugfreelasvegas.org/
[113] https://pcccarson.org/
[114] https://www.pdcnv.org/

- NAMI Western Nevada[115]

- The Nevada Community Health Worker Association (NVCHWA)[116]

Community Health Workers (CHWs) are a vital part of the healthcare workforce in Nevada in both public and behavioral health fields, as well as in clinical settings to support adherence to treatment plans, culturally appropriate communications, removal of preventable barriers to treatment such as lack of transportation, and the development of trust between the community and providers of healthcare. The Nevada Community Health Worker Association provides training, technical assistance, and grant opportunities to organizations ready to build up their CHW workforce.

In the 82nd Session of the Nevada Legislature, SB 117 passed which will allow CHWs to be supervised and support work in additional settings, including in behavioral health.

- Rural Clinics[117]*

Rural Clinics (RC) – provides a full array of outpatient behavioral health services for adults and children in 16 clinics in 12 counties across Rural Nevada. Services are provided Monday through Friday from 8:00 am to 5:00 pm, not including State holidays. Services assist individuals to achieve self-sufficiency and recovery. Services include (some services may only be available via tele-health technology, not on-site): Case Management, Rehabilitative Mental Health (RMH) services, Peer Support services, Residential Support, Counseling, Medication Clinic, Mobile Crisis Response Team for children, Immediate Mental Health CARE Team for adults, Mental Health Court Forensic Assessment and Triage Team (FASTT), Mobile Outreach Safety Team (MOST), and Juvenile Justice Assessment and Screening Triage Team (JJASTT).

*FPHS participants noted a decrease in staffing at the rural clinics in some counties, as well as restrictions on populations served related to the youth justice-involved population. The county-level reports will list currently active services at each clinic.

[115] https://namiwesternnevada.org/
[116] https://www.nvchwa.org/
[117] https://dpbh.nv.gov/Programs/Rural_Clinics_Administration/Rural_Clinics_Admin/

Additional Resources

Division of Public and Behavioral Health Community Health Nursing

Helpful links:

- Clinical Community Nursing (nv.gov)[118] ;
- Rural Community Health Services Locations (nv.gov)[119]

The hours listed below are when ***nursing services*** are available at the Community Health Clinics as of this writing. The clinics may be open for additional hours (staffed with county admin staff to support the CHN work).

The following staff are currently budgeted for Community Health Nursing at DPBH: 7 Community Health Nurses (active); 1 Advanced Practice Registered Nurse APRN (Pahrump, currently hiring), 2 Community Health Nurse vacancies (1 full-time position in Lincoln; 1 full-time position in Tonopah).

Nursing hours at DPBH Community Health Services Clinics:

- Humboldt County (1 full-time local nurse)
  - Winnemucca 7AM-5:30PM Weekly, Monday – Thursday
- Lincoln County (White Pine nurse visits x2 days monthly)
  - Panaca 10AM-2PM Monthly, 1st & 3rd Wednesdays
- Lyon County (3 full-time local nurses)
  - Dayton 8AM-5PM Weekly, Monday – Thursday
  - Fernley 7:30AM-5:30PM Weekly, Monday – Thursday
  - Yerington 8AM-4:30PM Weekly, Monday – Friday
- Nye County (Currently 1 full-time nurse in Pahrump that covers Tonopah x2 per month, hiring 1 APRN)
  - Pahrump 8AM-4PM Weekly, Monday – Thursday
  - Tonopah 10AM-2PM Monthly, x2 days
- White Pine (1 full-time local nurse)
  - Ely 7AM-5:30PM Weekly, Monday – Thursday

Division of Public and Behavioral Health – Environmental Health Services

How to pick your health department.pdf (nvnaco.org)[120]

Veteran's Services

A limitation of the FPHS process is that the survey did not have a separate column to collect data on federally provided services, such as earned benefits available through Veterans Affairs. Across most FPHS, federal support is limited to funding streams. However, in the case of Veterans, there are federally managed, locally delivered services. Local access points for these services will be in the county-level reports.

VA.gov Home | Veterans Affairs[121]

Benefits and Services - Nevada Department of Veterans Services (nv.gov)[122]

[118] https://dpbh.nv.gov/Programs/ClinicalCN/Clinical_Community_Nursing_-_Home/
[119] https://dpbh.nv.gov/Programs/ClinicalCN/Locations/Rural_Community_Health_Services_Locations/
[120] https://www.nvnaco.org/wp-content/uploads/How%20to%20pick%20your%20health%20department..pdf
[121] https://www.va.gov/
[122] https://veterans.nv.gov/benefits-and-services/

Appendix A – Tables for Accessibility

Table 52. Numeric Values of Ratings for Table 1. Expertise of FPHS Across Nevada, 2024

Health Authority	Central Nevada Health District				CC HHS*	State of Nevada Department of Public and Behavioral Health									
County	**Churchill**	**Eureka**	**Mineral**	**Pershing**	**Carson City**	**Douglas**	**Lyon**	**Storey**	**Humboldt**	**Lander**	**Elko**	**White Pine**	**Lincoln**	**Nye**	**Esmeralda**
Communicable Disease Control	3	3	2	2	3	3	3	2	2	2	1	3	3	3	1
Chronic Disease and Injury Prevention	3	2	2	2	3	3	2	2	3	2	2	1	2	3	1
Environmental Public Health	3	3	3	2	3	2	2	2	3	1	2	2	2	3	2
Maternal, Child, and Family Health	3	2	2	2	3	3	3	3	3	1	2	3	3	3	1
Access to and Linkage with Clinical Care	3	2	2	2	3	2	2	2	2	2	2	2	3	3	1
Assessment and Surveillance	3	2	3	3	3	2	2	2	2	2	2	1	2	3	1
Community Partnership Development	3	2	3	2	3	3	3	2	2	2	2	3	2	3	1
Equity	3	2	2	2	2	2	2	2	2	2	2	2	2	2	1
Organizational Competencies	3	3	3	3	3	2	2	1	2	2	2	2	2	1	1
Policy Development and Support	3	2	2	3	2	2	2	1	2	2	2	2	3	2	1
Accountability and Performance Management	3	2	2	3	3	2	2	1	2	2	2	3	2	2	1
Emergency Preparedness and Response	3	2	2	2	3	3	3	3	3	2	3	3	3	3	2
Communications	2	2	3	2	3	2	2	2	3	2	2	3	2	3	2

