




**CENTRAL
DISTRICT
HEALTH
DEPARTMENT**

STRATEGIC PLAN FY 2018 - FY 2022

INTEGRITY
RESPECT
ACCOUNTABILITY
TEAMWORK
EXCELLENCE



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 initiatives in order to address new challenges. CDHD and its Board of Health choose to devote resources to these challenges to achieve its overall mission of "partnering to promote, protect, and preserve health in our community."

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 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 2018 through 2022. 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 A.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 A.1.1: By June 2018, provide PSE change expertise to at least 20 community organizations and partners.

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 as requested.

Measure A.1.1.1: Number of community meetings attended to promote PANT PSE change.

Measure A.1.1.2: Number of educational presentations conducted on PANT PSE change.

Measure A.1.1.3: Number of PANT PSE policies or strategies implemented.

Objective A.1.2: By June 2018, provide technical assistance on PANT PSE change to at least five worksites.

Strategies:

- A. Conduct worksite assessments using National Healthy Worksite Program resources, the online CDC Health Scorecard Assessment, and assist with developing an action plan for worksites new to collaborating with CDHD.
- B. Promote model PANT PSE changes based on best practices.
- C. Assure that each worksite is compliant with the Fair Labor Standards Act, or “Lactation Law,” when relevant.
- D. Provide technical assistance to organizations for implementation and enforcement of PANT PSE change.
- E. Participate in quarterly “inspire!” forums to provide consultation to businesses and community organizations on worksite-related PSE opportunities.
- F. Report progress to CDHD leadership team, Board of Health, county commissioners, and community stakeholders as requested.

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

Measure A.1.2.2: Number of completed worksite assessments.

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

Objective A.1.3: By June 2018, provide education and technical assistance on PANT PSE change to at least 15 child care providers.

Strategies:

- A. Promote model PANT PSE change based on best practices through LMCC (Let's Move! Child Care) workshops.
- B. Conduct child care assessments using the LMCC checklist during LMCC workshops.
- C. Provide technical assistance to child care programs for implementation and enforcement of PANT policies and environmental changes.
- D. Report progress to CDHD leadership team, Board of Health, county commissioners, and community stakeholders as requested.

Measure A.1.3.1: Number of child care providers attending LMCC Workshops.

Measure A.1.3.2: Number of child care providers reporting changes made to policies and practices as a result of the LMCC workshops.

Objective A.1.4: By June 2018, promote increased access to physical activity through active transportation 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 COMPASS (Community Planning Association of Southwest Idaho) in updating the Communities in Motion: Long-Range Transportation and Sustainability Plan.
- C. Serve as a public health subject matter expert on collaborative efforts such as the COMPASS Active Transportation Work Group and Rail-with-Trail Group.
- D. Provide education through presentations to partners on active transportation and health in all policies concepts.
- E. Report progress to CDHD leadership team, Board of Health, county commissioners, and community stakeholders as requested.

Measure A.1.4.1: Number of community meetings attended to promote active transportation and/or health in all policies approaches.

Measure A.1.4.2: Number of educational presentations conducted on active transportation and/or health in all policies approaches.

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

Objective A.2.1: By June 2018, provide tobacco cessation counseling to 300 participants.

Strategies:

- A. Provide tobacco cessation resources to priority populations identified as pregnant/postpartum women, youth, worksites, and community organizations adopting and implementing tobacco policies.
- B. Utilize social media and small media (posters, brochures, flyers) to reach target populations to encourage participation in tobacco cessation programs.
- C. Utilize healthcare provider outreach to provide cessation counseling and increase referrals into tobacco cessation programs.
- D. Provide in-services to increase staff skills in tobacco cessation counseling and enrolling tobacco users into cessation services.

Measure A.2.1.1: Number of participants provided tobacco cessation counseling.

Objective A.2.2: By June 2018, establish a tobacco cessation counseling services baseline, which includes tobacco cessation counseling provided to PHS (Preventive Health Services) clients.

