



CENTRAL
DISTRICT
HEALTH
DEPARTMENT

Strategic Plan 2017 - 2021



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 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 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 2017 through 2021. 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 2017, 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 1.1.1: Number of community meetings attended to promote PANT PSE change.

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

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

Objective 1.2: By June 2017, 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 change 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 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 2017, provide education and technical assistance on PANT PSE change to at least 25 child care providers.

Strategies:

- A. Promote model PANT PSE change based on best practices through Let's Move! Child Care (LMCC) 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. Implement the classroom-based Healthy Initiatives trainings for licensed child care providers in Boise through September 2016.
- E. Develop and implement an online version of the Healthy Initiatives trainings for licensed child care providers in Boise beginning October 2016.
- F. Report progress to CDHD leadership team, Board of Health, County Commissioners, and community stakeholders as requested.

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

Measure 1.3.2: Number of child care providers attending classroom-based Healthy Initiatives Trainings.

Measure 1.3.3: Number of child care providers reporting changes made to policies and practices as a result of the LMCC Workshops.

Objective 1.4: By June 2017, 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 Community Planning Association of Southwest Idaho (COMPASS) 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.
- 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 1.4.1: Number of community meetings attended to promote active transportation and/or health in all policies approaches.

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

Goal 2: Provide tobacco cessation resources to target populations.

Objective 2.1: By June 2017, serve 250 participants in tobacco cessation classes.

Strategies:

- A. Provide tobacco cessation resources to target 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 and pharmacy outreach to increase referrals into tobacco cessation programs.
- D. Provide in-services to increase staff skills in referring/enrolling tobacco users into cessation services.

Measure 2.1.1: Number of participants in tobacco cessation classes.

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

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 2.2.1: Percentage of tobacco users among established 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: Through June 2021, maintain the percentage of WIC children ages 2 to 5 who are classified as obese at less than or equal 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: Through June 2021, maintain the percentage of WIC children ages 2 to 5 who are overweight at less than or equal to 7%.

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 2021, maintain the percentage of WIC participants who breastfeed at least six months at greater than or equal to 45%.

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 2021, maintain the percentage of WIC participants who exclusively breastfeed at least six months at greater than or equal 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 2021, 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.

B. Develop a plan to implement weight management interventions.

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.

Measure 3.5.3: Plan for implementation of weight management interventions.

Objective 3.6: By June 2021, reduce the percentage of established reproductive health clients with a body mass index (BMI) greater than 30 by 3% from a baseline of 26%.

Strategies:

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

Measure 3.6.1: Number of clients with serologic assessment for dyslipidemia at preventive health visit.

Measure 3.6.2: Completion and implementation of reproductive health nursing and clinician staff training in the 5-A model for improving nutrition and exercise anticipatory guidance.

Measure 3.6.3: Percentage of clients with BMIs greater than 30.

Measure 3.6.4: Report of findings on reimbursement sources for medical nutrition therapy.

Measure 3.6.5: 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 2020, increase percentage of WIC clients who state an awareness of reproductive health services available at CDHD from a Boise office 2015 baseline of 46% to 51%.

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 2021, implement outreach activities regarding healthy relationships to all eight secondary schools in rural communities served by CDHD.

Strategies:

- A. Determine the subject matters or activities related to healthy relationships with which school administrators/teachers 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: Number of participating rural secondary schools of the eight eligible.

Objective 1.3: Through June 2020, offer first and second tier contraceptive methods, when medically appropriate, to all clients utilizing Title X funding, as recommended by the CDC and Office of Population Affairs guideline, "Providing Quality Family Planning Services."

Strategies:

- A. Assure adequate supply of first and second tier contraception to meet clinic demand.
- B. Engage in social marketing strategies to raise awareness of reproductive health services at CDHD, including contraceptives, especially targeting vulnerable populations.
- C. Assure adequate staffing to meet community need and staff training on contraceptive medical eligibility and contraceptive counseling using a tiered approach and method provision.
- D. Conduct yearly report on contraceptive utilization with a goal of 80% of clientele who will be prescribed a first or second tier contraceptive method.

Measure 1.3.1: Creation and implementation of pharmacy spreadsheet with contraceptive budget and methods ordered.

Measure 1.3.2: Types of social marketing tools utilized.

Measure 1.3.3: Creation and implementation of clinic efficiency tools to analyze client wait time for appointments.

Measure 1.3.4: Completion and documentation of staff training on contraceptive education with emphasis that contraceptive uptake must be completely voluntary and without coercion.

Measure 1.3.5: Family Planning Annual Report findings.

Objective 1.4: Through June 2021, promote and offer reproductive life planning (RLP) technical assistance to 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 1.4.1: Number of practices that are offered technical assistance.

Measure 1.4.2: Number of practices that complete the training on yearly report.

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

Objective 2.1: By June 2021, increase client awareness of effects of domestic and sexual abuse or coercion on health and wellbeing.

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 2.1.1: Percentage of clientele with positive response of past or current history of physical/sexual abuse or coercion.

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.

Objective 2.2: Through June 2018, ensure that at least 80% of PAT families participate in services for longer than 12 months.