**Carson City Health and Human Services*

Table 53. Color to Number to Rating Scale Key for Expertise

1 = Absent
2 = Basic
3 = Proficient
4 = Expert

Table 54. Numeric Values of Ratings for Table 2. Capacity of FPHS Across Nevada, 2024

Health Authority	Central Nevada Health District				CC HHS*	State of Nevada Department of Public and Behavioral Health									
County	**Churchill**	**Eureka**	**Mineral**	**Pershing**	**Carson City**	**Douglas**	**Lyon**	**Storey**	**Humboldt**	**Lander**	**Elko**	**White Pine**	**Lincoln**	**Nye**	**Esmeralda**
Communicable Disease Control	3	3	2	2	3	3	2	2	1	2	1	3	3	2	1
Chronic Disease and Injury Prevention	2	2	2	2	2	2	2	2	1	2	2	1	2	1	1
Environmental Public Health	2	3	2	2	3	2	2	2	2	2	2	2	2	1	2
Maternal, Child, and Family Health	2	2	2	2	2	3	3	2	2	2	2	3	3	2	1
Access to and Linkage with Clinical Care	2	2	2	2	2	3	2	2	2	2	2	2	3	2	1
Assessment and Surveillance	3	2	2	3	2	2	3	2	3	2	2	1	2	2	1
Community Partnership Development	3	2	3	2	3	3	3	2	2	2	2	3	3	2	1
Equity	3	2	2	2	2	2	2	2	2	2	2	2	2	2	1
Organizational Competencies	3	3	3	2	2	2	2	1	2	2	2	2	2	1	1
Policy Development and Support	3	2	2	3	2	2	2	1	2	2	3	2	3	1	1
Accountability and Performance Management	3	2	2	3	3	2	2	1	2	2	2	3	2	1	1
Emergency Preparedness and Response	3	2	2	2	3	3	3	3	3	2	3	3	3	3	2
Communications	2	2	3	2	3	2	2	2	3	2	2	3	2	2	2

**Carson City Health and Human Services*

Table 55. Color to Number to Rating Scale Key for Capacity

1 = Absent
2 = Minimal
3 = Moderate
4 = Full

Table 56. Numeric Values of Ratings for Table 3. Implementation of FPHS Across Nevada, 2024

Health Authority	Central Nevada Health District				CC HHS*	State of Nevada Department of Public and Behavioral Health									
County	**Churchill**	**Eureka**	**Mineral**	**Pershing**	**Carson City**	**Douglas**	**Lyon**	**Storey**	**Humboldt**	**Lander**	**Elko**	**White Pine**	**Lincoln**	**Nye**	**Esmeralda**
Communicable Disease Control	3	2	3	3	4	3	3	2	3	3	1	3	3	2	1
Chronic Disease and Injury Prevention	3	2	2	2	3	2	2	2	2	2	2	1	2	1	1
Environmental Public Health	3	3	3	2	4	3	2	2	3	2	3	2	3	1	2
Maternal, Child, and Family Health	3	2	2	2	3	3	2	2	3	2	3	3	3	1	1
Access to and Linkage with Clinical Care	2	2	2	2	3	3	2	2	3	2	2	2	3	1	2
Assessment and Surveillance	3	2	3	3	3	3	3	2	2	2	2	1	2	2	1
Community Partnership Development	3	2	3	2	4	4	3	2	2	2	3	4	2	2	1
Equity	2	2	3	2	3	2	2	2	2	2	2	2	2	1	1
Organizational Competencies	3	3	4	2	3	3	2	2	2	2	3	2	3	1	1
Policy Development and Support	3	2	2	2	3	3	2	2	2	2	2	2	3	1	1
Accountability and Performance Management	3	2	2	2	3	2	2	1	1	2	3	3	2	1	1
Emergency Preparedness and Response	3	2	2	2	3	3	3	3	3	3	4	4	4	3	2
Communications	2	2	3	2	4	3	3	2	3	2	3	3	2	2	2

**Carson City Health and Human Services*

Table 57. Color to Number to Rating Scale Key for Implementation

1 = Lacking/No Services
2 = Minimal Services
3 = Some Services
4 = Sufficient Services
5 = Fully Implemented/Meets Demand

Appendix B – Summary Handout

The following is an example handout document used in each Community Review and Verification Workshop.

This is a slightly modified version, removing identifying information for the county it was originally created for.