Strategies:

- A. Screen and assess clients using the 5-A model.
- B. Train reproductive health clinicians in CPT codes for tobacco cessation interventions.
- C. Adopt and implement evidence-based tobacco cessation tools in reproductive health services.

Measure A.2.2.1: Number of PHS clients age 18-64 years who are provided cessation counseling.

Measure A.2.2.2: Number of PHS clients under age 18 years who are provided cessation counseling.

Goal A.3: Reduce the prevalence of obesity among CDHD clients receiving Preventive Health Services (PHS).

Objective A.3.1: Through June 2022, maintain the percentage of PHS children ages 2 to 5 who are classified as overweight or obese at less than or equal to 6%.

Strategy:

- A. Provide nutrition counseling referrals to a registered dietitian; use existing WIC policies and procedures.

Measure A.3.1.1: Percentage of WIC children age 2 to 5 years with an assigned nutrition risk criteria for overweight.

Measure A.3.1.2: Percentage of WIC children age 2 to 5 years with an assigned nutrition risk criteria for obesity.

Objective A.3.2: By June 2022, increase the percentage of PHS participants who breastfeed at least six months to greater than or equal to 50%.

Strategy:

A. Encourage participants to breastfeed as outlined in the WIC District 4 breastfeeding plan and refer to a WIC breastfeeding lactation consultant as needed.

Measure A.3.2.1: Percentage of WIC participants who breastfeed at least six months.

Measure A.3.2.2: Percentage of PAT (Parents as Teachers) participants who breastfeed at least six months.

Objective A.3.3: By June 2022, maintain the percentage of PHS participants who exclusively breastfeed at least six months at greater than or equal to 25%.

Strategy:

A. Encourage participants to breastfeed as outlined in the WIC District 4 breastfeeding plan and refer to a WIC breastfeeding lactation consultant as needed.

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

Measure A.3.3.2: Percentage of PAT participants who exclusively breastfeed at least six months.

Objective A.3.4: By June 2018, establish a baseline for the number of adult PHS clients with a BMI greater than 30%.

Strategies:

A. Offer serologic assessment for dyslipidemia to all clients with BMIs greater than 30% at PHS visit and evaluate risk for cardiac disease.

B. Refer adult PHS clients with a BMI greater than 30% for nutritional counseling services.

Measure A.3.4.1: Percentage of PHS clients, age 18-64 years with a BMI greater than 30%.

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

Objective B.1.1: By June 2022, implement Reducing the Risk curriculum in three of the four counties served by CDHD.

Strategies:

- A. Determine the subject matter or activities related to healthy relationships with which school administrators/teachers would like assistance.
- B. Offer Reducing the Risk curriculum to schools within counties served by CDHD, per staffing and school interest.

Measure B.1.1.1: Number of counties receiving Reducing the Risk curriculum.

Measure B.1.1.2: Number of students reached through Reducing the Risk curriculum.

Objective B.1.2: By June 2022, increase the number of CDHD clients receiving reproductive health services by 5%, focusing on target populations.

Strategies:

- A. Assure adequate supply of first and second tier contraceptives to meet clinic demand.
- B. Engage in social marketing strategies to raise awareness of reproductive health services at CDHD, including contraceptive distribution, especially targeting vulnerable populations.
- C. Assure adequate staffing to meet community need and provide staff training on contraceptive medical eligibility and contraceptive counseling while adhering to Title X family planning requirements.

Measure B.1.2.1: Percent of reproductive health clients served who are 150% or below federal poverty level.

Measure B.1.2.2: Number of reproductive health clients who are under 19 years of age.

Objective B.1.3: By June 2018, offer reproductive health services to incarcerated individuals within Public Health District 4.

Strategies:

- A. Offer Reproductive Life Planning (RLP) concepts to incarcerated individuals.
- B. Develop and share talking points with administrators and staff about reproductive health services for incarcerated individuals.

Measure B.1.3.1: Number of incarcerated individuals who are offered reproductive health education.

Measure B.1.3.2: Number of incarcerated individuals who receive contraceptives.

Measure B.1.3.3: Development of educational overview of reproductive health services for local county jails.

