

# Central District Health Department

Strategic Plan | FY 2015-FY 2019



*Healthy People in Healthy Communities*

## Strategic Planning Group

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## INTRODUCTION

Idaho's Public Health District 4, more commonly known as Central District Health Department (CDHD), serves the counties of Ada, Boise, Elmore, and Valley. CDHD is one of seven multi-county health districts within the state [Appendix A]. The shared vision of local public health in Idaho is "Healthy People in Healthy Communities." CDHD strives to achieve this vision through the implementation of an agency-wide strategic plan.

New public health challenges emerge over time, and CDHD is flexible and responsive in tackling these challenges. The overarching goals of Healthy People 2020, CDC's Winnable Battles, and other national public health priorities were considered in the establishment of CDHD's three priority areas of focus. The priority areas include two *core public health* strategic priorities and one overarching *agency* strategic priority.

- The *core public health* strategic priorities address traditional public health functions, which are often mandated by Idaho Statute or funded as Federal health program priorities.
- The *agency* strategic priority reaches beyond traditional public health to address new public health challenges, to which CDHD and its Board of Health choose to devote resources in order to achieve its overall mission of "partnering to promote, protect, and preserve health in our communities."

Goals and objectives, which touch upon the major functions of CDHD, have been developed under each of the strategic priorities. The goals are broad and often span across multiple programs or divisions. They define what CDHD hopes to achieve toward each priority. The goals are supported by quantifiable objectives, often set at the program level. Strategies describe the methods which will be employed to attain the goals and objectives, and measures define how progress will be tracked.

This strategic plan is a living document and focuses on goals and objectives for fiscal years 2015 through 2019. The plan will undergo annual updates in order to refine goals and objectives. The intent of this approach is to maintain momentum towards achieving CDHD's vision.

# VISION, MISSION, AND CORE VALUES

## Vision

Healthy People in Healthy Communities

## Mission

Partnering to promote, protect, and preserve health in our community.

## Core Values

***Integrity:*** We are honest and trustworthy.

***Respect:*** We are mindful of everyone; treating others with kindness and understanding.

***Accountability:*** We take responsibility for our actions and obligations.

***Teamwork:*** We work together to support individual and organizational success.

***Excellence:*** We strive to surpass expectations in all we do.

## PRIORITIES, GOALS, AND OBJECTIVES

### Agency Priority

#### **Strategic Priority: Decrease Risk Factors for Chronic Diseases**

*Increase physical activity, improve nutrition, and decrease tobacco initiation and use.*

**Goal 1:** Provide policy, systems, and environmental (PSE) change expertise to increase physical activity, improve nutrition, and decrease tobacco initiation and use in Public Health District 4.

**Objective 1.1:** By June 2016, provide PSE change expertise to at least five community organizations and partners per quarter.

**Strategies:**

- A. Educate and advocate for physical activity, nutrition, and tobacco (PANT) PSE changes in local communities and at the state level.
- B. Report progress to CDHD leadership team, Board of Health, County Commissioners, and community stakeholders.

**Measure 1.1.1:** Number and types of organizations receiving PSE change technical assistance.

**Objective 1.2:** By June 2016, conduct worksite assessments or provide technical assistance on PANT PSE change to at least ten worksites.

**Strategies:**

- A. Conduct worksite assessments using the CDC Worksite Health ScoreCard.
- B. Develop an action plan for each worksite.
- C. Promote model PANT PSE change based on best practices.
- D. Provide technical assistance to organizations for implementation and enforcement of PANT PSE change.
- E. Report progress to CDHD leadership team, Board of Health, County Commissioners, and community stakeholders.

**Measure 1.2.1:** Number of worksites receiving technical assistance.

**Measure 1.2.2:** Number of completed worksite assessments.

**Measure 1.2.3:** Number and type of PANT policies implemented.

**Objective 1.3:** By June 2016, conduct child care assessments or provide technical assistance on PANT PSE change to at least ten child care sites.

**Strategies:**

- A. Conduct child care assessments using the Let's Move! Child Care Checklist.
- B. Promote model PANT PSE change based on best practices through Let's Move! Child Care Workshops and Action Planning.
- C. Provide technical assistance to child care programs for implementation and enforcement of PANT policies and environmental changes.
- D. Assist local municipalities with the adoption, implementation, and evaluation of health policies for city level child care licensing.
- E. Report progress to CDHD leadership team, Board of Health, County Commissioners, and community stakeholders.