Foundational Public Health Services Assessment: [County Name]

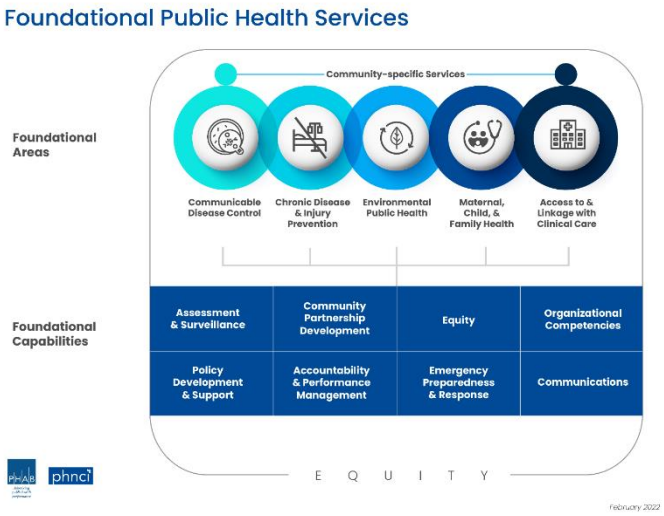
The Nevada Association of Counties (NACO), the Nevada Economic Assessment Project (NEAP) at UNR Extension, the Office of the Governor, and the Division of Public and Behavioral Health at the State of Nevada have come together to gather data on public health infrastructure in Nevada's rural and frontier counties. The purpose is to provide local governments with baseline data regarding the expertise, capacity, and level of implementation of public health services in their region, as well as an understanding of the specific programs and capabilities available at various levels of government (State, County, Regional Health Department/District) and through community partners.

Background

In 2013, the Public Health Leadership Forum, a project led by RESOLVE and funded by the Robert Wood Johnson Foundation (RWJF) convened a group of public health stakeholders to explore a recommendation from the Institute of Medicine (IOM) – **to define a minimum package of public health capabilities and programs that no jurisdictions can be without.** The result was the Foundational Public Health Services (FPHS), now housed at the Public Health National Center for Innovations (PHNCI) at the Public Health Accreditation Board (PHAB).

FPHS provide:

- A common language and national understanding of the vital role and unique responsibilities of governmental public health.
- The ability to assess gaps in capacity.
- Standardization to assure continuity across all states, but with the flexibility for communities to adapt to specific needs; and
- Alignment with national initiatives, such as public health accreditation.



This document contains the responses from an initial data collection of [County] public health experts. This is a baseline data assessment, not a total and complete collection. Collected through Qualtrics, this document contains [County]'s current public health infrastructure in alignment with the FPHS. The FPHS is a framework for local, state, and federal governments to assess progress towards a minimum public health infrastructure.

Rating System

Respondents were asked to rate their County's individual FPHS based on three categories: Expertise, Capacity, and Implementation. The choices for Expertise and Capacity were converted to values of 1 through 4 with each number rating representing the levels of Expertise and Capacity listed in the following table:

Table 58. Rating System Categories-Expertise and Capacity

Expertise Knowledge, skills, education, and experience related to the headline responsibility.		**Capacity** Staff and/or other resources, materials, and supplies to implement the headline responsibility.
Absent: No or basic awareness of the expertise, but limited ability to apply it.	**1**	**Absent**: Staff time and other resources and not present or are largely unavailable.
Basic: Knowledge of the expertise and can apply it at a basic level.	**2**	**Minimal**: Some staff time and/or other resources are present to complete basic functions.
Proficient: Expertise is available and can be applied adeptly.	**3**	**Moderate**: Most staff time and other resources are present to partially implement most functions.
Expert: Expertise is routinely applied and those with the expertise can build it within others.	**4**	**Full**: Sufficient staff time and other resources are present to fully implement all functions.

The choices for Levels of Program Implementation are listed below. In the heatmaps on the following pages, the ratings are reflected by a color gradient from green to yellow to red with a rating of **Fully Implemented/Meets Demand** indicated in **GREEN** and **Lacking/No Services** (representing the other end of the scale) indicated in **RED**.

Table 59. Levels of Program Implementation

Implementation Meeting the baseline recommendations for governmental public health for the headline responsibility.	
Fully Implemented/Meets Demand: Services are fully implemented as well as meet the community's overall demand for public health services in this area.	**5**
Sufficient Services: Services are mostly implemented as well as meet the community's overall demand for public health services in the area.	**4**
Some Services: Some public health services are available. There is an overall demand for public health services in the community.	**3**
Minimal Services: Minimal public health services are available. There is significant overall demand for public health services in the community.	**2**
Lacking/No Services: There are no public health services available in this foundational area. There is significant overall demand for public health services in this community.	**1**

Foundational Program Areas

Below please find the overview for the five Foundational Program Areas from the initial data collection through Qualtrics of County Public Health experts.

Foundational Program Areas:

Communicable Disease Control
Chronic Disease & Injury Prevention
Environmental Public Health
Maternal, Child, & Family Health
Access to & Linkage with Clinical Care

Table 60. Foundation Program Areas: Expertise and Capacity rating scale of 1 to 4

Expertise	Capacity		Implementation
		Communicable Disease Control	
		Chronic Disease and Injury Prevention	
		Environmental Public Health	
		Maternal, Child, and Family Health	
		Access to and Linkage with Clinical Care	

Lower scores are red moving through yellow to green being the highest scores.
Expertise and Capacity were rated on a scale of 1 to 4.
Implementation was rated on a scale of 1 to 5.

Scale Key:

Expertise and Capacity

Table 61. Expertise and Capacity Scale Key

1	2	3	4

Implementation

Table 62. Implementation Scale Key

1	2	3	4	5

The above table shows the average score when combining all Qualtrics responses. One main point of today's discussion is to create a group decision on how to round the averages to a whole number answer.

The following ten pages go into detail regarding the five Program Areas and include the headline responsibilities of the FPHS, detailed data collected in Qualtrics, and a list of programmatic efforts delivering this FPHS into the local community.