Goal B.2: Promote healthy family relationships and mental well-being through identification of risky behaviors and risk-reduction strategies.

Objective B.2.1: By June 2022, increase client awareness of the effects of domestic and sexual abuse or coercion on health and well-being in order to make appropriate referrals.

Strategies:

- A. Identify clients seeking any preventive 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 B.2.1.1: Percentage of clients reporting past or current history of physical/sexual abuse or coercion.

Measure B.2.1.2: Number of CDHD staff trained on sexual coercion, abuse, and impact to health.

Objective B.2.2: Through June 2022, increase the number of children enrolled in the PAT home visiting program who have a completed health record and developmental screenings questionnaires.

Strategies:

- A. Complete child health screening, consisting of health status, safety, vision and hearing elements, by seven months of age or within 90 days of enrollment, and at least annually thereafter.
- B. Complete child developmental screening for all PAT-enrolled children within 90 days of enrollment or birth, and then at least every six months thereafter.

Measure B.2.2.1: Percentage of children enrolled in PAT with a completed Health Record.

Measure B.2.2.2: Percentage of children enrolled in PAT with a completed Ages and Stages Questionnaire-3 and Social-Emotional-2 screening tool.

Measure B.2.2.3: Percentage of children in PAT with a completed MIECHV Child Health Form.

Objective B.2.3: Through June 2022, increase number of PAT-completed home visit encounter forms and goal tracking sheets.

Strategies:

- A. Conduct home visits to address parent-child interaction, development-centered parenting, and family well-being.
- B. Develop and document caregiver and child goals with each family served.

Measure B.2.3.1: Number of completed home visit encounter forms documenting 12 visits for families with one or fewer high-need characteristics and 24 visits for families with two or more high-need characteristics.

Measure B.2.3.2: Number of completed home visit encounter forms documenting parent-child activities, progress notes, and family well-being.

Measure B.2.3.3: One or more identified goals documented on the goal tracking sheet and in the data system for every PAT family.

Objective B.2.4: By June 2018, re-establish an infant/children's mental health program.

Strategies:

- A. Assess community need for behavioral health services for infants and children.
- B. Explore behavioral health requirements for contract with Optum.
- C. Identify protocols for referral to program services.

Measure B.2.4.1: Hiring of licensed staff to implement program.

Measure B.2.4.2: Identification of operational procedures for program implementation and billing.

Measure B.2.4.3: Establishment of list of community mental health providers willing to act as a referral source for program.

Measure B.2.4.4: Number of Medicaid children served by infant/children's mental health program.

Objective B.2.5: By June 2018, provide administrative and PSE change technical support to the Region 4 Behavioral Health Board (R4BHB).

Strategies:

- A. Attend R4BHB Executive Committee and regular Board meetings.
- B. Promote and provide PSE change technical support as needed during Executive Committee and regular Board meetings.
- C. Provide strategy and sustainability expertise as needed during Executive Committee and Board meetings.

Measure B.2.5.1: Number of Executive Committee and Region 4 Behavioral Health Board meetings attended.

Measure B.2.5.2: Number of opportunities to provide PSE change technical assistance.

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

Objective B.3.1: By June 2022, increase the awareness and utilization of CDHD oral health services by 6% from a FY-17 benchmark of 2,424 practices and individuals.

Strategies:

- A. Provide outreach information to area dentists on oral health services offered by CDHD.
- B. Provide preventive oral health education to children ages 0 to 5 and their caregivers.
- C. Provide fluoride varnish to at-risk children ages 0 to 5.

Measure B.3.1.1: Number of dental practices receiving information on CDHD dental services.

Measure B.3.1.2: Number of children and adults receiving oral health education (FY-17, Qtr. 3 average is 1,643 adults and children).

Measure B.3.1.3: Number of fluoride varnish applications to children ages 0 to 5 (FY-17, Qtr. 3 average is 781 children).

Objective B.3.2: By June 2018, maintain partnerships with four to eight schools in Public 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) or the Community Eligibility Provision (CEP), or that have difficulty accessing dental care in their community.
- 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 schoolchildren participating in school-based sealant clinics.
- E. Apply sealants to children meeting criteria for sealant application.