**Measure 1.3.1:** Number of organizations receiving technical assistance.

**Measure 1.3.2:** Number of completed child care assessments.

**Measure 1.3.3:** Number and type of PANT policies implemented.

**Objective 1.4:** By June 2016, promote a Health in All Policies (HiAP) approach with at least five community partners.

**Strategies:**

- A. Develop and sustain collaborative relationships that support smart growth concepts.
- B. Collaborate with community partners associated with Community Planning Association of Southwest Idaho (COMPASS) in updating the Communities in Motion: Long-Range Transportation and Sustainability Plan.
- C. Report progress to CDHD leadership team, Board of Health, County Commissioners, and community stakeholders.

**Measure 1.4.1:** Number of community partners receiving HiAP education.

**Measure 1.4.2:** Number of collaborative opportunities after receiving HiAP education.

**Objective 1.5:** By June 2016, identify and pursue PANT PSE changes within CDHD to align with agency strategic priorities.

**Strategies:**

- A. Educate CDHD staff on PSE change to reduce chronic disease risk factors.
- B. Assess opportunities among divisions and programs to support PANT policies and environmental changes.
- C. Report progress to CDHD leadership team and Board of Health.

**Measure 1.5.1:** Number and type of changes made to align with agency strategic priorities.

**Goal 2:** Provide tobacco cessation resources to target populations.

**Objective 2.1:** By June 2016, increase participation in tobacco cessation classes by 10%.

**Strategies:**

- A. Provide tobacco cessation resources to target populations identified as pregnant/postpartum women, youth, and community organizations adopting and implementing tobacco policies.
- B. Develop social media messages to reach target populations.
- C. Utilize social media to reach target populations to encourage participation in tobacco cessation programs.

**Measure 2.1.1:** Number of participants in tobacco cessation classes.

**Objective 2.2:** By June 2019, decrease the percentage of reproductive health clients using tobacco products to Healthy People 2020 initiative goal of 12%.

**Strategies:**

- A. Develop report to identify percentage of reproductive health clients who are tobacco users by December 2014.
- B. Screen and assess clients using the 5-A model.
- C. Train reproductive health clinicians in CPT codes for tobacco cessation interventions.
- D. Adopt and implement evidence-based tobacco cessation tools in reproductive health services.

**Measure 2.2.1:** Percentage of tobacco users among reproductive health clients.

**Measure 2.2.2:** Percentage of clients screened and assessed using the 5-A model.

**Measure 2.2.3:** Percentage of reproductive health clinicians trained on CPT codes for tobacco cessation interventions.

**Measure 2.2.4:** Evidence-based tobacco cessation tools adopted and implemented.

**Goal 3:** Reduce the prevalence of obesity among CDHD clients receiving preventive health services.

**Objective 3.1:** By June 2015, reduce the percentage of WIC children ages 2 to 5 who are classified as obese from 8% to 6%.

**Strategy:**

- A. Provide nutrition counseling based on existing WIC policies and procedures.

**Measure 3.1.1:** Percentage of obese children ages 2 to 5.

**Objective 3.2:** By June 2015, reduce the percentage of WIC children ages 2 to 5 who are overweight from 11.5% to 9%.

**Strategy:**

A. Provide nutrition counseling based on existing WIC policies and procedures.

**Measure 3.2.1:** Percentage of overweight children ages 2 to 5.

**Objective 3.3:** Through June 2015, increase the percentage of WIC participants who breastfeed at least six months from 49% to 51%.

**Strategy:**

A. Conduct education activities as outlined in the WIC District 4 breastfeeding plan.

**Measure 3.3.1:** Percentage of WIC participants who breastfeed at least six months.

**Objective 3.4:** Through June 2015, increase the percentage of WIC participants who exclusively breastfeed at least six months from 20% to 22%.

**Strategy:**

A. Conduct education activities as outlined in the WIC District 4 breastfeeding plan.

**Measure 3.4.1:** Percentage of WIC participants who exclusively breastfeed at least six months.

**Objective 3.5:** By June 2016, increase weight management interventions for WIC postpartum women in the greater-than-ideal weight category.

**Strategy:**

A. Research the feasibility of implementing a weight management intervention program for WIC postpartum women in the greater-than-ideal weight category.