Communicable Disease Control – Overview and Data

Headline Responsibilities for Communicable Disease Control

- Develop a communicable disease prevention plan, as well as plans for the prevention and control of specific communicable diseases.
- Provide timely, scientifically accurate, and locally relevant information on communicable diseases and their control.
- Implement population-based communicable disease prevention and control programs and strategies.
- Inform, communicate, work cooperatively with, and influence others on policy, system, and programmatic changes for communicable disease prevention and control.
- Conduct disease investigations and respond to communicable disease outbreaks.
- Enforce public health laws to prevent and control communicable diseases.
- Maintain or participate in a statewide immunization program and assure the availability of immunizations to the public.

Table 63. Communicable Disease Control had a total of 3 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	2.67	Proficient	Expertise is available and can be applied adeptly.
Capacity	2.67	Moderate	Most staff time and other resources are present to partially implement most functions.

Table 64. Communicable Disease Control had a total of 3 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	3.67	Sufficient Services	Services are mostly implemented as well as meet the community's overall demand for public health services in the area.

Rounding the averages in the table above produces the following ratings for **[County]** for Communicable Disease Control:

Table 65. Rounding the averages in the table above produces the following ratings for [County] for Communicable Disease Control:

	Expertise	Capacity
Communicable Disease Control	Proficient	Moderate

Implementation
Sufficient Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Communicable Disease Control table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Communicable Disease Control – Programs

Table 66. Communicable Disease Control – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
OSC, HAI – Hospital Acquired Infections	Public Health Officer	Public Health Department	Schools monitoring immunizations and communicable diseases in schools
Epidemiology and Laboratory Capacity (ELC), funding only, subbed to locals	County Hospital	– collect and reports communicable diseases to the State; Monitors outbreaks and works with the State on communication and control	– Diagnosis and treats patients with communicable diseases
HIV/AIDS Surveillance Program			[County] School District – Health Class
Nevada Birth Outcomes Monitoring System (NBOMS)			Family Quick Care
Nevada Central Cancer Registry (NCCR)			Tribal Clinic
Sentinel Events Registry (SER)			
Sickle Cell Anemia Registry			
Syndromic Surveillance (BioSense)			
Viral Hepatitis Surveillance and prevention	**STATE CONTINUED**		
Tuberculosis (TB) Control and Elimination Program	State of Nevada Community Health Nursing Clinic		
441A Disease Investigations, NRS 441, includes HIV investigations	Food/Restaurant Health Inspections		
Controlled Substances Action Team and Review Board	Foodborne Illness Control - Complaints and Outbreaks		
State-level Epidemiologists coordinating state and federal data repositories; they are partner for ICCR	Nevada State Public Health Lab (NSPHL);		
Nevada State Immunization Program (NSIP) – Immunizations	Responsibility for tracking of vaccine exemptions tracked locally by schools;		
Youth Risk Behavior Surveillance System (YRBSS) - UNR	Legionellosis Case Report Plan in place		
Behavioral Risk Factor Surveillance System (BRFSS) - UNR	Labs, Testing, Epidemiology, Surveillance		
Long-term care/healthcare facility regulatory oversight (HCQC) and disease outbreak in facilities	Department of Health and Human Services (DHHS)		

Notes:

Chronic Disease and Injury Prevention – Overview and Data

Headline Responsibilities for Chronic Disease and Injury Prevention

- Develop a chronic disease and injury prevention plan, as well as plans for the prevention and control of specific chronic diseases or sources of injury.
- Provide timely, scientifically accurate, and locally relevant information on chronic diseases and injury prevention.
- Implement population-based strategies to address issues related to chronic disease and injury.
- Inform, communicate, work cooperatively with, and influence others on policy, system, and environmental changes that will prevent harm and improve health related to chronic disease and injury.

Table 67. Chronic Disease and Injury Prevention had a total of 3 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	1.00	Absent	None, or basic awareness of the expertise, but limited ability to apply it.
Capacity	1.00	Absent	Staff time and other resources are not present or are largely unavailable.

Table 68. Chronic Disease and Injury Prevention had a total of 3 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	1.00	Lacking/No Services	There are no public health services available in this foundational area. There is significant overall demand for public health services in this community.

Table 69. Rounding the averages in the table above produces the following ratings for [County] for Chronic Disease and Injury Prevention:

	Expertise	Capacity
Chronic Disease and Injury Prevention	Absent	Absent

Implementation
Lacking/No Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Chronic Disease and Injury Prevention table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Chronic Disease and Injury Prevention – Programs

Table 70. Chronic Disease and Injury Prevention – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Injury Prevention: Suicide Prevention, Overdose Prevention (both now in BBHWP – The Bureau of Behavioral Health, Wellness, and Prevention)	County Hospital	Classes offered at County Hospital by Providers	Prevention of injury on playgrounds at the school district level
Partner with Nevada Department of Transportation (NDOT) on Complete Streets, Traffic Safety			– Providers physicals, well checks, Treatment education, health fair, immunizations, preventative medicine
Statewide Exec Committee for Child Fatality Review			School District – Evaluates immunization status and requires immunizations
State Strategic Plan Chronic Disease Prevention and Health Promotions (CDPHP), tableau dashboards and program reports for all CDPHP programs			Tribal Clinic
NV Quality and Technical Assistance Center (QTAC)			
Rape Prevention and Education Program			
Fetal Infant Mortality Review (FIMR)			
Local Child Death Reviews			
DPBH Tobacco Control and Prevention			
9-8-8			

Notes:

Services are provided at a cost, but with access to sliding-scale fees, charity care, etc...