Measure B.3.2.1: Number of school partnerships established or maintained to provide school-based sealant clinics.

Measure B.3.2.2: Number of children participating in school-based sealant clinics.

Measure B.3.2.3: Number of children receiving sealants.

Measure B.3.2.4: Total number of sealants applied.

Goal B.4: Improve the nutritional health of Public Health District 4 clients receiving preventive health services.

Objective B.4.1: Through June 2022, increase the number of PHS clients referred for appropriate nutritional intervention beyond the baseline of FY-18.

Strategies:

- A. Provide nutrition counseling in accordance with existing WIC policies and procedures.
- B. Provide breastfeeding support to WIC participants through the use of peer counselors.

Measure B.4.1.1: Number of WIC clients referred to a registered dietitian for nutritional counseling.

Measure B.4.1.2: Number of WIC clients contacted by a breastfeeding peer counselor for support.

Objective B.4.2: By June 2022, increase WIC participation to 97% or greater of annual funded contract caseload.

Strategies:

- A. Implement the Local Agency Nutrition Education Outreach Plan of activities for increasing caseload.
- B. Work collaboratively with the CDHD public information officer to identify targeted outreach efforts.
- C. Participate in local, state, and national discussions on caseload.
- D. Explore enrollment versus participation disparity.

Measure B.4.2.1: Percentage of WIC participants.

Goal B.5: Participate in evolving Idaho’s health care delivery system from a fee-for-service, volume-based system to a value-based model of care based on improved health outcomes.

Objective B.5.1: By June 2018, convene and facilitate bi-monthly Central Health Collaborative meetings.

Strategies:

- A. Maintain stakeholder’s participation on the Central Health Collaborative.
- B. Identify two Central Health Collaborative initiatives.
- C. Facilitate the Central Health Collaborative and set meeting schedules.
- D. Review Regional Community Health Needs Assessment and other available data sources to identify key public health initiatives.
- E. Continue to develop and maintain a strategic plan for the Central Health Collaborative.
- F. Report progress to CDHD leadership team and Board of Health, DHW subgrant managers, and community stakeholders.

Measure B.5.1.1: Number and type of stakeholders participating on the Central Health Collaborative.

Measure B.5.1.2: Number of meetings held.

Measure B.5.1.3: Number and type of initiatives identified.

Objective B.5.2: By June 2018, increase the number of primary care practices seeking national PCMH (Patient-Centered Medical Home) recognition.

Strategies:

- A. Support primary care practices identified by IDHW to participate in the PCMH recognition process.
- B. Provide technical assistance to primary care practices currently seeking or maintaining national PCMH recognition.
- C. Report progress to CDHD leadership team and Board of Health, DHW subgrant managers, the regional health collaborative, and community stakeholders.

Measure B.5.2.1: Number of primary care practices receiving technical assistance.

Measure B.5.2.2: Number of primary care practices pursuing PCMH recognition.

Measure B.5.2.3: Number of primary care practices achieving or maintaining their PCMH recognition.

Objective B.5.3: By June 2018, work with community partners to launch a Pathways Model initiative to establish a comprehensive approach to integrate clinical and community care.

Strategies:

- A. Establish and convene a stakeholder group of various agencies and community partners to advise in the development of the Pathways HUB Model.

- B. Establish meeting schedule for the Pathways HUB advisory group.
- C. Develop a strategic plan for the Pathways HUB advisory group.
- D. Collaborate with SHIP Patient-Centered Medical Home (PCMH) clinics to establish best-practices for facilitating referrals and communication between primary care PMCH clinics and the Pathways HUB.
- E. Report progress to CDHD leadership team and Board of Health, DHW subgrant managers, and community stakeholders.

Measure B.5.3.1: Number and type of stakeholders participating on the Pathways HUB advisory group.

Measure B.5.3.2: Number of meetings held.

Measure B.5.3.3: Number and type of initiatives identified within strategic plan.

Objective B.5.4: By June 2021, implement a new EMR (electronic medical record) system in PHS.