**Measure 3.5.1:** Report of findings on reimbursement sources (i.e., insurance, grant funding, etc.) for weight management intervention program.

**Measure 3.5.2:** Report of findings on client interest in weight management intervention program.

**Objective 3.6:** By June 2015, identify the percentage of reproductive health clients with dyslipidemia and a body mass index (BMI) greater than 30.

**Strategies:**

- A. Create and implement report tool to identify percent of reproductive health clients with a BMI greater than 30 and compare to U.S. percentage.
- B. Offer serologic assessment for dyslipidemia to all clients with BMIs greater than 30 at preventive health visit and evaluate risk for cardiac disease.
- C. Train reproductive health nursing and clinician staff in the 5-A model for improving nutrition and exercise anticipatory guidance.
- D. Research feasibility of third-party reimbursement for medical nutrition therapy services.
- E. Analyze costs of offering medical nutrition therapy to reproductive health clients with BMI greater than 30.

**Measure 3.6.1:** Implementation of report tool.

**Measure 3.6.2:** Number of clients with serologic assessment for dyslipidemia at preventive health visit.

**Measure 3.6.3:** Completion and implementation of reproductive health nursing and clinician staff training in the 5-A model for improving nutrition and exercise anticipatory guidance.

**Measure 3.6.4:** Percentage of clients with BMIs greater than 30.

**Measure 3.6.5:** Report of findings on reimbursement sources for medical nutrition therapy.

**Measure 3.6.6:** Report of findings on client interest in medical nutrition therapy counseling.

## Core Public Health Priorities

### **Strategic Priority: Health Improvement and Health Promotion**

*Improve the quality of life and increase the years of healthy life among residents in the counties of CDHD.*

**Goal 1:** Reduce the incidence of unintended pregnancies in Public Health District 4.

**Objective 1.1:** By June 2015, 85% of WIC clients will state an awareness of reproductive health services available at CDHD.

**Strategies:**

- A. Provide outreach materials (e.g., flyers, brochures, new mom envelope) at all WIC clinical locations.
- B. Ask WIC clients, at time of scheduling their appointment, if they are in need of other services at the health department, (i.e., birth control/reproductive health, oral health for young children, immunizations).
- C. Provide birth control information in each edition of the Public Health Informer.
- D. Conduct semiannual survey of WIC clients to determine awareness of reproductive health services at CDHD.

**Measure 1.1.1:** Percentage of WIC clients reporting awareness of reproductive health services based upon semi-annual survey of all WIC clients.

**Objective 1.2:** By June 2015, develop a plan to expand outreach regarding unintended adolescent pregnancies to secondary schools in rural communities.

**Strategies:**

- A. Determine the subject matters or activities related to unintended adolescent pregnancies with which school leaders/proponents would like assistance.
- B. Offer suggestions such as presentations, newsletter articles, or a health/wellness event.
- C. Train staff in any topics or activities to assure follow-through.
- D. Meet with community leaders to assure access to desired population.

**Measure 1.2.1:** Development of plan for implementation by September 1, 2015.

**Objective 1.3:** By June 2019, increase the number of unduplicated clients served at CDHD reproductive health by 10% over June 2014 number.

**Strategies:**

- A. Engage in social marketing strategies to raise awareness of reproductive health services at CDHD, especially targeting vulnerable populations.
- B. Evaluate scheduling system for adequacy of allotted time slots to assure clinic appointment availability.
- C. Assure adequate staffing to meet community need.
- D. Conduct quarterly reproductive health client satisfaction survey.

**Measure 1.3.1:** Social marketing tools utilized.

**Measure 1.3.2:** Report of wait time for scheduling appointments.

**Measure 1.3.3:** Number of new reproductive health clients and proportion of new clients to continuing clients.

**Measure 1.3.4:** Report of how new reproductive health clients learned of CDHD's reproductive health services.

**Measure 1.3.5:** Number of unduplicated clients served at reproductive health clinics annually.

**Objective 1.4:** By June 2019, decrease the rate of unintended pregnancies to less than 10% among CDHD reproductive health clients.

**Strategies:**

- A. Assess individual reproductive health clients' short-term (next 12 months) pregnancy intentions.
- B. Recommend effective contraceptive methods based upon individual clients' intents for pregnancy in short term future.
- C. Assure adequate levels of contraceptives to meet client demands.