Environmental Public Health – Overview and Data

Headline Responsibilities for Environmental Public Health

- Develop a plan to promote environmental health.
- Provide timely, scientifically accurate, and locally relevant information on the environment and environmental threats and their control.
- Implement population-based environmental health programs and strategies.
- Inform, communicate, work cooperatively with, and influence others whose work impacts environmental health.
- Diagnose, investigate, and respond to environmental threats to the public's health.
- Conduct mandated environmental public health inspections and oversight to protect the public from hazards in accordance with federal, state, and local laws and regulations.

Table 71. Environmental Public Health had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	2.00	Basic	Knowledge of the expertise and can apply it at a basic level.
Capacity	2.00	Minimal	Some staff time and/or other resources are present to complete basic functions.

Table 72. Environmental Public Health had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	2.00	Minimal Services	Minimal public health services are available. There is significant overall demand for public health services in the community.

Table 73. Rounding the averages in the table above produces the following ratings for [County] for Environmental Public Health:

	Expertise	Capacity
Environmental Public Health	Basic	Minimal

Implementation
Minimal Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Environmental Public Health table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Environmental Public Health – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Bottled water permitting (445A)			Sun Safety taught in schools, hand hygiene
Shell-fish distribution			– Monitor disease trends, look at population health within diabetes and working toward cardio; Monitor outbreaks of communicable diseases; Participate in immunization clinics, Flu Pods, COVID Pods etc…
Office of State Epidemiology supports with waterborne illness			
Waste Management (bureau of safe drinking water-public water systems; division of water resources, individual wells) permits			
Nevada Division of Environmental Protection (NDEP) - Wastewater and Drinking Water			
Clean Air + Water Programs	**STATE CONTINUED**		
Clean Indoor Air Act, Outdoor air NDEP	Health Permits		
Childcare Centers – permitting/licensing	Food Handler Certification – Food Handlers are food certified in Serve Safe		
Healthcare facilities - licensing	Mobile Home/RV Parks		
UNLV led Partnership with Occupational and Environmental (OE) Health	Tattoo/Piercing		
UNR Cooperative Extension - Radon	Vector Control		
NV State Emergency Response Commission (SERC) - Hazmat	Dept of Health and Human Services (DHHS)		
Environmental Health Specialists inspect food establishments, hotel/motel inspections, septic and well inspections, daycare inspections, body decorations (tattoos), public pool & Spa inspections, brothel inspections	Nevada Environmental Health		

Maternal, Child, and Family Health – Overview and Data

Headline Responsibilities for Maternal, Child, and Family Health

- Develop a maternal and child health plan, as well as plans for addressing specific maternal, child, and family health issues.
- Provide timely, scientifically accurate, and locally relevant information on maternal, child, and family health.
- Implement population-based strategies to address issues related to maternal, child, and family health.
- Inform, communicate, work cooperatively with, and influence others on policy, system, and environmental changes that will prevent harm and improve maternal, child, and family health.
- Assure provision of mandated newborn screenings and follow-ups according to state or federal mandates.

Table 74. Maternal, Child, and Family Health had a total of 3 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	2.67	Proficient	Expertise is available and can be applied adeptly.
Capacity	3.00	Moderate	Most staff time and other resources are present to partially implement most functions.

Table 75. Maternal, Child, and Family Health had a total of 3 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	3.33	Some Services	Some public health services are available. There is an overall demand for public health services in the community.

Rounding the averages in the table above produces the following ratings for [County] for Maternity, Child, and Family Health:

Table 76. Rounding the averages in the table above produces the following ratings for [County] for Maternity, Child, and Family Health:

	Expertise	Capacity
Maternity, Child, and Family Health	Proficient	Moderate

Implementation
Some Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Maternity, Child, and Family Health table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Maternal, Child, and Family Health – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Maternal Infant and Early Childhood Home Visiting (MIECHV) Program	County Hospital		Full-service OB/GYN in clinic and hospital; Providing courses for expecting mothers to provide the best care for them and their babies; This includes information on Substance abuse, proper prenatal care and post-natal care, sleep safe, breastfeeding education
Maternal and Child Health (MCH) - Title V (non-direct Services: public health and enabling services Statewide)			We monitor outcomes and look for differences due to social determinants of health, access issues, etc...;
Early Hearing Detection and Intervention (EHDI)			
Pregnancy Risk Assessment Monitoring System (PRAMS)			
Account for Family Planning			
Alliance for Innovation on Maternal Health			
Maternal Mortality Review Committee (MMRC)			
State Systems Development Initiative (SSDI) - Data enhancement			
WISEWOMAN, Women's Health Connection Health Facilities			
Teen Pregnancy Prevention (activity not designated state program)	**STATE CONTINUED**		
Maternal and Child Health (MCH) Dashboards and Data	Nevada Early Intervention Service		
Woman Infants and Children (WIC)	Vaccines for Children (VFC) Program		
NV WebIZ	Nevada Newborn Screening Program; Critical Congenital Heart Disease Screenings		
CARA Open beds			
Maternal and Child Health (MCH) planning and services			

Notes:

Access to and Linkage with Clinical Care – Overview and Data

Headline Responsibilities for Access to and Linkage with Clinical Care

- Develop a plan to address gaps and barriers and assure access to clinical care services.
- Provide timely, scientifically accurate, and locally relevant information on the importance, impact, and accessibility of healthcare systems, including barriers to care.
- Implement population-based strategies to improve barriers to accessing clinical care.
- Inform, communicate, work cooperatively with, and influence others on policy, system, and programmatic changes to facilitate access to health services.
- Examine and monitor the quality, effectiveness, and cost-efficiency of clinical care.
- Ensure licensed health care facilities and providers comply with laws and rules as appropriate.