Strategies:

- A. Partner with Southwest District Health to form a workgroup to explore possible EMR systems.
- B. Work with PHS and IT staff to identify key elements of a new EMR system.

Measure B.5.4.1: Identification of priority components of an EMR for CDHD use.

Measure B.5.4.2: Identification of potential EMR system(s) for use in PHS.

Goal B.6: Participate in Idaho's response to the opioid epidemic through education, planning, training, and evaluation.

Objective B.6.1: By August 2017, two physician champions engage in contacts with professional organizations, clinic practices, or individual providers and provide education and technical assistance on opioid misuse and abuse.

Strategies:

- A. Identify or recruit two physician champions currently licensed in Idaho to assist in education and engagement in the provider community.
- B. Physician champions provide presentations or education at large group meetings, clinic huddle meetings, live webinars, brown bag lunches, medical lectures, or one-on-one meetings.
- C. Report progress to CDHD leadership team, Board of Health, and DHW subgrant managers.

Measure B.6.1.1: Signed contract from each physician champion.

Measure B.6.1.2: Number of educational contacts made by the physician champions.

Measure B.6.1.3: Number of attendees participating in meetings, presentations, and trainings.

Objective B.6.2: By August 2017, promote use of developed provider toolkit and active use of the Idaho Prescription Monitoring Program to at least ten primary care clinics.

Strategies:

- A. Develop a provider toolkit for educational use.
- B. Provide education and assistance to clinics and providers.
- C. Report progress to CDHD leadership team, Board of Health, and DHW subgrant managers.

Measure B.6.2.1: Number of clinics where education and assistance were provided.

Measure B.6.2.2: Type of clinic where education and assistance were provided.

Strategic Priority: Health Protection

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

Goal C.1: Prevent cases and outbreaks of vaccine-preventable diseases in Public Health District 4.

Objective C.1.1: Through June 2018, maintain at least 90% of 0- to 24-month-old PHS clients are up-to-date and late up-to-date by 35 months on ACIP-recommended immunizations.

Strategies:

- A. Conduct immunization assessments on all children between the ages of 0 and 24 months who are active WIC or PAT participants.
- B. Offer same-day or future immunization appointments at WIC visits.
- C. Refer PAT-enrolled children to CDHD for immunization services.
- D. Provide semiannual trainings to WIC staff on immunizations and recommended ACIP schedule.

Measure C.1.1.1: Percentage of 0- to 24-month-old clients who are up-to-date and late up-to-date by 35 months on ACIP-recommended immunizations.

Objective C.1.2: By June 2018, increase the percentage of PHS clients age 11 to 19 years receiving CDHD services who are up-to-date and late up-to-date on ACIP-recommended immunizations to 85%.

Strategies:

- A. Provide targeted outreach to teens and providers for ACIP-recommended immunizations. Send immunization reminder cards to clients' homes.
- B. Schedule next immunization appointment for follow-up doses at current appointment.
- C. Provide education on preventive aspect of immunizations to target group.

Measure C.1.2.1: Percentage of youth age 11 to 19 years who are up-to-date and late up-to-date for Tdap.

Measure C.1.2.2: Percentage of youth age 11 to 19 years who are up-to-date and late up-to-date for meningococcal.

Measure C.1.2.3: Percentage of youth age 11 to 19 years who received one dose of HPV.

Measure C.1.2.4: Percentage of youth age 11 to 19 years who received two doses of HPV.

Objective C.1.3: By June 2022, decrease rates of missing or incomplete immunization records to below 7%, as measured at the county level, among kindergarten, 1st grade, and 7th grade students enrolled in Public Health District 4 schools.

Strategies:

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

Measure C.1.3.1: CDHD total missing and incomplete rate in K, 1st, and 7th grades.

Measure C.1.3.2: Ada County total missing and incomplete rate in K, 1st, and 7th grades.

Measure C.1.3.3: Boise County total missing and incomplete rate in K, 1st, and 7th grades.

Measure C.1.3.4: Elmore County total missing and incomplete rate in K, 1st, and 7th grades.