**Measure 1.4.1:** Percentage of positive/negative client responses.

**Measure 1.4.2:** Report of birth control method (BCM) congruence with individual clients' pregnancy intents.

**Measure 1.4.3:** Percentage of continuing clients whose pregnancies were unintended because no BCM was used or BCM failure.

**Measure 1.4.4:** Yearly report on the utilization of each BCM supplied through the Idaho Contraceptive Program.

**Objective 1.5:** By June 2019, promote and offer reproductive life planning (RLP) technical assistance to 20 medical practices within Public Health District 4.

**Strategies:**

- A. Identify practices that would most benefit from technical assistance in learning about RLP concepts.
- B. Develop promotional information.
- C. Offer brown bag luncheon learning opportunities to medical practices.

**Measure 1.5.1:** Number of practices that are offered technical assistance.

**Measure 1.5.2:** Number of practices that complete the training on yearly report.

**Goal 2:** Promote healthy relationship decision-making through identification of risk behaviors and risk-reduction strategies.

**Objective 2.1:** By June 2019, increase client awareness of effects of domestic and sexual abuse or coercion on health and wellbeing.

**Strategies:**

- A. Identify clients seeking any reproductive health service who acknowledge any past or current history of physical or sexual abuse or coercion.
- B. Implement annual training of staff to raise awareness.
- C. Provide healthy relationship classes within the CDHD communities, with an emphasis on the health effects of abuse.
- D. Collaborate with community partners to educate community, create school/work policies, and exchange referrals.

**Measure 2.1.1:** Percentage of clientele with positive response.

**Measure 2.1.2:** Percentage of staff receiving awareness-level training.

**Measure 2.1.3:** Report on types of training provided.

**Measure 2.1.4:** Number of Healthy Relationship classes provided.

**Measure 2.1.5:** Report on collaboration activities with community partners.

**Goal 3:** Improve the oral health of children within Public Health District 4.

**Objective 3.1:** By June 2019, reduce dental caries rate to less than 10% in children ages 0 to 5 years attending CDHD oral health programs.

**Strategies:**

- A. Screen, assess, and collect data on children ages 0 to 5 receiving oral health services.
- B. Provide preventive oral health education to children ages 0 to 5 and their caregivers.
- C. Provide fluoride varnish (FV) to at-risk children ages 0 to 5.
- D. Plan and implement a pilot pre-dental home for at-risk children ages 0 to 3 in Ada County.

**Measure 3.1.1:** Dental caries rate in children ages 0 to 5 attending CDHD oral health programs.

**Measure 3.1.2:** Number of children and adults receiving oral health education.

**Measure 3.1.3:** Number of fluoride varnish applications to children ages 0 to 5.

**Measure 3.1.4:** Establishment of pre-dental home in Ada County by January 2015.

**Objective 3.2:** By June 2016, create partnerships with 8 to 12 schools in Health District 4 to offer school-based sealant programs.

**Strategies:**

- A. Identify and select schools with 35% or more students enrolled in the Free and Reduced Lunch Program (FRLP).
- B. Coordinate efforts with Delta Dental of Idaho Community Outreach Program to avoid duplication of efforts.
- C. Educate staff and parents to promote use of dental sealants and promote participation in school-based sealant clinic.
- D. Educate, screen, and assess all school children participating in school-based sealant clinics.
- E. Apply sealants to children meeting criteria for sealant application.

**Measure 3.2.1:** Number of schools identified that meet the criteria of 35% or more FRLP participation and are not currently being served by Delta Dental of Idaho's Community Outreach Program.

**Measure 3.2.2:** Number of school partnerships established to provide school-based sealant clinics.

**Measure 3.2.3:** Number of children eligible for dental screening.

**Measure 3.2.4:** Number of children participating in school-based sealant clinics.

**Measure 3.2.5:** Number of children receiving sealants.

**Measure 3.2.6:** Number of sealants applied.

**Goal 4:** Improve the nutritional health of CDHD clients receiving preventive health services.

**Objective 4.1:** By June 2015, maintain the health of children receiving WIC services by keeping the overall low hematocrit rate at or below 6%.