Table 77. Access to and Linkage with Clinical Care had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	2.00	Basic	Knowledge of the expertise and can apply it at a basic level.
Capacity	2.00	Minimal	Some staff time and/or other resources are present to complete basic functions.

Table 78. Access to and Linkage with Child Clinical had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	2.00	Minimal Services	Minimal public health services are available. There is significant overall demand for public health services in the community.

Rounding the averages in the table above produces the following ratings for [County] for Access to and Linkage with Clinical Care:

Table 79. Rounding the averages in the table above produces the following ratings for [County] for Access to and Linkage with Clinical Care:

	Expertise	Capacity
Access to and Linkage with Clinical Care	Basic	Minimal

Implementation
Minimal Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Access to and Linkage with Clinical Care table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Access to and Linkage with Clinical Care – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Account for Family Planning			Schools have access to web IZ
Community Health Worker (CHW) support with Federally Qualified Health Centers (FQHCs) to help improve education and quality around blood pressure control			provides services to all people without prejudice; Clinic and hospital services have opportunities for sliding fee schedule and charity care; Access is widely available for entire community; We also have our language line so there is no issue with language barrier.
J1 Visa Program			
Health Care Quality and Compliance (HCQC)			
Early Hearing Detection Intervention (EHDI) in Maternal and Child health (MCH)			
Nevada Medicaid and Aging and Disability Services Division (ADSD)			
NV Health Link			
NV State Immunization Program			
Community Health Worker (CHWs) Program			
WISEWOMAN, Women's Health Connection			
Medical Transport - Medical Transportation Management (MTM)			
Medicaid Navigators			
State Health Insurance Assistance Program (SHIP) (Support to Nevada Medicare beneficiaries)			
Tobacco Quitline			
9-8-8			
Nevada Rural Clinics - Mental health treatment & clinical work			

Notes:

This is not done on a country-wide level, we do not do a lot of studies looking at access specific to this question. We are simply available for anyone and make it as easy as possible for people to get health care when needed.

Foundational Capabilities

Below please find the overview for the eight Foundational Capabilities from the initial data collection through Qualtrics of [County] Public Health experts.

Foundational Capabilities:

Assessment and Surveillance
Community Partnership Development
Equity
Organizational Competencies
Policy Development and Support
Accountability and Performance Management
Emergency Preparedness and Response
Communications

Table 80. Foundation Capabilities: Expertise and Capacity rating scale of 1 to 4

Expertise	*Capacity*		*Implementation*
		Assessment and Surveillance	
		Community Partnership Development	
		Equity	
		Organizational Competencies	
		Policy Development and Support	
		Accountability and Performance Management	
		Emergency Preparedness and Response	
		Communications	

Lower scores are red moving through yellow to green being the highest scores.
Expertise and Capacity were rated on a scale of 1 to 4.
Implementation was rated on a scale of 1 to 5.

Scale Key:

Table 81. Scale Key-Expertise and Capacity

1	2	3	4

Table 82. Scale Key Implementation

1	2	3	4	5

The above table shows the average score when combining all Qualtrics responses. One main point of today's discussion is to create a group decision on how to round the averages to a whole number answer.

The following pages go into detail regarding the eight Capabilities and include the headline responsibilities of the FPHS, detailed data collected in Qualtrics, and a list of programmatic efforts delivering this FPHS in the local community.

Assessment and Surveillance – Overview and Data

Headline Responsibilities for Assessment and Surveillance

- Develop and maintain an assessment and analysis infrastructure.
- Use collaborative processes to assess community health and identify health priorities.
- Develop and maintain a surveillance and epidemiology infrastructure.
- Develop and maintain a vital records infrastructure.
- Develop and maintain a public health laboratory infrastructure.

Table 83. Assessment and Surveillance had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	1.00	Absent	None, or basic awareness of the expertise, but limited ability to apply it.
Capacity	1.00	Absent	Staff time and other resources are not present or are largely unavailable.

Table 84. Assessment and Surveillance had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	1.00	Lacking/No Services	There are no public health services available in this foundational area. There is significant overall demand for public health services in this community.

Rounding the averages in the table above produces the following ratings for [County] for Assessment and Surveillance:

Table 85. Rounding the averages in the table above produces the following ratings for [County] for Assessment and Surveillance:

	Expertise	Capacity
Assessment and Surveillance	Absent	Absent

Implementation
Lacking/No Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Assessment and Surveillance table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Assessment and Surveillance – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Pregnancy Risk Assessment Monitoring System (PRAMS)			– We work with public health lab and state
Critical Congenital Heart Disease Registry (CCHD)			
Early Hearing Detection and Intervention (EHDI)			
UNR Nevada State Public Health Laboratory (NSPHL)			
State Board of Health			
State Health Needs Assessment/Improvement Plan			
Birth and Death Registry			
Immunization School Surveys			
Kindergarten Health Survey			
CARA Open Beds			
Behavioral Risk Factor Surveillance System (BRFSS)			
Youth Risk Behavioral Surveillance System (YRBS)			
State of Nevada - epidemiology, vital records			
Web Infrastructure for Treatment Services (WITS) – Certified Community Behavioral Health Centers (CCBHC) Quality Measures			
State of Nevada Confidential Morbidity/Mortality Disease Report System			

Notes:

does not do a lot in this area. We leave this to epidemiologists and state/county health initiatives.

Community Partnership Development – Overview and Data

Headline Responsibilities for Community Partnership Development

- Develop and maintain capabilities to cultivate relationships and convene partners.
- Develop and maintain strategic partnerships with governmental and non-governmental partners.
- Develop and maintain trusted relationships with communities.
- Use collaborative processes to develop health improvement plans to address identified priorities.