Measure C.1.3.5: Valley County total missing and incomplete rate in K, 1st, and 7th grades.

Goal C.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 Public Health District 4 residents.

Objective C.2.1: By June 2022, increase the percentage of persons infected with CT/GC/syphilis who return for retesting three months after treatment by 5% above FY-17 baseline for CT (29%); GC (20%); and syphilis (18%).

Strategies:

- A. Educate all clients, at time of treatment, regarding the need for abstinence for required timeframe and the need for partners to be 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 as needed.

Measure C.2.1.1: Number of treated CT-positive clients who return to clinic for retesting at three months.

Measure C.2.1.2: Number of treated GC-positive clients who return to clinic for retesting at three months.

Measure C.2.1.3: Number of syphilis-positive clients who were treated and return to clinic for retesting at six months.

Objective C.2.2: By June 2019, increase testing and/or preventive treatment to 90% among notifiable partners in GC, syphilis, and HIV investigations.

Strategies:

- A. Develop clinical scheduling strategies to minimize obstacles to care for partners of people with lab-confirmed infections.
- B. Provide incentives for CDHD clinic visits for partners of known (GC and syphilis cases) positives.

Measure C.2.2.1: Number/percentage of notifiable GC partners with testing and/or preventive treatment documented on field record.

Measure C.2.2.2: Number/percentage of notifiable syphilis partners with testing and/or preventive treatment documented on field record.

Measure C.2.2.3: Number/percentage of HIV notifiable partners with testing documented on field record.

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

Objective C.3.1: By June 2020, decrease occurrence of cold holding, clean food contact surfaces, and handwashing facility violations observed in CDHD-inspected food establishments.

Strategies:

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

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

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

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

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

Objective C.3.2: By June 2020, decrease the risk of ground water and surface water contamination resulting from onsite wastewater permitting.

Strategies:

- A. Assure drain fields are constructed to maintain specified separation from limiting layers.
- B. Assure drain fields are constructed to maintain specified separation from surface water.
- C. Encourage the use of nutrient-reducing systems when appropriate.
- D. Annually train CDHD land development staff on the latest version of the statewide sewage program SOP (standard operation procedures) manual.
- E. Educate homeowners on proper landscaping near septic tanks and drain fields.
- F. Respond to sewage on the ground complaints within 48 hours of notification.
- G. Resolve sewage on the ground complaints within 30 days.

Measure C.3.2.1: Percentage of sewage permits issued in conformance with Idaho sewage rules.

Measure C.3.2.2: Number of staff trainings focused on the sewage SOP.

Measure C.3.2.3: Number of homeowners educated on proper landscaping near septic tanks and drain fields.

Measure C.3.2.4: Percentage of sewage permits issued for nutrient-reducing systems.

Measure C.3.2.5: Percentage of sewage on the ground complaints responded to within 48 hours.

Measure C.3.2.6: Percentage of sewage on the ground complaints resolved within 30 days.

Objective C.3.3: By June 2020, decrease risk factors for recreational water-related illness.

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

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

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

Measure C.3.3.4: Percentage of regulated pools utilizing UV or equivalent advanced treatment.

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

Objective C.4.1: By June 2018, complete and score the MCM (Medical Countermeasure) ORR (Operational Readiness Review) assessment tool.

Strategies:

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

Measure C.4.1.1: Completion of updated plan.

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

Objective C.4.2: By June 2018, complete annual 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 C.4.2.1: Completion of quarterly exercises and/or trainings and annual full-scale exercise.

Measure C.4.2.2: Evaluation and implementation of improvement plans of associated exercises.

Objective C.4.3: By June 2018, 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).
- C. Conduct HAN (Health Alert Network exercise, including new pharmacies).

Measure C.4.3.1: Establishment of baseline plan to ensure safety of vulnerable populations in emergency response.

Measure C.4.3.2: Number of pharmacies included on the CDHD HAN list.

Measure C.4.3.3: Completion of HAN exercise, including new pharmacies.

APPENDIX A

Idaho's Public Health District 4