**Strategies:**

- A. Conduct hemoglobin assessment every six months on 1- to 2-year-old children and annually on 2- to 5-year-old children.
- B. Provide nutrition counseling in accordance with existing WIC policies and procedures.
- C. Develop visual aids/posters to educate all WIC participants on hemoglobin and anemia.

**Measure 4.1.1:** Percentage of WIC children with a hematocrit rate at or below 6%.

**Objective 4.2:** By June 2015, increase WIC participation to 97% of contract caseload based on FFY-2015.

**Strategies:**

- A. Implement the Local Agency Nutrition Education Outreach Plan of activities for increasing caseload.
- B. Research possibilities for satellite clinics through community partnerships for co-location of services.

**Measure 4.2.1:** Number of WIC participants.

**Strategic Priority: Health Protection**

*Protect the public's health by minimizing the impact of infectious diseases and environment-related illnesses.*

**Goal 1:** Prevent cases and outbreaks of vaccine-preventable diseases.

**Objective 1.1:** Through June 2019, ensure at least 95% of 0- to 24-month-old WIC clients are up-to-date on ACIP-recommended immunizations.

**Strategies:**

- A. Conduct immunization assessment on all children between the ages of 0 and 24 months who are active WIC participants.
- B. Offer fast-track, same-day, or future immunization appointments at WIC visits.
- C. Send immunization reminder cards to clients' homes.
- D. Provide semi-annual trainings to WIC staff on immunizations and recommended ACIP schedule.

**Measure 1.1.1:** Percentage of 0- to 24-month-old WIC clients who are up-to-date on ACIP-recommended immunizations.

**Objective 1.2:** By June 2019, ensure at least 85% of CDHD clients between 19 and 35 months of age are up-to-date on ACIP-recommended vaccines.

**Strategies:**

- A. Send immunization reminder cards to clients' homes.
- B. Schedule future appointments with parent at current immunization appointment.
- C. Assure adequate appointment availability within two weeks of contact.

**Measure 1.2.1:** Percentage of 19- to 35-month-old clients who are up-to-date on ACIP-recommended immunizations.

**Objective 1.3:** By June 2019, increase to 85% the percentage of all 14- to 18-year-olds receiving CDHD services and attending other offsite clinical events who are up-to-date for ACIP-recommended immunizations.

**Strategies:**

- A. Assure availability of all vaccine for all services and offsite clinical events.
- B. Conduct social marketing of services and of vaccine availability prior to all clinical events.
- C. Send immunization reminder notices using the contact method identified by the client.

**Measure 1.3.1:** Percentage of meningococcal vaccine coverage of youth attending immunization and reproductive health clinics each year.

**Measure 1.3.2:** Percentage of Tdap vaccine coverage of youth attending immunization and reproductive health clinics each year.

**Measure 1.3.3:** Percentage of Hepatitis A vaccine coverage of youth attending immunization and reproductive health clinics each year.

**Measure 1.3.4:** Percentage of HPV vaccine coverage of youth attending immunization and reproductive health clinics each year.

**Objective 1.4:** By June 2019, decrease rates of missing or incomplete immunization records to below 7%, as measured at the county level, among kindergarten, 1<sup>st</sup> grade, and 7<sup>th</sup> grade students enrolled in Health District 4 schools.

**Strategies:**

- A. Determine schools and grades with greatest opportunity for improvements.
- B. Provide guidance and technical assistance to school staff based on need.
- C. Engage with school administrators.
- D. Collaborate with local Immunization Coalition.
- E. Conduct tabletop exercises and other coordination efforts to emphasize the importance of complete immunization records.

**Measure 1.4.1:** CDHD total missing and incomplete rate in K, 1<sup>st</sup>, and 7<sup>th</sup> grades.

**Measure 1.4.2:** Ada County total missing and incomplete rate in K, 1<sup>st</sup>, and 7<sup>th</sup> grades.

**Measure 1.4.3:** Boise County total missing and incomplete rate in K, 1<sup>st</sup>, and 7<sup>th</sup> grades.

**Measure 1.4.4:** Elmore County total missing and incomplete rate in K, 1<sup>st</sup>, and 7<sup>th</sup> grades.

**Measure 1.4.5:** Valley County total missing and incomplete rate in K, 1<sup>st</sup>, and 7<sup>th</sup> grades.

**Objective 1.5:** By June 2019, ensure that 90% of clinics currently participating in CDHD's Provider Immunization Education reach an 85% CASA rate by National Standards in the 19 to 35 months of age category.