Strategies:

- A. Provide initial incentives for families entering the PAT program and then again at a six-month interval and twelve-month interval.
- B. Conduct outreach to community agencies that serve children under age two in order to enroll families that will qualify for services for longer than twelve months.

Measure 2.2.1: Percentage of PAT families who participate in services for longer than twelve months.

Objective 2.3: By June 2017, provide infant mental health services to 50 families in Ada and Elmore Counties.

Strategies:

- A. Provide initial incentives for families entering the PAT program and then again at a six-month interval and twelve-month interval.

Measure 2.3.1: Number of families served.

Objective 2.4: By June 2017, provide administrative and PSE change technical support to the Region 4 Behavioral Health Board.

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. Report progress to CDHD leadership team, Board of Health, County Commissioners, and community stakeholders as requested.

Measure 2.4.1: Number of Executive Committee and Region 4 Behavioral Health Board meetings attended.

Measure 2.4.2: Number of opportunities to provide PSE change technical assistance.

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

Objective 3.1: Through June 2021, maintain dental caries rate at less than 8% 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.

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.

Objective 3.2: By June 2017, maintain partnerships with 4 to 8 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) 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 3.2.1: Number of school partnerships established or maintained to provide school-based sealant clinics.

Measure 3.2.2: Number of children eligible for dental screening.

Measure 3.2.3: Number of children participating in school-based sealant clinics.

Measure 3.2.4: Number of children receiving sealants.

Measure 3.2.5: Number of sealants applied.

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

Objective 4.1: Through June 2016, maintain the health of children receiving WIC services by keeping the overall low hemoglobin rate at or below 7%.

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 7%.

Objective 4.2: By June 2017, increase WIC participation to 97% of contract caseload based on FFY-2017.

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.

Goal 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 5.1: By June 2017, convene and facilitate 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 schedule.
- D. Review Regional Community Health Needs Assessment and other available data sources to identify key public health initiatives.
- E. Create 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 5.1.1: Number and type of stakeholders participating on the Central Health Collaborative.

Measure 5.1.2: Number of meetings held.

Measure 5.1.3: Number and type of initiatives identified.

Objective 5.2: By June 2017, increase the number of primary care practices seeking national Patient-Centered Medical Home (PCMH) 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 national PCMH Recognition, or maintaining or advancing the PCMH Recognition Level.
- C. Report progress to CDHD leadership team and Board of Health, DHW subgrant managers, the regional health collaborative, and community stakeholders.

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

Measure 5.2.2: Number of primary care practices pursuing PCMH Recognition.

Measure 5.2.3: Number of primary care practices achieving PCMH Recognition or maintaining or advancing their PCMH Recognition.

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 2017, maintain at least 95% of 0- to 24-month-old WIC clients are up-to-date and late up-to-date by 35 months 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 and late up-to-date by 35 months on ACIP-recommended immunizations.

Objective 1.2: By June 2017, maintain at least 85% of CDHD clients between 0 and 24 months of age are up-to-date and late up-to-date by 35 months on ACIP-recommended immunizations.

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 0- to 24-month-old clients who are up-to-date and late up-to-date by 35 months on ACIP-recommended immunizations.

Objective 1.3: By June 2020, 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 and late up-to-date on 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, 1st grade, and 7th 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, 1st, and 7th grades.

Measure 1.4.2: Ada County total missing and incomplete rate in K, 1st, and 7th grades.

Measure 1.4.3: Boise County total missing and incomplete rate in K, 1st, and 7th grades.

Measure 1.4.4: Elmore County total missing and incomplete rate in K, 1st, and 7th grades.

Measure 1.4.5: Valley County total missing and incomplete rate in K, 1st, and 7th grades.

Objective 1.5: By June 2020, ensure that 50% of clinics currently participating in CDHD's Provider Immunization Education and the Central District Health Department Immunization Reminder System (CIRS) 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: 4:3:1:3:3:1) for 0 to 24 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 Ada, Boise, Elmore, and Valley Counties who participate in the Vaccines for Children (VFC) program to a goal of 20 practices enrolling.

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 are trained to provide education.
- D. Offer educational classes at convenient times and locales.

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 2021, increase by 2%, the percentage of persons infected with CT/GC/syphilis who will return for re-testing three months after treatment from a baseline of CT (34%); GC (28%); and syphilis (17%).

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 if possible.

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

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

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

Objective 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 access quick care for partners for documented positives.
- B. Incentivize CDHD clinic visits for partners of known (GC and syphilis cases) positives.

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

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

Measure 2.2.3: Number/percentage of HIV notifiable partners with testing 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 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 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 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 standard operation procedures manual (SOP).
- 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 3.2.1: Percentage of sewage permits issued in conformance with Idaho sewage rules.

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

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

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

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

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

Objective 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 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.

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

Objective 3.4: Through June 2020, decrease avoidable bat exposures based on information available in CDHD records.

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 2016, 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 June 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 and/or trainings.

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

Objective 4.3: By June 2017, 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 exercise including new pharmacies.

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

Measure 4.3.2: Number of pharmacies included on CDHD health alert network list.

Measure 4.3.3: Completion of HAN exercise including new pharmacies.

APPENDIX A

Idaho's Public Health District 4