Table 86. Community Partnership Development had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	2.50	Proficient	Expertise is available and can be applied adeptly.
Capacity	3.00	Moderate	Most staff time and other resources are present to partially implement most functions.

Table 87. Community Partnership Development had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	3.50	Sufficient Services	Services are mostly implemented as well as meet the community's overall demand for public health services in the area.

Table 88. Rounding the averages in the table above produces the following ratings for [County] for Community Partnership Development:

	Expertise	Capacity
Community Partnership Development	Proficient	Moderate

Implementation
Sufficient Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Community Partnership Development table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Community Partnership Development – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Ambulatory Patient Group (APG) / SPEC quarterly meeting			School district is actively developing community partnerships for mental health
NV Vaccine Equity Collaboration (NVEC) and State Public Health Lab meetings			– We do a lot of education for the community, health fair, etc.…
School and Childcare Immunization Providers taskforce meeting			
Health Services Advisory Committee (HSAC) for Little Peoples Head Start			
Vaccines for Children (VFC) Program			
NV State Emergency Response Commission (SERC)			
Maternal Child Health Advisory Board (MCHAB)			
Statewide MCH Coalition			
Breastfeeding Coalitions			
NV Vaccine Equity			
Nevada Quality and Technical Assistance Center (QTAC)			
Rural tribal Health meeting			
Nevada Medicaid (DPBH)			
Nevada State Immunization Program (NSIP)			
Radioactive Material (RAM) Program Meetings			
ADSD & DCFS - Multi-disciplinary team meeting			
Nevada Statewide Cardiovascular Learning Collaborative			

Equity – Overview and Data

Headline Responsibilities for Equity

- Develop and demonstrate agency commitment to equity.
- Inform and influence public and external organizational policies to advance equity.

Table 89. Equity had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	1.50	Basic	Knowledge of the expertise and can apply it at a basic level.
Capacity	1.50	Minimal	Some staff time and/or other resources are present to complete basic functions.

Table 90. Equity had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	1.50	Minimal Services	Minimal public health services are available. There is significant overall demand for public health services in the community.

Table 91. Rounding the averages in the table above produces the following ratings for [County] for Equity:

	Expertise	Capacity
Equity	Basic	Minimal

Implementation
Minimal Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Equity table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Equity – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Nevada Office of Minority Health and Equity (NOMHE)			- Our focus with equity has been on cardiology and maternal outcomes at this point. We have not ventured to far out due to a lack of information and reporting availability.
Work of Equity unit at Chronic Disease & Health Promotion			
Maternal Mortality Review Committee (MMRC) collab with Nevada Office of Minority Health and Equity (NOMHE)			
Nevada Vaccine Equity collab			
National Partnership for Equity			
Nevada Minority Health & Equity Coalition			
Department of Education - Office for a Safe and Respectful Learning Environment (OSRLE)			
Disability Access & Functional Needs Coordinator, NV DEM			
DHHS Diversity and Inclusion Liaisons			

Organizational Competencies – Overview and Data

Headline Responsibilities for Organizational Competencies

- Maintain a governance structure and establish the strategic direction for public health.
- Provide or access services for information technology, privacy, and security.
- Provide or access human resources services and develop and maintain a competent workforce.
- Provide or access financial management services and facilitate contracting, procurement, and maintenance of facilities and operations.
- Access public health legal services and analysis.

Table 92. Organizational Competencies had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	2.00	Basic	Knowledge of the expertise and can apply it at a basic level.
Capacity	2.00	Minimal	Some staff time and/or other resources are present to complete basic functions.

Table 93. Organizational Competencies had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	2.00	Minimal Services	Minimal public health services are available. There is significant overall demand for public health services in the community.

Table 94. Rounding the averages in the table above produces the following ratings for [County] for Organizational Competencies:

	Expertise	Capacity
Organizational Competencies	Basic	Minimal

Implementation
Minimal Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Organizational Competencies table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Organizational Competencies – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Governor's Office Public Health Resource Officer			Immunization rates submitted to state by school district
State of NV Division of Public Health drives the policy for the State level			- Runs a quality health system with sufficient staffing and financial stability; We have a Board that looks at strategic planning and plan years in advance; We don't have a focus due to lacking resources on public health; We do monitor and look at some areas, but this is not our focus.
Public Health Infrastructure and Improvement leadership and planning			
State Boards of Licensure & Certification - Nursing, Marriage and Family Therapist (MFT), Licensed Clinical Social Worker (LCSW), Certified Alcohol and Drug Abuse Counselor (CDAC)			

Policy Development and Support – Overview and Data

Headline Responsibilities for Policy Development and Support

- Develop, amend, and enact public health policies in collaboration with partners, policymakers, and community members.
- Participate in policy development initiatives being considered by partners that affect the public's health.
- Implement and support enacted public health policies.

Table 95. Policy Development and Support had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	1.50	Basic	Knowledge of the expertise and can apply it at a basic level.
Capacity	1.50	Minimal	Some staff time and/or other resources are present to complete basic functions.

Table 96. Policy Development and Support had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	2.00	Minimal Services	Minimal public health services are available. There is significant overall demand for public health services in the community.