**Strategies:**

- A. Assess current CASA rate (National Immunization Survey standard: 4:3:1:3:3:4:1) for 19 to 35 months of age at entry to program.
- B. Provide medical practices with a CASA rate of less than 85% with strategies to improve rates within three months of status known.
- C. Monitor immunization rates of participating medical practices with a CASA rate of less than 85% on 6-month intervals.

**Measure 1.5.1:** Current CASA rate (National Immunization Survey standard: 4:3:1:3:3:4:1) for 19 to 35 months of age.

**Measure 1.5.2:** Number of medical practices provided with strategies to increase CASA rate.

**Measure 1.5.3:** Percentage of participating clinics that achieve 85% CASA rate.

**Objective 1.6:** Through June 2019, offer and promote provider immunization education to all medical practices in Boise, Elmore, and Valley Counties who participate in the Vaccines for Children (VFC) program.

**Strategies:**

- A. Identify VFC providers in each county.
- B. Market the benefits of enhanced education and the relationship with increased immunization rates of clientele.
- C. Assure adequate number of staff trained to provide education.
- D. Offer educational classes at convenient times and locales.
- E. Offer "incentive" to participate, i.e., certificate and listing on website of up-to-date practices.

**Measure 1.6.1:** Number of VFC-participating practices in each county.

**Measure 1.6.2:** Number of practices contacted with education program marketing.

**Measure 1.6.3:** Number of practices participating in provider immunization education.

**Goal 2:** Reduce the incidence of re-exposure and re-infection of Chlamydia trachomatis (CT), Neisseria gonorrhoeae (GC), and syphilis within three months after initial diagnosis of District 4 residents.

**Objective 2.1:** By June 2019, 95% of persons infected with CT/GC/syphilis will test negative three months after treatment.

**Strategies:**

- A. Educate all clients, at time of treatment, regarding the need for abstinence for required timeframe and the need for partners to get treated.
- B. Offer partner services when appropriate.
- C. Assure appointment availability within one week for contacts.
- D. Provide education to health providers within district on need for partner treatment and affordable area resources for care.
- E. Offer expedited partner therapy for presumptive treatment of CT if unable to access care.
- F. Encourage follow-up in three months and schedule appointment if possible.

**Measure 2.1.1:** Number of treated CT-positive clients who return to clinic for re-testing at three months.

**Measure 2.1.2:** Percentage of treated CT-positive clients who are CT-positive at 3-month follow-up.

**Measure 2.1.3:** Number of treated GC-positive clients who return to clinic for re-testing at three months.

**Measure 2.1.4:** Percentage of treated GC-positive clients who are GC-positive at 3-month follow-up.

**Measure 2.1.5:** Number of syphilis-positive clients who were treated and returning to clinic for re-testing at six months.

**Measure 2.1.6:** Percentage of treated syphilis-positive clients with evidence of reinfection 6-month follow-up.

**Objective 2.2:** Through June 2019, increase percentage of CT, GC, and syphilis partners who receive testing and/or preventive treatment.

**Strategies:**

- A. Develop clinical scheduling strategies to minimize obstacles to access quick care for partners for documented positives.
- B. Incentivize CDHD clinic visits for partners of known (GC and syphilis cases) positives.
- C. Offer expedited partner therapy for presumptive treatment of CT if unable to access care.

**Measure 2.2.1:** Percentage of CDHD clients diagnosed with CT infection receiving prescription for expedited partner therapy for a partner who is unable to access care.

**Measure 2.2.2:** Number/percentage of GC partners with testing and/or preventive treatment documented on field record.

**Measure 2.2.3:** Number/percentage of syphilis partners with testing and/or preventive treatment documented on field record.

**Goal 3:** Protect health and prevent disease through assurance of physical environments that minimize exposure to harmful pathogens and environmental toxins or hazards.

**Objective 3.1:** By June 2019, decrease occurrence of the three most common food-borne illness major risk factor violations observed in CDHD-inspected food establishments.

**Strategies:**

- A. Identify and quantify the three most common major risk factor violations observed in CDHD-inspected facilities.
- B. Develop informational materials for distribution to food establishment operators to raise awareness and to provide guidance on how to mitigate the major risk factors.
- C. Emphasize verbal education about the major risk factors during food establishment inspections.
- D. Include articles in the Food Review newsletter or the Public Health Informer newsletter about the major risk factors.
- E. Emphasize education to food service workers about the major risk factors in food safety courses taught by CDHD staff.

**Measure 3.1.1:** Percentage of inspected food facilities with one or more of the three most common major risk factors observed.

**Measure 3.1.2:** Number of major risk factor informational materials distributed to food establishment operators.

**Measure 3.1.3:** Number of major risk factor articles published in the Food Review or Public Health Informer newsletters.

**Measure 3.1.4:** Number of food service workers trained on the major food-borne illness risk factors.

**Objective 3.2:** By June 2017, increase awareness of private well owners about exposure to levels of metals in drinking water that exceed state or federal health standards.

**Strategies:**

- A. Assist the Idaho Bureau of Laboratories in obtaining grant funding to perform testing of private water well samples for metals.
- B. Establish system to distribute information and sampling materials to private well owners.
- C. Collaborate with partner organizations to develop and distribute information for private well owners explaining how to reduce harmful levels of metals in their drinking water.

**Measure 3.2.1:** Number of private wells in District 4 with levels of any sampled metal exceeding an established primary health standard.

**Measure 3.2.2:** Number of mitigation consultations or information packets distributed to private well owners exposed to harmful levels of metals.

**Measure 3.2.3:** Number of sampling material packets distributed to private well owners.

**Objective 3.3:** By June 2019, decrease illness associated with exposure to pathogens in recreational water.

**Strategies:**

- A. Compare cases of reported human illness to the types of recreational water and treatment technologies used, if any.
- B. Research the effectiveness of available treatment technologies in recreational water venues and provide information to facility operators.
- C. Develop public information campaigns to increase awareness about recreational water illness in natural settings and in manmade facilities.
- D. Promote the use of the most effective treatment technologies in zero-depth recreational facilities.
- E. Collaborate with key stakeholder organizations in increasing the effectiveness of educational materials aimed at improving awareness of recreational water illness in natural settings.

**Measure 3.3.1:** Number of Cryptosporidium and Giardia infections linked to recreational water exposure.

**Measure 3.3.2:** Number of public information campaigns delivered with the aim of preventing or reducing recreational water illness.

**Measure 3.3.3:** Number of consultations or interventions with facility operators or stakeholders aimed at preventing or reducing recreational water illness.

**Objective 3.4:** Through June 2019, increase knowledge of risks associated with bat exposures and rabies among residents of Health District 4.

**Strategies:**

- A. Provide public information.
- B. Explore possibility of including education on bat exposure and rabies in scouting curriculum.

**Measure 3.4.1:** Number of reported human bat exposures.

**Measure 3.4.2:** Number of reported human bat exposures classified as avoidable.

**Measure 3.4.3:** Number of reported animal bat exposures where animal is up-to-date on rabies vaccination.

**Goal 4:** Prepare for and respond to public health-related emergencies and mitigate poor outcomes following public health-related emergencies.

**Objective 4.1:** By November 2015, establish a baseline score on the new Medical Countermeasure (MCM) Operational Readiness Review (ORR) assessment tool.

**Strategies:**

- A. Establish plan changes for new tool by working with local partners.
- B. Measure our Emergency Operations Plan against new MCM/ORR tool.

**Measure 4.1.1:** Completion of updated plan.

**Measure 4.1.2:** Score of the MCM/ORR.

**Objective 4.2:** By April 2017, complete statewide full-scale exercise.

**Strategies:**

- A. Work with and prepare CDHD employees for emergency response duties and roles.
- B. Conduct preparatory exercises with community partners.

**Measure 4.2.1:** Completion of four exercises.

**Measure 4.2.2:** Evaluation and implementation of improvement plans of four exercises.

**Objective 4.3:** By June 2015, increase community partnerships in an effort to promote preparedness for public health-related emergencies.

**Strategies:**

- A. Conduct outreach efforts with elderly, refugee, and other vulnerable populations.
- B. Maintain relationships with community pharmacies with the intent to gain support during public health emergencies (e.g., point-of-dispensing assistance and/or medication delivery).

**Measure 4.3.1:** Establishment of a baseline register of local and national partners.

**Measure 4.3.2:** Number of community partner relationships.

APPENDIX A

Idaho's Public Health District 4