Table 97. Rounding the averages in the table above produces the following ratings for [County] for Policy Development and Support:

	Expertise	Capacity
Policy Development and Support	Basic	Minimal

Implementation
Minimal Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Policy Development and Support table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Policy Development and Support – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Governor's Office Public Health Resource Officer			- Sits on various state and legislative boards to help influence policy and laws; We work closely with AHA, NHA and NRHP; We are active with legislative opportunities; Time is an issue as it's hard to find time to do everything, but we are active in the most important areas to us and our community.
Deputy Attorney General (DAG) also helps with this			
Nevada Medicaid			
Policy Committee for Public Health & Emergency Preparedness			
PSE Unit in Chronic Disease Prevention and Health Promotion (CDPHP)			
Nevada Quality and Technical Assistance Center (QTAC)			
Division of Public and Behavioral Health (DPBH) Admin			

Accountability and Performance Management – Overview and Data

Headline Responsibilities for Accountability and Performance Management

- Maintain accountability according to accepted business practices, applicable policies, and public health accreditations.
- Maintain a performance management structure and establish appropriate quality improvement initiatives.

Table 98. Accountability and Performance Management had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	2.50	Proficient	Expertise is available and can be applied adeptly.
Capacity	2.50	Moderate	Most staff time and other resources are present to partially implement most functions.

Table 99. Accountability and Performance Management had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	3.00	Some Services	Some public health services are available. There is an overall demand for public health services in the community.

Table 100. Rounding the averages in the table above produces the following ratings for [County] for Accountability and Performance Management:

	Expertise	Capacity
Accountability and Performance Management	Proficient	Moderate

Implementation
Some Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the FPHS table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Accountability and Performance Management – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Public Health Infrastructure and Improvement leadership and planning			very active in reporting metrics to show accountability and performance. We go above and beyond in this area and do a great job.
Annual Quality Compliance Check			

Emergency Preparedness – Overview and Data

Headline Responsibilities for Emergency Preparedness

- Establish governmental public health's role in preparedness and response to incidents.
- Develop, exercise, and maintain preparedness and response plans.
- Assure public health continuity of operations.
- Respond to incidents.
- Recover from incidents.

Table 101. Emergency Preparedness had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	3.00	Proficient	Expertise is available and can be applied adeptly.
Capacity	3.00	Moderate	Most staff time and other resources are present to partially implement most functions.

Table 102. Emergency Preparedness had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	3.50	Sufficient Services	Services are mostly implemented as well as meet the community's overall demand for public health services in the area.

Table 103. Rounding the averages in the table above produces the following ratings for [County] for Emergency Preparedness:

	Expertise	Capacity
Emergency Preparedness	Proficient	Moderate

Implementation
Sufficient Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Emergency Preparedness table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Emergency Preparedness – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Continuity of Operations (COOP) Plans			School district is involved with emergency preparedness and response with county and state fire and police officials
Access and Functional Needs (AFN) work with Developmental Disabilities (DD) Council			very active in emergency preparedness and response; We attend community events, trainings, coordination with other services; We are very active with the state and federal gov. regarding programs and education in this area.
UNR State Public Health Lab			
State Emergency Medical System (EMS) permits all counties ambulance agencies except Clark County			
Nevada Division of Emergency Management (DEM)			
Fund Family Navigation Network to support Children and Youth with Special Health Care Needs (CYSHCN) and Public Health Preparedness (PHP)			
Some support for LEPC communities at a county level			
Office of Surveillance and Epidemiology (OSE)			
Public Health Preparedness (PHP) Programs			
Nevada Resilience Advisory Committee (NRAC)			
Public Health Emergency Operations Plans (i.e. PODs)			
MRC/ESAR – VHP Volunteers			
Education to county staff			

Communications – Overview and Data

Headline Responsibilities for Communications

- Develop and maintain a public communications infrastructure.
- Develop and maintain public health education and risk communication capabilities.

Table 104. Communications had a total of 2 responses for Expertise and Capacity.

	Average Value	Rounded Rating	Definition
Expertise	2.50	Proficient	Expertise is available and can be applied adeptly.
Capacity	2.50	Moderate	Most staff time and other resources are present to partially implement most functions.

Table 105. Communications had a total of 2 responses for Implementation.

	Average Value	Rounded Rating	Definition
Implementation	3.00	Some Services	Some public health services are available. There is an overall demand for public health services in the community.

Table 106. Rounding the averages in the table above produces the following ratings for [County] for Communications:

	Expertise	Capacity
Communications	Proficient	Moderate

Implementation
Some Services

Discussion and Verification

Considering the ratings above, the definition in the rating system, and the data in the Communications table on the following page, **do these ratings accurately reflect the current state in [County]**? If not, what adjustments do you recommend?

Communications – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Nevada Division of Emergency Management (DEM) and Division of Public and Behavioral Health (DPBH) have Public Information Officers (PIOs), websites, and social media accounts			- We post a lot of information on social media, and on monitors inside the facility that focus on "public service announcements" regarding healthcare, prevention, where and how to get care that is needed.
Safe Voice			
Public Information Office (PIO) Team			
NV Health Alert Network (NVHAN)			
Language Services			

Behavioral Health – Programs

State of Nevada	County Government	Regional Health Department/District	Community Supported Services
Regional Behavioral Health Coordinator (contracted to Nevada Rural Hospital Partners)	County Hospital/Clinic	City Mental Health	Counseling offered at all schools in the district
NV Dept of Education - Safe Voice, Handle w/ CARE		Counselors at the hospital	– We provide behavioral health services to some extent (ED, Clinic with LCSW's). We do not have providers that can prescribe for serious behavioral health issues. We work with City Mental health, the school district, and the state to help provide the best care or transfer patients to additional resources. This is an area lacking due to few providers in the state.
Rural Clinics – Mental Health Services			School District
Office of a Safe and Respectful Learning Environment (OSRLE), DOE			
NV Dept of Health and Human Services (DHHS)			
Aging and Disability Services Coordinator (housed at DHHS)			
9-8-8 Implementation			
Division of Child and Family Services (DCFS)			
Ely Mental Health			

EXTENSION

College of Agriculture,
Biotechnology & Natural Resources